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March 6, 2018

Submitted Electronically via: www.regulations.gov

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

Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85.

Dear Sirs and Madams,

Gravie, Inc. (“Gravie”) respectfully submits these comments in response to the Notice of Proposed Rulemaking (“NPRM”), clarifying the “Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans,” 83 FR 614 (Jan 5, 2018) (the “Proposed Rule”). Gravie provides services to employers, including third party administration of self-funded group health plans subject to the Employee Retiree Income Security Act of 1974 (“ERISA”) based in Minnesota, and is licensed in 34 states.

We applaud the effort to implement Executive Order 13813 (the “Executive Order”) by broadening the criteria under ERISA section 3(5) for determining when employers may join together in an employer group or association that is treated as the “employer” sponsor of a single multiple-employer group health plan as those terms are defined in Title I of ERISA. We also applaud the dual treatment of working owners as employers and employees. Small business owners (such as family farmers) often earn too much to be eligible for premium tax credit subsidies on the American Health Care Exchanges, and they face skyrocketing *premiums* and diminished *insurance* options.”¹ We believe the guidance permitting self-employed workers to

¹ Snowbeck, Christopher. Farmer cooperative health plans may rattle individual market in Minnesota. Star Tribune, Nov. 14, 2017 (<http://www.startribune.com/farmer-cooperative-health-plans-may-rattle-individual-market-in-minnesota/457321193/>). This article notes that in Owatonna, Minnesota, a 60-year-old married couple who buys the least expensive insurance plan through the state’s MNSure exchange in 2018 will have a combined annual premium of \$25,848 for coverage that includes a \$6,000 deductible for each spouse. If both spouses meet the deductible, they will pay a total of \$37,848 before insurance begins to cover claims other than preventive care.

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participate in Association Health Plans (“AHPs”) is critical in light of unsustainable premiums in the individual market.

But we have some concerns that the Proposed Rule may not go far enough to ensure the viability of AHPs for small employers. Our comments address two aspects of the Proposed Rule: (1) the nondiscrimination protection that would prohibit an AHP from developing different premium rates for different employer members, and (2) a class exemption that would exempt self-insured AHPs from non-solvency requirements of a State law regulating these arrangements.

1. AHPs should be permitted to rate employers separately.

A. Rating employers separately is consistent with existing federal law.

Self-funded AHPs with enough members to be treated as a large employer must have the flexibility to establish rating methodology consistent with other self-funded large employers. ERISA does not prescribe a rating methodology, but it offers protections to individual employees. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits discrimination based on health factors in eligibility, benefits, premiums and contributions.² But the rule applies only to individual employees; variations are expressly permitted between groups of “similarly situated” individuals.³

For this purpose, each participating employer in an AHP represents a distinct group of similarly situated employees that may be rated separately based on aggregate claims experience. HIPAA expressly permits group health plans to vary premium rates among groups of similarly situated individuals if the distinction is based on a bona fide employment-based classification.⁴ The fact that an AHP will be treated as a single employer under the MEWA rules does not make it the common law employer of enrolled employees; each participating employer retains its separate identity. As noted in the HIPAA nondiscrimination rule, “Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.”⁵

The characterization under the Proposed Rules of self-employed individuals as both employers and employees create small employers with a single employee. Although the HIPAA rules prohibit discrimination in premiums based on health factors of “individuals,” it does not address rate-setting where an employer has a single employee. FAQs issued by the Department under HIPAA provide as follows:

² 29 CFR 2590.702.

³ 29 CFR 2590.702(d)(1).

⁴ *Id.*

⁵ 29 CFR 2590.702(c)(2)(i)

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Q20: Is it permissible for a health insurance issuer to charge a higher premium to one group health plan (or employer) that covers individuals, some of whom have adverse health factors, than it charges another group health plan comprised of fewer individuals with adverse health factors?

Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer. Whether any plan provision or practice with respect to benefits complies with this rule under HIPAA does not affect whether the provision or practice is permitted under the Affordable Care Act (including the requirements related to community rating administered by HHS).⁶

Every example in the HIPAA nondiscrimination rule pertains to discriminatory treatment among similarly situated employees of employers. When an employer has a single employee, such discrimination cannot occur. A self-employed employee is not “similarly situated” with other self-employed employees in an AHP. Nor should such an employer be treated differently than any other employer in the AHP. Though HIPAA will continue to apply to employers with more than one employee, individual underwriting and rate setting should be permissible with respect to single employee employers.

