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

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

To Whom It May Concern:

The American Council of Engineering Companies ("ACEC") and the American Council of Engineering Companies Life/Health Insurance Trust (the "Trust") appreciate the opportunity to comment on the Employee Benefits Security Administration's proposed rule "Definition of 'Employer' Under Section 3(5) of ERISA – Association Health Plans," released on January 5, 2018 (the "Proposed Rule"), in response to the Executive Order entitled "Promoting Healthcare Choice and Competition Across the United States" issued by President Trump on October 12, 2017 (the "Executive Order"). As more fully described below, we believe that the Proposed Rule, if finalized in its current form, could result in a death sentence for many existing association health plans ("AHPs") sponsored by bona fide associations, including the Trust, and would materially inhibit the establishment of new AHPs.

BACKGROUND ON ACEC AND THE ACEC LIFE/HEALTH TRUST

ACEC

ACEC is the oldest and largest business association representing the engineering industry and is organized as a federation of 52 state and regional member organizations. ACEC members – numbering more than 5,000 firms representing hundreds of thousands of engineers and other specialists throughout the country – are engaged in a wide range of engineering works that propel the nation's economy and enhance and safeguard America's quality of life.

The Trust

The Trust was formed in 1965 for the purpose of providing benefits through a group health plan (the "ACEC Health Plan" or "Health Plan") to engineering firms who are members of ACEC and one or more state member organizations. The ACEC Health Plan is fully insured; the Trust holds group insurance contracts issued by UnitedHealthcare Insurance Company, pursuant to which benefits are provided to employees of the member firms and their beneficiaries.

Currently, the Trust operates in 50 states and provides insurance coverage for more than 91,500 members working for more than 1750 employers. Approximately 60% of employee-participants are employed by member employers with more than 50 employees.

We believe it is not an exaggeration to state that the ACEC Health Plan is one of the most successful AHPs in the country. This success derives largely from the altruistic efforts of the trustees of the Trust, each of whom are principals of consulting engineering firms. Over the past 50 years, the trustees have volunteered hundreds of thousands of hours of their time without compensation in order to build a health insurance program comparable to those offered by the largest employers in the country. They are passionate about their cause to make available to engineering firms the very best health insurance at an affordable price.

Employers and their employees who participate in the Trust enjoy significant benefits. The Trust's substantial membership affords the Trust the ability to exercise its group purchasing power in the marketplace, allowing the Trust to negotiate low administrative fees as well as obtain the best available provider discounts and other benefits. While these efforts translate into substantial savings to member firms with respect to their premiums, such savings only scratch the surface of what the Trust provides to member firms. Additional value-added services offered at no cost include the following solutions typically only available to employees of very large employers:

- A comprehensive wellness program with two full-time wellness coordinators on the Trust's permanent staff. The Trust's mission is to provide Health Plan participants with the resources to become the healthiest citizens in the nation. While the cost of engaging member firms and their employees in this mission is substantial, we believe the savings in health care costs and the increased productivity and happiness of Health Plan participants resulting from a healthier lifestyle far outweigh the costs.

- Around-the-clock telemedicine services, which allow Health Plan participants immediate access to quality care when their primary care physician is unavailable.

- State-of-the-art advocacy services, which assist Health Plan participants in navigating our country's complex health delivery system so they can obtain the highest quality care at the best price.

- A cutting-edge online enrollment platform of the type offered to employees by the largest and most sophisticated employers.

Each of these programs is offered with the assistance of top-tier third-party firms with specific expertise in wellness programs, telemedicine, advocacy services, and enrollment services, respectively. Each third-party firm was selected through a comprehensive RFP process conducted by the trustees. As a practical matter, a small or mid-size engineering firm would not have the resources to build a health insurance program of this quality on its own.

