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***Submitted Electronically via:*** ***www.regulations.gov***

Office of Regulations and Interpretations, Employee Benefits Security Administration
Attn: RIN 1210–AB85
Room N–5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Comments on Proposed Regulations to Facilitate the Formation of Small Business Health Plans

To Whom It May Concern:

On behalf of employer-run organizations that currently offer "group health plan" coverage to employer members and their employees through an "association health plan," I respectfully submit the following comments in response to the Notice of Proposed Rulemaking ("NPRM"), clarifying the definition of "employer" under Section 3(5) of the Employee Retirement Income Security Act ("ERISA") for purposes of establishing a "Small Business Health Plan" ("SBHP"). The below comments address three aspects of the NPRM: (1) The criteria for satisfying the "commonality of interest" test, (2) The nondiscrimination protection that would prohibit an SBHP from developing different premium rates for different employer members based on the members' "health claims experience," and (3) The Request for Information ("RFI") for input about the merits of developing a "class exemption," which would exempt self-insured "multiple employer welfare arrangements" ("MEWAs") from the non-solvency requirements of a State law regulating these arrangements.

## I. Background on Existing Employer-Run Organizations That Provide Services and Benefits to Employer Members and Their Employees

For decades, employers in the same industry (i.e., "related" employers) as well as employers in different lines of business (i.e., "unrelated" employers) have joined together to collectively provide certain services and benefits to their employees through a third-party organization. These services and benefits range from Human Resource and Training services to Payroll, Recruiting, and Safety services. The benefits offered range from Health and Retirement benefits to Employee Assistance, Legal Assistance, and Education benefits. In the case of these third-party organizations, they are structured in a way where their employer members govern (1) the operations of the organization and (2) the provision of services and benefits to employees. Such governance is provided through a multiple-member Board of Directors or Trustees, which distinguishes this "employer-run" organization from other "non-employer-run" third-party organizations.

These employer-run organizations have played a critical role in providing workplace assistance and employee benefits to small- and mid-sized employers that do not have the capital or the expertise to perform these functions in-house. For example, those small- and mid-sized employers that have chosen to out-source the provision of these services and benefits to an employer-run organization have traditionally found greater success in performing their core business functions and generating business income, ensuring the long-term sustainability of their company.

Specific to the provision of Health benefits, these employer-run organizations have consistently offered affordable and quality health coverage to employer members and their employees through a group health plan. In most cases, the health coverage is superior to coverage an employer member might independently find in the commercial insurance market, both from a coverage and cost perspective. And in virtually all cases, there is less volatility – relative to the commercial insurance market – as it relates to (1) the type and level of health coverage that is made available and (2) the premium rates for such coverage.

In total, health coverage made available through a group health plan sponsored by an employer-run organization is more predictable, more reliable, and more affordable. As a result, the employer members of the employer-run organization not only have the ability to attract and retain talented workers, but these employers have the opportunity to maximize their earnings potential by focusing on their core business functions. And, the employees of the employer members benefit from a comprehensive level of coverage – subject to consumer protections under ERISA and the Affordable Care Act ("ACA") – at a competitive price. A win-win for employers *and* employees.

## II. Support for the NPRM, But a Suggestion on Modifying the Framework of the "Commonality of Interest" Test

### A. Background on the "Commonality of Interest" Test

As the Department knows, the "commonality of interest" test is a facts and circumstances test that is not always easy to satisfy. Prior to the issuance of the NPRM, when examining the various facts and circumstances involved, courts and the Department have found that the "commonality of interest" test may be satisfied if a sufficient bond exists between employers engaged in the same line of business in the same geographical area or where there is a nexus or other genuine organizational relationship that is unrelated to the provision of health benefits, which typically includes employers in the same industry.[1] In other words, the "commonality of interest" test was limited to (1) "related" employers that are (2) located in the same State or tri-State area.

In the NPRM, the Department has opted to modify its interpretation of the various factors that must be present to satisfy the "commonality of interest" test. Under the proposal, a group of employers would meet the "commonality of interest" test if (1) the employers are in the same industry, line of business or profession or (2) the employers have a principal place of business in a particular State or metropolitan area (that may span more than one State).

