EXPANDING AFFORDABLE HEALTH CARE OPTIONS: EXAMINING THE DEPARTMENT OF LABOR'S PROPOSED RULE ON ASSOCIATION HEALTH PLANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR, AND PENSIONS

COMMITTEE ON EDUCATION
AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

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C O N T E N T S

EXPANDING AFFORDABLE HEALTH CARE OPTIONS: EXAMINING THE DEPARTMENT OF LABOR'S PROPOSED RULE ON ASSOCIATION HEALTH PLANS

Tuesday, March 20, 2018
House of Representatives
Committee on Education and the Workforce,
Subcommittee on Health, Employment, Labor, and Pensions
Washington, D.C.

The Subcommittee met, pursuant to call, at 10:03 a.m., in Room 2175, Rayburn House Office Building. Hon. Tim Walberg [chairman of the Subcommittee] presiding.

Present: Representatives Walberg, Wilson of South Carolina, Roe, Lewis, Mitchell, Smucker, Estes, Wilson of Florida, Norcross, Blunt Rochester, Espaillat, Courtney, and Bonamici.

Also Present: Representatives Foxx and Scott.

Staff Present: Courtney Butcher, Director of Member Services and Coalitions; Michael Comer, Deputy Press Secretary; Rob Green, Director of Workforce Policy; Nancy Locke, Chief Clerk; John Martin, Workforce Policy Counsel; Kelley McNabb, Communications Director; James Mullen, Director of Information Technology; Alexis Murray, Professional Staff Member; Krisann Pearce, General Counsel; Benjamin Ridder, Legislative Assistant; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Olivia Voslow, Legislative Assistant; Joseph Wheeler, Professional Staff Member; Michael Woeste, Deputy Press Secretary; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Mishawn Freeman, Minority Staff Assistant; Carolyn Hughes, Minority Director Health Policy/Senior Labor Policy Advisor; Richard Miller, Minority Labor Policy Director; Udochi Onwubiko, Minority Labor Policy Counsel; and Veronique Pluviose, Minority Staff Director; and Kimberly Toots, Minority Labor Policy Fellow.

Chairman WALBERG. A quorum being present, the Subcommittee on Health, Employment, Labor, and Pensions will come to order.

Good morning, and welcome to today's Subcommittee hearing. I'd like to thank our panel of witnesses and our members for joining today's important discussion on the Department of Labor's proposed rule on association health plans, or AHPs, and how we can make affordable health care options a reality for more working Americans.

The timing of this particular hearing is appropriate, as this week marks eight years since the passage of the *Affordable Care Act*. Since ObamaCare became the law of the land, America's small businesses have struggled to dig themselves out from under the law's crushing weight.

Since 2008, the share of small businesses with fewer than 10 employees offering health coverage has dropped by a shocking 36 percent, leaving working Americans with fewer health care options or no coverage at all. It's estimated that 300,000 small business jobs have been eliminated because of the *Affordable Care Act*, and 10,000 small businesses nationwide have been forced to close their doors. The financial burden this law has placed on Main Street businesses has been debilitating, with its costs and mandates amounting to an estimated $19 billion in lost wages for small business employees.

Time and again, those of us on this Committee have heard from small business owners that one of their greatest concerns is the high cost of health insurance. America's job creators deserve better than the failing status quo of limited coverage options at sky-high prices. Instead, small businesses should be empowered to negotiate for the very best coverage at the very best prices on behalf of their employees, just as big businesses and labor unions do.

In 2017, this committee favorably reported the House-passed H.R. 1101, the *Small Business Health Fairness Act*, legislation I introduced with our colleague, Representative Sam Johnson from Texas, chairman of the Ways and Means Subcommittee on Social Security. This legislation would expand health care coverage and lower costs for workers by empowering small businesses to band together through association health plans and negotiate for lower costs on behalf of their employees.

