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September 28, 2018 – **sent electronically-**

Mr. Robert Wake, Chair, ERISA (B) Working Group
and Ms. Jennifer Cook, Senior Health & Life Policy Counsel
National Association of Insurance Commissioners
701 Hall of the States
444 North Capitol Street, N.W.
Washington, D.C. 20001-1509

Re: **AHIP's Comments on the ERISA Working Group's NAIC ERISA Handbook Draft**

Dear Mr. Wake and Ms. Cook:

AHIP offers these comments to the ERISA (B) Working Group ("the Working Group") on the draft language updating the NAIC's (*Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation)* "the ERISA Handbook". The work on the ERISA Handbook has resulted in a good update to the manual providing guidance on the jurisdictional authority of states and the federal government on ERISA plans coverage and ERISA employer groups. It includes key areas that assist states and their regulated entities in understanding the scope of actions states may take in various situations. We appreciate all the work done on this Handbook and its value as guidance on these key issues. And we like the helpful updated chart on Regulatory Jurisdiction on page 77.

Our comments focus on the language in Section VII. C. *Association Coverage: Is it Individual, Small Group or Large Group Coverage?"* We found the format somewhat difficult to follow. The June 2018 Final DOL AHP Rule wasn't mentioned in that section until the end of long commentary about the CMS 2011 Bulletin. Our attached redline revisions insert relevant references to the rule changes in context in that section.

The reference to the AHP final rule properly appears in the Handbook on page 41, in the discussions of types of employer associations. It includes on page 42 the recognition that associations that qualify as employee benefit plans under prior DOL guidance can continue to be recognized, and the AHP Rule nondiscrimination provisions are not applied to associations that qualify under the pre-2018 DOL guidance.

There are now essentially three paths to associations and how they are treated. We suggest it would be helpful to outline them:

- Multi- employer associations where each employer in the association is subject to the "look through" process to determine whether they are treated as a small group or a large group,

- Associations that sponsor a single employer health plan and are bona fide employer plans that qualified as such under prior DOL guidance, and not affected by the new rule, and

- New associations that sponsor a single employer health plan meeting the requirements of the 2018 AHP Rules 'that can be offered beginning September 1, 2018 if fully insured; or January 1, 2019 for existing non-fully insured plans, and on April 1, 2019 for all other plans.

It is important to note that associations formed under prior DOL guidance can continue to be sold moving forward, or the associations can choose to conform to the provisions under the AHP Final Rule if they want to expand within a geographic area, regardless of industry, or include working owners. And new plans can also form and elect to follow either the old rules or the new rules.

We suggest that those clarifications should be added to the MEWA section beginning on page 48.

Finally, it may be helpful to note in the Handbook, whether in footnotes or on the ERISA Working Group's NAIC website, the other sub-regulatory guidance that the DOL and Treasury have provided on the Final AHP Rule. Those can be found at:

- DOL Compliance Assistance Document https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-publication-ahp.pdf
- IRS Employer Q&A on the shared responsibility mandate – see Q&A No. 18 https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act#Employers

We've attached pages from Section VII. C with tracked changes to the section on AHPs. We refer to the Handbook's page number to identify the page where the edits occur.

Thank you for the opportunity to present these comments. We look forward to discussing these on the next Working Group's call.

Sincerely,

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Attachment

ATTACHMENT

AHIP's proposed Revisions to the Draft ERISA Handbook's Language in the section on AHPs

(**Pg 82**) **Association Coverage: Is it Individual, Small Group or Large Group Coverage?**

Most people have health coverage either through their employer (ERISA-covered group health plans), or by purchasing a plan directly from an insurer (individual plans). An alternative is to obtain coverage through a membership-based organization, like an association. This coverage is often issued through a group policy, with the organization or a trustee as the master policyholder, (**Pg 83**) and is subject to state laws regulating group health insurance. This can be a source of confusion, because the phrase "group health insurance coverage" has an entirely different meaning under HIPAA and the ACA. For purposes of federal law, the distinction between "individual" and "group" coverage is not based on whether the contract is a group policy, but rather whether the coverage is issued in connection with a group health plan. [342] "Group health plan," in turn, means an employee benefit plan, as defined in ERISA, to the extent that the plan provides medical care.[343]

How Association Coverage is Classified

It is important to note that there are now several classifications of Association coverage. In essence, there are now three paths to associations and how they are treated:

- Multi- employer associations where the association does not sponsor a single group health plan. Thus, each employer in the association is subject to the "look through" process to determine whether they are treated as a small group or a large group;
- Associations that sponsor a single group health plan and are bona fide employer plans that qualified as such under prior DOL guidance, and not affected by the rule, and
- Associations that sponsor a single group health plan and are formed and operate under the new DOL Final Rule.

