UPMC LIFE CHANGING MEDICINE

UPMC Health Plan

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U.S. Department of Labor
Room N-5655
200 Constitution Avenue, NW
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Submitted electronically via www.regulations.gov

Re: Definition of Employer—Small Business Health Plans (RIN 1210-AB85)

UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division (collectively, "UPMC") are pleased to submit the following comments in response to the Employee Benefits Security Administration (EBSA or the "Department") Proposed Rule regarding changes to the definition of "employer" under Section 3(5) of ERISA to expand allowances for Association Health Plans (AHPs), as published in the Federal Register on January 5, 2018 (the "Rule").

UPMC is pleased to offer a full range of commercial individual and group health insurance, Medicare Advantage (MA), Medicare Special Needs Plans (SNPs), CHIP, Medicaid, behavioral health, dental, vision, employee assistance and workers' compensation coverage products. Since beginning operations in 1996, UPMC has been recognized for its dedication to quality and the provision of outstanding customer service across its product lines, which collectively provide commercial and government programs coverage to more than 3 million members. UPMC has offered consumers a variety of coverage options as a Qualified Health Plan (QHP) issuer since the launch of the Marketplace in 2014, and currently provides coverage to approximately 145,000 Marketplace enrollees. In several Pennsylvania counties, UPMC is the only QHP issuer currently offering a product through the Marketplace.

We thank EBSA for affording issuers and other stakeholders an opportunity to comment on anticipated changes to the definition of "employer" under ERISA, and specifically on the Agency's proposed expansion of AHPs. UPMC supports EBSA in its efforts to provide increased flexibility and coverage options for employers, while also ensuring the stability and long-term viability of existing small group and individual insurance markets. It is with this support in mind that we respectfully offer for your consideration the following comments.

1. Effective Date

While the Rule does not include an expected effective date for its implementation, the scale of its proposed changes and potential market impact (as further discussed herein) call for a measured implementation date that provides both employers and issuers adequate opportunity to plan for and implement the new market rules. Large group health plan contracts, and particularly those that include custom benefits or incorporate complex and novel provisions, can take as long as 24 months to create, negotiate, and adopt in time for orderly enrollment in, and the timely provision of, plan benefits. The Rule includes a variety of provisions and operational implications that suggest final regulations will make AHP coverage a unique product that requires substantial contract and document customization; any attempt to rush such a product into the market without thorough review could inadvertently be a disservice to the very small businesses that the Rule seeks to support. In addition, the Rule's proposals are likely to have implications for the individual and small group markets at large, which both issuers and regulators will need time to evaluate. We strongly recommend that any AHP proposal be implemented no sooner than January 1, 2020.

2. State Oversight and Market Integrity

The Rule seeks feedback regarding the implications of, and any recommendations for, a variety of policies that could limit the ability of State regulators to exercise effective oversight of AHPs operating within their borders (e.g., more fully exempting self-funded MEWAs from State regulation), and also solicits comments on the manner in which AHPs might appropriately be differentiated from other group market products (e.g., by freely age rating their membership or offering less comprehensive policies). Uniform coverage standards and effective regulatory oversight are fundamental to the long-term stability of any insurance market. While the nature of coverage standards and the level of regulation may be appropriate matters of discussion and flexibility, we suggest to you that uniformity and efficacy are not. State regulators have long been the arbiters of their insurance markets, and many, including Pennsylvania, have a well-established history of ensuring the existence of functional insurance markets while also representing and protecting insurance consumers from harm; these functions become much more difficult in the face of unregulated insurance products that further fragment existing risk pools. In order to avoid inadvertently and unsustainably increasing costs for the individual and small group markets at large, we think it critical that AHPs be positioned to operate on a level playing field with other forms of group coverage. This should include being subject to State regulation, oversight, and filing requirements of the State in which the AHP has a plurality of its membership, and should also include prohibitions against varying rates based on age, geography, or gender in a manner that increases costs or threatens market stability. We respectfully urge the Department to adopt such standards, and any other standards implied by a "level playing field" approach to the group market, in final rulemaking.

3. **Expanding the Definition of "Employer" to Include Sole Proprietors and Working Owners (29 CFR 2510.3-5(a) and (e))**

Under current guidance, a legal entity, including one established by a sole proprietor and/or a working owner, is included in the relevant ERISA definition of "employer" only when the subject business has employees other than the owner(s) and their spouse(s). The Rule would modify this historical limitation by allowing sole proprietors and/or working owners to be treated as both employers and employees for purposes of participating in, and being covered by, a group health plan (whether via an association or otherwise). We support the Department's fundamental goal of expanding health coverage options for small businesses, but are concerned that the proposed approach is unduly disruptive. The proposed definition of "employer" is fundamentally inconsistent with ERISA's statutory language and, if implemented, is likely to create additional inconsistencies with group health plan (GHP) rules under the Public Health Service Act (PHSA). As proposed, owners without employees (and issuers providing their coverage) would be subject to individual market rules under the PHSA but group market rules under ERISA. In addition, we believe that other such inconsistencies are likely to arise under current State law or regulation with respect to both group health coverage and associations, resulting in a confounding patchwork of market rules and authorities that will sow confusion in many markets, raise administrative costs, and risk creating untenable regulatory and compliance conflicts that have no clear resolution. We respectfully urge the Department the withdraw the proposed definition of "employer," and to engage stakeholders in a collaborative effort to discuss ways in which issuer flexibility and individual market stabilization efforts (e.g, a Federally-sponsored reinsurance program) can achieve the goal of increasing affordable coverage options for sole proprietors and working owners without a significant risk of disruption.