The Executive Order begins as follows:

It shall be the policy of the executive branch, *to the extent consistent with law*, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people.

(Emphasis added). Allowing AHPs to separately rate groups of similarly situated employees is consistent with HIPAA and other existing federal law. An artificial nondiscrimination scheme, by comparison, has no basis in federal law as applied to large employer plans. If an AHP is to be treated as a single large employer plan, it must be entitled to the same benefits and rights that flow naturally from the law. Should these arrangements become successful enough to provide the intended relief to millions of Americans who cannot afford insurance, but have a negative

⁶ Health Coverage Portability (HIPAA) Compliance FAQs, Q&A-20, accessible at: <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance>.

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impact on traditional markets, it is for Congress to weigh the effect and enact legislation for the greater good.⁷

B. Rating employers separately improves the solvency of AHPs

The nondiscrimination rules under the Proposed Rule were promulgated out of concern that AHPs would select healthy groups by setting rates to the detriment of unhealthy groups.⁸ If rates reflect the aggregate claims experience of similarly situated employees, there will in fact be differences among participating employers as permitted under HIPAA. This is necessary to protect the solvency of AHPs, because participation is voluntary. If healthy groups are required to bear the costs of unhealthy groups, unhealthy groups will seek AHP coverage, and healthy groups will leave the association. This may ultimately lead to a death spiral for the AHP. If the nondiscrimination rules survive, AHPs may not, which would be inconsistent with the policy promulgated by the Executive Order.

The State of Washington, which as of 2018 had over 400,000 individuals enrolled in AHPs with separately rated groups, provides an example of how essential this rating flexibility is to the viability of AHPs. In 2014, the Office of the Insurance Commissioner (OIC) began to deny rate and form filings for the AHPs with separately rated groups, leading to lawsuits and administrative hearings.⁹ In the Matter of Washington Technology Industry Association,¹⁰ the Administrative Law Judge ruled against the OIC, concluding in part as follows:

The OIC's denial . . . deprives thousands of Washington state residents from the opportunity to access more affordable and comprehensive health care services for themselves and their families. Moreover, its denial is contrary to the public interest and does not advance the objectives of the OIC.

⁷ We also note that the Executive Orders requires the Department to issue guidance to allow HRAs to be used in conjunction with nongroup coverage. We anticipate that such guidance will overturn the interpretation of the last administration that HRAs may not be “integrated” with individual policies of insurance, and possibly reverse similar subregulatory guidance that reimbursement of individual policies under Section 106 of the Code is an “employer payment plan”. We believe these interpretations contributed greatly to the disintegration of the individual market by precluding the participation of healthy, working adults on a pre-tax basis, and their reinstatement will likewise shore up these markets by more than enough to offset any impact of AHPs that use group-by-group rating.

⁸ Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans, 83 Fed. Reg. 614, 623 (Preamble) (Jan 5, 2018).

⁹ Stiffler, Lisa. Small businesses hail ruling that protects association health plans. The Seattle Times (July 2, 2015).

¹⁰ Accessible at: <https://www.insurance.wa.gov/sites/default/files/documents/15-0290-wtia-mot-summary-judgment.pdf>.

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In the matter of Master Builders Association of King and Snohomish Counties,¹¹ the Administrative Law Judge found that state law and HIPAA permitted individual rating of groups under an AHP. It concluded, as should the Department, that if a remedy was necessary due to perceived inequities, it was for the legislative branch, not the regulator, to act upon.