By granting small businesses the ability to join together through AHPs, small businesses would be able to strengthen their bargaining power in the health insurance market in order to secure health coverage options on par with that of larger companies and unions.

In October of last year, President Trump issued an executive order directing the Departments of Labor, Health, and Human Services and the Treasury to use their regulatory authority to expand access to AHPs. In response to the President's directive, the Department of Labor proposed a rule in January to broaden the criteria for determining whether employers may join together in an employer group or association in order to form an AHP.

Given the Committee's longstanding interest and activities on AHPs, this recent action by Department of Labor presents an opportunity to examine the Department's plan to expand small business access to affordable health care options, and thereby decrease the number of uninsured individuals.

Empowering small businesses to form AHPs is especially near and dear to my heart, and I'm pleased to see such strong progress on an issue that will directly benefit our nation's job creators and their employees.

I look forward to hearing from our panel of witnesses and from other members of the Subcommittee today as we examine this proposed rule and work to do right by America's small businesses.

I now yield to our ranking member today, Ms. Blunt Rochester, for opening remarks.

[The statement of Chairman Walberg follows:]

Prepared Statement of Hon. Tim Walberg, Chairman, Subcommittee on Health, Employment, Labor and Pensions

Good morning, and welcome to today's subcommittee hearing. I would like to thank our panel of witnesses and our members for joining today's important discussion on the Department of Labor's proposed rule on association health plans, or AHPs, and how we can make affordable health care options a reality for more working Americans.

The timing of this particular hearing is appropriate as this week marks eight years since the passage of Obamacare. Since Obamacare became the law of the land, America's small businesses have struggled to dig themselves out from under the law's crushing weight.

Since 2008, the share of small businesses with fewer than 10 employees offering health coverage has dropped by a shocking 36 percent, leaving working Americans with fewer health care options or no coverage at all. It is estimated that 300,000 small business jobs have been eliminated because of Obamacare, and 10,000 small businesses nationwide have been forced to close their doors. The financial burden this law has placed on Main Street businesses has been debilitating, with its costs and mandates amounting to an estimated $19 billion in lost wages for small business employees.

Time and again, those of us on this Committee have heard from small business owners that one of their greatest concerns is the high cost of health insurance. America's job creators deserve better than the failing status quo of limited coverage options at sky-high prices. Instead, small businesses should be empowered to negotiate for the very best coverage at the very best prices on behalf of their employees, just as big businesses and labor unions do.

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Given the Committee's longstanding interest and activity on AHPs, this recent action by DOL presents an opportunity to examine the Department's plan to expand small business access to affordable health care options, and thereby decrease the number of uninsured individuals. Empowering small businesses to form AHPs is especially near and dear to my heart, and I am pleased to see such strong progress on an issue that will directly benefit our nation's job creators and their employees.

I look forward to hearing from our panel of witnesses and from other members of the subcommittee today as we examine this proposed rule and work to do right by America's small businesses.

Ms. BLUNT ROCHESTER. Thank you, Chairman Walberg.

Today's hearing comes just days before the eighth anniversary of the *Affordable Care Act*, or the ACA; legislation that has helped 20 million people gain health coverage, including 38,000 Delawareans, and also expanded protections to millions more across the country who had preexisting conditions.

Over the past year, we have seen continual efforts by the administration and congressional Republicans to undermine that

progress, including one of many failed attempts to repeal the law this last -- this past year. But with Congress' inability to pass legislation to repeal and replace the ACA, the administration has been unyielding in its attacks, refusing to faithfully implement the law of the land.

The Department of Labor's proposed rule to expand association health plans is another attempt to sabotage Americans' access to comprehensive, affordable health coverage.

Under current law, health insurance coverage offered through a group or association to individuals or small employers is generally treated like individual or small group coverage. This means businesses and individuals with health insurance through associations have the same protections as people in state-regulated, individual, and small group markets. This includes coverage of essential health benefits, including maternity care and substance abuse disorder treatment, and prohibitions against being charged more based on gender.