In the event that the Department is nonetheless compelled to adopt its proposed definition in final rulemaking, we respectfully recommend that the Department incorporate the following principles into any final rule.

(i) In order to claim status as an employer for purposes of a group health plan, a sole proprietor or working owner must:
   a. Not be eligible to participate in *any* group health plan maintained by his/her employer or the employer of his/her spouse, and must not be eligible for coverage under Medicare; and
   b. Work in furtherance of his/her subject business in a full-time capacity.

(ii) In order to claim status as an employer for purposes of participating in an association, a sole proprietor or working owner must:
   a. Satisfy existing Internal Revenue Service criteria for recognition as a business (rather than as a "hobby"); and

b. Satisfy similar criteria applied by the State in which they are domiciled (e.g., the Pennsylvania "Business or Profession" and "Commercial Enterprise" tests).

(iii) State regulators should be expressly authorized to directly enforce the requirements of (i) and (ii).

We believe that these commonsense requirements are necessary to ensure the integrity of the new group health plan market that would be established by the Rule, while still advancing the Department's interest in expanding coverage options for legitimate small businesses.

4. The "Commonality of Interest" Test (29 CFR 2510.3-5(c))

Current guidance requires an AHP to be established by a *bona fide* association. This test uses a somewhat flexible "facts and circumstances" analysis that includes, among other factors, requirements for a "commonality of interest," sometimes also referred to as an "organizational nexus," intended to evaluate the legitimate business and organizational purposes, other than pooling insurance risk, of asserting an association relationship. The Rule would dramatically reduce the level of underlying shared interest or inter-member relationship required to assert association status, and would allow a diversity of employers to claim such status based merely on their participation in the "same trade, industry, line of business, or profession." We acknowledge the Department's intention to reduce barriers to the formation of associations, but are concerned that the Rule goes beyond facilitating associations and, by adopting the foregoing broad and amorphous criteria, all but eliminates the historical requirements of a legitimate, shared economic or organizational interest among association members. The wholesale elimination of historical criteria in this regard risks inadvertently creating a marketplace that is ripe for the establishment of specious or fraudulent associations that, under limited State oversight, could lead to deleterious financial consequences for participating small businesses; indeed, minimally regulated AHPs and Multiple Employer Welfare Arrangements (MEWAs) have a well-established history of fraud and insolvency.[1] We respectfully urge the Department to withdraw the proposed "commonality of interest" test, and to engage with State regulators and insurers to evaluate the manner in which the current *bona fide* association criteria could reasonably be expanded without an increased risk of fraud or associated financial losses among small employers and the group health plan market at large.

In the event that the Department nonetheless adopts the new "commonality of interest" test in final rulemaking, we respectfully recommend that any such final rule incorporate the following principles.

[1] *See* Kofman, Mila, "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud." Georgetown University Health Policy Institute (2005).

(i) To promote protections and reduce fraud for both member employers and plan participants, AHP-sponsoring organizations should be required to annually distribute written notices that describe the association (e.g., its governance and domicile), describe any other rights and responsibilities of AHP members or participants, and provide appropriate contact information for both the association and regulators who can assist consumers; and

(ii) To ensure adequate State oversight and protection for small businesses, AHPs should be limited to pooling member employers within the boundaries of a State; and

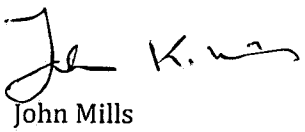
(iii) Formation of an AHP based on a geographic area other than a State or county (e.g., a metropolitan area) should not be permitted until the impact of the new "commonality of interest" test can be more fully evaluated. If "metropolitan area" AHPs are permitted, the Department should:

   a. Adopt defined geographies based on the U.S. Census Metropolitan Statistical Area (MSA) designation; and
   b. Establish an independent task force to resolve issues of interstate regulation and oversight among impacted States.

Given the referenced storied history relative to minimally regulated associations, we believe the foregoing principles will help provide small businesses with reasonable protections against fraud and financial loss, while still advancing the Department's goal of increased participation in AHPs.

We again thank the Department for affording issuers and other stakeholders the opportunity to provide input on proposed changes to the group health plan and association health plan market rules. We appreciate your consideration of these comments and look forward to continued collaboration with CMS in the future.

Respectfully Submitted,



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