

March 6, 2018

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

Attn: Definition of Employer – Small Business Health Plans; RIN1210-AB85 (submitted electronically via: <http://www.regulations.gov>)

Ladies and Gentlemen:

Mercer welcomes the opportunity to provide input to the Department's proposed rule expanding the definition of employer under ERISA Section 3(5) to facilitate the adoption and administration of Association Health Plans (AHPs) in response to the Department's request for comments on key issues as part of the rulemaking process.

Mercer is a global leader delivering advice and technology-driven solutions that help organizations meet the health, wealth and career needs of a changing workforce. In the United States, Mercer provides brokerage, consulting and actuarial services to more than 4,800 health and benefit clients, which includes employers of all sizes, with varying employee demographics, in all parts of the country. Mercer's Affinity business has an extensive 65-year history with associations providing tailored benefits (e.g., life, disability, property & casualty, professional liability) to more than 350 associations.

We agree with the Department that expanded AHP coverage will give many more employers – particularly small employers – access to more affordable and comprehensive coverage options and with consumer protections similar to those provided to large employer group health plans under ERISA. That coverage would be especially valuable to many self-employed individuals whose only current option is the individual market.

We applaud the Department's proposed regulation, including the more flexible "commonality of interest" test that will allow more organizations to offer coverage. We also believe that the considerable promise of expanded AHPs could be enhanced if the Department makes some modifications. We are concerned that, without certain clarifications and expanding the preemptive scope of self-funded AHPs, the proposed



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rules may create an unattractive insurance market for AHPs that ultimately limits consumer access and frustrates the intended purpose of the rules – which is to expand access. To summarize and as discussed in more detail below, we recommend that the final regulations:

- Retain the proposed nondiscrimination rules and clarify certain aspects of the rules permitting distinctions based on non-health factors. AHPs are not likely to be viable – and insurance carriers may be unwilling to write policies for AHPs – unless certain distinctions among participating employers are permitted under nondiscrimination rules.
- Provide a class exemption under ERISA Section 514(b)(6)(B) for certain self-funded multiple employer welfare arrangements (MEWAs). This would allow AHPs to offer health coverage like a large employer’s plan – without having to comply with state insurance laws (including those that apply only to the small group and individual markets), other than state laws related to reserves and contributions. We recognize the potential for abuse related to self-funded MEWAs, however, and provide suggestions below that could minimize insolvency risks.
- Retain the proposal to allow working owners (including independent contractors, freelancers, and gig workers) to be treated as “employers” and “employees” eligible for employer-based coverage under an AHP, without imposing undue administrative constraints.

Discussion

A. The final regulations should retain the nondiscrimination provisions in the proposed regulations, but provide clarifications.

Mercer supports the Department’s proposed application of the HIPAA nondiscrimination provisions to AHPs, and asks the Department to confirm that AHPs can charge different employer members of the group or association differently based on non-health factors.

The proposed AHP rules prohibit conditioning employer membership in an association based on an individual’s health factor and require AHPs to prohibit nondiscrimination on

the basis of a health factor as to eligibility for benefits, and premiums or contributions¹. The proposed rules build on the HIPAA nondiscrimination rules by permitting AHPs, like other group health plans, to make distinctions in eligibility, and premiums or contributions that are not based on a health factor. The proposed rules also provide that an AHP can't treat different employer members of the group or association as distinct groups of similarly-situated individuals (Prop. Reg. sec. 2510.3-5(d)(4)). Mercer asks the Department to confirm that this paragraph (d)(4) does not prevent an AHP from charging different employer members different premiums or contributions based on non-health factors, including non-health factors of their employees. For example, the premiums for an AHP's members could vary based on the employers' industries or ages of members' employees. As detailed below, without these distinctions, a viable insurance market for AHP coverage is unlikely to exist.

1. The Department should add two new clarifying examples.

To ensure that the nondiscrimination rules take into account the unique characteristics of AHPs, we ask the Department to clarify paragraph (d)(4) and confirm its application with new examples such as the ones proposed below:

- › Example 7. (i) Facts. Association P sponsors an insured group health plan, available to all employers doing business in Town Q. Employer R has 3 employees, ages 25, 30, and 35. Employer S has 3 employees, ages 45, 50, and 55. The insurer for Association P's group health plan takes participants' ages into account when establishing the premiums for the Association's policy, and the Association applies those same Association-wide rating factors when establishing the premiums required of each participating employer. As a result the premiums charged to Employer R and Employer S vary, reflecting the demographics of each enrolled population.