C. Rating employers separately will improve competition and choices in the market

As noted in the Executive Order, “the PPACA has . . . largely failed to provide meaningful choice or competition between insurers, resulting in one-third of America’s counties having only one insurer offering coverage on their applicable government-run exchange in 2017.” A robust AHP market will create more options for small employers and self-employed individuals, providing meaningful choice and competition. In a recent release, U.S. Representative Jaime Herrera Beutler describes AHPs as follows:

Here in Washington state, Association Health Plans (AHPs) currently provide roughly 400,000 individuals with quality, affordable health care plans – and that’s despite these popular programs being undermined and restricted by our state’s Insurance Commissioner. For many years, I’ve worked in a bipartisan manner to strengthen AHPs because they are a critical solution to making good health care more attainable for more people. If implemented correctly, the President’s expansion of AHPs could help bring down costs of quality care for thousands of Washingtonians.¹²

An AHP may use individual rating based on a small employer’s aggregated claims experience, but in practice, AHPs often take multiple factors into account when rating groups. Some AHPs mix historical claims data with a modified community rating formula for smaller employers to limit annual premium variation. Many will give premium discounts to groups that adhere to best practices (adequate employer contributions for both single and family coverage, avoidance of cash-in-lieu, encouragement of high participation rates, etc.). Most importantly, AHPs compete directly for groups with insurers and other sources of group health coverage, the beneficiary of which is the employer and its employees. Even if a group with poor experience declines to join an AHP because of a high rate, they can seek quotes in future years when experience has turned around through chance or better still, the implementation of best practices. Imposing a nondiscrimination rule with uniform rates denies the AHP a chance to compete in the market on a case-by-case basis, in contravention of the Executive Order.

D. Rating employers separately will permit AHPs to act in the “best interest” of participants

¹¹ Accessible at: <http://www.conniff.com/wp-content/uploads/07-01-2015-Cambia-Judgment-OIC-Admin-15-0062.pdf>.

¹² Accessible at: <https://herrerabeutler.house.gov/news/documentsingle.aspx?DocumentID=399003>

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The best interest standard of care is described in the Department’s new fiduciary rule. It is a combination of ERISA’s prudent man rule and duty of loyalty.¹³ An AHP acts in the best interest of participants when it utilizes a rating methodology not susceptible to adverse selection, death spirals, and insolvency. It acts in the best interest of participants when permitted to compete for groups in a free market. It acts in the best interests of participants when it encourages and rewards best practices. The proposed nondiscrimination rules will stifle these practices and free market forces intended to drive down rates.

2. The Department should issue a class exemption for self-insured MEWAs under Section 514(b)(6)(B) of ERISA

ERISA section 514(b)(6)(A)(ii) provides that states may regulate self-funded MEWAs to the extent “not inconsistent” with ERISA. According to the DOL’s MEWA Guide, this means that states may:

- Require self-funded AHPs to meet more stringent standards of conduct
- Require self-funded AHPs to provide state mandated benefits; and
- Require self-funded AHPs to obtain a license or certificate of authority – which may ultimately be at the discretion of state insurance regulators – or face taxation, fines and other civil penalties, including injunctive relief.¹⁴

The Executive Order notes that the goal of AHP reform is to permit small employers to overcome the “competitive disadvantage” with large employers and “allow more small businesses to avoid many of the PPACA’s costly requirements.” But as of 2014, at least 46 states have enacted and signed more than 175 laws specific to ACA health insurance implementation, including mandated “essential health benefits.”¹⁵ And nearly all states have existing “anti-MEWA” statutes on the books.¹⁶ Without an exemption from non-solvency rules, self-funded AHPs based on geography will be limited to a handful of states without restrictive anti-MEWA laws, and it may be unfeasible for those AHPs to provide coverage for metropolitan areas that cross state lines. And due to the patchwork of state laws and regulations throughout the United

¹³ Best Interest Contract Exemption, 81 Fed. Reg. 21002, 21004 (Preamble) (April 8, 2016).

¹⁴ Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA), United States Department of Labor, p. 30. Accessible 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>.

¹⁵ National Conference of State Legislature, *2011 - 2014 Health Insurance Reform Enacted State Laws Related to The Affordable Care Act* (June 17, 2014).

¹⁶ See, e.g. Minn. Stat. §§ 62H.01 through 62H.17.

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States, it will be virtually impossible to establish self-funded AHPs that cross state lines for workers in the same industry, line of business or profession.

