WORLD FLOOR COVERING ASSOCIATION
Simplify Your Success

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Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655,
U.S. Department of Labor
200 Constitution Avenue NW, Washington, DC 20210
Attention: Definition of Employer – Small Business Health

Re: Proposed Regulation on Association Health Plans, RIN 1210-AB85

Dear Sir or Madam:

The World Floor Covering Association ("WFCA" or "Association") welcomes the opportunity to submit these comments in response the U.S. Department of Labor's Proposed Regulation to broaden the definition of employer to expand the use of association health plans. 83 *Federal Register* 614 (January 5, 2018). The WFCA supports the Department's goal of easing the barriers to association health plans ("AHP") to expand the availability of group health insurance coverage, particularly for smaller businesses and their employees. The Association, however, believes that some modifications are needed to ensure the success and viability of AHPs.

The WFCA focuses its comments on: (1) organizational requirements to ensure opportunities to offer AHPs, while minimizing the risks that have historically plagued multiple employer association health plans; (2) clarification and simplification of the regulatory structure that has limited AHPs in the past; and (3) clarification of the nondiscrimination rule to ensure an AHP can meet the needs of its members.

I. The World Floor Covering Association

The WFCA is a national trade association organized under section 501(c)(6) of the Internal Revenue Code.[1] WFCA's members include flooring retailers, commercial contractors, restoration contractors, and inspectors.[2] WFCA members operate over 1,130 retail-flooring stores nationwide. In addition, WFCA has an installer division, the Certified Flooring Installers ("CFI"), which provides education and training for flooring installation. CFI has trained tens of

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1 26 U.S.C.§501(c)(6).

2 The WFCA membership also included flooring manufactures, flooring distributors and other companies involved in the flooring industry as associate members.

thousands of installers, and the CFI division has over 1,100 active members, most of whom operate as small businesses.

The WFCA provides information and training to its members and supports other organizations that provide training to entities involved in the flooring industry. The WFCA represents its members' interests before Congress, state legislative bodies and federal and state agencies. The WFCA also provides its members with information regarding federal and state legislation and agency action. The WFCA acts by consensus through a Board of Directors elected by its members and collects data from its members to develop information regarding legislation and agency matters.

II. The Average Retail Flooring Dealer and Installer

National statistics indicate that the average retail-flooring store is a small business. According to the most recent North American Industry Classification System (NAICS) report from Census Bureau, there were 14,031 retail-flooring firms in 2015.[3] Revenues for the industry were $19.754 billion in 2016, the last year in which a full report is available.[4] Applying those statistics, the average retail-flooring store had total sales of $1,407,883 in 2016. According to The Retail Owner's Institute, the average pre-tax profit margin for retail flooring stores in 2016 was 3.5%.[5] Applying that profit margin to 2016 sales, the pre-tax profits for the average retail store would be only $49,276 in 2016. These margins leave little room for a flooring dealer to buy health insurance for themselves or their employees at the current rates.

The vast majority of flooring installers are also small businesses. According to the 2015 NAICS report, there were 14,435 flooring contractors with 96% having 20 or fewer employees.[6] The average flooring installer makes $45,250.00 a year.[7] As with the flooring retailer, installers often simply cannot afford to buy health insurance for themselves at the current rates. These small businesses and their employees need to have access to affordable health insurance and expanding the availability of AHPs can significantly expand their options.

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3 U.S. Census Bureau, NAICS code 442210 (Floor Covering Stores) *Number of Firms, Number of Establishments, Employment, Annual Payroll, and Estimated Receipts by Enterprise Employment Size for the United States, All Industries: 2015*.

4 *Id.*

5 The Retail Owner's Institute Benchmark, Pre-Tax Profit Trends, Floor Covering Stores (2017)

6 U.S. Census Bureau, NAICS code 238330 (Flooring Contractors) *Number of Firms, Number of Establishments, Employment, Annual Payroll, and Estimated Receipts by Enterprise Employment Size for the United States, All Industries: 2015*.

7 *Id.*

III. The Current System Restricts the Development of AHPs

Employer sponsored health plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA). AHPs that are not self-insured are classified under ERISA as a Multiple Employer Welfare Arrangement ("MEWA"), subject to state insurance laws and regulations. States can regulate the underlying employer-health plan to the extent that the regulations are not inconsistent with ERISA. Moreover, the insurance companies that insure group health plans are subject to state insurance laws and regulations. As the Department recognized, however, the regulations covering AHPs have been narrowly interpreted and effectively allow only self-insured association plans. AHPs that are fully-insured have been held to be acting like an insurance agency and are "simply the mechanism by which each individual employer obtains benefits and administrative services for its own separate plan."[8] The result is that each employer was viewed independently and only the number of employees of each member was considered to determine if the AHP was a large or small group plan. Unless an AHP is treated as a single ERISA-covered plan that covers multiple employers and its employees across state lines, an association cannot offer the benefits of a large group plan to its members.