REGULATORY COMPLIANCE

1. ERISA Definition of Employer.

The ACEC Health Plan has been designed to meet all the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA") and the existing sub-regulatory guidance related to the treatment of a bona fide association as an "employer" under Section 3(5) of ERISA, and the treatment of an AHP it sponsors as a single "employee welfare benefit plan" under Section 3(1) of ERISA. Specifically:

- ACEC was not organized for the purpose of providing health insurance to its member firms, but in fact was formed 60 years prior to the establishment of the Trust for the purpose of providing resources to employers in the engineering industry.

- The Trust and the member employers of ACEC are tied by a common economic and representational interest.

- The Trust is controlled by its members in form and in substance. Only executive officers or owners of participating engineering firms may serve as trustees of the Trust and are elected by a majority vote of the member employers. The Trust is administered solely by the trustees and may be amended or terminated only in a written document signed by all the trustees.

- The trustees operate pursuant to a formal written governance structure.

- The Trust does not permit sole proprietors to participate.

2. Compliance with ACA and HIPAA.

Because ACEC is treated as the "employer" and the Health Plan is treated as a single "employee welfare benefit plan" under ERISA, ACEC also is treated as the "employer" and the Health Plan is treated as a single "group health plan" for purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Affordable Care Act ("ACA"), and together "HIPAA/ACA"),[1] and the number of employees covered by the entire Health Plan determines the group size. Pursuant to these rules, the Health Plan is treated as offering large group coverage to its member employers. For this reason, the Trust is not subject to the ACA's small group requirements relating to mandated essential health benefits. Having said this, the trustees have nonetheless structured the Health Plan so that comprehensive essential health benefits are included in the Trust's health insurance offerings.

The Health Plan is currently operated in accordance with the nondiscrimination requirements applicable under HIPAA/ACA, which prohibit discrimination within groups of similarly situated individuals with respect to eligibility, benefits and premiums based upon health-status factors. The Health Plan currently permits all member firms to participate and does not provide different benefit levels across different groups of member employers. However, as permitted under the HIPAA/ACA rules, the Health Plan does vary premiums on an employer-by-employer basis based on actuarially-sound rating factors. As discussed below, the ability to vary premiums among member firms is critical to the Health Plan's survival as an AHP.

OVERVIEW OF COMMENTS

Our comments specifically focus on Section 2510.3-5(d)(4) of the Proposed Rule ("Section (d)(4)") to the extent it limits an AHP from treating different member employers as distinct groups of similarly

[1] CMS Insurance Standards Bulletin, Application of Individual and Group Market Requirements Under Title XXVII of the Public Health Service Act when Insurance Coverage is Sold to, or through, Associations (Sept. 1, 2011) available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

situated individuals for purposes of establishing premiums.[2] In the Preamble to the Proposed Rule (the "Preamble"), the Department of Labor (the "DOL") seeks specific comments with respect to Section (d)(4) as to (1) whether its requirements would create a cross-subsidization across employers which would discourage the formation and use of AHPs; (2) whether Section (d)(4) is an appropriate or sufficient response to the need to distinguish AHPs from commercial insurance providers and, if not, whether alternative provisions might achieve the same goal; and (3) whether Section (d)(4) could destabilize the AHP market or hamper employers' ability to create flexible and affordable coverage options for their employees.

The DOL states in the Preamble that the purpose of the Proposed Rule is to encourage the establishment and growth of AHPs and to expand access of employers and their employees (especially small businesses) to more affordable health coverage by relaxing the regulatory requirements applicable to AHPs. Section (d)(4) would create the opposite result. Section (d)(4), if promulgated as is, would create significant challenges in pricing for AHPs that cover employers that otherwise would purchase insurance in the large group market that would outweigh the other potential advantages of AHPs. In short, compliance with Section (d)(4) would result in healthier large employer groups choosing to insure with commercial insurers rather than AHPs, leaving AHPs to insure less healthy groups, ultimately resulting in a death spiral for such AHPs. The result would be the erection of a regulatory barrier to the formation of new AHPs and the ultimate demise of existing AHPs, thereby destabilizing the AHP market and hampering employers' ability to provide flexible and affordable coverage options. For the reasons set forth below, Section (d)(4), as currently proposed, is not appropriate or necessary to distinguish AHPs from commercial insurance providers. As requested in the Preamble, we propose below several alternatives to Section (d)(4).

