American Bankers Association
HSA Council

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

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

Dear Sir:

Thank you for the opportunity to comment on the Department of Labor's (DOL) Association Health Plan (AHP) proposed regulation. The American Bankers Association's HSA Council represents about ninety-four percent of all the Health Savings Accounts (HSAs) in the United States and the millions of Americans who finance their healthcare with these plans. We consider the AHP proposal as a potentially useful structure for making HSA-qualified plans available to a wider audience of Americans.

We agree with the intent of President Trump's Executive Order (No. 13813), that by expanding the utility of AHP and Multiple Employer Welfare Arrangement (MEWA) regulation, Americans disadvantaged by the high cost of health coverage in the Affordable Care Act's (ACA) individual markets or SHOP Exchanges may be able to find alternate health coverage through expanded AHPs.

We also agree with the Department's principle assumption, that the most advantageous rates, comparable to those present in large self-funded employer plans, can only be achieved if AHPs are unbound from the ACA's narrow definition of "employer" under Section 3(5) of the Employee Retirement Income Security Act (ERISA) of 1974.

Our comments will focus on that definition, and the definition of "*Bona Fide* Group or Association of Employers" since we believe that AHPs will serve the greatest number of Americans if they can access large group rates.

Supporting Community Banks as Small Employers

The ACA effectively prohibits small employers with fifty or fewer employees from banding together to form large group fully insured plans, a prohibition felt especially hard among

community banks. Currently, one solution to which many community banks turn is their state bankers association sponsored plan. Most of these plans are not currently AHPs. Under current law, to be considered a "*bona fide* group or association of employers" the "group" must satisfy the following requirements:

> *Bona fide association* means, with respect to health insurance coverage offered in a State, an association that meets the following conditions:
>
> **(1)** Has been actively in existence for at least 5 years.
> **(2)** Has been formed and maintained in good faith for purposes other than obtaining insurance.
> **(3)** 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 any employee).
> **(4)** Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).
> **(5)** Does not make health insurance coverage offered through the association available other than in connection with a member of the association.
> **(6)** Meets any additional requirements that may be imposed under State law. [1]

In addition, a current AHP must meet "commonality of interest" and "control" tests as set forth in regulation. As the name implies, the control test measures the ability of a participating employer to exercise his voice in plan design and operation. The "commonality of interest" test is a facts and circumstances test which, according to DOL guidance, determines if a group of employers is considered "*bona fide*." This status is achieved if the employer members are in the same industry and the same geographical area.

But, current rules prohibit inclusion of self-employed individuals in group health plans, meaning that self-employed individuals with no employees are forced to find health care coverage in the fully-insured individual market. Despite better than expected enrollment this benefit season, individual markets in most states offer few plan choices offered by even fewer insurance companies at rates which can only be described as punitive.

Small Employers and Working Owners

In response to current market dynamics, the DOL's proposed regulations would make it easier for small employers like community banks to form a fully-insured large group or self-insured AHP.

Current rules restricting a *bona fide* group to similar geographic locations would be eased and we support this change.

[1] 45 CFR 144.103

Under the proposed regulation, employers in the same industry or profession may participate in the same AHP and offer large group fully-insured or self-insured AHP health coverage to their employees, regardless of the employers' geographic location.

The proposed regulations would also allow employers in different industries and professions to offer group coverage but only if they are located in the same city or state.

Self-employed individuals – working owners according to the proposed regulation - with no employees, could participate in an AHP. This is perhaps the most advantageous part of the proposal. According to the proposed changes, working owners in the same industry could participate in the same AHP but working owners in different industries would be able to join AHPs formed by business groups like the local Chamber of Commerce provided the working owners are located in the same city or state as the local Chamber's employer members.

ACA Actuarial Sensitivity and Essential Health Benefit (EHB) Exemption

Because the intent of the proposed rule is to allow small employers and working owners to combine into large groups, AHPs formed under the new rule would be treated as such by the ACA, meaning that the minimum value, EHB, community rating and single risk pool restrictions normally applied to small group and individual plans would not apply.

We are generally in favor of this approach; however, the Department should be aware of two significant concerns. First, successful MEWAs arise from successful associations and the loyalty of the members who join them. AHP rules should be crafted in order to avoid the emergence of AHPs where the only motivation for joining arises from the sale of insurance. If insurance is the only benefit, employers will enroll and dis-enroll based predominantly on price. Unpredictable membership dynamics may have a harmful effect on risk pool stability.

Second, if proposed AHP regulation liberates MEWAs from EHB standards, employers could decide to avoid the higher cost of comprehensive health insurance in favor of catastrophic coverage, moving between the two as medical need arises. The result would likely be higher and more frequent premium increases in comprehensive plans, which is exactly the premium dynamic stable plans seek to avoid. Much of the criticism of past AHP proposals has centered around the likelihood of healthy participants avoiding higher cost insurance in favor of more modest or even catastrophic plans. Regulation should be tailored so existing, and therefore successful, MEWAs should not be harmed.

Lastly, nothing in the proposal would exempt fully insured AHPs from state coverage mandates. Accordingly, AHPs that have multistate participation by member employers should take care to harmonize the minimum benefit requirements in each state.

Alternatively, the Department should consider exempting fully insured AHPs from state coverage mandates in order to achieve benefit parity among the AHP's members.

Self-Funded AHPs, MEWAs and a Recommendation for HSAs

One of the tremendous benefits of ERISA plans is the ability to harmonize benefits to all members regardless of their location in the country. But, a limitation of the proposed regulation is its inability to overcome state jurisdiction over MEWA regulation. For example, some states have decided to require MEWAs to respect state coverage mandates while others have elected not to allow these arrangements at all.

Accomplishing uniform benefit structure through the proposed AHP regulation would likely be very difficult absent pre-emption of state jurisdiction and we are not confident regulatory authority can change that. This shouldn't be construed as a reason to avoid the AHP structure but simply one limitation of it.

We further believe that AHPs should at least recommend – but not require - adoption of HSAs as a benefit offering. AHPs have traditionally suffered criticism around consumer protection and coverage issues; HSAs are regulated by the Internal Revenue Service (IRS), provide preventive care services below the deductible per IRS and HHS regulation and have well-known operational rules. If AHPs were to become dominated by HSA-qualified plans, the consumer protection rules would emanate from DOL, IRS and state insurance departments. It would be hard to imagine a more robust regulatory environment.

We look forward to helping the Department enact this proposal and thank you, again, for your efforts.

Respectfully,

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