



March 6, 2018

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Ms. Jeanne Kinefelter Wilson
Deputy Assistant Secretary
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

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

Dear Ms. Wilson:

The Council of Insurance Agents and Brokers (“Council”) appreciates this opportunity to comment on the Department of Labor’s (“Department” or “DOL”) proposed rule to revise the definition of “employer” under section 3(5) of ERISA for purposes of determining when employers may join together to sponsor a single ERISA-covered association health plan (“AHP”).¹

By way of background, The Council represents the largest and most successful employee benefits and property/casualty agencies and brokerage firms. Council member firms annually place more than \$300 billion in commercial insurance business in the United States and abroad. Council members conduct business in some 30,000 locations and employ upwards of 350,000 people worldwide. In addition, Council members specialize in a wide range of insurance products and risk management services for business, industry, government, and the public.

Executive Summary

The Council commends the Department’s ongoing efforts to increase flexibility and spur innovation to increase affordable healthcare options, particularly in the small group and individual markets. Alongside those efforts, however, we urge you to maintain proper consumer protections and insurance oversight, and bear in mind potential ramifications for broader market dynamics. For instance, Council members are concerned that the current AHP Proposed Rule could further destabilize individual insurance markets and that—without proper regulation and

¹ Department of Labor, Employee Benefits Security Administration, Proposed Rule, *Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans*, 83 Fed. Reg. 614 (Jan. 5, 2018) (hereinafter “Proposed Rule”).

supervision—some AHPs may repeat the negative experiences of Multiple Employer Welfare Arrangements (“MEWAs”) that in the past have been plagued with fraud, abuse and inability to pay policyholder claims. Below we provide more specific comments on the Proposed Rule and suggestions for how to minimize risk of any such harmful—albeit unintended—consequences.

Overall, the Council supports:

- Preservation of robust “bona fide association” and “commonality of interest” parameters for single ERISA-plan AHPs;
- Allowing “working owners” to participate in AHPs, so long as other existing bona fide association requirements are retained and appropriate solvency and consumer protection safeguards are in place;
- Exclusion from AHPs of individual members without a legitimate employment connection (i.e., those not genuinely engaged in a trade or business); and
- To prevent historical fraud- and solvency-related problems with MEWAs—which may be exacerbated with an expansion/growth of AHPs—ensuring adequate solvency protections for all AHPs, particularly self-insured arrangements, via domicile restrictions and other requirements such as actuarial attestations, reinsurance, minimum reserve or funding requirements, or similar oversight measures.

I. Regulatory and Operational Challenges for AHP Adoption Likely will Persist

As a practical matter, Council members question whether the Proposed Rule actually will result in more AHPs that constitute single ERISA-covered plans. Despite the Proposed Rule’s goal of eliminating some hurdles for creation of these arrangements, several regulatory and operational barriers will still exist for AHPs.

For example, the Department acknowledges that AHPs satisfying the Proposed Rule’s requirements would be subject to ERISA’s provisions governing employee welfare benefit plans and any additional requirements governing MEWAs.² Of course, states have broad authority to regulate MEWAs (whether insured or self-insured) and treatment of MEWAs varies widely across the country. Notably, the Proposed Rule does not provide greater uniformity or address any existing challenges for AHP MEWAs at the state level. Our members believe that this will continue to be a significant obstacle for widespread adoption of AHPs.

Additionally, Council members are concerned about AHPs under the Proposed Rule from an actuarial soundness perspective. Allowing individuals to join in AHPs with groups of various sizes, in conjunction with the nondiscrimination provisions’ community rating requirement (i.e., not allowing employer-by-employer underwriting), will make it very difficult—particularly with

² *Id.* at 625. The Proposed Rule notes that “AHPs as described in this proposal are one type of MEWA.”

what will presumably be a relatively small number of participants in these plans—to adequately spread risk.

Also, for insurers to be willing to offer AHP coverage, there need to be clear rules with respect to enrollment eligibility. Under the Proposed Rule, AHPs must accept as members all employers, including self-employed individuals, who satisfy membership criteria. Insurers, however, will be reluctant to provide coverage if participants—especially individuals—can jump in and out of the pool at any time. Therefore, at a minimum, AHPs would have to be able to restrict enrollment to specified times of the year (with appropriate exceptions for special coverage-related events).

Ultimately, it is not clear that the myriad of challenges currently facing AHPs can or will be overcome by the Proposed Rule’s attempts to provide more flexibility in this space. To the extent the Department does finalize new AHP rules, however, we encourage you to consider the specific suggestions below to ensure that AHPs are properly supervised and do not unnecessarily disrupt and/or compound problems in the individual and small group healthcare markets.

II. Comments on Features of the Proposed Rule

Broadly speaking, Council members are concerned that—absent solvency protections—extending single ERISA-plan eligibility to non-bona fide associations may exacerbate MEWA solvency issues that have occurred in the past. To combat this, we recommend maintaining the current bona fide association structure (while allowing working owners to participate) and ensuring that adequate financial oversight will apply to all AHPs.

A. Maintain Bona Fide Associations and Avoid Harming Consumers and the Individual and Small Group Markets.

The Proposed Rule’s significant loosening of the current commonality of interest test and expansion of AHPs to include individual members run the risk—we worry—of creating potentially mismanaged and insolvent AHPs and destabilizing the individual and small group markets. Accordingly, Council members oppose the Proposed Rule’s substantial relaxation of the Department’s current “bona fide association” requirements.³ The Council generally is supportive, however, of including “working owners” engaged in a genuine trade or business (but not individuals who do not have such an employment connection), provided robust “bona fide association” requirements and, as discussed below, solvency protections are in place to protect consumers.

