Multi-Association Health Plan Coalition

March 1, 2018

Office of Regulations and Interpretations
Employment Benefits Security Administration
U.S. Department of Labor, Room N-5655
200 Constitution Avenue, NW
Washington, DC 20210

Attn: Definition of Employer – Small Business Health Plans RIN 1210-AB85

To the Docket:

On behalf of the Multi-Association Health Plan (MAHP) Coalition, comprising the National Newspaper Association and Printing Industries of America, we enthusiastically support President Trump's Oct. 12, 2017, Executive Order (EO) 13813 "Promoting Healthcare Choice and Competition Across the United States," to expand healthcare options for America. Our coalition operates within the printing, publishing, communications and allied industries and was formed to obtain association health insurance for our small business members.

Our small business members have struggled before the Affordable Care Act (ACA) was passed as well as after its implementation to find affordable health plans. Most have long since been priced out of group plans for themselves and their employees. As such, they and their staffs either are attempting to purchase affordable insurance on the ACA exchanges or are going without coverage, at great risk to their health and productivity. Many report that even if they can find coverage on the exchanges, the choices are too limited for them to find what they need, and some of our members are in counties where no plans or only one plan have been offered for periods of time.

We believe association health plans (AHPs) can be part of the solution for America's healthcare, and are gratified by the proposed regulatory framework that has been put forward for comment from the Dept. of Labor (DOL). Specifically, we are pleased by proposed language that would expand the ability to meet "commonality-of-interest" requirements in DOL advisory opinions (AO 94-07A and AO 2001-04A) that interpret the definition of an "employer" under Section 3(5) of the Employee Retirement Income Security Act (ERISA). We are particularly pleased that this language would promote AHP formation on the basis of industry.

Definition of "Employer"

The proposed rule would amend the definition of "employer" to expand the types of groups and associations that would qualify as single employers for purposes of sponsoring an ERISA health plan.

Under current law, only a "bona fide" employer association can act as an employer and establish an ERISA plan. A bona fide employer association must consist of individual member employers who:

- Join together for reasons other than providing health coverage;
- Have one or more common law employees;
- Control the association; and
- Share a "commonality-of-interest," which generally means the member employers and the association share a sufficiently close economic or representational interest, such as operating in the same industry.

AHPs have been regulated under ERISA as multiple employer welfare arrangements (or MEWAs), which could be an employee benefit plan covering all members of an association. As stated, this has been defined as a bona fide group or association over which dues paying members exercise the requisite control. DOL would determine the existence of a bona fide association of employers based on criteria listed above per AO 2005-20A.

This criterion has prevented employers from joining together for the exclusive purpose of providing health coverage and prevented employers from joining together if they are not closely related, even if in the same geographic area. The rationale for this traditional definition is sound, as it discourages creation of risky plans, ensures that individuals with experience in their industries have a stake in the governance of the plans and lends credibility in the marketplace.

Bona fide employer associations also have another advantage over individual plans and small group markets (50 or fewer employees) under the Affordable Care Act in that they qualify for the large group market (51 or more employees) and are not required to provide ACA essential health benefits. Thus, a group health plan established and maintained by a bona fide employer association is considered a single plan and, assuming there are at least 51 employees in the aggregate among all member employers, the plan will fall into the large group market rather than having to comply with more costly rules in the smaller health plan regulatory structure.

We support the proposed rule's expanded definition of "employer" to allow more associations to qualify as bona fide and ask that the final rule clarify that a related group of associations can band together (as a Multi-Association Health Plan or MAHP) and be considered an "employer" in order to provide a health plan to the collective membership. This would be done consistent with current protections that are designed to prevent adverse consequences and to ensure that AHPs resemble employer-sponsored arrangements and not commercial insurance.

AHP Certainty

Many of us have desired the opportunity to develop health insurance plans for our small business members for more than two decades and have supported bipartisan legislation to that effect. In so doing, it has always been our goal to create a regulatory framework that fosters legitimate AHPs and precludes fraudulent activity that could leave participants in the lurch. For example, we are pleased that S. 1818, the Small Business Health Plans Act of 2017, establishes financial transparency and regulatory oversight for AHPs in Sec. 806 Requirements for Application and Related Requirements, including a bonding disclosure requirement to state officials where an AHP operates, and that these requirements are augmented in Sec. 3 Cooperation Between Federal and State Authorities.

Also, Sec. 801 Association Health Plans and Sec. 803 Requirements Relating to Sponsors and Boards of Trustees in H.R. 1101, the Small Business Health Fairness Act of 2017, provide criteria for sponsorship of

AHPs that we support. However, please note that we prefer the clarifying language in S. 1818 that a consortium of bona fide associations [a Multi-Association Health Plan or MAHP] qualifies as a plan sponsor, so that organizations with insufficient numbers of small members to form a favorable risk pool can join together for a more solvent and attractive offering.

