

March 6, 2018

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

To Whom It May Concern:

The Minnesota Department of Commerce (“Minnesota”) submits the following comments in response to the U.S. Department of Labor (DOL)’s proposed rule “Definition of ‘Employer’ Under Section 3(5) of ERISA—Association Health Plans,” published January 5, 2018.

Minnesota encourages the DOL to provide further guidance and clarification around the Proposed Rule. Specifically, Minnesota is concerned that consumers will be negatively impacted by a Final Rule that does not clearly identify states as providing the regulatory oversight for the plan operations and solvency of Association Health Plans (AHPs). Further, Minnesota has taken significant steps to stabilize its individual and small group health insurance markets, and requests that the Final Rule not disrupt or destabilize these markets in our State.

Background

Minnesota Regulates Association Health Plans as Multi-Employer Welfare Arrangements (MEWAs). Minnesota state law allows groups of commonly aligned employers to form alternative health plan options for their employees. Minnesota Statutes § 62H and the associated Minnesota Rules Part 2765 provide guidance for Minnesota’s MEWAs whether as individuals or employers. Minnesota Statutes § 62N provides guidance to an entity seeking to provide health plans to a group of individuals and/or employers based on their connection to a community, with coverages generally matching the coverages in a major medical HMO plan. Minnesota Statutes § 471.617 and Minnesota Rules Part 2785 provide guidance for joint risk pools formed by governmental employers, though these plans can be designed to also allow non-governmental employers to participate.

In general, Minnesota’s state laws already allow joint risk pools to apply Minnesota’s large group coverage and rating laws, similar to the Proposed Rule’s new guidance. However, Minnesota law addresses critical consumer protection and sustainability issues such as nondiscrimination,

underwriting practices, minimum reserves, minimum capital, entity governance, membership, termination of membership, the role of interested financial parties and third party administrators, and the need for reinsurance or stop loss coverage.

While Minnesota has a history of adopting state laws allowing joint risk pool health plans (the most recent law was enacted in 2017 with regard to agricultural cooperatives), these laws reflect serious consideration of the governance, capital, and consumer protection concerns surrounding joint risk pools. Even well intentioned entities can cause serious financial harm to unsuspecting consumers because of the financial and professional resources needed to properly implement and maintain a solvent, viable health plan. Minnesota law provides consumers with an appropriate level of governance and consumer protection and should not be limited by the Final Rule.

General Comments

The Final Rule should clarify that State authority to regulate MEWAs and AHPs, which are a subset of a MEWA, is not preempted.

While the preamble to the AHP Proposed Rule states that the DOL, “would not alter existing ERISA statutory provisions governing MEWAs ... [and] would not modify the States’ authority to regulate health insurance issuers or the insurance policies they sell to AHPs,” Minnesota recommends further clarification be provided. The Final Rule should explicitly state that all AHPs are required to comply with applicable state laws where health plan members live. This clarification includes, but is not limited to, state laws that address associations specifically, plan and entity governance, membership, recruitment, large group benefit mandates, underwriting, solvency, reinsurance, nondiscrimination, and voting rights.

States have provided effective regulatory and financial oversight of AHPs and have the resources to continue to do so. The Proposed Rule, however, does not adequately clarify that states will maintain this responsibility in the future. The Final Rule should provide clear guidance to state regulators, consumers and AHPs, regarding which financial oversight requirements apply to these products – particularly in situations where multiple state and/or federal regulatory agencies could potentially have jurisdiction.

The Final Rule should adopt stronger nondiscrimination protections.

The Proposed Rule states that AHPs cannot reject enrollees or set premiums based on health factors. The Proposed Rule allows AHPs, however, to charge higher premiums based on gender, age, geography, plan design, covered services and industry market targets that may result in these products becoming available to some consumers, but not all. Minnesota recommends that the Final Rule make clear that anyone with a preexisting health condition that meets an association’s membership criteria must be accepted by the association at rates that are actuarially appropriate and only reflect factors that are unrelated to health conditions and past health claims.

Expansion of AHPs will cause further market segmentation if only healthier individuals enroll in AHPs while those with higher health care costs remain in the individual and small group markets. Thus, no material gains will be made to address the affordability of health insurance for those with potentially high cost health care claims.

The Final Rule should promote stability in the individual and small group markets and not limit states from taking further steps to stabilize their own markets in the future.

Sales of AHPs may lead to further market segmentation, which could result in instability and increased costs in the individual and small group markets. Allowing AHPs to market to individuals for the first time, as well as potentially allowing sales of AHPs in communities across state boundaries, will create regulatory confusion for insurers and consumers. Minnesota is concerned that the Proposed Rule has the potential to destabilize the individual and small group market, which could cause health insurers to leave the market, result in increased prices for consumers remaining in the individual market and undo the progress states like Minnesota have made to stabilize their own individual and small group markets.