It is important to note that associations formed under pre-2018 DOL guidance can continue to be sold moving forward, or the associations can choose to conform to the provisions under the AHP Final Rule if they want to expand within a geographic area, regardless of industry, or include working owners. And new associations can also form, decide to sponsor a single group health plan, and elect to follow either the old rules or the new rules.

Under federal law, group policies issued to associations, or to any other group comprising more than one employer or more than one household, are regulated on a "look-through" basis; i.e., the individual, small group and large group markets are defined by the nature of the customer that buys the coverage, not by the form of the contract. In particular, the Public Health Service (PHS) Act defines the "small group market" as "the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer."[344] In exactly the same manner, all health insurance provided through a large employer's group health plan, "directly or through any

arrangement," is defined to constitute the large group market.[345] These may still apply, but the D0L's AHP Final Rule, *the* 2018 *Final Rule on the "Definition of 'Employer' under Section 3(5) of ERISA -- Association Health Plans,* provided for other options for small groups. In the *Continued Availability of "Bona Fide Association" Standard section*[new footnote] the DOL clarified that Associations may continue to operate under the Pre-2018 Rule guidance in how employer is defined. The Final Rule provides for other coverage options working owners to be included as an employer group. And the Final Rule provides an additional mechanism for groups or associations to sponsor an ERISA health plan. The bona fide association standard established under previous guidance remains an option for groups or associations. That "old" standard, like the "new "standard described in paragraphs (b)–(d) of this section of the rule, is based on a facts-and-circumstances test. The factors considered include:

- Who is entitled to participate and who actually participates in the association;
- The association's purpose and its members' preexisting relationships; and
- Who controls the benefit program's operations.

Under the 2018 AHP Final Rule An association must have at least one "substantial business interest" unrelated to health coverage, although offering health benefits may be the primary purpose of the association. The AHP Final Rule does not define "substantial business purpose" but the regulatory text does contain an explicit safe harbor where the "group or association would be a viable entity even in the absence of sponsoring an employee benefit plan".

And the AHP Final Rule establishes a requisite "Commonality of Interest" [new footnote2] for employers to form an association. Employers may band together to form an association based on common industry or common geography. The final rule adopts standards for determining which employers may be considered an association for purposes of an AHP. The two routes to establish a commonality of interest are:

- The employers are in the same trade, industry, line of business, or profession, or
- The employers have a principal place of business within the same State or the same metropolitan area (including areas that cross into multiple States).

~~And~~ T~~t~~he individual market is defined to encompass everything else falling within the federal definition of "health insurance coverage," whether it is written as an individual policy~~,~~ ,or a family policy, ~~or as; some~~"the market for health insurance coverage offered to individuals other than in connection with a group health plan. ~~type of non-employment-based group policy~~.[346]

The PHS Act also includes some specific "rules for determining employer size," including an aggregation rule spelling out limited circumstances in which some (but not all) "persons treated as a single employer" for tax purposes – notably, affiliated businesses under common ownership and control – are combined for purposes of determining "small" or "large" employer status.[347] The look-through principle reflects concerns that granting small employers the right to choose between buying community-rated small group coverage and non-community-rated large group coverage might result in adverse selection against the small group market. Some actuaries believe the destabilizing impact could be significant.

This framework entitles individuals to the same consumer protections whether they buy their coverage directly or through some other "arrangement" such as an association, and does the same for small employers that maintain group health plans. It reduces the opportunity for regulatory