APPLICABLE STATUTORY AND REGULATORY RULES

Description of Section (d)(4)

Section (d)(4) provides that, for purposes of applying the existing HIPAA/ACA nondiscrimination requirements described under Section 702 of ERISA and Section 2590.702(c) of the DOL Regulations ("Section 702") related to eligibility for benefits or levels of premiums or contributions, an AHP generally is not permitted to treat each member employer as a distinct group of similarly situated individuals.

Description of Section 702

Section 702 contains the current nondiscrimination provisions applicable to group health plans. Under these rules, a group health plan or a health insurance issuer offering coverage under a group health plan may not discriminate against similarly situated individuals with regard to eligibility, benefits or premiums based on any of the following health factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. A group health plan or issuer may treat participants as distinct groups of similarly situated individuals, and thus establish different levels of eligibility, benefits and premiums for them even if

[2] We have no issue with the nondiscrimination requirements in the Proposed Rule to the extent they prohibit discrimination among member employers with respect to eligibility and benefits. Our concern relates specifically to the portion of the Proposed Rule which limits an AHP's ability to vary premiums.

that otherwise would violate Section 702, if the distinctions are based on bona-fide employment-based classifications.

Significantly, under Section 702, different employer groups are not considered to constitute one group of similarly situated individuals. The regulations specifically provide that nothing in section 702 "restricts the aggregate amount that an employer may be charged for coverage under a group health plan."[3] However, the regulations include an important caveat prohibiting so-called "list billing" practices. A group health insurance issuer or group health plan "may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor."[4]

Interaction of Section (d)(4) with Section 702

Section (d)(4) expands the application of the nondiscrimination requirements under Section 702 by specifically prohibiting AHPs from treating different employer groups as distinct groups of similarly situated individuals.[5] This expansion limits the ability of AHPs to vary premiums on an employer-by-employer basis.[6] As drafted, the Proposed Rule's expansion of Section 702 is a significant and unwarranted departure from the existing sub-regulatory framework.

ACA Rating Rules

Under the current ACA health insurance premium rules, carriers offering small group insurance coverage (for employers with 50 or fewer employees) may not vary premiums except based on geography, age, family size and tobacco use. Health insurance issuers in the large employer market are not subject to these ACA limitations and may therefore vary premiums on an employer-by-employer basis based on health-related status factors without violating the ACA rules. Rating practices of commercial health insurers vary based on the number of employees of any given employer and reflect current ACA rules.

COMMENTS

[3] DOL Reg. Section 2590.702(c)(2)(i).

[4] DOL Reg. Section 2590.702(c)(2)(ii). See also Health Coverage Portability (HIPAA) Compliance FAQs, Q&A-20 & Q&A-21, available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance.

[5] We would also point out that a prohibition on treating different employers as distinct groups of similarly situated employees would appear to prohibit an AHP from allowing employers to provide for different levels of cost-sharing for health insurance coverage, because that could result in a violation of the HIPAA/ACA nondiscrimination requirements under Section 702.

[6] Section (d)(4) contains an example indicating that AHPs may vary premiums based on geography because geography is a bona fide employment-based classification consistent with usual business practices. We also acknowledge that Section 1.6 of the "Regulatory Impact Analysis" in the Preamble provides: "Of course, the nondiscrimination provisions in this proposal would prohibit any such discrimination based on health factors, but some non-health factors (such as age) correlate to a large degree with healthcare expenditures, and AHPs under this proposal could vary premiums to reflect actuarial risk based on such non-health factors." Looking at the Proposed Rule itself, however, it is not at all clear that AHPs may vary member employer premiums on any basis other than geography or similar employment-based classifications consistent with usual business practices. While we strongly oppose any rule which would limit an AHP's ability to vary premiums on an employer-by-employer basis, if the Department nonetheless retains this limitation, then the final rule should explicitly state whether an AHP may vary premiums on an employer-by-employer basis based on age and all other factors which are correlated to a large degree with healthcare expenditures, such as gender and tobacco use.

