



March 6, 2018

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

By electronic submission

**Re: RIN 1210-AB85; Proposed Rule; ERISA Definition of Employer—Association Health Plans; Request for Information on Promoting Healthcare Consumer Choice and Competition**

Dear Assistant Secretary Rutledge:

Western Growers Assurance Trust (WGA Trust) is pleased to provide comments in response to the above-referenced proposed rule.<sup>1</sup> Specifically, we are responding to the request for information (RFI) concerning self-insured multiple employer welfare arrangements (MEWAs).<sup>2</sup>

The substantive provisions of the proposed rule would administratively reinterpret the definition of “employer” under the Employee Retirement Income Security Act of 1974 (ERISA) to establish more flexible criteria for treating an association health plan (AHP) as the employer sponsor of a single employee welfare benefit plan, which in certain cases would allow AHPs to purchase insurance in the large group market. Coverage in the large group market is not subject to the requirement for “essential health benefits” under the Affordable Care Act (ACA).

This AHP proposal, however, is separate from the RFI in terms of both legal and policy issues. In contrast to the AHP proposal, the RFI concerns the issue of whether the Department of Labor (DOL) should exercise particular statutory authority that Congress provided to the DOL in 1983, which concerns preemption-related exemptions for self-insured MEWAs that are ERISA employee welfare benefit plans.<sup>3</sup> WGA Trust believes that the DOL can exercise this exemptions authority for self-insured MEWA group health plans in a manner that will increase the access of ERISA participants and their beneficiaries to affordable, high-quality health plans. These ERISA plans would be subject to stringent requirements established by the DOL to protect against misuse of their exempted status; therefore, the only necessary

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<sup>1</sup> 83 Fed. Reg. 614 (January 5, 2018).

<sup>2</sup> *Id.* at 625.

<sup>3</sup> ERISA section 514(b)(6)(B) (29 U.S.C. 1144(b)(6)(B)).

State regulations would be those that concern maintaining specified levels of reserves, and specified levels of contributions, to ensure that the health plan is able to pay benefits in full when due.<sup>4</sup>

We have unique insights into the questions posed by the RFI because WGA Trust is a self-insured MEWA that, since 1957, has offered group health benefit plans to agricultural employers and their employees in California and Arizona. For decades the conventional insurance market underserved our participating employers. The members of Western Growers Association formed WGA Trust to solve this problem by offering unique health plans tailored to the needs of their workers. We do not offer health plans to the market at large, but rather only to the agricultural market.

Group health plans offered by WGA Trust are high quality. They provide major medical coverage including coverage for pregnancy, prescription drugs, hospitalization, emergency services, surgery, mental health, substance abuse, preventive, dental, and vision benefits. As a self-insured MEWA that offers ERISA group health plans, WGA Trust is not subject to the requirement to provide essential health benefits. (Again, the legal and policy issues posed by the RFI are different than those of the AHP proposed rule.) In enacting the ACA, Congress did not subject self-insured ERISA group health plans to the essential-benefits requirement, for reasons similar to why that requirement was not imposed on plans in the large group market—there was no history of coverage problems. The historical problems were in the individual and small group markets; therefore, plans in those markets are required to provide essential health benefits.

As explained in more detail below, self-insured MEWA group health plans should primarily be subject to regulation by the DOL, not by every State. This would be more consistent with the preemption provisions that apply to self-funded ERISA group health plans that are not MEWAs. As a condition of providing an exemption to a self-insured MEWA group health plan, the DOL should:<sup>5</sup>

- Require that the plan not be marketed to employers at large, but rather be limited to markets determined by the DOL to be appropriate (e.g., specific industries or specific geographic regions).
- Require reporting to demonstrate the plan's compliance with ERISA, the ACA, and MEWA regulations.
- Track actuarial soundness, proper maintenance of reserves, and adequate underwriting to ensure solvency, and require a certified actuarial opinion.
- Present the above data to stakeholders—States, consumers, carriers, and the exempted MEWAs themselves—to demonstrate whether individual exempted MEWA group health plans are succeeding or failing.

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<sup>4</sup> See ERISA section 514(b)(6)(A)(i).