[342] 42 U.S.C. §§ 300gg-91(b) (4). Some states make similar distinctions under state law. For example, in Maine, "individual health plans" include both individual policies and certificates under association, credit union, and discretionary group policies, except for coverage issued through an employer that is a member of an association or discretionary group. 24-A Me. Rev. Stat. §§ 2701(2)(C) & 2736-C(1)(C) (2018).
[343] 42 U.S.C. §§ 300gg-91(a) (1) (2018).
[344] 42 U.S.C. § 300gg-91(e)(5). See also ACA § 1304(a)(3) (42 U.S.C. § 18024(a)(3)).
new footnote AHP Final Rule 29 CFR §2510.3-5(a))
new footnote 2 29 CFR (§2510.3-5(c)).
[345] 42 U.S.C. § 300gg-91(e)(3).
[346] 42 U.S.C. § 300gg-91(e)(1).
[347] 42 U.S.C. § 300gg-91(e)(6)(A) (2018), referencing I.R.C. §§ 414((b), (c), (m) & (o). See also ACA § 1304(b)(4). (The list of referenced Tax Code provisions also expressly excludes I.R.C. § 414(n), relating to employee leasing companies.)

(**Pg 84**) arbitrage by providing a level playing field where carriers competing for the same customers are subject to the same rules. The only way in which HIPAA recognized any difference between association coverage and coverage sold directly to individuals or employers was through limited exceptions to guaranteed issue and guaranteed renewal for coverage that "is made available … only through one or more bona fide associations." These exceptions allowed the insurer to deny coverage under such plans to employers that were not association members and to terminate such coverage if association membership ceased. However, the ACA repealed the bona fide association exception to guaranteed issue. The guaranteed renewal exception remains in force,- but applies only to the remaining "association-only" plans that are still in force, largely grandfathered plans.

Individual Market Coverage

If health insurance coverage offered to an individual through an association is not offered in connection with a group health plan, it is defined in PHS Act §§ 2791(b)(5) and (e)(1)(A) as individual health insurance coverage being sold in the individual market. The ACA's "Health Insurance Market Rules; Rate Review" final rule (Market Rule final rule) provides: "Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage."[348] The individual members of the association are part of the individual market risk pool in the state and the carrier providing the association coverage must comply with individual market rating rules. The AHP Final Rule has changed the treatment of self-employed individuals, including sole proprietors without any employees, with regard to eligibility for group coverage. Under the ACA a sole proprietor with no employees is only eligible for individual coverage. In the AHP Final Rule's section on the *Dual Treatment of Working Owners as Employers and Employees,* new footnote 3 the individual may qualify as an employer to participate in an AHP. Generally, a self-employed individual may participate as a working owner if:

- They have an ownership right of any nature in a trade or business,
- They earn income from the trade or business for providing personal services to the trade or business and either provide, on average, at least: (a) 20 hours of personal services to the trade or business per week; or (b) 80 hours of service per month, or

- They have earned income from that trade or business that equals at least the cost of coverage for participation for the owner and any covered beneficiaries under the health plan.

Group Market Coverage

Employment-related coverage, on the other hand, is classified as either small group coverage or large group coverage, depending on the size of the employer. Under the ACA, the "small group market" consists of coverage obtained "through a group health plan maintained by a small employer,"[349] regardless of whether the employer has purchased that coverage directly or through some other arrangement, such as an association. However, because the ACA has imposed more stringent requirements on small group coverage, some association plans have sought treatment as large group plans so that they can continue offering health coverage to small employers without being subject to requirements such as adjusted community rating, restrictions on actuarial value (the metal tiers) and the essential health benefit package. The October 2017 Executive Order asserted that the high cost of small group insurance placed small employers at a disadvantage and that "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.[350]

new footnote 3 29 CFR (§2510.3-5(e)).

[348] 45 CFR § 144.102(c).

[349] 42 U.S.C. §§ 300gg-91(e)(5). Similarly, laws in some states expressly base eligibility for "small group" coverage on employer size rather than group size. See, e.g., 24-A Me. Rev. Stat. §§ 2808-B(1)(D) & (H) (defining "eligible group" to include a "subgroup," defined as "an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract.")

[350] EO 13813, supra note 218216, § 1(b)(i).

(Pg 85) Federal Guidance on Association Coverage

The status of association plans was addressed in a prior CMS Insurance Standards Bulletin (CMS Bulletin) published September 1, 2011. That bulletin stated that there is no distinct category of "association coverage" under the ACA. The CMS Bulletin explains: "Although the Affordable Care Act revised and added to Title XXVII of the PHS Act, it did not modify the underlying PHS Act framework for determining whether health insurance issued through associations was individual or group health insurance coverage." The Bulletin acknowledged that there are limited exceptions to certain provisions of the guaranteed issue and guaranteed renewability laws for coverage offered through "bona fide associations," but emphasized that "[t]he bona fide association concept has no other significance under the PHS Act, and, importantly, does not modify or affect the analysis of whether health insurance coverage belongs to the individual or group market."

