



Office of Regulations and Interpretations
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
ATTN: Definition of Employer – Small Business Plans RIN 1210-AB85

RE: RIN 1210-AB85

Dear Employee Benefits Security Administration:

Capstone Benefits Group, Inc. is a third-party benefits administrator. It has been in business since 2005. Its book of business relates almost exclusively to the administration of association health plans. Its clients include insurance issuers and the associations (or their trusts) themselves. Capstone's owners and its senior personnel have all worked with the AHPs prior to coming to the company, in some cases going back to the mid-1980s. Their experience includes fully-insured and self-funded AHPs and encompasses every aspect of AHP operation, from formation to marketing to underwriting and rate setting to administration of benefits and claims to termination and orderly wind down.

In short, we are proven, experienced practitioners of the craft of creating and managing association health plans.

We support the Department's goal of expanding the availability of group health insurance coverage, particularly to the employees of smaller employers. We also believe that one way to advance that goal is by easing the barriers to the use of Association Health Plans, provided that this can be done without an unacceptable increase in the hazards that have historically troubled such arrangements.

However, we are concerned that some aspects of the proposed rule do not meaningfully address such hazards. Moreover, we believe that the proposed rule fails to adequately account for the important difference between fully-insured and self-insured plans; and between existing trade association-based plans and the proposed entrepreneurial plans. Finally, we believe that the proposed rule will be not able to achieve its goals without companion regulation from the IRS and the Department of Health and Human Services.

A. Nondiscrimination Requirements / Coordination with Current Renewability Rules

We agree with the Department that nondiscrimination requirements are essential to the goals of the rule. However, like other aspects of the rule, we believe the proposal fails to appropriately distinguish between self-insured and fully-insured AHPs and between trade association-based plans and entrepreneurial health plans.

First, we note that the Department of Health and Human Services already regulates insurance issued to a trade association health plan as part of its guaranteed availability and renewability rules¹. See 45 CFR sec. 144.303. These rules apply, for all intents and purposes, to trade association plans that have been in existence for at least five years. They already include provisions that would prevent an association from conditioning membership in the association on any health status-related factor relating to any individual. They also require that health insurance coverage offered through the association be available to all members, regardless of any health status-related factor. Such arrangements are deemed to be “bona-fide association plans”. See 45 CFR sec. 144.103. The proposed rule would expand the nondiscrimination requirement to all associations but would leave intact the exception to the renewability rules (which the Department does not have the authority to change). In general, this exception permits insurers to non-renew coverage issued to bona-fide when association for a member employer when the employer’s membership ceases. This exception would not apply to AHPs that are not trade-association based, that are newly formed, or formed primarily for the purpose of providing insurance. According to the Department of Health and Human Services, this exception has several effects:

For example, an employer with association coverage leaving the association mid-year and losing coverage may be subject to a different premium rate under a new policy based on a quarterly rate update in the small group market or a new experience rate in the large group market. Further, we recognize that association members who cease membership in an association and lose coverage may have their deductible and maximum out of pocket limit reset under a new policy. The same logic applies with respect to employers whose coverage is terminated mid-year for failure to meet an issuer’s participation or contribution rules. And, small employers whose coverage is terminated for failure to meet minimum participation or contribution rules might not be able to purchase new coverage until the next annual enrollment period from November 15 to December 15. See 45 Fed. Reg. 12203 at 12214.

The effect of the absence of this exception for the Department’s newly-created categories of arrangements that would not qualify as bona-fide association plans is murky at best. What’s more, it is a question that can only be answered by HHS.

Another part of the proposed non-discrimination rules would prohibit the association from treating different employer members as distinct groups of similarly-situated individuals. The effect of this would be to prevent an association from charging higher premiums to an employer based on the health experience of its employees. The Department views this as critical to its view that plan sponsors under the expanded rule can still be said to act in the interest of employers, specifically

¹ Of course, the exception to the guaranteed availability rules was eliminated by the ACA.

those sponsors whose plans do not feature the traditional “common-bond” relationship among their employers. The Department is properly concerned about extending ERISA coverage to entities that are “indistinguishable from commercial-insurance-type entities.” PR at 624.

However, those concerns have no application to conventional trade association arrangements which the Department has long and consistently held to exhibit the necessary connections to qualify as acting in the interest of employers. The Department offers no rationale for changing or increasing the regulatory burdens on arrangements which it has approved in the past. Similarly, the concerns about the nature of the coverage being offered are misplaced if it is fully-insured as that coverage is regulated by the States and the Department has not cited any inadequacies in those regulations.

Proposed Revision: Suspend the rule-making process pending guidance from HHS on application of the guaranteed renewability rules to arrangements that are not bona-fide association plans. The expanded nondiscrimination rules in the proposed regulation should apply only to those arrangements that are not fully-insured “bona-fide association plans” as defined in 45 CFR sec. 144.103.

B. Protection Against Default and Manipulation

As the Department acknowledges, the current restrictions on AHPs have evolved from the too frequent failure of such arrangements “to pay promised health benefits to sick and injured workers while diverting, to the pockets of fraudsters, employer and employee contributions from their intended purpose of funding benefits.” 83 Fed. Reg. 614² at 617. It follows that any loosening of those restrictions must not promote a return to fraud and failure.

