March 6, 2018

The Honorable Preston Rutledge
Assistant Secretary of Labor
Employee Benefits Security Office of Regulations and Interpretations
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

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

Dear Secretary Rutledge:

The Society for Human Resource Management (SHRM) is the world's largest HR professional society, representing 285,000 members in more than 165 countries. For nearly seven decades, the Society has been the leading provider of resources serving the needs of HR professionals and advancing the practice of human resource management. SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China, India and United Arab Emirates.

Today's employers recognize the importance of offering competitive employee health care benefits to recruit and retain a talented and productive workforce. HR professionals are responsible for designing and implementing health benefit plans that meet the needs of an organization's workforce. According to the latest data from the U.S. Census Bureau, in 2016, over 177 million Americans were covered by employment-based health insurance.

Overview

SHRM applauds the Department of Labor's focus on developing tools that could be used to reduce regulatory burdens, lower premiums and increase competition in the health insurance marketplaces for small business. The small-business community needs substantial relief from health care costs and burdens imposed by the Affordable Care Act, many of which fall onto the shoulders of HR professionals. Health care costs are a leading concern for virtually all employers. Since health benefits are a prime factor in recruitment and retention, any reduction

in health insurance costs would have a positive effect on US-based companies' ability to attract and retain the best possible talent.

In general, SHRM believes every American citizen should have access to a basic core of health care services. This coverage may be achieved in different ways and at different levels, but any approach to health care reform must offer affordable access to care for all Americans. Because the human and economic costs of the uninsured pose serious consequences to the United States, all stakeholders, including purchasers, consumers, payers, providers, and policy makers have a shared interest in improving access to health care. In addition, some improvements can undoubtedly be made through administrative action and the Department of Labor is to be commended for exploring potential reforms.

Our comments have dual goals. First, we provide suggestions to help ensure that Association Health Plans (AHPs) live up to their purpose of providing greater choice and access for smaller employers and their employees. Second, we want to ensure that the millions of smaller employers who do not purchase coverage through an AHP do not see their insurance costs further escalate due to price disparities based on health status. This potential for "cherry-picking" has been the central conundrum throughout the long AHP debate, and it is crucial that these rules address the issue as thoroughly as possible.

Forming an AHP

Under the proposed rule, employers participating in an AHP must have a "commonality of interest." This requirement can be met in two ways: if the employers are in the same trade or industry or if they share a geographic region (to include an entire state), even if they are otherwise disparate.

The AHP itself must be operated by an association of member companies, and insurance issuers are explicitly and appropriately prohibited from forming an AHP. Under the proposed rules, however, AHPs can be formed for the sole purpose of selling health coverage. This change, particularly when combined with other provisions of the proposed rule (exemptions from rating rules, coverage requirements, etc.), could open the door for the formation of groups based primarily upon risk profile. Such activity would drive up premiums for the rest of the employer market and potentially make "legitimate" associations uncompetitive by shifting costs rather than driving down overall health care costs.

> *Recommendation*: AHPs formed solely for the purpose offering health coverage should be prohibited, at least until it can be shown that associations formed for other (legitimate) purposes are unwilling or unable to form and operate health plans on behalf of their members. Further, the rule should establish that only *bona fide* non-profit associations, that have been in operation for at least three years prior to the formation of an AHP and for substantial purposes other than offering health coverage, would be eligible to sponsor such a program.
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> *Recommendation*: The prohibition against insurance carriers forming AHPs should be maintained. However, the language should be expanded to make clear that other

entities, such as health systems, with a direct conflict of interest in representing member employers, are also included in this prohibition.

Eligibility, Rating and Risk

The proposed rule requires that any employer eligible for association membership is also eligible for AHP participation. Further, the proposed rule has relatively strong nondiscrimination provisions that prevent health status or claims experience from being used to restrict membership in the association, limit eligibility for benefits, or set financial contributions and rates.

While health status cannot be used directly as a form of discrimination among members, AHPs would be allowed a range of rating tools not currently permitted in the small group context, such as employment classification. Further—and distinct from the small group market—there appears to be no limit in the proposal on the degree to which age and gender could be used to set rates across companies. Combined with the ability to set their own membership criteria, some associations could use the combination of rating rules, benefit offerings, and membership criteria to create a pool that is very beneficial from an actuarial perspective, to the detriment of other employers unable to gain similar access.