(ii) Conclusion. In this Example 7, making a distinction between employer members based on the ages of their participating employees is a permitted distinction between similarly situated individuals under Section 2590.702(d) of this chapter, provided the distinction is not directed at individuals under Section 2590.702(d)(3) of his chapter. Accordingly, Association P's rule for charging different premiums based on age does not violate paragraph (d)(3) or (d)(4) of this Section. (Note that in the preamble to the AHP rules, the

¹ In this context, "premiums" is used to refer to the total cost of coverage under an insured group health plan and "contributions" is used to refer to the total cost of coverage under a self-funded group health plan.

Department indicates that age is a non-health factor (83 Fed. Reg. 628, Jan. 5, 2018) even though it may correlate with healthcare spending.)

- › Example 8. (i) Facts. Association T sponsors a group health plan, available to all employers doing business in Town U. Member Employers V and W are in the hospitality industry while member Employer S is in the manufacturing industry. Association T charges Employers V and W one premium amount and Employer S a different amount.

(ii) Conclusion. In this Example 8, making a distinction between employer members based on their industry is a permitted distinction between similarly situated individuals under Section 2590.702(d) of this chapter, provided the distinction is not directed at individuals under Section 2590.702(d)(3) of his chapter. Accordingly, Association T's rule for charging different premiums based on industry does not violate paragraph (d)(3) or (d)(4) of this Section.

Example 8 would also have the benefit of clarifying that industry is not a health factor. Final HIPAA nondiscrimination rule Section 2590.702(d)(1) identifies an employee's occupation as a non-health factor. AHPs will rarely know the specific occupations of the employees who work for their employer members but, like large group plans, should be able to take employment-based distinctions into account when determining eligibility and premiums or contributions. An employer's industry, determined by an independent standard such as the North American Industry Classification System (NAICS), is a non-health factor that is used widely in the insurance industry to set premiums and likewise should be available to AHPs.

2. AHPs should be able to create distinctions based on non-health factors.

The table below illustrates² how an AHP could create distinctions based on non-health factors like age and industry that apply to all employer members of the AHP and result in different premiums for different employer members.

INDUSTRY A		INDUSTRY B		INDUSTRY C	
Age bracket	Per enrolled employee per year	Age bracket	Per enrolled employee per year	Age bracket	Per enrolled employee per year
20-25	\$100	20-25	\$120	20-25	\$90
26-30	\$110	26-30	\$130	26-30	\$100
31-35	\$120	31-35	\$140	31-35	\$110
36-40	\$130	36-40	\$150	36-40	\$120
41-45	\$140	41-45	\$160	41-45	\$130

The ability to make these distinctions is important because without them AHPs may fail. AHPs are different from single-employer plans which typically have steady enrollment based on the employer's population (which exists for purposes other than procuring healthcare) and do not see variability in the underlying demographics of the eligible versus enrolled population. If the demographic risk of an AHP's enrolled population is dramatically different from the population upon which rates were set, the AHP might collect insufficient premiums or contributions to fund all claims for the year. This underfunding would lead to significant premium increases the following year – and possibly drive healthy enrollees out of the AHP. To ensure that premiums will be sufficient to pay incurred claims and attract a mix of risk, AHPs must be able to vary premiums and contributions based on the non-health demographic factors of their employer members. Without this variation, AHPs would become unaffordable and unsustainable and could make the entire AHP market unattractive to insurers and employers, which would not expand access beyond that which exists today.

² The numbers in this table are purely illustrative and do not represent actual premiums or the full array of age bands.

B. The final regulations should permit broadened ERISA preemption for self-funded AHPs, as permitted under ERISA Section 514(b)(6)(B).