<sup>5</sup> In the RFI (83 Fed. Reg. at 625), the DOL asked for input on (1) the potential for such exemptions to promote healthcare consumer choice and competition across the United States; (2) the risk such exemptions might present to appropriate regulation and oversight of MEWAs, including State insurance regulation oversight functions; (3) how best to ensure compliance with the ERISA and ACA standards that would govern MEWAs with any more guidance on the application of these standards or other needed consumer protections (taking into account the existing generally-applicable Federal regulatory standards governing ERISA plans and additional requirements governing MEWAs); and (4) how best it can use the provisions of ERISA Title I to require and promote actuarial soundness, proper maintenance of reserves, and adequate underwriting and other standards relating to MEWA solvency.

- Aggregate and present the data so that the DOL and stakeholders can determine the health of the overall market of exempted MEWA group health plans.

States would, as noted above, have authority to ensure that specified levels of reserves, and specified levels of contributions, are maintained to ensure that the exempted MEWAs are able to pay benefits in full when due. With respect to self-insured MEWA group health plans, State financial review bolsters stability, fiscal solvency, and is a necessary component of proper regulatory oversight.

In addition, the DOL has authority (provided by the ACA) to issue a cease and desist order against any MEWA that is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.<sup>6</sup> And a final rule in 2013 established reporting and registration requirements for MEWAs, building on reporting requirements that were established by a final rule in 2003.<sup>7</sup>

When appropriately regulated by the DOL on most matters, and by the States with respect to fiscal solvency, self-insured MEWA group health plans can increase the access of ERISA participants and their beneficiaries to affordable, high-quality health plans and create competition in the market for group health plans.

### **I. Background on MEWAs**

WGA Trust understands the concerns that some commentators have about MEWAs, but we wish to emphasize that, with respect to the historical problems with MEWAs, Congress recognized long ago that the situation with self-insured MEWAs was different than with fully-insured MEWAs. It is also important to understand that many if not most of the historical bad actors were not even true ERISA group health plans.

In 1983, Congress acted to respond to these historical problems. As one of the chief House sponsors of the legislation put it, “operators of bogus ‘insurance’ trusts are bleeding the trusts of funds and claiming bankruptcy, thus leaving thousands of people holding the bag for millions of dollars in unpaid hospital and medical bills.”<sup>8</sup> The States were having difficulty responding because these unscrupulous operators were claiming that ERISA preemption applied and therefore State laws could not reach these health plans. The DOL, however, found that, in virtually all cases it examined, these health plans were not employee welfare benefit plans and therefore did not qualify for ERISA preemption.<sup>9</sup>

The legislative provisions enacted in 1983<sup>10</sup> made clear that a MEWA health plan does not qualify for ERISA preemption unless it is an employee welfare benefit plan within the meaning of the Act. In addition, the legislation amended the ERISA preemption provisions to subject MEWA group health plans to certain State laws that regulate insurance.

Importantly, even though Congress took strong action to shut down these unscrupulous operators, the authors of the 1983 legislation treated self-insured MEWAs differently than fully-insured MEWAs. The legislation gave the DOL the authority to exempt self-insured MEWA group health plans from State

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<sup>6</sup> ERISA section 521 (29 U.S.C. 1151).

<sup>7</sup> These final rules are discussed in section III.A below.

<sup>8</sup> Statement of Representative John Erlenborn (R-IL) on H.R. 5470, 97<sup>th</sup> Congress, Congressional Record, H 9604, H 9610 (Daily Edition, December 13, 1982).

<sup>9</sup> *Id.* at H 9610.

<sup>10</sup> Section 302 of Public Law 97-473 (96 Stat. 2612) (January 14, 1983).

insurance laws, other than those that concern maintaining specified levels of reserves, and specified levels of contributions, to ensure that the health plan is able to pay benefits in full when due.

The general ERISA rule is that self-insured ERISA group health plans are not subject to State laws as they relate to employee welfare benefit plans. The exemption authority Congress created in 1983 recognized that there are circumstances in which it would be appropriate for the DOL to apply this general rule to self-insured MEWA group health plans. The DOL should exercise this exemption authority. Such MEWA plans are true ERISA employee welfare benefit plans, the DOL can establish appropriate consumer-protection regulations regarding the plans, and the plans would be subject to State fiscal-solvency laws. Moreover, as noted, the ACA gave the DOL the authority to issue cease and desist orders against MEWAs, and final rules in 2013 and 2003 established reporting and registration requirements for MEWAs.

Congress in 1983, and the DOL in the current RFI, recognized the potential for legitimate self-insured MEWA group health plans to increase healthcare consumer choice and competition.