IV. Proposed Regulation

The proposed rule would allow associations to offer an employer sponsored plan even if fully-insured. A plan will no longer be seen as a mere "mechanism" for selling insurance.[9] Accordingly, the employees of all members of the association covered by the plan will be counted to determine if it is a large market plan. In addition, the proposed rule changes the definition of who qualifies as an employee to ensure owner/operators can come within the association's health plan. This change will offer real benefits to small flooring retailers and installers.

As more fully explained below, the WFCA believes that the proposed regulation needs some modifications and clarifications. First, the proposed regulation's definition of an association is overbroad and needs additional safeguards to ensure against fraudulent activity by groups formed solely to create an AHP. Second, the proposed regulation should allow professional associations made up of individual members, such as the American Bar Association and WFCA's CFI division, to be able to offer AHPs. Third, the proposed rule needs to specifically state that state health insurance laws and regulations are preempted for qualified AHPs.

A. Organizational Structure

A primary change in the proposed rule is the elimination of the requirement that a group have a purpose other than offering health care to its members. As the Department acknowledges,

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8 83 *Fed. Reg.* at 615.

9 *Id.*

this and other current requirements are the result of the all too frequent failure of prior AHPs "to pay promised health benefits to sick and injured workers while diverting, to the pockets of fraudsters, employer and employee contributions from their intended purpose of funding benefits."[10] Allowing, as in the proposed regulation, for a group to be formed for the sole purpose of creating an AHP eliminates this important protection against under-capitalized AHPs.

Many of these may be by for-profit organizations, whose motive is making money, not ensuring an association's members receive adequate health care coverage at a reasonable price. Such entrepreneurial AHPs would be little more than a commercial insurance arrangement that lacks a *bona fide* connection to employment. Yet, as the proposed regulation recognizes, employer sponsored plans must be distinguished form a "mere commercial insurance arrangement."[11] To allow entrepreneurial AHPs dilutes the *bona fide* ERISA employer sponsored plan.

While the proposed regulations recommend some measures to ensure such entrepreneurial AHPs are legitimate, WFCA is concerned they are inadequate. For example, the requirement that participating employers control the functions and activities of the association does little to ensure a group's plan is properly capitalized and the group is committed to offering long term coverage. Many small employers seeking health care coverage may not really care about the governance of the plan.

Accordingly, WFCA recommends that the regulation keeps the requirement that the organization have a purpose other than offering health care to its members. It is further recommended that the organization be a non-profit. Such trade and professional associations have established relationships with their members beyond health insurance. These non-profits offer programs and benefits beyond health insurance. They are controlled by their members for the benefit of their industries and professions. An established non-profit association would not risk its reputation and goodwill, and its other programs, by offering a substandard health plan. An entrepreneurial AHP, on the other hand, would be formed only to offer health insurance and failure would not impact the organization's other programs like an established non-profit association. Such entrepreneurial AHPs would operate only as long as it makes a profit. A non-profit association, on the other hand, is motivated to help its members and is more likely to ensure its AHPs continue to offer affordable health insurance coverage.

Limiting AHPs to non-profit organization would not adversely impact the potential availability of AHPs. There are a substantial number of organizations that could offer AHPs at both the national and local level. There are trade associations in virtually every industry. Local groups like Chambers of Commerce, local real estate organizations, and state associations would all be eligible to offer AHPs. To allow commercial groups to enter the market and fracture the market into a host of small AHPs would eliminate many of the benefits envisioned by the new

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10 *Id.* at 617.

11 *Id.* at 616-17.

regulation. The proposed rule recognizes this potential, and specifically raises the concern that, if the rules were too relaxed, the market benefits of creating large groups could be diluted and could even raise premiums.[12] To allow any group to form an entrepreneurial AHP would have the very impact the Department was concerned with—the dilution of the market and diminish the economies of scale that are a hallmark of the proposed rule's design to lower insurance costs through AHPs.

To the extent that both trade association-based plans and entrepreneurial health plans will be allowed, the regulation should distinguish between them. Non-profit organizations are regulated by the Internal Revenue Service ("IRS") to ensure they meet their non-profit purpose. An entrepreneurial health plan is not subject to the same scrutiny. Accordingly, an entrepreneurial health plan should have additional requirements, such as having increased capitalization and reserves, insurance coverage, greater oversight and similar mandates to ensure such plans viability.

B. Individual Professional Organizations

The wording in the proposed regulation appears to limit AHPs to organizations whose members are employers. There a many well established professional organizations whose members are individuals in that profession, such as the American Bar Association and National Association of Social Workers. WFCA's CFI division for flooring installers is just such a group. These members are often independent contractors so they are not eligible to obtain health insurance from the general contractors and retailers who contract with them for installation services. Many are solo practitioners and the vast majority are small businesses. The need for affordable health insurance is just as important to these professionals as to other small businesses.