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[1] *Gruber v. Hubard Bert Karle Webber, Inc.*, 159 F.3d 780 (3rd Cir. 1998) (citing *Steen v. John Hancock Mutual Life Ins.*, 106 F.3d 904 (9th Cir. 1997)); *National Ben. Administrators, Inc., National Business Ass'n By and Through v. Morgan*, 770 F. Supp. 1169 (W.D.KY 1991); *see also*, DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-24A (Dec. 30, 2005), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 2003-17A (Dec. 12, 2003).

With respect to the first test, the Department has chosen to eliminate the geographical constraint for "related" employers. This would allow national trade associations and employer-run organizations to establish a fully-insured or self-insured SBHP, and offer such SBHP health coverage to employer members regardless of their geographic location. In other words, so long as the employer members are "related," SBHP health coverage could be offered to employer members located in all 50 States, or employers located in a particular region of the country (e.g., New England, the Southeast States, or the Pacific Northwest, just to name a few).

With respect to the second test, the Department maintains the geographical constraint, but eliminates the requirement that the employer members be "related." This would allow "unrelated" employers (i.e., employers in different industries) domiciled in a particular State to band together to establish a fully-insured or self-insured SBHP. And, this could allow local Chambers of Commerce or other employer-run organizations that are made up of multiple "unrelated" employers – but employers who share the same goal of promoting pro-business activities – to offer SBHP health coverage to their employer members in a specific geographic locale.

### B. "Unrelated" Employers – Like "Related" Employers – Should Not Be Limited to One State or a Single Standard Metropolitan Statistical Area

Existing employer-run organizations are supportive of the Department's proposal, and its decision to modify the criteria for satisfying the "commonality of interest" test. However, reasonable questions have been raised over why the geographical constraint that was eliminated for "related" employers, continues to apply in the case of "unrelated" employers?

A strong argument can be made that "unrelated employers" should *not* be limited to a geographic location. For example, if the Department was of the opinion that eliminating the geographical constraint for "related" employers was advisable, there does not appear to be a reason why this same policy change should not be available to "unrelated" employers. It is important to emphasize that the most critical component of a "bona group or association of employers" sponsoring an SBHP is "control" over (1) the operations of the employer group and (2) the provision of health coverage through the SBHP. Thus it follows that if the employer members of a particular group have the requisite "control" over the employer-run organization and the SBHP, it should *not* matter whether the group is made up of "related" or "unrelated" employers offering health coverage in one State or multiple States.

Based on this reasoning, the Department should consider allowing "unrelated" employers located in different parts of the country to meet the "commonality of interest" test, *but only if* the employer members have the requisite "control" over (1) the operations of the employer group and (2) the provision of health coverage through an SBHP. As the Department explains throughout the preamble of the NPRM, an SBHP must be an "employment-based arrangement" that is "controlled" by employer members. This "control" is critical to ensuring that the employer members operating the SBHP "act in the best interest" of the employees covered under the plan.

It is important to emphasize that in cases where "unrelated" employer members govern (1) the operations of the employer group and (2) the provision of health coverage through the SBHP, these employers *will be* "acting in the best interest" of their employees. This fact does *not* change if the "unrelated" employers are located in different States around the country, or in a particular region of the country. Which means, the geographical constraint for "unrelated" employers should be eliminated in cases where these "unrelated" employers can adequately show to the Department that they have the requisite "control" over (1) the operations of the employer group and (2) the provision of health coverage through an SBHP.

### C. At a Minimum, "Unrelated" Employers Located In Three Contiguous States Should Meet the "Commonality of Interest" Test

If the Department continues to believe that some sort of geographic constraint should apply in cases of "unrelated" employers, the Department should consider allowing "unrelated" employers located in three contiguous States to meet the "commonality of interest" test. As the Department may know, there is precedent set forth in proposed Department of Treasury ("Treasury") regulations relating to the "geographic locale" restriction for participation in a Voluntary Employees' Beneficiary Association ("VEBA"), governed by the rules set forth under section 501(c)(9) of the Internal Revenue Code ("Code").[2]