## **II. Exempting Self-Insured MEWAs Will Increase Consumer Choice**

An exempt, well-designed and administered self-insured MEWA could develop a number of attractive group health benefit plans options that are unavailable today. Unlike their fully-insured counterparts, exempt self-insured MEWA group health plans would not be subject to many State insurance laws because they would be subject to stringent DOL regulations.

These self-insured MEWAs would be pure ERISA plans that would create specific and distinct plan designs geared toward specific industries or geographic regions. Subject to these marketing limitations, these plans could be operated in any State. Moreover, self-insured MEWAs could reduce their administrative costs by offering a uniform plan that provides the same benefits at the same level to participating employers. Exempting self-insured MEWAs would allow employers to offer identical plans regardless of where their employees work—California or Florida, for example—and to select coverage options tailored to their needs and pass along the savings to their employees.

Administrative costs would further be reduced because the self-insured MEWAs would primarily be subject to a single regulator—the DOL—rather than a patchwork of State laws (although State fiscal-solvency laws would apply).

Some consumers would welcome the opportunity to purchase plan options that provide major medical coverage comparable to coverage in the large group market, including for pregnancy, prescription drugs, hospitalization, emergency services, surgery, mental health, substance abuse, and preventive services. Although some benefits required for the ACA exchanges may not be offered, the group health plans provided by self-insured MEWAs would be high-quality coverage at an affordable price.

These new options could spur innovation and encourage industry associations, third party administrators, and other stakeholders to sponsor and operate new self-insured MEWAs. Traditional fully insured carriers would likely develop insurance products to compete with this new line of plan benefit options further increasing competition for consumers' healthcare dollars, promoting even more choice.

As noted, however, the DOL must protect the insurance market and consumers from fraud and financial instability that, in the past, plagued some MEWAs.

### **III. DOL Can Mitigate Any Potential Risks by Tailoring the Exemption**

The key to mitigating potential risks posed by MEWA instability or fraudulent actors is to create a tailored comprehensive administrative-exemption process. Failure to establish a stringent exemption process would invite past mistakes. The DOL could, with stakeholder input, develop an exemption process centered on consumer protection, financial stability, and fraud prevention.

While MEWAs are governed by both Federal and State law, the DOL has, for the most part, taken a back seat to State insurance departments, which have historically been the primary regulators of self-insured MEWAs. The DOL—by creating this new exemption process—would be taking on greater responsibility by becoming the primary regulator. Below WGA Trust suggests the steps the DOL could take to accomplish this. In summary, the DOL should require reporting to demonstrate compliance with ERISA, the ACA, and MEWA regulations; should track actuarial soundness, proper maintenance of reserves, and adequate underwriting to ensure solvency; and should require a certified actuarial opinion.

#### **A. Ensuring Compliance with ERISA, ACA & MEWA Standards**

With respect to enforcement power over MEWAs, the ACA amended ERISA to give the DOL more power and built on the authority provided by the Health Insurance Portability and Accountability Act of 1996. These ERISA amendments and the DOL's implementing regulations have laid the groundwork for regulating exempt self-insured MEWAs. All MEWAs, including those that are not ERISA employee welfare benefit plans, are subject to reporting requirements and must register with the DOL. All MEWAs are required to report by filing a Form M-1. MEWAs that are ERISA employee welfare benefit plans must also file a Form 5500. In addition, MEWAs are subject to cease and desist orders.<sup>11</sup>

Thus, MEWA group health plans are subject to Federal laws and regulations governing employer-sponsored employee welfare benefit plans. For more than a decade, the DOL has required MEWAs to report about compliance with these requirements (specifically, part 7 of ERISA) by filing Form M-1. The Form M-1 and the MEWA reporting requirements were developed in a 2003 rule and used as a mechanism to help States identify problem MEWAs engaging in fraud and abuse. More regulations were finalized in 2013, amending the 2003 rule and establishing new registration and reporting requirements.

As noted, these requirements lay the groundwork for regulating exempt self-insured MEWA group health plans. The DOL could create a narrowly-tailored process to exempt qualified self-insured MEWAs. These entities would then demonstrate compliance with ERISA, ACA, and MEWA standards through Form M-1, Form 5500, and financial filings. In fact, the fortuitous timing of proposed changes to the Form 5500, the mandatory M-1 filing requirements, and the DOL's recently granted enforcement authority over MEWAs could provide the basis of a new regulatory mechanism to govern exempt self-insured MEWAs.