In our experience, self-insured AHPs are more prone to these defects than fully-insured AHPs. This observation is further supported by looking at the Department’s own enforcement actions as summarized at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/enforcement/healthcare-fraud>. There it appears that the vast majority of actions involving AHP failure or self-dealing were against self-insured arrangements³.

The proposed rule treats fully-insured and self-insured AHPs on an equal footing. Similarly, it makes no distinction between AHPs organized around a group of related trades or business and the new category of AHP organized around geographical proximity. Historically, this makes sense only if the proposed rule addresses the factors that make self-insured AHPs and those bound only by location riskier than plans that fully-insured or bound by common business interests. To determine whether this is the case, it’s necessary to understand the root causes of those risks.

1. Basic Business Competence

² Henceforth, the PR.

³ This listing includes plans involving both related and unrelated employers. Our comment is limited to those cases involving unrelated employers.

In general, insurers know how to run the business of insurance; exceptions exist, of course, but broadly speaking, an insurer is here today because it was there yesterday. It has survived. The proposed rule imposes no requirement or even expectation of competence on the part of the organizers of a self-insured AHP. While the rule does require certain formalities in connection with the operation of an AHP, the Department acknowledges that these do little more than “duplicate conditions in the Department’s existing sub-regulatory guidance under ERISA.” PR at 620. To the extent that those rules were unsuccessful in reining in abuses in the past, there is little reason to suppose they will do so now.

Proposed Revision: Require a self-insured AHP to use a state-licensed insurance professional to manage the day-to-day operation of the arrangement. This could be an insurer, insurance agent or broker, TPA or other entity defined by each state. This will provide assurance that the AHP will not fail due to the mismanagement or dishonesty of the promoters.

2. Size Matters

Insurers succeed because they have a large and stable population of insured risks and sufficient assets to weather the expected volume of claims. The Department notes in several places that largeness is an important element to the success of an AHP. For example, the Department observes that large employers can obtain better insurance terms:

“because of their larger pools of insurable individuals across which they can spread risk and administrative costs. Expanding access to AHPs can help small businesses overcome this competitive disadvantage by allowing them to group together to self-insure or purchase large group health insurance.” PR at 615.

See generally, the Department’s discussion under the heading “Potential Advantages of Scale” beginning at PR 627. E.g.:

“A self-insured AHP with a sufficiently large presence in a local market might capture some such efficiency” [through purchase of healthcare services];

and

“large payers, potentially including large, self-insured AHPs, may be able to negotiate discounts and other savings measures with hospitals, providers, and third-party administrators (TPAs)”.

Despite this, the Department does not include any size requirements for self-insured AHPs.

In our experience, the scale at which these types of advantages begin to emerge is not at the 51-participant level.

The inclusion of self-insured arrangements in the Department’s observations about size is something of a red herring; these are arguments about the advantages of size that are applicable to a health plan regardless of how it is funded; they are not arguments in favor of self-insurance *per se* unless the Department intends to limit the minimum size of the plan.

Of course, apart from these purchasing advantages, size is also a significant factor in the risk assumed by a self-insured AHP. Again, citing the preamble to the proposed rule: “The proposal seeks to enable AHPs to assemble large, stable risk pools.” PR at 628. Yet the proposal would not prohibit smaller, less stable risk pools.

Proposed Revision: Impose actuarially reasonable standards on the formation and on-going maintenance of self-insured AHPs, including minimum size, reserve and funding requirements.

3. The Effect of State Law

Some States regulate self-insured AHPs. However, as the Department correctly observes, “State rules vary widely in practice, and many States regulate AHPs less stringently than individual or small group insurance.” PR at 634. States with the less stringent regulation are more likely to breed AHPs at risk for mismanagement and, frankly, attract the fraudsters. Moreover, the ability of an AHP to operate in multiple States further complicates matters, as it begs the question of which State’s law will govern. The lack of an answer will inhibit the growth and complicate regulation of multi-state self-insured AHPs.

Similarly, the proposed rule is vague on what agency of government will be responsible for its enforcement. The Department outlines the preemption rules in the preamble. In the case of fully-insured AHPs, “State laws that regulate the maintenance of specified contribution and reserve levels (and that enforce those standards) may apply to the MEWA, but other State noninsurance laws are preempted.” PR at 617.

Conversely, in the case of an AHP that is not-fully insured, “any State law that regulates insurance may apply to the MEWA to the extent that such State law is not inconsistent with ERISA. For example, a State law could regulate solvency, benefit levels, or rating. Similarly, States could require registration and claims data reporting of MEWA operators.” *Id.* That said, the authority to enforce is not the same as the obligation or willingness to enforce and there will likely be cases where enforcement may require cooperation between States and the Department or where the Department simply needs to step in. Similar to the question of governing law, the question of dueling authorities in the case of a multi-state AHP needs to be addressed.