The CMS bulletin also ~~discusses~~ discussed "mixed" associations

A "mixed" association exists where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member's circumstances. In this situation, the members of the association cannot be treated as if all of them belonged to same market. For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members. Accordingly, each association member must receive coverage

that complies with the requirements arising out of its status as an individual, small employer, or large employer.

The CMS Bulletin ~~describes~~ described "health insurance coverage offered to collections of individuals or employers through entities that may be called associations, trusts, multiple employer welfare arrangements (MEWAs), or purchasing alliances." As discussed above, regardless of how it is structured, all such coverage is classified as either individual coverage, small group coverage or large group coverage, depending on whether it is sold to individuals and families, sold to small employers providing group health plans, or sold to large employers providing group health plans. The guidance states: "CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level."[351] In those cases, the size of each employer determines whether the employer's coverage belongs to the individual,[352] small group[353] or large group market. However, the guidance states further: "In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the 'employer,' the

[351] See CMS Bulletin http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.
[352] Before the ACA, some states permitted self-employed individuals to obtain coverage as "groups of 1." However, although the ACA lowers the minimum small group size from 2 employees to 1, the owner of the business and the owner's spouse are not counted as "employees" for that purpose. Thus, an association of self-employed individuals would be considered "individual" coverage under the ACA, except with respect to those sole proprietor members who are providing coverage to at least one "outside" employee.
[353] As amended by the PACE Act, P.L. 114-60, the ACA defines a small employer as an employer with 1 to 50 employees, but gives states the option to raise the threshold to 100 employees. 42 U.S.C. §§ 300gg-91(e)(4) & (7); 18024(b)(2) & (3).

(**Pg 86**) association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules."

The key to this analysis is CMS's conclusion that the association is deemed to be "the" employer for purposes of the small group health insurance law. Under ERISA, the association is merely deemed to be "an" employer – the "indirect" employer. As discussed earlier,[354] an indirect employer's existence depends on the direct employers in whose interest it acts; thus, the small employer that is an association member is still "an" employer too. That is why it is undisputed that an association-level ERISA plan is a MEWA. The reason the association is treated as if it were "the" sole employer for insurance purposes is that the direct employer is no longer seen as maintaining its own group health plan, once it has chosen for the current plan year to participate in a group health plan that is maintained at the association level.[355] If participation in an AHP means that there is no "group health plan maintained by a small employer," and that the sponsoring association is deemed to be "employing" all the plan participants, then AHPs that qualify as Plan MEWAs create an exception to the PHS Act's "look-through" principle, allowing small employers to buy large group health insurance.

~~Under traditional~~ Prior to the DOL 2018 AHP rule, ~~interpretations of ERISA~~, this exception to the "look-through" principle ~~is~~ was not particularly significant. As the CMS Bulletin phrased it, it applied only in "rare instances." As a result, association coverage became less prevalent under the ACA because there was little advantage to be gained from buying and selling it through associations rather than directly.

However, the 2018 AHP Rule has changed the landscape significantly. DOL has reaffirmed the interpretation that health insurance offered through a Plan MEWA is considered large group coverage under the ACA and revised the criteria for Plan MEWA status to allow a wide range of associations to qualify. Thus, all small employers in a trade or geographic area where an AHP is operating now have the option of buying "large group" coverage, and so will self-employed individuals who devote sufficient time or earn sufficient income from their business to qualify as "working owners" under the AHP Rule. The effect is to make the states once again the primary regulators of the group insurance market, as they were before the ACA. DOL has emphasized that the AHP Rule does not have preemptive effect.[356] For fully-insured AHPs, states can continue to apply their group insurance laws, such as benefit mandates,[357] rating rules, and prohibitions against fictitious groups. However, state insurance laws may not prevent the application of controlling provisions of the ACA or PHS Act.[358] Non-fully-insured MEWAs were already primarily regulated by the states, as they have