The M-1's ERISA part 7 questionnaire requires MEWAs to state whether they are in compliance with the following:

- HIPAA nondiscrimination provisions, including Title I of the Genetic Nondiscrimination Act of 2008

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<sup>11</sup> 78 Fed. Reg. 13781 (final rule on Form M-1), 13797 (cease and desist orders), 13897 (notice concerning Form M-1) (March 1, 2013).

- Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 and associated regulations
- Newborns' and Mothers' Health Protection Act of 1996 and associated regulations
- Women's Health and Cancer Rights Act of 1998
- Michelle's Law
- Patient Protection and Affordable Care Act of 2010 and associated regulations

The ACA also requires all MEWAs subject to M-1 filing requirements to file a Form 5500. This form requires certain information about the plan, including its name, the date it first became effective, plan sponsor information, information about the plan administrator, a breakout of the number of participants in the plan at the end of the plan year, plan funding, benefits provided, the schedules that are attached to the Form, and specific characteristics of the plan (for example, if it provides matching contributions).

The specific schedules required to be filed with the Form 5500 depend on the type of filer. These are generally broken into two categories: pension benefits and welfare benefits, and further subdivided into large plan or small plan. Each plan files:

- Financial information including assets and liability (Schedule H)
- Information about benefits provided using insurance (Schedule A)
- Information about services providers paid more than \$5,000 (Schedule C)
- Financial transaction information including loans, fixed income obligations and leases in default or uncollectible and nonexempt transactions (Schedule G)
- An accountant's report from an independent auditor

The DOL, Internal Revenue Service (IRS), and Pension Benefit Guaranty Corporation (PBGC) have jointly proposed significant changes to Form 5500, targeted to take effect with 2019 plan year filings.<sup>12</sup> The proposed changes include revisions to the main body and simplification of the various schedules and the addition of a comprehensive new Schedule J (Group Health Plan Information) to be filed by group health plans. The proposed regulations would make the Form 5500 more data-mineable and accessible for research, policy analysis, and enforcement purposes, and various elements would be presented in a more structured manner.

These reporting requirements could be supplemented by incorporating provisions similar to State-imposed annual financial filings like those currently imposed upon self-insured MEWAs. Several States impose financial reporting requirements that could form the basis of Federal financial filings. A typical State financial filing requires annual financial statements audited by a certified public accountant, an annual actuarial opinion rendered by a qualified actuary, quarterly unaudited financial statements, and a quarterly reserves report certifying that the MEWA maintains cash or liquid assets in a claim reserve account sufficient to meet its contractual obligations and that it maintains a policy of aggregate and specific stop loss insurance.<sup>13</sup>

<sup>12</sup> 81 Fed. Reg. 47496 (July 21, 2016).

<sup>13</sup> See, e.g., California Insurance Code Section 742.31.

## **B. Title I Authorizes DOL to Collect Data to Ensure Financial Stability**

The DOL, through the Employee Benefits Security Administration (EBSA), handles the administration and enforcement of the provisions of Title I of ERISA.<sup>14</sup> In general, ERISA prescribes minimum participation, vesting and funding standards for private sector pension benefit plans and reporting and disclosure, claims procedure, bonding and other requirements which apply to both private-sector pension plans and private-sector welfare benefit plans. ERISA also prescribes standards of fiduciary conduct which apply to persons responsible for the administration and management of the assets of employee benefit plans subject to ERISA.

Title 1 imposes the Form M-1 and Form 5500 filing requirements discussed above. The proposed changes to the form 5500 include the addition of a Schedule J that would require detailed information.

The DOL could use Schedule J to track actuarial soundness, proper maintenance of reserves, and adequate underwriting to ensure the solvency self-insured MEWA group health plans. If the final regulations do not contain all the data points, the Department could draft reporting regulations that incorporate Schedule J's financial solvency data points including, but not limited to:

- Plan funding: employer contributions and employee contributions;
- Plan stop loss coverage including premium paid, specific deductible and aggregate attachment factors, terms of the coverage and plan limits;
- Claims the plan processed including number of claims paid and number of claims denied; and
- Whether they were unable to pay claims during the plan year. If so, they would need to disclose the number of unpaid claims

The Department could also require self-insured MEWAs to annually file with its Form 5500, in addition to its audited financial statement, a certified actuarial opinion. Title 1 provides the authority and reporting mechanisms to ensure that the DOL can determine actuarial soundness, proper maintenance of reserves, and adequate underwriting and other standards relating to MEWA solvency.