Commonality-of-Interest

Among the factors considered by DOL for a bona fide group or association have been the purpose for which a group/association was formed and who controls and directs operations of the benefit program. Also, employers that participate in a benefit program must directly or indirectly exercise control over the program, and DOL further clarified that the person or group that maintains the plan must be "tied to the employers and employees that participate in the plan by *some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits.*"

The degree of commonality-of-interest has depended on the facts, but an association of employers in unrelated industries would most likely not meet the current criteria. However, a group of associations whose members comprise different facets of a common industry, such as a supply or distribution chain, would appear to meet the current criteria and definitely would appear to qualify under the proposed language's expanded view. As such, we support that aspect of the proposal and hope the Department (EBSA) makes clear that such a group would qualify.

Under the proposed rule, member employers can establish a commonality-of-interest if they "Are in the same trade, industry, line of business, or profession, regardless of state boundaries."

Accordingly, the MAHP Coalition urges consideration of these concerns:

1. Many associations are too small or have too few eligible plan participants to form a viable risk pool. We are not seeking a self-insured plan, but hoping to attract a qualified underwriter. One of the lessons from the Senate Health Education Labor and Pensions (HELP) and House Education and the Workforce Committees' thorough examination of healthcare over the past decade is that the widest possible pool of enrollees is necessary to enable insurers to underwrite viable plans. We believe the concept is sound to require associations to prove that they were formed and are in continuing existence for purposes other than providing health insurance. But DOL must allow bona fide associations to create umbrella entities that can serve a number of otherwise-qualified associations and allow them to combine their enrollees into a large, consolidated pool in order to attract competition for the plans.

2. We have worked with Sen. Mike Enzi to ensure that these networks (Multi-Association Health Plans or MAHPs) can be created, and his Small Business Health Plans Act of 2017 (S. 1818) includes language in Section 801(b)(4) that a qualified plan sponsor can be "a bona fide trade association or a consortium of such associations." This language ensures that smaller associations can band together to sponsor a health plan, thus creating a more attractive economy-of-scale for underwriters. For these reasons, we support the proposed rule's expanded view of "commonality-of-interest" and request that DOL's final regulations take the same approach.

Preemption of State Rules

Finally, the question of requiring nationally-based, federally-regulated health plans to comply with regulations of the various states must be carefully addressed. Simply put, states have two kinds of mandates in place: 1) health coverage mandates; and 2) financial solvency mandates.

While our organizations intend to seek plans that provide coverage of pre-existing conditions, the impossibility and expense of complying with each state's coverage mandates have defeated AHPs in the past. It is crucial that federal regulations provide flexibility for the market to offer plans that address various coverage needs, and for associations to shop for and provide the plans that best fit their members' needs.

Federal regulations will have to preempt state coverage mandates to some extent in order for AHPs to maintain the efficiencies that will translate to lower insurance costs for participants. The vast majority of AHPs, including the Multi-Association Health Plan we want, would be fully insured. Therefore, they would be based on insurance offerings already registered, regulated and routinely filed in every state (under the rubric of policy-holder protection), which lends itself to federal streamlining.

Also, the issue of "must offer vs. must provide" for coverage requirements should be addressed since "must provide" mandates are driving up the costs of health insurance. The ability of bona fide employer associations to qualify for the large group market and not be required to provide ACA essential benefits will need to be augmented with federal preemption over "must-provide" state coverage mandates.

One possibility would be modeled on the Health Insurance Marketplace Modernization and Affordability Act of 2006 introduced by Sen. Mike Enzi. Under that legislation, Small Business Health Plans (or AHPs) would have to offer at least one comprehensive benefit package modeled on a state employee plan in one of the five most populous states. AHPs that offer such a plan would be granted the flexibility to offer other benefit packages that are exempt from state mandated benefits laws (from which large corporations and unions are now exempt).

With regard to financial solvency mandates, states certainly have an interest in requiring a sound fiscal basis for plans operating within their borders. And, per ERISA's preemption rules, if a MEWA (including an AHP) is fully insured, state insurance regulations can require the MEWA to maintain specified levels of reserves and/or contributions. However, fifty varying mandates on other coverage requirements will be problematic to the viability of AHPs that want to cross state lines.

As stated, we support reasonable financial solvency and transparency requirements for AHPs, but the viability of nationwide AHPs will depend on their being able to maintain their economies-of-scale. The patchwork quilt of state mandates creates complex legal barriers that will thwart the promise of AHPs as envisioned in the proposed rule. Therefore, we recommend that federal regulations preempt these mandates perhaps by sweeping them into ERISA-level regulation, and we again also suggest language in S. 1818 and H.R. 1101 as possible templates for the proposed rule's interplay with state solvency and transparency requirements.

Conclusion

We note that White House talking points that accompanied President Trump's Executive Order state that a factor for regulatory action to allow AHPs across state lines is that, "A broader consumer-friendly interpretation of the federal law governing insurance (ERISA) could potentially allow employers in the

same line of business *anywhere in the country* to join together to offer healthcare coverage to their employees."

We agree that employers who belong to bona fide associations in the same line of business should be able to form AHPs and MAHPs anywhere in the country, and urge Secretary Acosta and EBSA to enable associations related by supply chain or other common interests to band together to offer such health plans.

Thank you,

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