[354] See supra ***INTERNAL CROSS-REFERENCE TO DISCUSSION OF DIRECT AND INDIRECT EMPLOYERS
[355] It is not clear how this analysis can be reconciled with the traditional analysis for determining when an employer establishes or maintains a group health plan, see supra ***INTERNAL CROSS-REFERENCE TO DISCUSSION OF "ESTABLISHED OR MAINTAINED", since the direct employer continues to be the party employing the plan participants, paying for their health coverage, and deciding which coverage to buy every year after working with its broker to review all the different AHPs and non-AHP coverage options that are available in the market.
[356] See, e.g., Preamble to AHP Final Rule at 93, 178.
[357] See Preamble to AHP Final Rule at 82.
[358] PHS Act § 2762; ACA §1321(d). For example, CMS issued a letter in 2013 advising the State of Washington that

(**Pg 87**) always been generally exempt from all ACA requirements except the limited number that apply to self-insured plans,[359] and DOL has reaffirmed states' broad authority to regulate these arrangements, either as insurers or as alternative risk-bearing-entities under some specialized licensing regime.[360] States may choose to amend their group insurance laws or MEWA laws to take advantage of the increased flexibility the AHP Rule provides in their markets, to close perceived regulatory gaps left by the diminished scope of the ACA standards, or to combine both approaches. However, these choices have been left to the states.

~~Experience~~ **Rating Requirements for Association Health Plans**

If an association group policy is determined to be a "large group" policy, it is exempt from the ACA's community rating requirements. This means the insurer is free to use claims experience and other underwriting factors when pricing the policy, except as prohibited by state law~~,~~; and states do not generally regulate large group premium rates. The question then arises whether the exemption from community rating applies at the member employer level or at the association level. If the association as a whole can obtain favorable rates based on its purchasing power but cannot deny membership or charge member employers higher rates based on health-related factors, the risk of a destabilizing impact on the community-rated market is reduced.

Large group status, as discussed above, means that all participating employees have been deemed to be employed by the "same employer" for health benefit purposes. Many regulators conclude that the association as a single employer should be rated in the same manner as a single large employer plan, without discriminating between employees or groups of employees within the plan based on health status or claims experience. If the association sponsors a single "group health" plan, that plan is subject to the PHS Act's prohibitions against discrimination based on health status. In particular, individuals

covered through the same employer may not be charged more due to "Health status," "Claims experience," or "Any other health status-related factor determined appropriate [sic] by the Secretary.[361]

~~Insurers have responded that under~~ Under the implementing regulation, a group insurance policy or group health plan may charge different premiums or employee contribution rates to "similarly situated individuals" enrolled in the plan on the basis of "bona fide employment-based classifications" such as "full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations."[362] ~~They assert that treating each member employer as a separate rating unit is a bona fide employment-based classification.~~ However, the regulation also expressly provides that "a classification based on any health factor is not a bona fide employment-based

[(358)] a state law deeming association plans to be large group coverage, and thus purporting to exempt them from community rating, was preempted to the extent that the plans in question were small group coverage under the ACA.

[359] With the exception of any entities that were treated as "health insurance issuers" by CMS before the adoption of the AHP Rule but will qualify as Plan MEWAs as of 2019. It is not clear whether any such entities are in operation.

[360] See Preamble to AHP Final Rule at 93, 178. See generally *** CROSS_REFERENCE TO STATE AUTHORITY TO REGULATE NFI MEWAs, supra.

[361] PHS Act § 2705 (42 U.S.C. § 300gg-4) (a)(1), (a)(3), (a)(7), & (b)(1).

[362] 29 CFR § 2590.702(d).

(Pg 88) classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors)." [363] In the 2018 AHP Rule, DOL established nondiscrimination requirements that prohibit experience rating at the member employer level for AHPs formed under the Rule. However, DOL indicated that it did not interpret the prohibition on experience rating as being required in all cases by the underlying statute, and that DOL would permit AHPs qualifying under the pre-2018 regulatory guidance to experience-rate at the member level, as long as it was not a pretext for discriminating against a particular employer or plan participant, because the pre-2018 guidance "had a stronger employer nexus requirement."[364] Likewise, the AHP Rule does permit experience rating that takes into account other non-health factors such as industry or location, or its employees' ages or genders, or occupations[365]. The AHP Final Rule provides specific examples at the occupation or industry level.[~~365~~366]

[363] Id.

[364] Preamble to AHP Final Rule at 61 n.40.

[365] Preamble to AHP Final Rule at 41 n.22-30.

[~~365~~ 366] 29 CFR § 2510.3-5(d)(5), Examples 7–9