³ The Proposed Rule would allow employers, including self-employed individuals,³ to band together for the express purpose of providing health coverage under very broad circumstances; specifically, when they share a trade, industry, or line of business (regardless of geographic distribution), or when they share a geographical region, including a multi-state metropolitan area (regardless of trade, industry, etc.).

Relatedly, Council members are concerned that the Proposed Rule’s construct (i.e., extending AHPs to include non-bona fide associations) could lead to AHPs “cherry picking” their members. Under the Proposed Rule, for example, it seems that a new AHP for semi-professional and professional athletes across the country could be formed for the express purpose of offering health coverage to those athletes. This, of course, could drain young, healthier people from the individual and small group markets, particularly because, if the AHP is regulated as a large group plan under the ACA, it could offer skinnier plans at lower premiums.⁴ Similarly, an AHP could be formed around any trade or line of business (or geographic region) that—on the whole—tends to be comprised of less costly insureds.

So, rather than increasing take-up rates by relatively healthy people in the now-struggling individual and small group markets, the Proposed Rule could do the opposite and pull those people out of those pools. This, we believe, will only heighten present dilemmas (including potential public expense) related to stabilizing skyrocketing costs and dwindling product options in the states’ individual and small group markets.

B. Protect Consumers through Proper Solvency Regulation and Oversight.

Additionally, Council members strongly encourage the Department to ensure that AHPs (along with all other types of MEWAs) are properly regulated for solvency and consumer protection purposes to avoid historical problems such as fraud, abuse and mismanagement. Generally, any new regulatory regime should contain clear rules identifying which state’s laws and enforcement authority apply when an AHP covers multiple states. Relatedly, to more specifically address the aforementioned consumer protection concerns, the Department could consider requiring AHPs under the Proposed Rule—specifically those covering participants in multiple states—to be domiciled and regulated in a state that has in place adequate solvency requirements for MEWAs.

⁴ AHPs’ potential regulation as large group plans not subject to many of the Affordable Care Act’s market reforms, including provision of essential health benefits, free preventive care, etc., raises separate issues with respect to comprehensiveness and adequacy of coverage for participants, as well as indirect discrimination against potential high-cost members. New AHPs that form single large-group plans could, for example, forego covering prescription drugs—which would naturally deter sicker, older individuals and those with chronic health conditions from joining. It also could allow AHPs to offer coverage at a significantly lower premium cost than the Exchange plans, which naturally will appeal to younger “invincibles.”

Again, the ultimate result is to draw relatively healthier people into AHPs and leaving higher-cost individuals in the general markets and on the Exchanges, which require more generous coverage for all plans. To the extent the Exchange pools become even less healthy overall, cost issues (in terms of premiums and subsidies) will likely get even worse.

One example, we believe, of a strong state model is Indiana’s regulatory structure for self-insured MEWAs.⁵ There, self-insured MEWAs (i.e., MEWAs providing benefits which are not fully insured by an authorized insurer) are required to annually obtain a certificate of registration with the state, which entails, *inter alia*: providing audited financial statements, proof of a fidelity bond to protect against fraud or dishonesty by any person servicing the MEWA, and an actuary opinion showing the MEWA will operate in accordance with sound actuarial principles. The MEWA’s benefit plan must be filed and approved by the insurance department and the department must examine—at the MEWA’s expense—domestic self-insured MEWAs at least every five years (and may examine them more often if regulators deem it necessary). Moreover, to become certified, the MEWA must have stop-loss insurance sufficient to cover anticipated claims for the year and maintain a minimum fund balance of \$500,000.

Council members are not opposed to the Department exercising its exemption authority to equalize state-law treatment for insured and self-insured MEWAs, provided that some mechanism is in place to prevent a so-called “race to the bottom” for MEWA oversight and regulation (e.g., a domicile requirement like the one referenced above that would ensure threshold oversight). Generally speaking, particularly for self-insured MEWAs, Council members support meaningful solvency-related requirements and other safeguards to ensure that claims get paid and consumers are protected. Specific mechanisms could include: actuarial attestations, robust reinsurance requirements (such as the ones currently in place in Indiana), minimum reserve requirements, and funding requirements.

“Best practice” or other “model state” guidance from the Department for MEWAs—and/or the states that regulate MEWAs—may also help promote consumer protection and responsible management of AHPs. Under the Affordable Care Act, MEWAs must report annually to the Department on Form M-1. The Form requires MEWAs to report certain financial and actuarial information, ERISA compliance information, as well as information about states where beneficiaries reside and MEWA licensure information in those states. This existing tool provides some tracking capacity for the federal government and states, which may help to identify potential bad actors early on.

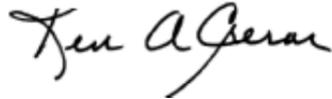
Accompanying Form M-1 is a Self-Compliance Guide to help MEWA administrators understand and assess their compliance with various ERISA requirements (e.g., HIPAA nondiscrimination rules, guaranteed availability/renewability requirements, annual/lifetime limit restrictions, wellness programs, mental health parity, etc.). The Department could consider expanding its MEWA compliance tool library by providing states and MEWAs with “best practice” or “model state” (e.g., Indiana) guidance on solvency and actuarial soundness issues (e.g., laying out essential features of internal MEWA processes and regulatory requirements that would constitute minimum solvency protections).

⁵ See generally, IND. CODE § 27-1-34-1 (2017), *et seq.*; see also, 760 IND. ADMIN. CODE 1-68-1 (2016), *et seq.*

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Again, we appreciate this opportunity to provide comments. Please do not hesitate to contact us if we can provide further information or answer any questions.

Respectfully submitted,

A handwritten signature in black ink that reads "Ken A. Crerar". The signature is written in a cursive style with a large, sweeping initial "K".

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