The current proposed Schedule J requires information about the following:

- Plan eligibility (employees, spouses, dependent children, retirees)
- Approximate number of plan participants and beneficiaries covered by the plan as of the end of the plan year
- Plan benefits
  - Medical and surgical vs. mental and substance abuse
  - Pharmacy benefits
  - Wellness and preventive care
  - Emergency care services
  - Pregnancy benefits
  - Vision
  - Dental
- Plan funding
  - Employer contributions
  - Employee contributions

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<sup>14</sup> 29 U.S.C. 1001 et seq.

- Benefits paid from general assets, trusts, or insurance carrier
- Type of plans offered
  - Grandfathered
  - Qualifying high deductible health plans (HDHPs)
  - Health Reimbursement Arrangements (HRAs)
  - Flexible Spending Accounts
- COBRA
  - Number of employees offered COBRA
  - Number elected COBRA
- Rebates, reimbursements or refunds the plan received other than those reported on the Schedule A. Details on how the rebates were used
- Any potential delinquent contributions
- The plan's service providers not already reported on Schedule A or Schedule C
- Plan stop loss coverage, including premium paid, specific deductible and aggregate attachment factors, terms of the coverage and plan limits
- Claims the plan processed including:
  - Number of pre-service and post-service claims submitted
  - Number of claims paid and number of claims denied
- Number of appeals the plan received
  - Numbers of appeals upheld
  - Number of appeals determined within the required time frames
- Whether they were unable to pay claims during the plan year. If so, they would need to disclose the number of unpaid claims.
- Whether the plan complies with ACA and ERISA regulatory requirements including:
  - Providing Summaries of Benefits and Coverage (SBCs) and meeting the SBC content requirements
  - Providing Summary Plan Descriptions (SPDs) and meeting the SPD content requirements
  - Providing Summary Material Modifications (SMMs) for plan changes
  - Providing a Summary Annual Report (SAR)
  - Meeting Genetic Information Nondiscrimination Act (GINA) requirements
  - Meeting Michelle's Law requirements
  - Meeting Affordable Care Act (ACA) requirements
  - Meeting Newborns' and Mothers' Health Protection Act requirements
  - Meeting Mental Health Parity and Addiction Equity Act (MHPAEA) requirements
  - Meeting Women's Health and Cancer Rights Act (WHCRA) requirements
  - Meeting the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination requirements

#### **IV. Transparency is Crucial to the Regulatory Process's Security and Validity**

Collecting the data specified above is necessary to monitor a self-insured MEWA's legal and regulatory compliance, as well as its solvency. Disclosing the data to stakeholders in a meaningful way is very nearly as important. The DOL should translate the information for States, consumers, carriers, and the exempted MEWAs themselves to demonstrate whether any individual exempted MEWA is succeeding or failing. Likewise, the Department should display aggregate data to illustrate the health of the overall



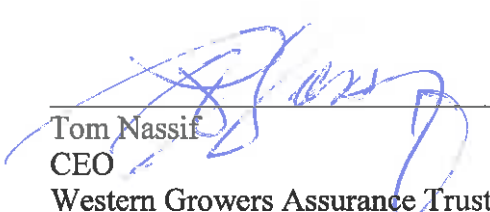
exempted MEWA market. Taking the extra steps to make this data available, transparent, and understandable is critical to the creditability and viability of the DOL's regulatory process for exempted MEWAs.

**V. Conclusion**

DOL has the authority under ERISA section 514(b)(6)(B) to provide preemption-related exemptions under which the Department would become the primary regulator of self-insured MEWAs that are ERISA group health plans. Exercising that authority would provide more choice for consumers, increase competition among health benefit plan providers, and spur product innovation. WGA Trust understands the risks that the exemptions would present if not carefully regulated; therefore, we urge DOL to mitigate these risks by using a tailored exemption process and stringent reporting requirements that collect enough data to establish legal and regulatory compliance, fiscal responsibility, solvency, and responsible claims-payment practices. In addition, State fiscal-solvency requirements would apply.

WGA Trust appreciates the opportunity to provide these comments. We would also welcome the opportunity to provide additional information upon your request. Please feel free to contact me if you have questions or if you believe we can serve as a resource on these matters.

Very truly yours,



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