1. The Proposed Rule as Drafted Would Have a Substantial Adverse Impact on Larger Employers.

The Proposed Rule appears to have been drafted largely in consideration of its effect on small employers (i.e., employers with 50 or fewer employees). The DOL notes in the Preamble that it expects "minimal interest among large employers in establishing or joining an AHP." ACEC and the Trust strongly disagree with this assertion. As noted above, 60% of the participants covered under the Trust are employed by larger employers (i.e., employers with more than 50 employees) who would be very interested in the Proposed Rule and its effect on them, particularly Section (d)(4). We suspect that the same can be said about a number of the AHPs sponsored by bona fide associations that currently exist and satisfy the DOL standards. Larger employers enjoy many of the same advantages as small employers (i.e., more affordable coverage, increased bargaining power with insurance providers, administrative efficiencies, transfer of plan maintenance responsibilities) by participation in AHPs. In addition, the Trust's participants have access to wellness solutions, telemedicine options, advocacy programs, and state-of-the-art enrollment platforms. These services would not be available to larger employers in the absence of the AHP. The impact of Section (d)(4) on all potential members of AHPs, including larger employers, should be considered when enacting a final rule. Enactment of the Proposed Rule with Section (d)(4) would negatively affect small and larger employers alike if the prohibition on variation of premiums on an employer-by-employer basis results in the demise of AHPs generally.

Specifically, as reflected in the attached letter from Scott Weltz of Milliman to the Trust ("Milliman Letter"), the Trust would likely lose a significant portion of its membership if the Proposed Rule were promulgated in its current form. A large reduction in the Trust's membership base would make it more challenging to offer insurance coverage efficiently. In addition, blending large employer claims experience with small employer claims experience may result in increased costs for the small employer groups participating in the Trust. While the extent of the adverse ramifications would depend on how many large employers remain enrolled in the Trust and their health status relative to the small employer groups enrolled in the Trust, the potential for negative cost impact is highly probable.

2. The Proposed Rule as Drafted Would Create Adverse Selection and Destabilize the AHP Marketplace.

As described above, Section (d)(4) would result in expansion of the current HIPAA/ACA nondiscrimination provisions applicable to AHPs by limiting an AHP's ability to vary premiums on an employer-by-employer basis. In other words, AHPs would be limited in their ability to set different premium levels for different member employers. Commercial insurance carriers would not be so limited except to the extent of the ACA requirements applicable to small groups. AHPs would be forced to quote basically the same rates for all member employers, and commercial carriers would quote unhealthy large employer groups at higher rates than healthy groups, ultimately resulting in adverse selection in the AHP market. Large employer groups with higher-than-average claims would have a financial incentive to join AHPs, and healthier-than-average-groups with lower costs would inevitably choose to purchase health insurance from commercial carriers. This dynamic would result in AHPs that cover large employer groups enrolling, on average, more costly groups than carriers in the non-AHP market. As a result, AHPs would then be required to increase premiums across the

board, diminishing the ability to attract even moderately healthy groups, resulting in further market segmentation and destabilizing the AHP marketplace.[7]

The following example from the Milliman Letter illustrates the impact of Section (d)(4) on AHPs. For purposes of this example, assume an AHP has five large employers of the same size with varying health-status factors while all other rating characteristics are the same (benefits, age / gender, family size, geography, etc.). The premium rates charged to each group with and without health status adjustments are shown in Table 1.