In short, Code section 501(c)(9) contemplates an association of employees that may establish a VEBA, which is a tax-exempt organization intended to provide health and welfare benefits to its members. Membership in a VEBA must consist of individuals who are employees and whose eligibility for membership is based on an "employment-related common bond."[3] For example, all employees of one or more employers engaged in the same line of business in the same geographic locale may be considered to share an employment-related bond for purposes of establishing a VEBA.[4] It appears that employees of one or more employers engaged in the same geographic locale may also be considered to share an employment-related common bond.[5]

When issuing the proposed regulations, Treasury recognized that questions have arisen about the extent of a single "geographic locale," especially in light of the decision in *Water Quality Ass'n Employees' Benefit Corp. v. U.S.*,[6] in which the 7th Circuit ruled that that the "geographic locale" restriction had no basis in the statute. Treasury explained that the 7th Circuit agreed that the existence of an employment-related common bond is the essential factor that distinguishes a tax-exempt VEBA from a taxable insurance company, but concluded that restricting VEBAs covering employees of unrelated employers to those employers located in the same geographic locale did not enhance the employment-related bond of the employees participating in the organization.[7]

In light of this court decision and the history of Code section 501(c)(9), Treasury opted to develop a "safe harbor" that treats any three contiguous States as a single geographic locale.[8] The proposed regulations also authorize the IRS Commissioner to recognize larger areas as a single geographic locale on a case-by-case basis upon application by an organization seeking recognition as a VEBA.[9] Treasury justified clarifying Code section 501(c)(9)'s geographic locale restriction, explaining that if VEBA participation were always limited to employees of employers located in the same State or a single standard metropolitan statistical area ("SMSA"), the diversity of regional population density and employment patterns in the United States could make it infeasible in many cases for benefits to be provided through a VEBA.

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[2] *See* 57 Fed. Reg. 34,886 (Aug. 7, 1992).

[3] Treas. Reg. section 1.501(c)(9)-2(a)(1).

[4] *Id.*

[5] 57 Fed. Reg. at 34,886 (Aug. 7, 1992).

[6] 795 F.2d 1303 (7th Cir. 1986).

[7] 57 Fed. Reg. at 34,887 (Aug. 7, 1992).

[8] *Id.; see also,* Prop. Treas. Reg. section 1.501(c)(9)-2(d)(1).

[9] *Id.; see also,* Prop. Treas. Reg. section 1.501(c)(9)-2(d)(2).

The Department should consider adopting the same three contiguous State safe harbor as proposed by Treasury for VEBA membership for purposes of "unrelated" employers satisfying the "commonality of interest" test. The Department should also consider giving the Assistant Secretary of the Employee Benefits Security Administration ("EBSA") the authority to recognize larger areas as a geographical limitation for purposes of the "commonality of interest" test on a case-by-case basis upon application by an SBHP seeking to offer health coverage to employer members located in multiple States. For example, with respect to States with limited populations, "unrelated" employers located in an area that might include Montana, Idaho, Wyoming, North Dakota, and South Dakota should still satisfy the "commonality of interest" test. The analog between a VEBA and an SBHP – both membership-driven organizations that serve as a mechanism through which health benefits are offered to employees – cannot be over-stated, thereby justifying the application of similar rules to similar entities.

## III. Support for the NPRM, But Concerns About One of the Proposed Nondiscrimination Protections

Existing employer-run organizations that have been providing group health plan coverage through an "association health plan" prior to the issuance of the NPRM are supportive of the Department's efforts to provide more flexibility so small employers and self-employed individuals with no employees (referred to as "working owners") can form SBHPs. However, the Department's proposal that would prohibit these employer-run organizations from developing different premium rates for different employers (i.e., "experience-rating") would adversely impact their ability to develop competitive premium rates for their employer members. Stated more directly, if an employer-run organization offering group health plan coverage through an SBHP cannot develop different premium rates for different members, it is highly likely that these plans will be forced into insolvency, thus requiring the organization to discontinue their group health plan coverage. A result that is *not* "in the best interest" of employees receiving health coverage through the plan.