Under current Department of Labor sub-regulatory guidance, there are strict criteria under which employer association health coverage is treated as a single large group ERISA-covered plan, and thus exempt from adhering to these laws, these rules. The use of this strict criteria in this way helps protect against cherry picking only healthy consumers for the sole purpose of providing health coverage that has nothing to do with the actual employment.

The Department's proposed rule would weaken the criteria for associations to be able to purchase insurance exempt from certain federal consumer protections. Simply put, the rule takes us backwards.

While the rule's proponents claim it will help small businesses, in fact, this rule could limit access to comprehensive coverage for many small businesses and their workers, increase costs, and threaten access to those with preexisting conditions. Troublingly, it also has the potential to leave small businesses and their workers on the hook for millions of unpaid medical bills.

First, this proposed rule would limit access to comprehensive health coverage without guaranteed coverage for essential health benefits, such as maternity care, mental health treatment, and substance use treatment. This means people may be left with skimpy and inadequate coverage that neither gives them access to the care they need, nor offers adequate financial protection against serious medical conditions.

Second, the proposed rule will increase costs and threaten coverage for people with preexisting conditions. As healthier and lower cost consumers get cheap plans with skimpy benefits that may not meet their health needs, older or sicker consumers would be left behind in the traditional market with skyrocketing costs, making it difficult to obtain coverage.

Third, the proposed rule could potentially leave small businesses and their workers on the hook for millions of -- in unpaid medical bills. As we have seen through testimony in previous hearings on this topic, association health plans have a long history of insolvencies, scams, and fraud. Between 2000 and 2002, scams impacted more than 200,000 people and left more than $252 million in un-

paid medical bills. As we all know, those who do not learn from history are doomed to repeat it.

The Coalition Against Insurance Fraud stated that, under the rule, quote, "Small businesses and their workers will face a huge and intolerable risk of fraud," end quote. It seems to me that a commonsense approach to supporting small businesses and helping them thrive would not and should include needlessly exposing them to the insolvencies, scams, and fraud that could force them to shudder their doors for good.

Taken together, this proposed rule would leave some with cheaper coverage that fails to meet their basic health needs and leave everyone else with higher costs. While the Department of Labor is not represented on this panel today, the gaps in the proposed rules' justification and analysis provided by the Department are very troublesome.

Members of Congress and the general public would benefit from an opportunity to hear from the Department. I will note that members of this Committee have requested more information from the Department on its analysis to no avail.

As pointed out in a comment letter submitted by 17 state attorneys general, including Matt Denn, attorney general of my home state of Delaware, the rule would reverse critical consumer protections and unduly expand access to AHPs without sufficient justification or consideration of the consequences.

Rather than continuing to campaign this campaign of interference, I hope the administration and my colleagues will join with Democrats to find ways to strengthen the ACA and increase access to affordable comprehensive health coverage.

I thank the witnesses for joining us here today, and I yield back.

[The statement of Ms. Blunt-Rochester follows:]

Prepared Statement of Hon. Lisa Blunt-Rochester, a Representative in Congress from the State of Delaware

Today's hearing comes just days before the eighth anniversary of the Affordable Care Act, or the ACA – legislation that has helped 20 million people gain health coverage, including 38,000 Delawareans, and also expanded protections to millions more across the country who have preexisting conditions.

Over the past year, we have also seen continual efforts by the administration and Congressional Republicans to undermine that progress – including one of many failed attempts to repeal the law this time last year. But with Congress' inability to pass legislation to repeal and replace the ACA, the administration has been unyielding in its attacks – refusing to faithfully implement the law of the land.

The Department of Labor's proposed rule to expand association health plans is yet another attempt to sabotage American's access to comprehensive, affordable health coverage.

Under current law, health insurance coverage offered through a group or association to individuals or small employers is generally treated like individual or small group coverage. This means businesses and individuals with health insurance through associations have the same protections as people in state-regulated individual and small group markets. This includes coverage of essential health benefits, including maternity care and substance abuse disorder treatment, and prohibitions against being charged more based on gender.