Table 1
Illustration of AHP Large Group Rating With and Without Health Status Adjustments
Monthly Health Insurance Rates per Member

	Current Rules	Proposed AHP Rules
Employer	**Rates with health status adjustment**	**Rates without health status adjustment**
#1	$250	$350
#2	$300	$350
#3	$350	$350
#4	$400	$350
#5	$450	$350
Average	$350	$350

Note: All groups are the same size and have identical rating characteristics (benefits, age/gender, family size, geography, etc.) other than health status.

If Section (d)(4) became effective as presently written, the AHP rates would likely be significantly different from quotes the five groups received from other commercial insurance carriers in the marketplace for a non-AHP plan (which would still follow the current large employer group rating rules). Groups #1 and #2 have a clear financial incentive (lower rates) to find coverage outside of an AHP while groups #4 and #5 can take advantage of lower rates by remaining with the AHP. Group #3 is financially indifferent. Presuming the employers follow their financial incentives, the AHP rates would need to increase the following year to reflect the increased average cost of the remaining groups. These higher rates change the financial incentive calculus, driving more groups to the non-AHP market over time, thus beginning a "rate spiral" until all but the highest cost groups remain in the AHP. As a result, AHPs that enroll large groups would be forced to charge higher prices to offset the risk of adverse selection while losing membership.

The bottom line is that, if AHPs cannot use the same rating tools as commercial insurance carriers, AHPs would not be able to compete effectively and would lose the ability to provide the cost savings and other intended advantages the Proposed Rule is supposed to foster.

3. Effects Not Limited to Large Employers.

[7] This treatment would be even worse than that of non-bona fide AHPs, i.e., AHPs that are not treated as single plans under ERISA or HIPAA/ACA, because they are subject to a "look-through" rule that subjects participating large employers to the same group rating rules that apply in the large group market.

The adverse effects of Section (d)(4) would not be limited to large employer groups and AHPs that cover them. The Trust's comprehensive wellness program reflects its deep commitment to improving the health of its members. In its experience, the ability to set different premium levels for different member employers and their employees is one of the most effective methods of achieving that, because it rewards employers and employees for becoming full partners in that effort. Conversely, the application of Section (d)(4) would undermine the incentive for employers – both large and small – and their employees to join the Trust or similar AHPs and benefit from their healthier lifestyles and other cost-saving efforts. Such efforts are one of the few ways available to truly reduce health care costs in the long run.

4. Inequitable Result for Existing AHPs.

As noted above, the Trust was formed in 1965 and has operated in compliance with all applicable laws since its inception, including ERISA when enacted in 1974, subsequent DOL guidance, and the HIPAA/ACA nondiscrimination provisions, none of which have imposed a limitation as onerous as the one set forth in Section (d)(4). If enacted, Section (d)(4) would require the Trust, and other similar AHPs, to abandon their current method of operation and would jeopardize their continued existence as AHPs because of the inability to compete with traditional insurance providers. This result is inconsistent with the Executive Order and would ultimately result in the failure of the Trust and other existing or potential bona-fide AHPs, leaving thousands of employers and employees in the same position that the Proposed Rule was intended to address. Existing AHPs and potential AHPs would be in a better position to offer affordable health care to employers and employees under the existing sub-regulatory framework rather than under the Proposed Rule as currently structured.

5. The Control Requirement and the Eligibility and Benefit Nondiscrimination Requirements are Sufficient to Address ERISA-Based Concern.

The Preamble suggests that permitting AHPs to vary premiums on an employer-by-employer basis undermines the treatment of the association as the "employer" under Section 3(5) of ERISA and the legislative intent that ERISA apply only to employment-based relationships. ACEC and the Trust believe that the "commonality of interest" requirement, as clarified and expanded, and the requirement that an AHP have a formal organizational structure and be functionally controlled by its members, combined with the new requirement that AHPs not discriminate among member firms with respect to benefits or eligibility, adequately serve this purpose. The HIPAA regulations expressly permit group health plans to vary premiums subject to the prohibition on "list billing."[8] Imposing an additional limitation on an AHP's ability to vary premiums is unnecessary.