The proposed regulation should be clarified to allow such professional association members to offer AHPs to their members. To clarify that individual membership organizations can offer AHPs, the proposed regulation need only to provide that any 501(c)(6) or 501(c)(3) non-profit organization can offer an AHP. The regulation should also clarify that an AHP offered by an individual membership association could also cover spouse and family, even if there the individual member has potential coverage though a spouse.

C. State Health Insurance Laws and Regulations

Under the current state regulatory system, a national association like WFCA, is unable to design and implement a single AHP plan that would comply with the requirements in all fifty states and the District of Columbia. To serve its members, WFCA would have to offer several different plans, at different costs and with escalating compliance requirements. To succeed, any

[12] *Id*. at 627-28.

national association would need relief from state regulations. The Secretary of Labor's exemption authority in ERISA section 514(b)(6)(B) could remove many of these obstacles.

States generally regulate two aspects of health insurance plans: 1) health coverage mandates; and 2) financial solvency requirements. For AHPs to achieve the efficiencies anticipated in the proposed regulation, the regulation needs to preempt state coverage mandates. Since the majority of AHPs would likely be fully insured, the proposed regulation needs to state that the AHP is the "employer" for the purposes of offering an ERISA health insurance.[13] The proposed regulation should then preempt state coverage mandates under the Secretary's ERISA exemption authority.

Even with the Secretary exercising his current exemption authority, there may still be state requirements that are not exempted. As a result, a national or multistate AHP may have to include benefits that vary from state-to-state to meet state requirements and regulations. The proposed regulation should specify that a fully-insured AHP whose benefits vary from state-to-state to meet state requirements and regulations will be still considered a single plan.

With regard to financial solvency mandates, state insurance regulations require insurance plans to maintain specified levels of reserves and/or contributions. The problem is that complying with fifty varying state mandates on coverage requirements will be problematic to the viability of AHPs that want to offer an AHP across state lines. The Department should consider allowing the home state of the fully-insured AHP to reasonably regulate the AHP, rather than having each state impose its own regulations. If the AHP meets its state's requirements, it should be treated like a self-funded plan, exempt from other state regulations. Allowing a single state control with a clear state preemption will allow AHPs to thrive and offer reasonably priced health insurance.

It is important to note that non-profit associations are already regulated by the IRS. Moreover, a nonprofit association has a commitment to its members that is often developed over decades. A nonprofit organization is motivated to help its members and the industry it serve. An AHP would be just one of many programs the association offers to help its members. As a result, an established non-profit association would not risk its reputation by offering a substandard health plan.

D. Non-Discrimination

WFCA agrees that nondiscrimination requirements are essential to the goals of the rule. WFCA, however, suggests a clarification that an AHP can offer different coverage and different prices based upon legitimate differences within an association's membership. An association should be able to create a plan that meets the need of its membership and any subsets of

[13] An AHP should not be characterized as a Multiple Employer Welfare Arrangement ("MEWA"). As explained above, the AHP should be considered the "employer" for the purposes of offering the health insurance

members. WFCA, for example, has distinct subgroups within its membership, including flooring retailers, installers, inspectors, and commercial contractors. Installers may want a health plan that has increased orthopedic coverage given that installers carry and install heavy flooring products. Similarly, a commercial flooring company may have different needs than that of a flooring retailer. The proposed regulation should specifically allow different coverage based on such legitimate differences in.

VI. Conclusion

WFCA supports the Department's goal of easing the barriers to AHPs, especially to allow access to affordable health insurance by small businesses. To protect against the fraud and mismanagement that plagued earlier AHP and MEWAs, WFCA recommends the following changes and clarification,

1. An organization offering an AHP should meet the following requirements:
    - Be established as a non-profit corporation with a federal tax exemption;
    - Was formed and maintained for purposes other than obtaining insurance;
    - Been operating for at least 5 years;
    - Offer programs, such as education/training programs, beyond an AHP;
    - Have adequate finances to meet its obligations, including adequate capitalization of an AHP;
    - Have a minimum of 50 members; and
    - Provide members with voting rights and participation in the direction and management of the association.
2. Individual member associations should be specifically included as an organization able to offer AHPs.
3. An AHP should be considered a single employer.
4. An association can offer different coverage at different price to meet the need of its members and any subset of members.
5. The Secretary exercise his exemption authority under ERISA and make clear that state health insurance laws and regulations are preempted to the fullest extent permissible.

On behalf of WFCA and its members, I appreciate this opportunity to comment on the expansion of AHPs and hope that the Department will address the issues raised in our comments and implement the suggested changes to the proposed regulation.

Respectfully Submitted,

Scott Humphrey

Gregory Scott Humphrey
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cc: Jeffrey King
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