February 27, 2018

The Honorable R. Alexander Acosta
Secretary of Labor
c/o Office of Regulations and Interpretations
Employee Benefits Security Administration
Attention: Definition of Employer – Small Business Health Plans RIN 1210-AB85.
U.S. Department of Labor, Room N-5655
200 Constitution Avenue NW
Washington, DC 20210

Dear Mr. Secretary,

The Building Industry Association of Washington (BIAW) submits the following comments regarding the Department of Labor (DOL) proposed rulemaking governing the definition of "Employer" under Section 3(5) of ERISA and Association Health Plans. BIAW is the second largest state association affiliated with the National Association of Home Builders (NAHB) in the country.

BIAW established the current BIAW Health and Welfare Trust in 2002. The Trust constitutes a bona fide association of employers under 29 USC § 1002(5) providing coverage to approximately 700 employers in every Washington State county and their 15,000 employees. The Trust provides benefits to employer members of the association engaged in building trades and professions. In 2012, the Trust was amended following demands by the Washington State Insurance Commissioner (OIC) that associations conform to the Affordable Care Act's small group rate and plan requirements unless the association excluded employers not closely related to building trades. The OIC also required regulatory filing of Trust plans along with the Trust agreement and attestation that the association meets the requirements of ERISA for regulatory treatment as large group coverage. BIAW Trust plans meet these Washington State requirements in addition to federal regulations.

Background

In 1995, The Washington State Legislature explicitly recognized the right of small employers to purchase health plans "through member-governed groups formed specifically for the purpose of purchasing health care" and exempted these plans from state small group health plan rating and other insurance rules.[1] Because no federal law governed association health plan (AHP) rates and plan designs then, Washington State permitted fully insured "bona fide" and "non-bona fide" association health plans underwritten at the employer member level.

[1] Chapter 265, § 23, Laws of 1995, Revised Code of Washington (RCW) 48.44.023.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations caused some associations to focus on the "bona fide" status of their health plans. HIPAA provides exceptions for the guaranteed issue and renewal of health plans made available to "bona fide association" members. The ACA extended the renewability exception for employer plans provided through bona fide associations and imposed rating rules on non-bona fide associations.[2]

Before implementation of the ACA regulations, association health plan issuance and pricing depended upon the state exemption from state rate regulation without regard to an association's "bona fide" status and the federal statutory definition of a "bona fide association."

> The term “bona fide association” means, with respect to health insurance coverage offered in a State, an association which -
> (A) has been actively in existence for at least 5 years;
> (B) has been formed and maintained in good faith for purposes other than obtaining insurance;
> (C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);
> (D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);
> (E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
> (F) meets such additional requirements as may be imposed under State law.[3]

After implementation of the ACA, Washington AHPs became subject to federal small group community rating and plan requirements unless the AHP could satisfy DOL interpretations of the meaning of "association of employers" under 29 USC. § 1002(5).[4] Following protracted disputes with the Insurance Commissioner, nearly every Washington association health plan existing prior to implementation of the ACA either revised operations to become "bona fide" under current DOL standards for treatment as a large group plan under ERISA or ceased operation as an association plan.

Summary of Comments

While BIAW supports association health plans, the proposed regulation would add to our regulatory burden, create legal uncertainty, and undermine our success in creating a stable health plan for our members. If DOL allows individuals to purchase group

---

[2] 42 USC § 300gg-2 (b)(6).
[3] 42 USC § 300gg-91 (d)(3).
[4] Department of Labor Publication, Multiple Employer Welfare Arrangements Under ERISA, A Guide to Federal and State (available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf).

health plan coverage from new associations whose sole purpose is marketing health insurance to every employer in the state, we recommend that DOL establish a separate non-bona fide association plan arrangement subject to insurance regulations. DOL should not disrupt existing bona fide association plans by altering fundamental principles of employee benefits and employment law. Below you will find a summary of our comments followed by a more detailed discussion.

1. The proposed "commonality of interest" and "purpose" tests essentially eliminate the fundamental market protections that exist when employers who share common goals and interests regularly interact and develop programs and services to meet their collective needs. By substituting a broad geographic criteria as a common interest and insurance marketing as the animating purpose for creation of an association, DOL increases risk to employers and undermines existing bona fide association health plans. The proposed revisions could also prompt state lawmakers to impose new restrictions on multiple employer welfare arrangements. DOL can increase access to association health plans by easing the strictness of current commonality of interest standards without eliminating these longstanding rules.
2. The proposed change in the definition of "employer" needlessly complicates the stated goal of expanding sole proprietor access to association health plan coverage by creating conflict and ambiguity with a wide range of laws governing employers and group health plans. Declaring individuals to be groups and to be both an employer and an employee raises complicated plan administration issues. Instead of easing AHP regulatory burdens, the proposed regulations will add to cost and confusion. DOL can increase opportunities for sole proprietors to purchase association plan coverage by permitting a more regulated non-bona fide association plan in addition to the existing plans.
3. The extension of ACA small group nondiscrimination requirements to existing bona fide association plans will require a substantial revision of our underwriting and rating with unknown financial consequences to our Trust. The risk selection issues identified by DOL arise from an expansion of association plans to marketing organizations whose only common interest is presence in the state. DOL should not force small businesses to subsidize individuals.