The proposed rules request comments on whether the Department should exercise its authority under ERISA Section 514(b)(6)(B) to exempt self-funded AHPs that are employee benefit plans from state insurance regulations “as a way of promoting consumer choice across state lines.” Mercer encourages the Department to issue these regulations. Without this relief under ERISA, the advantages of self-funding are lost to many working owners and small employers, especially for AHPs operating in multiple states or those operating in states that broadly subject self-funded multiple employer welfare arrangements (MEWAs) to their state insurance laws. Issuing these regulations will further the Department’s goal of leveling the playing field by making more affordable plans available to small employers and working owners in the same way they are available to large groups and facilitating such an offering across state lines. Accordingly, the Department should issue regulations providing broader state law preemption to self-funded AHPs, but subject to federal safeguards to minimize the risk of plan insolvency.

1. ERISA currently treats self-funded AHPs differently from self-funded single employer plans

ERISA generally preempts “any and all state law” that relates to an ERISA employee benefit plan. ERISA Section 514(a). In contrast, self-funded AHPs – because they are MEWAs covering employees of more than one employer – don’t preempt state insurance law unless the law is not consistent with ERISA. ERISA Section 514(B)(6)(A)(ii). Congress added this provision to ERISA in 1983, in part responding to instances of underfunded – and in some cases fraudulent – self-funded MEWAs. But the 1983 amendment also recognizes that relief from this limitation on preemption may be appropriate. Under ERISA Section 514(b)(6)(B), the Department can issue regulations providing that state insurance law does not apply to self-funded MEWAs, except for state laws that impose:

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. ERISA Section 514(b)(6)(A)(i)(I).

States can also impose provisions to enforce these reserve and contribution³ standards. ERISA Section 514(b)(6)(A)(i)(II).

Mercer recognizes the potential state concerns presented by the Department's exercising this authority to expand state insurance law preemption. But, as discussed below, these concerns can be addressed so that self-funded AHPs function more like large employer self-funded plans, while protecting plan participants, beneficiaries and employers.

2. Self-funded health plans offer competitive and design advantages.

While the Department's proposed regulations will let AHPs comply with large-group – rather than small-group and individual market – ACA mandates, without expanded access to self-funding AHPs will still face competitive disadvantages and fewer options when compared to single employer large group plans. Self-funding permits plans to exercise more control over plan design and multistate plans to offer a uniform design (because the plan is not complying with differing state insurance laws). Self-funded plans have more opportunity to control costs by minimizing the impact of state mandates and premium taxes, as well as adopting innovative designs. The ability to self-fund AHPs could create savings for the consumer in excess of 5% of the average employee premium for a small company, which could generate a savings of nearly \$540 per employee per year.⁴ This savings is derived from the reduction in state premium taxes and removal of state benefit mandates. Small employers and working owners should be afforded the same access to self-funding as large employers; without issuing regulations under ERISA Section 514(b)(6)(B) to expand ERISA preemption, this goal cannot be achieved.

3. Without new federal guidance, self-funded AHPs will continue to operate at a disadvantage in some states, may not be practical in other states, and will have difficulty operating across state lines.

Currently, states can regulate self-funded MEWAs as insurance or by MEWA-specific laws. While state laws vary, in some states there are significant legal barriers to establishing a self-funded MEWA. If a self-funded MEWA wants to operate in multiple states, the barriers become virtually insurmountable.

³ We understand “contributions” in this context to refer to the amounts the AHP charges employer members to obtain coverage for their employees and beneficiaries through the AHP.

⁴ This estimated savings is based on an average per employee per year cost of \$10,770 paid by small employers, according to Mercer's 2017 Survey of Employer Sponsored Health Plans.

Following is a brief summary of how two states – California and New York – regulate self-funded MEWAs, illustrating that without preemptive relief, the proposed rules cannot achieve their intended purposes:

- California regulates MEWAs in its Insurance Code, so state benefit mandates for insured coverage apply to self-funded MEWAs. A self-funded MEWA must also be a non-profit, with at least 2,000 employees and 50 paid employer members operating actively for at least five years, pursuant to a trust agreement. The MEWA must be established by a trade, industry or professional association with at least 200 paid members that has operated for five years for purposes other than obtaining or providing health care coverage. California specifies certain aggregate and specific stop-loss insurance attachment points, loss and adjustment reserves, and a specific surplus governed by certain investment requirements. Plans must have a fiduciary liability policy of at least \$500,000, and a fiduciary bond.
- New York requires self-funded MEWAs to be licensed to do an insurance business in the state, making them subject to New York statutes and regulations applying to health insurance policies, including mandated benefits. Based on Opinions from the New York Office of General Counsel, MEWAs established out of state cannot provide coverage to New York employer groups, and MEWAs with small employer members are subject to New York's small insurer laws. New York insurance law generally prohibits self-funded small groups – that are subject to community rating requirements – including MEWAs that include small group employers – from purchasing stop-loss insurance.