As discussed above, this risk selection scenario would be made more acute by allowing the formation of associations for the sole purpose of providing health coverage. It appears likely to us that such associations would take advantage of all these tools for the benefit only of their member companies and to the detriment of the larger employer/group market. More tenured associations formed for broader purposes are more likely to consider the interests of the larger industry and region.

Another factor that could increase the chances for negative risk selection is the inclusion of individual "working owners" as eligible for AHP participation--it is well known that individual coverage poses the most difficult risk selection issues. Under the proposed rule, only associations that permit self-employed individuals as members are required to admit them for coverage. Again, this issue creates a significant distinction between traditional associations and those created simply to sell coverage. Single-purpose associations would exclude the self-employed from membership if they had reason to believe their risk profile would be negative. Conversely, they would welcome them if they believed they could establish rating criteria that ensured better-than-average risks.

Finally, AHPs could find themselves becoming the insurer of "last resort" for larger employers unable to secure fully insured coverage and unwilling to self-insure because of their negative risk profile. While it is important that smaller companies that otherwise would participate in the small group market be protected from health underwriting, the market for larger employers is very different.

> *Recommendation*: The rating rules that generally apply in the small group market should also be used in the AHP marketplace. AHPs are primarily promoted as a tool to help smaller employers, which are expected to form the majority of AHP participation.

Creating a degree of rating parity between the AHP and non-AHP markets would help to ensure that competition occurs around the ability to drive down administrative and claims costs and not simply the ability to avoid risk. While SHRM believes that the gender and age ratios should be greater than the current 3:1 standard, it is important that all small employer markets share common rules.

Recommendation: SHRM generally supports the non-discrimination rules included in the proposal, and believes they should be maintained.

Recommendation: SHRM believes that AHPs should have the ability to underwrite larger firms (otherwise ineligible for the small group market) applying for access to the plan. Such an ability may be vital for some AHPs to maintain viable coverage for their many other members.

Recommendation: The Department should consider creating more uniform rules and standards for the eligibility of the self-employed. AHPs should be allowed/required to demand greater proof of self-employment and length in business as a tool for ensuring market stability, for both the AHP and the individual insurance market. A defined open enrollment period for the self-employed could also help to ameliorate potential selection issues in this market.

It is also important to have a clear but sensible test for the eligibility of business owners in order to identify those legitimately in business and those part-owners who are not truly active in the business. For example, there needs to be a way to ensure that a one-person bicycle shop would be allowed into an AHP, but a part-time real estate investor would not.

Pre-emption for Self-Insured AHPs

The proposal wisely avoids preemption of state law regarding self-insured AHPs and Multi-Employer Welfare Arrangements (MEWAs). Significant issues—such as insolvency and non-payment of claims—arose before state oversight of MEWAs was clearly established. If single-purpose self-insured AHPs are allowed to exist, we would expect similar issues to arise. The Department plainly does not have the resources to provide meaningful oversight of this sector, leaving the state regulatory bodies as the only potential guarantors that coverage purchased through self-insured AHPs by smaller employers for the benefit of their employees will remain viable.

Recommendation: The final rule should move beyond the assumption of the status quo and explicitly maintain that state authority to regulate in the self-insured AHPs and MEWAs arena remains intact under the rule. Also, any multi-state AHP should be governed by each of the states in which it operates but only for employers located in that state.

Conclusion

We appreciate the Department's focus on the urgent need for cost containment and expanded choice in the markets for small employer health insurance. As you move forward, we hope these comments can help you develop policy that addresses the needs of a broad cross-section of the small employer community, whether they are purchasing coverage in the traditional small group market, a newly reformed and created AHP market, existing SHOP plans, or other arrangements.

To achieve this result, SHRM believes that proposals to create AHPs should focus on their potential to reduce regulatory burdens and increase choice while avoiding scenarios where the AHPs are merely given tools to manage (and reduce) their risk. Shifting risk is a zero-sum game where one employer wins because another loses. However, lifting unnecessary and burdensome regulations, inducing competition around real health care costs, and creating greater transparency and access through competition, can create positive results where the entire small employer market benefits. As you address these rules, we urge you to do everything you can to avoid simple risk-shifting and to create that positive result.

Thank you for the opportunity to offer comments on these proposed regulations. If we can provide further information or perspective from our members, please don't hesitate to contact me.

Respectfully Submitted,

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