Discussion

1. Commonality of Interest and Purpose

By including broad geographic criteria for "commonality of interest," the proposed regulation overrides traditional tests designed to ensure that employers have enough in common to effectively design, develop, and oversee benefits for their respective employees. Under the DOL proposal, the common interest would be reduced to shared status as taxable business entities.

An association could market to every employer, of every type or size within a state. The common interest among employers would be replaced by the interest an insurer has in marketing a health plan to any employer. The proposed regulation would essentially eliminate the need for an association to broadly serve the common interests of its members. As DOL noted in providing an opinion on the bona fide status of the Bend Chamber of Commerce association health plan:

> The Bend Chamber's structure is not the type of connection between employer members that the Department requires for a group or association of employers to sponsor a single "multiple employer" plan. Rather, the Department would view the employers that use the Bend Chamber's arrangement as each having established separate employee benefit plans for their employees. Although we do not question the Bend Chamber's status as a genuine regional chamber of commerce with legitimate business and associational purposes, the primary economic nexus between the member employers is a commitment to private business development in a common geographic area. This would appear to open membership in the Bend Chamber, and in turn participation in the proposed health insurance arrangement, to virtually any employer in the region.
>
> The Department's conclusion that the Bend Chamber's health insurance program is not itself an employee welfare benefit plan under ERISA does not, however, prohibit the Bend Chamber from establishing and maintaining its proposed arrangement. Rather, the principal consequence for the Bend Chamber of its arrangement not being an employee benefit plan is that ERISA would not limit Oregon's ability to regulate the Bend Chamber's program under state insurance law.[5]

Moreover, geographic "commonality of interest" that extends over state boundaries creates jurisdictional issues in Washington State for associations that would market to the Vancouver, Washington / Portland, Oregon area. Oregon maintains and applies entirely different rules governing insured MEWAs than Washington State both in terms of regulatory requirements and jurisdiction. For example, Oregon requires certification by an attorney that the association is a single large group and that employers are in the same or related industry.[6] Washington has no similar requirements for associations and does not define associations apart from reference to ERISA's definition of employer.[7]

The primary effect of the proposed commonality of interest change would be the elimination of the application of ACA small group and individual market (as to the self-

[5] DOL Advisory Opinion 2008-07A.
[6] Oregon Department of Consumer and Business Services - *Transmittal And Standards For Group Health Coverage to be issued to an Association, Union Trust, Trust Group, Credit Union, or fully insured Multiple Employer Welfare Arrangement (MEWA)* (available at - http://dfr.oregon.gov/rates-forms/Documents/2441a.pdf).
[7] Washington Administrative Code § 284-43-0330.

employed) requirements for AHPs in Washington State. The change would be both costly and destabilizing to existing bona fide association plans and markets.

As for potential legislative and regulatory reaction to DOL proposed regulations, we would observe that Washington exercised its jurisdiction over self-insured MEWAs by essentially eliminating them through requirements that self-insured MEWAs become licensed as insurers. Washington requires an association to have been in existence for 10 years prior to sponsoring a self-funded health plan and to begin sponsoring the plan prior to October 1, 1995.[8] Washington's exercise of jurisdiction effectively prohibits self-insured association health plans despite federal law.

Definition of Employer

The proposed change to the definition of employer imposes unknown and costly burdens upon existing bona fide associations and their insurers. ERISA already includes self-employed individuals in defining a MEWA.[9] We recommend that DOL explore ways to differentiate between existing bona fide associations and proposed new associations with a focus on MEWA regulation and state preemption rather than create unintended consequences in pretending individuals are their own employers.

The requisite analysis of applicability of various laws to these new plan participants create greater complexity for association reporting and plan administration which in turn, drive up plan costs. Reducing regulatory burdens requires simplicity and predictability. With the addition of new conflicting standards, the burden will increase.

> Insurers build risk margins into their premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion should costs be greater than projected. Greater levels of uncertainty typically result in higher risk margins and higher premiums. Changes to the level of uncertainty regarding claim costs or other aspects of ACA provisions can cause changes to the risk margins.[10]

The advantage in granting a self-employed individual access to a large group association health plan depends upon the extent to which large employer practices translate to individual AHP member participation, e.g., open enrollment, waiting periods, minimum contribution, and other requirements. To the extent that systems must be redesigned to exclude or administer individuals separately from traditional common law employers, these costs will be passed on to existing, true employers to subsidize self-employed individuals.

---

[8] RCW 48.125.010(1) For example, see Washington Insurance Commissioner response to request for licensing of Washington Technology Industry Association Trust as a self-funded MEWA. (WTIA Demand for Hearing).
[9] 29 U.S.C.1002(40)(A).
[10] American Academy of Actuaries Issue Brief: "Drivers of 2017 Health Insurance Premium Changes."