### A. Allowing Experience-Rating Would Not Render the Proposed Nondiscrimination Protections Ineffective

The proposed regulations establish four different nondiscrimination protections applicable to SBHPs. Under the first proposed nondiscrimination protection, an employer group cannot deny other employers and/or working owners membership in the group – and by extension participation in an SBHP – on account of any "health factor" of an employee, a former employee, or the working owner. Under the second and third proposed nondiscrimination protections, the premiums for SBHP health coverage – and eligibility for benefits covered under the plan – cannot vary based on a particular participant's health factor. And under the fourth proposed nondiscrimination protection, an SBHP cannot experience-rate premiums for different employer members.

In the preamble of the NPRM, the Department explains that if this fourth nondiscrimination protection was not finalized, the first three nondiscrimination protections discussed above could be rendered ineffective (because an employer group could offer membership to all employers meeting the requisite membership criteria, but then charge specific employer members higher premiums based on their health-claims experience). However, employer-run organizations do *not* believe that these nondiscrimination protections would be rendered ineffective if an SBHP could develop premiums based on health claims experience.

For example, in cases where a prospective employer member may employ employees who utilize a significant amount of health care (i.e., "high-medical-utilizers"), this employer may benefit by finding more affordable health coverage through an SBHP, due to the fact that this employer *cannot* be denied

membership in the employer group sponsoring the plan on account of these high-medical-utilizers. More affordable premium rates will likely be available to an employer with high-medical-utilizers because – on account of experience-rating – the SBHP will be able to attract employer members with "healthy" employees (by offering these employers a lower premium rate). The fact that these healthy risks may now be a part of the SBHP, these healthy risks are able to offset the exposure the high-medical utilizers may pose to the risk pool. This allows the SBHP to develop competitive premium rates for the employer with high-medical-utilizers, notwithstanding the fact that this employer's premiums may be higher than employer members with healthy employees.

In other words, by allowing an SBHP to develop different premiums for different employers, the SBHP will be able to offer competitive premium rates that *both* employers with healthy employees *and* employers with high-medical-utilizers may find attractive, which not only benefits the employer member (from a financial perspective), but also its employees (especially those employees who may be high-medical-utilizers because they may now have access to affordable and quality health coverage subject to ERISA's and the ACA's consumer protections).

With respect to the prohibition against varying premiums and eligibility for benefits based on any health factor, these are requirements that currently apply to existing group health plans under HIPAA. As the Department knows – currently – self-insured and fully-insured "large group" health plans develop their premium rates based on experience-rating, which is not prohibited under HIPAA. Importantly, this current law prohibition against varying premiums or eligibility for benefits based on any health factor of a particular participant is in *no* way rendered ineffective by virtue of the existing experience-rating practice adopted by these plans. Allowing employer-run organizations sponsoring an SBHP to engage in the practice of experience-rating will similarly do *nothing* to change or inhibit the effectiveness of these nondiscrimination protections.

### B. Contrary to the Department's Belief, Experience-Rating Would Be Done To Maintain the Solvency of the SBHP, Which Is "Acting In the Best Interest" of Employees

As discussed, employer-run organizations are structured in a way where the employer members govern (1) the operations of the employer group and (2) the provision of health coverage through an SBHP through a Board of Directors or Trustees. This "control" is critical because it ensures that the employer members sponsoring the SBHP are "acting in the best interest" of their employees. Contrary to the Department's belief, developing different premiums for each employer member based on their health claims experience is actually is done in furtherance of "acting in the best interest" of the employees covered under the SBHP. For example, if the SBHP did not develop different premium rates for particular employer members, the SBHP would likely go insolvent, and the employees currently covered under the plan would lose their health coverage.

As a result, to ensure that affordable and quality health coverage is consistently made available to employees of the sponsoring employer members, the SBHP is required to experience-rate employer members to maintain its solvency. Engaging in practices that would ensure the long-term viability of the SBHP is by definition "acting in the best interest" of employees participating the plan because, again, without experience-rating, the employer-run organization would no longer be able to offer health coverage.