We believe this is particularly true for AHPs like the Trust that are treated as single plans under ERISA and HIPAA/ACA under the existing sub-regulatory framework, which requires the association to exist for more than the sole purpose of sponsoring a group health plan for its members, and requires a tighter "commonality of interest" than the Proposed Rule does.

The DOL's stated purpose for codifying the more lenient commonality requirement and the control requirement is to ensure that AHPs have the organizational structure and governance to act "in the interest" of participating employers, as opposed to merely operating as a traditional insurance provider offering insurance to unrelated employers. In the Preamble, the DOL states that the control

[8] DOL Reg. Section 2590.702(c)(2)(ii). The Proposed Rule, as drafted, would effectively override the existing DOL regulations which explicitly permit group health plans such as AHPs to vary premiums.

requirement together with the nondiscrimination provisions which require AHPs to accept all employers who satisfy the membership criteria create a level of cohesion and commonality among the entities acting on behalf of member employers and employees, contrary to the relationship between otherwise unrelated employers and traditional insurance providers. ACEC and the Trust agree that the control requirement and the new eligibility and benefit nondiscrimination requirements are sufficient to ensure that AHPs act "in the interest" of member employers as required under Section 3(5) of ERISA and distinguish AHPs from traditional insurance providers. The ability of an AHP to vary premiums across employers is not mutually exclusive of the requirement that the AHP be created with the intent of serving as an "employer" acting "in the interests" of its member employers. After all, current law does not appear to prohibit an actual single employer or controlled group of employers from varying premiums or benefit packages across different divisions or different members of the group. The nondiscrimination requirements applicable to eligibility for membership and benefits are acceptable limitations for AHPs and would adequately protect employers and employees while allowing AHPs to succeed and provide the advantages intended by the Proposed Rule.

6. Alternatives to the Imposition of a Limitation on Varying Premiums

To the extent that the DOL believes it is important to place some additional restrictions on the practices of AHPs in setting premiums for member firms, we would suggest the following alternative to the current proposal. As indicated above, AHPs are already subject to the HIPAA restrictions prohibiting "list billing" of individual employees based on a health factor.[9] While we believe that compliance with this prohibition is sufficient to assure fair rating practices, we offer the following as an additional protection in this respect: Under this alternative, subject to the HIPAA prohibition on list billing, AHPs would be permitted to vary the aggregate amount that member employers may be charged for coverage based solely on sound actuarial rating factors which have been certified by a member of the American Academy of Actuaries.

Alternatively, we ask the DOL to consider excluding from Section (d)(4) AHPs that satisfy the current sub-regulatory guidance with respect to AHP status, at least those that already exist. Under this alternative, group health plans which qualify as AHPs under existing guidance could continue to operate as AHPs without having to satisfy the new nondiscrimination requirements.

As a third alternative to meeting the nondiscrimination requirements of Section (d)(4), we ask the DOL to consider allowing a group health plan to satisfy a "facts and circumstances" test to establish that the group health plan sponsor is acting "in the interest" of participating employers, as opposed to merely operating as a traditional insurance provider offering insurance to unrelated employers. For example, as fully detailed above, it is apparent that each of the trustees who control the ACEC Health Plan annually volunteers hundreds of hours of their time solely in the interest of member engineering firms for the purpose of constructing a world-class health insurance arrangement. Notwithstanding the fact that the Health Plan varies premiums among member firms, it bears no resemblance whatsoever to a commercial insurance carrier in substance or in form.

CONCLUSION

[9] DOL Reg. Section 2590.702(c)(2)(ii).

It would constitute the ultimate irony if the DOL under the Trump administration promulgated a rule which caused the demise of AHPs. The Proposed Rule in its current form, while well intentioned, would do just that. ACEC and the Trust have worked together for over 50 years to construct a very special health insurance arrangement which continues to get better and better. We ask the DOL to consider modifying the Proposed Rule so that the Trust may continue to grow and thrive as an AHP.

Thank you for your consideration of these comments.

Sincerely,

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