A review of the all potential conflicts between the proposed regulations and existing statutes and regulations was not possible for these comments; however, a few observations demonstrate the effects of changing long-standing regulation of employer benefits to fit individuals. For example, under ACA regulations, the small group medical loss ratio (MLR) is 20% and large group loss ratio is 15% aggregated by state as these markets are defined.[11]

> Large group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer, unless otherwise provided under State law.[12]

Regulatory reporting requirements of MLR reveal particular issues with coverage provided through associations:

> (1) For individual market business sold through an association or trust, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage.
> (2) For employer business issued through a group trust or multiple employer welfare association (MEWA), the experience of the issuer must be included in the State report for the State where the employer (if sold through a trust) or the MEWA (if the MEWA is the policyholder) has its principal place of business.[13]

Medicare provisions governing its secondary payer status create reporting and administration issues for AHPs. Medicare rules determine when a group health plan must pay benefits first with Medicare as a secondary payer.[14] These Medicare regulations reference IRS excise tax penalties for failure to comply and IRS Code definitions of group health plan. Special statutory provisions are directed at small employers purchasing through multiple employer group health plans:

> (iii) **Exception for small employers in multiemployer or multiple employer group health plans**
> Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding

[11] 45 CFR 158.120.
[12] 45 CFR §158.103 citing to 45 CFR §144.103.
[13] 45 CFR 158.120 (d).
[14] 42 USC § 1395y (b).

calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.[15]

In turn, the IRS code defines group health plan and large group health plan as:

(1) **Group health plan**
The term "group health plan" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.
(2) **Large group health plan**. The term "large group health plan" means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year. For purposes of the preceding sentence—
(A) all employers treated as a single employer under subsection (a) or (b) of section 52 shall be treated as a single employer,
(B) all employees of the members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer, an
(C) leased employees (as defined in section 414(n)(2)) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n).[16]

Presumably other federal agencies will propose conforming regulations to the many conflicting standards that are not currently available for review.

Non-Discrimination

The proposed DOL regulations governing rate discrimination conflict with existing ACA regulatory requirements and would require an overhaul of existing plan design and pricing.

(c) **Prohibited discrimination in premiums or contributions -**
…(2) **Rules relating to premium rates** -

[15] 42 USC § 1395y (b)(1)(A)(iii).
[16] 26 USC § 5000 (b).

> (i) **Group rating based on health factors not restricted under this section**. Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.[17]

The proposed regulation would adopt the fiction that employer participants of an association plan are "employees" that must be charged the same rate as similarly situated "employees." These regulations would extend the fiction by defining an individual as her own employer and employee and also an "employee" of the "large group" AHP for rating purposes. Naturally, this change would further destabilize existing bona fide associations by causing large employers to leave the association to obtain a better rate; since, federal rate regulations expressly permit this experience rating.

> **Example 1**.
> (i) **Facts**. An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F's claims experience.
> (ii) **Conclusion**. In this Example 1, the issuer does not violate the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F's claims experience. [18]

The focus of both the ACA and ERISA is upon the employer plan, the relevant market and the plan issuer. While a bona fide association may be considered an employer plan, the beneficiaries are not converted to association employees. As DOL explained in an advisory opinion:

> Merely because a person, group or association may be determined to be an "employer" with the meaning of ERISA section 3(5) does not mean that the individuals covered by the plan with respect to which the person, group or association is an "employer" are "employees" of that employer.[19]

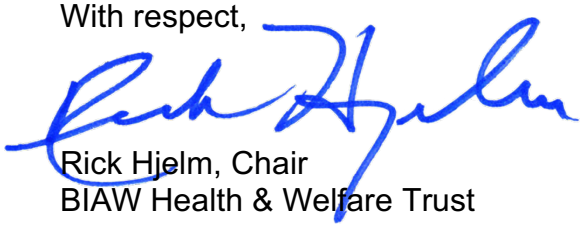
Understandably, DOL worries that an individual defined as an employer may face a much higher premium in an association than the price available in the community rated individual market or in an ACA exchange. Rather than help small employers gain access to association plan coverage, the proposed regulations help individual sole proprietors at the expense of small employers by forcing employers to subsidize a high-risk individual who seeks association health plan benefits knowing of their own need for coverage. Associations cannot refuse membership or association plan coverage based upon the health of the individual. DOL would also prohibit pricing based upon risk.

---

[17] 29 C.F.R. § 2590.702 (c)(2).
[18] 29 C.F.R. § 2590.702 (c)(2).
[19] DOL Advisory Opinion 92-04A.

The proposed regulations should be reconsidered with greater attention to changes in federal health care reform and amendments to the ACA rather than amending longstanding employee benefit rules to achieve this indirect aim. While we share the view that association plan coverage provides necessary choices for employers, we know that bending something too far can break it.

With respect,



Rick Hjelm, Chair
BIAW Health & Welfare Trust