Fortunately, the Department has complete discretion to issue a class exemption from most of these impediments and effectuate the intent, purpose and objective of the Executive Order. ERISA section 514(b)(6)(B) gives the Department the authority to exempt self-funded AHPs from state laws, with one exception. State insurance laws that can apply to a fully insured MEWA plan will still apply to self-funded AHPs. These laws are limited to standards requiring the maintenance of specified levels of reserves and contributions required to pay benefits in full when due, and provisions to enforce those standards.

As noted in the Preamble to the Proposed Rule, some MEWAs have historically been unable to pay claims due to fraud, insufficient funding, or inadequate reserves.¹⁷ State laws that require the maintenance of specified levels of reserves and contributions required to pay benefits in full when due will greatly alleviate this problem. Unlike in 1983, when ERISA was amended to provide an exception to ERISA's broad preemption provisions for the regulation of MEWAs under State insurance laws, almost all states now require registration and regulation of group health plan third party administrators.¹⁸ The licensure of TPAs, combined with reserve and contribution requirements, greatly reduce the likelihood of fraud and underfunding.

A class exemption is absolutely necessary to effectuate the goals of the Executive Order, and well within the statutory authority granted the Department by Congress. Because fully-insured AHPs are predicated on the assumption that insurance carriers can and will issue such coverage, and those insurers will take into account issues not related and possibly inimical to the goals of the Executive Order, self-insured AHPs are the last best hope of providing premium relief to the millions of Americans who have seen their premiums double, and even triple, during the last few years.

Even once a class exemption is issued, state insurance laws regulating reserve and contribution levels will continue to apply to AHPs. We believe this is generally good policy, since a defined set of solvency requirements helps ensure the viability of self-insured AHPs. However, some states and or state insurance commissioners may respond to a class exemption under ERISA Section 514(b)(6)(B) by imposing reserve and contribution levels that are unreasonable and inconsistent with Actuarial Standards of Practice, making self-funded AHPs too expensive to be commercially viable. But Section 514(b)(6)(A) is capable of an interpretation that allows the Department to impose a reasonableness standard on such requirements. Section 514(b)(6)(A)(i)(I) provides as follows:

¹⁷ Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans, 83 Fed. Reg. 614, 625 (Preamble) (Jan 5, 2018).

¹⁸ National Association of Insurance Commissioners (NAIC), Registration and Regulation of Third Party Administrators (Oct. 2011); accessible at <http://www.naic.org/store/free/GDL-1090.pdf>

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Notwithstanding any other provision of this section . . . any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides. . . standards, requiring the maintenance of *specified* levels of reserves and *specified* levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due.¹⁹

The law does not indicate *who* specifies levels of coverage and reserves. If the Department publishes specified levels of reserves and coverage in its final rule, it will resolve the ambiguity in its favor. Alternatively, the Department may choose to reserve the exercise of that power by specifying that reserves and contribution requirements must be “reasonable,” and include a discussion of factors to be considered in that determination within the preamble to the final rule. This will give self-funded AHPs standing in the federal courts to challenge state law efforts to preclude their establishment through state laws and regulations that impose unreasonable requirements for reserves and contributions.

In conclusion, the Department has the clear power and authority to give self-funded AHPs a fighting chance to provide relief for millions of Americans from excessively high health insurance premiums. In its current form, the Proposed Rule takes them part-way there. But its proposed non-discrimination rule threatens the solvency of self-funded AHPs, and is likely to create conditions similar to those that existed before ERISA was amended in 1983. The Proposed Rule also does not currently contain a class exemption from ERISA § 514(b)(6)(A), without which self-funded AHPs cannot achieve the clear directive of the Executive Order. Now that the Proposed Rule has adopted the proper definition of “employer” under Section 3(5) of ERISA, self-funded AHPs that qualify as large employers are best served by allowing them the same benefits and rights granted other large employer plans that flow naturally from existing federal law. And providing a class exemption within the Department’s power is clearly necessary if the Department intends to implement the intent and spirit of the Executive Order.

Thank you in advance for considering these comments. Please feel free to contact me if you have any questions regarding the above.

Sincerely,



Marek Ciolko
Chief Operating Officer
Gravie, Inc.

¹⁹ ERISA § 514(b)(6)(A)