Presumably certain provisions of California and New York law – such as California's requirement that an association must exist for purposes other than providing health care and New York's imposition of small group rules if any members are small groups – would conflict with ERISA if the Department finalizes the proposed AHP rules. But unless the proposed rules are expanded to provide a class exemption for self-funded MEWAs, other requirements that would not be preempted would make a self-funded AHP covering employees in both New York and California virtually impossible to establish. These requirements would include the application of state insurance mandates to self-funded coverage, stop-loss requirements (which are required by California but might not be available to a self-funded MEWA in New York), and New York's prohibition on an out-of-state MEWA covering New York residents. Even if operating in only one of these states, the cost of complying with the raft of state requirements would largely eliminate the benefits of self-funding.

4. Expanding access to self-funded AHPs should not increase the risk of underfunded plans that would be prone to insolvency.

Various safeguards exist – or can be written into class exemption regulations – to promote financial solvency of AHPs. As discussed below, these include continued state law authority in certain areas, other federal law that will apply to self-funded AHPs, the association standards as set forth in proposed rule Section 2510.3-5(b) and the ability of the Department to impose conditions on which AHPs qualify for the exemption.

a. If ERISA Section 514(b)(6)(B) regulations are issued, state reserve and contribution levels will continue to apply.

As stated in the preamble to the proposed rules, if the Department issues regulations under ERISA Section 514(b)(6)(B), ERISA preemption will apply in a more limited fashion to self-funded AHPs than to single employer self-funded group health plans. Specifically, the state where an AHP is established will continue to have authority in two key areas: setting reserve and contribution levels, as well as authority to enforce these requirements. This retained statutory authority recognizes the state interest, but also affords AHPs most of the advantages of self-funding that are enjoyed by large group single employer plans, permitting employees of small employers or working owners more competitive health care choices.

While ERISA provides that state contribution and reserve requirements would continue to apply to self-funded MEWAs qualifying for preemption under ERISA 514(b)(6)(B), the Department's guidance should specify that permitted reserve and contribution requirements will be construed narrowly to limit the burden on AHPs. Additionally, an AHP should only be subject to the state reserve and contribution laws of the state in which it is established. This will prevent the AHP from having to comply with multiple state laws that would unduly burden and complicate establishing a multi-state AHP. To the extent the Department concludes that certain reserve or contribution standards should apply to all self-funded MEWAs, the Department can impose those standards if the state in which the AHP is established lacks them.

b. Various federal laws will continue to apply to AHPs, protecting their participants and beneficiaries.

Federal health care protection has become more comprehensive since the provision limiting ERISA preemption for self-funded MEWAs was added in 1983. These laws will afford AHP participants and beneficiaries important substantive rights, including:

- Bans on pre-existing conditions and waiting periods longer than 90 days

- Bans on lifetime and annual limits on covered essential health benefits
- Requirements for out-of-pocket maximums for covered essential health benefits obtained in-network
- First dollar coverage on ACA preventive services
- Expanded claims and appeals rights
- Enhanced federal MEWA reporting requirements and enforcement tools under the ACA

Self-funded AHP plans will also be subject to those federal requirements already in place in 1983, including benefit disclosure provisions, and ERISA's bonding requirements and enforcement scheme. In sum, AHPs will not operate in a legal and regulatory vacuum – but will be subject to a uniform set of federal substantive requirements.

c. The proposed rules' parameters for permissible associations will promote member interests.