Proposed Revision: The federal management, operational and actuarial standards proposed above should be the floor for all self-insured AHPs. States may impose more stringent standards consistently with the ERISA preemption rules. However, for multi-state AHPs, the federal standards should apply. States may enforce permitted (i.e., non-preempted) State regulations but the Department should always have the authority to intervene.⁴

C. Organizational Requirements

⁴ We applaud the Department’s forthrightness in acknowledging that enforcement will demand additional resources, perhaps to the point of causing an increase in the federal deficit. In this regard, we simply urge the Department to be realistic and not to create new rules that it does not reasonably and honestly believe it will have the wherewithal to enforce. That helps no one.

As noted earlier, the proposed regulation codifies existing sub-regulatory guidance on the structural requirements for AHPs. That guidance evolved over several years, primarily in the context of trade association health plans (“TAHPs”). It was largely immaterial to entrepreneurial association health plans (“EAHPs”) since the latter could never meet the commonality of interest test to begin with. The Department does not discuss why the same structural standard should work for EAHPs. Of particular concern here is the requirement that participating employers control the functions and activities of the association. It can meet this requirement through the election of directors and officers. While we admit that this is somewhat speculative, we are concerned that in practice, small employers (who have no connection beyond the place where they reside) will not really care about the governance of the plan; they will simply elect the promoter and his nominees (who may not even be covered under the plan) to serve in these roles. This would undermine the intent of the proposed regulation.

Proposed Revision: Require that the majority of the board of an EAHP be comprised of employers who participate in the plan.

D. Coordination with the IRS

In general, it is advantageous for an AHP to shelter its income from taxation through a VEBA. However, the current VEBA rules are incompatible with the proposed rule. In particular, Section 1.501(c)(9)-2(a)(1) imposes both a common bond requirement and a geographic location requirement. The former is expressly based on member employers being in the same line of business; the scope of the latter requirement, while less certain, clearly does not contemplate the kinds of national AHPs that would be permitted under the proposed rule. We believe that AHPs (other than those that could currently qualify as a VEBA) will be reluctant to form without knowing what, if anything, the IRS intends to do with its VEBA rules.

Proposed Revision: Suspend the rule-making pending guidance from the IRS on whether it intends to expand its VEBA rules to permit multi-state VEBAs and VEBAs that do not require a same-line-of-business connection among members.

Summary

We suggest the following revisions to the Proposed Rules:

- 1. Proposed Revision: Suspend the rule-making process pending guidance from HHS on application of the guaranteed renewability rules to arrangements that are not bona-fide association plans. The expanded nondiscrimination rules in the proposed regulation should apply only to those arrangements that are not fully-insured “bona-fide association plans” as defined in 45 CFR sec. 144.103.***
- 2. Proposed Revision: Require a self-insured AHP to meet minimum reserve thresholds and to use a state-licensed insurance professional to manage the day-to-day operation of the arrangement. This could be an insurer, insurance agent or broker, TPA or other entity defined by each state. This will provide assurance that the AHP will not fail due to the mismanagement or dishonesty of the promoters.***

- 3. Proposed Revision: Impose actuarially reasonable standards on the formation and on-going maintenance of self-insured AHPs, including minimum size and funding requirements.**
- 4. Proposed Revision: The federal management, operational and actuarial standards proposed above should be the floor for all self-insured AHPs. States may impose more stringent standards consistently with the ERISA preemption rules. However, for multi-state AHPs, the federal standards should apply. States may enforce permitted (i.e., non-preempted) State regulations but the Department should always have the authority to intervene.**
- 5. Proposed Revision: Require that the majority of the board of an EAHP be comprised of employers who participate in the plan.**
- 6. Proposed Revision: Suspend the rule-making pending guidance from the IRS on whether it intends to expand its VEBA rules to permit multi-state VEBAs and VEBAs that do not require a same-line-of-business connection among members.**

Conclusion

As discussed above, we support the Department's goal of expanding the availability of group health insurance coverage, particularly to the employees of smaller employers. We also believe that one way to advance that goal is by easing the barriers to the use of Association Health Plans, provided that this can be done without an unacceptable increase in the hazards that have historically troubled such arrangements.

With our professional expertise in the association market, we can attest to the value that bona-fide association health plans bring to small employers, without creating instability or disruption in the overall market. We also know that while approximately 96%⁵ of employers are small businesses more than half of the small (less than 50 employees) private employers do not offer health insurance⁶ coverage to their employees and we believe that the Department's proposed rule could create needed expansion in the small group market.

However, we are concerned that some aspects of the proposed rule do not meaningfully address such hazards. Moreover, we believe that the proposed rule fails to adequately account for the important difference between fully-insured and self-insured plans; and between existing trade association-based plans and the proposed entrepreneurial plans. Finally, we believe that the proposed rule will be not able to achieve its goals without companion regulation from the IRS and the Department of Health and Human Services.

Should the Department or Agency wish to discuss this letter we can be reached at Capstone Benefits Group, Inc., Aaron Curtis, Principal, (317) 793-2902, acurtis@capstonebenefits.com or Mark Lamberth, SVP, (859) 300-6432, mlamberth@capstonebenefits.com .

⁵ Source: U.S. Treasury Department Fact Sheet, "Final Regulations Implementing Employer Shared Responsibility"

⁶ Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017