Responses to DOL Requests for Comment

Minnesota submits the following comments in response to several of the specific questions asked by the DOL in the proposed rule “Definition of ‘Employer’ Under Section 3(5) of ERISA—Association Health Plans,” published January 5, 2018.

Commonality of Interest (83 FR 619)

Minnesota recommends clarification that state laws related to commonality of interest and filing requirements are not preempted by the AHP Final Rule. Minnesota law requires entities to file information about membership criteria, expulsion criteria, and guarantee renewal provisions in advance for state regulators to review for consumer protections and equity. Allowing AHPs to engage in “redlining,” by selling or marketing only in certain areas to avoid covering people with high-cost conditions, should be prohibited in the Final Rule. Further, the Final Rule should not preempt states who have the regulatory responsibility to enforce nondiscrimination requirements as well as the resources to do so, from continuing to prevent these harmful business practices from occurring.

Eligibility Requirements (83 FR 620)

In Minnesota, two structures are available that already allow worker-owners to enroll in a joint risk pool: Agricultural Cooperatives formed under Minnesota Statutes § 62H; and Community Health Plans formed under Minnesota Statutes § 62N. The Final Rule should not preempt states from enforcing existing state statutory requirements related to definitions of employer, employee and associations as well as consumer protection requirements that shield enrollees from financial repercussions in the event an AHP cannot pay claims.

Minnesota recommends that the Final Rule limit worker-owner participation in AHPs to those who file taxes as self-employed individuals under the Internal Revenue Code. Using this definition would ensure

consistency with the stated intent of the Proposed Rule that worker-owners who join an AHP are genuinely engaged in a trade or business and are performing services for the trade or business in a manner that is in the nature of an employment relationship. It is also important that the association is provided tax guidance as to how to report benefits differently for worker-owners versus other association members.

Health Status (83 FR 624)

Minnesota recommends that the Final Rule clearly prohibit health status as a factor in pricing of any member or group of members' premiums. Allowing AHPs to charge some consumers more based on health status would be discriminatory and would not decrease the overall cost of health insurance.

Based on four years of consistent findings and data collection, Minnesota's unique age curve follows closely the age-related differences caused by health care conditions. In other words, the premiums charged for individual and small group market coverage already reflect many of the health-related differences between individuals. Further subgroupings (such as by individual, family, and employer) are far too small in this circumstance to be statistically credible and are already addressed fairly and in large part by the age curve. Minnesota is concerned that these subgroupings could be implemented to discriminate by health condition, a practice prohibited by Minnesota law.

Risk Pools (83 FR 625)

Minnesota recommends that the DOL carefully review the comments submitted by the Academy of Actuaries' issue brief on risk pools. Data related to co-ops should also be considered, as their poor performance shows how difficult it is to properly capitalize and underwrite new lines of major medical health plan business.

For more information, Minnesota suggests the following publication:

http://actuary.org/files/publications/AHP_modeling_considerations_02092018.pdf

ERISA Exemption (83 FR 625)

Minnesota recommends that the Final Rule clearly state that AHPs continue to fall under ERISA in order to protect the interest of consumers. Further, Minnesota urges DOL to reinstate its former program of issuing determination letters, both in terms of a comprehensive review of the structure of the risk pool as well as the plan's coverages and processes.

A best practice is for "pool" and "plan" issues to be reviewed by DOL staff every three to five years. DOL may require that Association Health Plans hire or employ an actuary who is a Member of the American Academy of Actuaries, and capitalize the AHP annually to a level that meets the actuary's recommendation. Further, AHP funds should be held in trust, under requirements similar to, or identical to, those required of Voluntary Employment Benefit Associations (VEBAs). Finally, Minnesota recommends that DOL require Form 5500s be filed annually by the AHP, changing the Form 5500 and Form M-1 so that the AHP structure is immediately apparent to the DOL and the public.

Other Issues Not Addressed in the Proposed Rule

Minnesota is concerned that the Proposed Rule does not adequately address several topics, including minimum capital, minimum essential coverage status, minimum value, minimum participation and minimum contribution rules as applicable to AHPs. In addition, to the extent the Final Rule allows AHPs to be sold to consumers across state boundaries, Minnesota recommends that the Final Rule clearly identify the locus for financial solvency oversight for AHPs that have enrollees in these types of products.

Thank you for the opportunity to provide comments on the Proposed Rule. If you have any questions or if we can be of further assistance, please do not hesitate to contact me or Assistant Commissioner Peter Brickwedde at peter.brickwedde@state.mn.us.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Looman". The signature is written in black ink and is positioned above the printed name and title.

Jessica Looman
Commissioner