The proposed rules (Section 2510.3-5(b)) would apply only to a “bona fide group or association of employers.” AHPs must be controlled by their employer members directly or indirectly, the association must have a commonality of interest – as defined by the proposed rules, and the organization must have a formal organizational structure with a governing body and by-laws (or similar governing documents). These requirements will help ensure that the association acts in the interest of employer members and their employees. Employer members will be concerned with providing stable and ongoing health coverage; as a result they will exercise their control to promote the AHP's financial stability rather than commercial gain.

d. The Department should impose conditions on self-funded AHPs that address potential solvency concerns.

Additionally and separately, the Department can – and should – impose conditions on qualifying for the exemption to bolster financial stability and solvency. Mercer suggests that the Department – in consultation with various stakeholders – consider the following provisions.

- Improve compliance monitoring of federal reporting requirements and the audited financial statement included with a Form M-1 filing.

- Require a federal certificate of authority that includes an actuarial certification of the AHP's established contribution levels and plan liability estimates.
- Require AHPs to purchase aggregate and individual stop-loss coverage. Stop-loss insurance transfers to insurers the exposure the AHP otherwise has to unexpected catastrophic claims.
 - » Catastrophic claims are low frequency, high severity events and are difficult for all organizations to predict accurately. By requiring an AHP to purchase stop-loss coverage, the plan expense and cash flow becomes more stable from period to period, which will greatly increase the likelihood of plan solvency compared to a self-funded AHP without stop-loss coverage. In addition, the larger the enrolled population, the more predictable the plan expenses are. As a result, Mercer recommends that the level of required stop-loss protection should be reduced as the size of an AHP's enrolled population grows. As an example, an AHP that has fewer than 1,000 participants should be required to have a lower individual stop-loss deductible than AHPs with a larger population.
- Require AHPs with fewer than 500 participants to be fully insured. In addition, require that newly established AHP plans be insured for a minimum of three plan years before qualifying for self-insurance and have a minimum average of 500 enrolled participants (including beneficiaries) in the preceding plan year. The three plan years with an insured policy will allow time for the AHP to build underlying experience to better project future plan expenses.
 - » The three-year waiting period also will allow time for the AHP to establish an initial reserve needed to cover unexpected plan expenses associated with self-funding.
- Require that any plan reserves or surpluses be available only to pay future plan expenses.
- Require that self-funded administration contracts include terminal premium obligations, which requires an insurance company to pay run-out claims upon plan termination.
- Require disclosure to participants of plan features (e.g. self-insurance, exemption from state benefit mandates, etc.).

C. The final regulations should permit working owners to participate in AHPs.

Mercer supports the Department's proposal to treat working owners as both employers and employees eligible to participate in group health plans sponsored by AHPs. Sole proprietors and partners who do not have common law employees should have access to the same quality of coverage available to large employers, and this can be achieved only by allowing them to band together in AHPs. This segment of the population is projected to grow in the coming decades and allowing AHPs to provide health coverage options for working owners will further the Department's goal of expanding access to health coverage among small businesses and entrepreneurs. The Department should finalize its proposal to permit working owners (and family members) to participate in AHPs without imposing undue administrative constraints on working owners' eligibility.

1. Determination of working owner status should allow for administrative flexibility

The Department has proposed that working owners be defined by reference to their working hours or earned income, and lack of eligibility for other subsidized employer group health plan coverage. Mercer supports the proposed criteria as an effective means to distinguish legitimate trades and businesses from individuals not engaged in meaningful commercial activities.

Furthermore, we support the provision allowing AHPs to rely on the written representations from individuals seeking to participate as working owners as to their status, absent knowledge to the contrary. This approach is consistent with administrative processes used by single-employer ERISA plans, which generally rely on the representations of participants as to their own and their beneficiaries' eligibility. Plan fiduciaries who have knowledge suggesting the representations are false will fulfill their duty to administer the plan eligibility requirements according to plan terms.



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We thank the Department for the opportunity to respond to the request for comments in the proposed regulation and would welcome the opportunity to meet with you to discuss. If you have any questions or need further information, please contact Judy Bauserman (judy.bauserman@mercer.com or 202 263-3901), Leslie Anderson (leslie.anderson@mercer.com or 612 642-8711), or Cheryl Hughes (cheryl.hughes@mercer.com or 202 263-3918).

Sincerely,

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