In addition, by experience-rating different employer members, an SBHP has a better chance to attract employer members with "healthy" employees who are then able to offset the health risks associated with high-medical-utilizers. This means that high-medical-utilizers can enjoy a competitive premium rate for affordable and quality health coverage, which is no doubt in these employees' "best

interest." And, healthy employees can also enjoy a competitive rate relative to, for example, the small group market, which again, is in these employees' "best interest."

Lastly, the Department seems to believe that if an SBHP is able to develop different premiums for different employers based on health claims experience, this would undermine the status of the SBHP being considered a "single employer plan." The Department's belief appears to stem from its concern that by allowing employer-by-employer risk-rating, SBHPs would simply devolve into commercial-type-insurance entities that are no different from commercial insurance carriers under-writing risk. In this case, the Department feels that this result is too far removed from ERISA's statutory aim of limiting plan sponsors to employers "acting in the best the interest" of their employees. But, as discussed above, because an employer-run organization sponsoring an SBHP will have the requisite "control" over the plan, engaging in the practice of experience-rating employer members will *not* cause the SBHP to operate like an unlicensed health insurance provider selling commercial group health coverage (because the employer sponsors will continue to "act in the best interest" of their employees receiving coverage under the SBHP).

### C. SBHPs Would Be Placed At a Competitive Disadvantage If SBHPs Cannot Develop Different Premiums for Different Employer Members

Without the ability to experience-rate employer members, SBHPs would be placed at a competitive disadvantage relative to commercial insurance carriers. It appears, however, that commercial insurance carriers have argued that if SBHPs were permitted to develop different premiums for different employer members, that commercial insurers would be the entities placed at a competitive disadvantage, especially as it relates to selling health plans to small employers. In addition, it appears that the commercial carriers argued that if SBHPs could engage in a premium rating practice that commercial carriers in the small group market were prohibited from adopting, SBHPs would "segment" the market, leaving only employers with high-medical-utilizers for commercial carriers to cover.

As the Department knows, the ACA's small group market reforms prohibit the development of premiums based on the health claims experience of a small employer. Instead, premiums for small group plans may only vary by age, tobacco, geography, and family size. Based on these new rules – and in response to the commercial carriers' arguments – it appears that the Department developed a nondiscrimination protection that essentially mirrors the premium rating practices now required in the ACA's small group market.

Unfortunately, by imposing similar premium rating practices that apply to commercial insurers selling small group plans to SBHPs, the Department is detrimentally impacting existing SBHPs, and calling into question whether SBHPs will be formed in the future. This is due in large part to the fact that commercial insurance carriers have greater scale relative to SBHPs. In other words, SBHPs can only cover a finite number of "lives" under their plan. Which means, the risk pool of SBHPs are going to be small relative to commercial carriers who have access to a much greater number of lives on account of under-writing coverage for small employers that are not members of an employer-run organization.

More specifically, if an SBHP is not permitted to develop different premium rates for different employer members, the SBHP would not be able to compete with the commercial carriers, and therefore, the plan would not be able to attract enough lives – especially "healthy" lives – to create a sustainable risk pool. As discussed above, the practice of experience-rating will help an SBHP attract employer members with "healthy" employers, which is critical to offsetting the exposure of employer members with high-medical-utilizers that will likely seek health coverage through an SBHP (especially because employer groups cannot deny membership based on the health status of an employer's employees).

Even if SBHPs become the preferred choice for health coverage among small employers in a particular State's small group market, employer-run organizations do *not* believe that the ability to experience-rate employer members will result in "cherry-picking" small employers with good health risks over small employers employing high-medical-utilizers (a scenario that it appears the Department is trying to prevent through the development of this nondiscrimination protection). This is because – as stated – the employer members sponsoring the SBHP (as an employment-based arrangement) will be "acting in the best interest" of their employees, taking the necessary steps to provide affordable and quality health coverage to each and every employer member. In other words, an SBHP is not going "price" its employer members out of the SBHP coverage, thereby leaving small employers with high-medical-utilizers to the commercial insurance carriers.

