March 6, 2018

Secretary Alexander Acosta
United States Department of Labor
Employee Benefits Security Administration, Room N-5655
200 Constitution Avenue NW
Washington, DC 20210
Attn: Definition of Employer—Small Business Health Plans
RIN 1210-AB85
Document Number 2017-28103

SUBMITTED ELECTRONICALLY

Re: Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans

Dear Secretary Acosta:

We support the proposed Department of Labor ("DOL") modifications to the definition of "Employer" in the Employee Retirement Income Security Act of 1974, as amended ("ERISA") to recognize Association Health Plans ("AHPs"). We agree that AHPs are an innovative option for expanding access to employer-sponsored group health plans, especially for small businesses.

ABD Insurance and Financial Services, Inc. is a consulting firm providing risk management, insurance brokerage, human resources, and retirement consulting services. Our advisors offer guidance and craft innovative solutions to help address risk for clients of varying sizes, growth stages and industries. The following comments represent our response to the proposed regulation. These suggested enhancements and additions are designed to further foster the goal of providing a robust health insurance marketplace for small employers.

- **Comment #1: Nondiscrimination**
  Suggested Approach: Eliminate Requirement to Treat All Employer-Members Identically
  Relevant Proposed Regulation: 29 CFR §2510.3-5(d)(4)

Prohibiting employer-by-employer risk-rating would discourage formation and use of AHPs. In particular, employers in an industry that typically has a less advantageous risk profile for health coverage purposes may effectively be shut out of the AHP alternative to the small group market.

One of the primary enhancements the DOL proposes for AHPs is the ability to avoid the "look-through" doctrine, as set forth in the September 1, 2011 CMS guidance addressed in the preamble to the proposed regulations. In other words, although an AHP does not meet the traditional "Plan MEWA" definition, the AHP would nonetheless constitute a single plan determined by reference to the number of employees in the entire AHP (and thereby avoid the small group market restrictions, including community rating).

Another primary enhancement the DOL proposes for AHPs is the ability for the AHP to satisfy the commonality of interest requirements by a regional connection (*i.e.*, without a direct industry tie).

These two core AHP enhancements will be available to employers in a less advantageous risk-profile industry only if AHPs are formed with a membership eligibility structure broad enough to encompass such employers. We fear that such employers will largely be excluded from AHP availability if the AHP is not permitted to engage in employer-by-employer risk-rating.

For example, AHPs are far less likely to form in an industry-specific arrangement for less advantageous risk-profile industries. Such AHPs likely may not present a material, if any, rating advantage over the community-rated small group market that currently exists.

Furthermore, AHPs are far less likely to develop in a region-specific form—again, one of the key features of the proposed regulation—because the AHP would be required to accept all employers within the region without accounting for the differences in risk profiles. We think it is likely that AHPs will instead target industries with established risk profile advantages to provide a clear cost distinction with the small group market.

These industry-wide effects will have clear consequences for employers in a less advantageous risk-profile: a) lack of significant improvement to affordable coverage access via AHPs, and b) an even more severe adverse selection problem in the small group market for those industries without clear access to affordable AHP alternatives.

If the DOL does not agree with removing the §2510.3-5(d)(4) proposal in its entirety, we suggest at a minimum permitting AHPs to engage in industry-by-industry risk-rating. This would at least have the effect of encouraging AHP formation in the region-specific format, without the fear of certain industries making the regional approach ineffective and unaffordable in relation to the existing small group market. Industry-by-industry risk-rating could be arranged in line with the six-digit Form 5500 business codes for principal business activity (Part II, Line 2d), or another reasonable equivalent.

- **Comment #2: ERISA Preemption**
  Suggested Approach: Enhance ERISA Preemption of Small Group Market Rating
  Relevant Statute: ERISA §514(b)(6)(A)(i)

We suggest that the DOL provide nationwide confirmation for AHPs that the "look-through" doctrine, which results in the group health plan existing at the individual employer level and not the association-of-employers level, will not apply for federal or state purposes. In other words, AHPs need to be able to operate in any state with the assurance that no state law will require application of the small group market community rating requirements to each individual employer participating in the AHP.

As noted in the preamble to the proposed regulation, association coverage does not currently exist as a distinct meaningful category of health insurance for federal law purposes. This is also the case in many states. A state could fully undermine the purpose and efficacy of AHPs by failing to recognize AHPs as the functional equivalent of a "Plan MEWA" with respect to application of the small group rating requirements. In other words, states could make AHPs inviable simply by treating them as a "Non-Plan MEWA" subject to the look-through doctrine.

The DOL should make clear that any state insurance law intended to apply the small group rating requirements to AHPs is not consistent with ERISA §514(b)(6)(A)(i), and therefore such state law is preempted by ERISA pursuant to ERISA §514(a).

- **Comment #3: The Control Test**
  Suggested Approach: Permit Limited Service-Provider Control Responsibilities
  Relevant Proposed Regulation: 29 CFR §2510.3-5(b)(4)

The proposed regulation essentially retains the existing "Plan MEWA" requirements that the group or association sponsoring the AHP have a governing body, and that the member employers control its functions—including the establishment and maintenance of the group health plan.

The DOL should take this rulemaking opportunity to promote AHP formation not only through relaxing the "Commonality of Interest Test" (*e.g.*, regional AHPs), but also through relaxing this existing "Control Test" to ease current limitations.

We first suggest that brokers and service be permitted to play an active role in establishing the AHP. One of the key enhancements of the proposed AHP regulations is to allow employers to band together for the single purpose of creating an association solely to obtain health care (provided there is the sufficient industry or regional connection among the employers).

However, we fear that this enhancement may be more symbolic than substantive if it is not also paired with a clear mechanism to facilitate the creation of such associations. An emergent order of associations is not likely to arise among industry or regional competitors without significant assistance from the brokers and other service providers who specialize in establishing such plans and developing the requisite administrative framework for them to function.

Therefore, we suggest that service providers be expressly permitted to assist in association creation and AHP group health plan establishment, provided they receive approval from the employers who choose to join the broker/service providers in this pursuit. The existing Control Test rules will prevent any conflict of interest from being a detriment to the AHP in its ongoing administration after the initial establishment.

We further propose that brokers and service providers be permitted to play some limited role in the ongoing control of the AHP through a sufficiently-diluted position on the association's board of directors. For example, the DOL may permit any combination of brokers and/or service providers to be elected to the association's board, provided such non-employer-member board participation is limited to 15% of the association's voting rights (or some reasonable equivalent).

Brokers and service providers play a crucial role in the proper maintenance of any employer-sponsored group health plan, and particularly so with the added scale and complexity in a MEWA. The DOL can accommodate that role to a limited degree in a manner that fosters creation and efficient administration of AHPs, yet without compromising the interests of employer-members.

The DOL should clarify that such a limited broker or service-provider role on an association's board would not present a prohibited transaction with a party in interest within the meaning of ERISA §406(a)(1), nor would it present a fiduciary self-dealing prohibited transaction within the meaning of ERISA §406(b).

Summary

We thank you for proposing the AHP regulations discussed in this comment, as well as for your consideration of these comments that we feel can further improve small-employer access to affordable health coverage within the scope of existing statutory authority.

Sincerely,

Brian Gilmore
Lead Benefits Counsel, VP
ABD Insurance and Financial Services, Inc.
3 Waters Park Drive, Suite 100
San Mateo, CA 94403
650-437-0583
brian.gilmore@theabdteam.com