### D. Prohibiting an SBHP from Experience-Rating Large Employers Seeking Health Coverage Would Be Devastating to the SBHP's Risk Pool

Prohibiting an SBHP from developing different premiums for different employer members would attract large employers that employ high-medical-utilizers, which would detrimentally impact the SBHP's risk pool. Although the Department expects minimal interest among large employers in joining an SBHP, the Department does acknowledge that some large employers will seek SBHP health coverage, along with small employers. As stated – currently – self-insured and fully-insured "large group" health plans develop their premium rates based on experience-rating. There could be a scenario where, for example, a large employer sponsoring a fully-insured plan cannot get affordable premium rates in the commercial insurance market, but this large employer may find more reasonable premium rates through an SBHP if premiums *cannot* be experience-rated. Because the employer members sponsoring the SBHP cannot deny this large employer membership in the group because the employer employs high-medical-utilizers – and because these high-medical-utilizers cannot be denied coverage under the SBHP due to a pre-existing condition (an existing ACA requirement) – it is highly likely that this large employer will seek health coverage for its employees through the SBHP. This could be catastrophic for the SBHP's risk pool if the SBHP is *not* able to experience-rate this large employer and charge its employees actuarially fair premium rates.

## IV. Support for a "Class Exemption" From the Non-Solvency Requirements of a State MEWA Law, Provided Federal Requirements Are Met

### A. Currently, Self-Insured MEWAs Must Comply With a "Patchwork" Set of Legal Requirements and Licensing Practices

An SBHP is by definition a MEWA. In the case of a self-insured MEWA, ERISA gives States the exclusive authority to impose any State insurance law requirement on these arrangements. Over the years, States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. This has created a "patchwork" set of rules and requirements that self-insured MEWAs must meet if an employer-run organization sponsoring this type of arrangement wants offer health coverage to employees located in multiple States.

As a result, a self-insured SBHP (as a self-insured MEWA) must satisfy each State MEWA law in each of the States in which the SBHP coverage may be offered. Unfortunately, however, this fact may limit the extent to which self-insured SBHPs are formed. This is because a self-insured SBHP wanting to offer health coverage in multiple States must navigate the different legal requirements and licensing practices in each State in which the coverage may be offered. The cost and time associated with complying with this "patchwork" set of regulations and licensing rules is often times prohibitive.

**B. A "Class Exemption" Would Provide Some "Uniformity" In the Law**

As the Department knows, Congress enacted ERISA to avoid the multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans. Consistent with the purpose of ERISA, developing a "class exemption" would provide a level of "uniformity" that would allow self-insured SBHPs to offer health coverage in multiple States free from the burden of complying with a set of regulations that differ State-by-State.

Please note, employer-run organizations are not suggesting that self-insured MEWAs should be freed from regulation, but rather, that such regulation should be uniform. And such uniformity can be accomplished through developing a "class exemption" that would include specific Federal rules that must first be met prior to a self-insured SBHP availing itself of any exemption from a State MEWA law's non-solvency requirements.

Providing specific suggestions on what may be considered "reasonable" and "appropriate" regulation of a self-insured SBHP through a "class exemption" is beyond the scope of this comment letter. However, employer-run organizations believe the Department should consider developing a "class exemption" that codifies an existing State MEWA statute that the Department – and outside stakeholders – believe provides an appropriate level of regulation and oversight. The "class exemption" may also require a specified number of lives be covered under the self-insured SBHP – as well as a requirement to meet a reasonable solvency requirement – as conditions to qualifying for the "class exemption."

Employer-run organizations understand that even if a "class exemption" is developed (so that self-insured SBHPs may be exempt from the non-solvency requirements of State MEWA laws), State insurance laws regulating reserve and contribution levels will continue to apply. We believe this is good policy (not to mention a statutory requirement under ERISA) because employer-run organizations believe a defined set of solvency requirements are imperative to ensure the viability of self-insured SBHPs. However, while the Department does not have the authority to dictate the type of reserve requirement a State may put into place, consideration must be given to the fact that States may choose to enact prohibitive reserve requirements as a back-door way of preventing self-insured SHBPs from operating within the State. An argument can be made that such State actions are inconsistent with ERISA.

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Thank you in advance for considering these comments. Please do not hesitate to contact me with any questions, or if I can serve as a resource on these very important issues.

Sincerely,

Christopher E. Condeluci