Under current Department of Labor sub-regulatory guidance, there are strict criteria under which employer association health coverage is treated as a single, large group ERISA-covered plan, and thus exempt from adhering to these rules. The use of this strict criteria in this way helps protect against cherry-picking only healthy consumers for the sole purpose of providing health coverage that has nothing to do with actual employment.

The Department's proposed rule would weaken the criteria for associations to be able to purchase insurance exempt from certain federal consumer protections. Simply put, this rule takes us backwards.

While the rule's proponents claim it will help small businesses, in fact, this rule could limit access to comprehensive coverage for many small businesses and their workers, increase costs, and threaten access for those with pre-existing conditions. Troublingly, it also has the potential to leave small businesses and their workers on the hook for millions in unpaid medical bills.

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substance use treatment. This means people may be left with skimpy and inadequate coverage that neither gives them access to the care they need nor offers adequate financial protection against serious medical conditions.

Second, the proposed rule will increase costs and threaten coverage for people with pre-existing conditions. As healthier and lower cost consumers get cheap plans with skimpy benefits that may not meet their health needs, older or sicker consumers would be left behind in the traditional market with skyrocketing costs, making it difficult to obtain coverage.

Third, the proposed rule could potentially leave small businesses and their workers on the hook for millions in unpaid medical bills. As we have seen through testimony in previous hearings on this topic, association health plans have a long history of insolvencies, scams, and fraud. Between 2000 and 2002, scams impacted more than 200,000 people and left more than $252 million in unpaid medical bills. As we all know, those who do not learn history are doomed to repeat it. The Coalition Against Insurance Fraud stated that under the rule "small businesses and their workers will face a large and intolerable risk of fraud."1 It seems to me that a common sense approach to supporting small businesses and helping them thrive would not and should not include needlessly exposing them to the insolvencies, scams, and fraud that could force them to shutter their doors for good.

Taken together, the Department of Labor's (DOL) proposed rule will leave some with cheaper coverage that fails to meet their basic health needs, and leave everyone else with higher costs.

The gaps in this rule's justification and analysis provided by the Department are troubling. Members of Congress and the general public would benefit from hearing directly from DOL, which is why Members of this Committee have requested more information from the Department, to no avail. I hope the Majority will join us in having an open and honest discussion about the real effect this proposed rule will have on small businesses and their employees.

As pointed out in a comment letter submitted by 17 state Attorneys General, including Matt Denn, Attorney General of my home state of Delaware, the rule would reverse critical consumer protections and "unduly expand access to AHPs without sufficient justification or consideration of the consequences."2

Rather than continuing a campaign of interference, I hope the administration and my Republican colleagues will join with Democrats to find ways to strengthen the ACA and increase access to affordable, comprehensive health coverage.

I thank the witnesses for joining us here today. I yield back.

1 https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210–AB85/00041.pdf

2 https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210–AB85/00669.pdf

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Chairman WALBERG. I thank the gentlelady.

Pursuant to Committee rule 7(c), all members will be permitted to submit written statements to be included in the permanent hearing record. And without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

It's now my pleasure to introduce our distinguished witnesses. Ms. Catherine Monson is the CEO and president of FASTSIGNS International, Incorporated, in Carrollton, Texas, and is testifying on behalf of the International Franchise Association. Mr. Michael McGrew is the CEO of McGrew Real Estate in Lawrence, Kansas,

and is testifying on behalf of the National Association of Realtors. Mr. John Arensmeyer is founder and CEO of the Small Business Majority, here in Washington, D.C. Mr. Christopher Condeluc -- Condeluci -- forgive me for that -- is principal and sole shareholder of CC Law & Policy PLLC, here in Washington, D.C.

I welcome each of you.

I'll now ask our witnesses to raise your right hand.

Do you solemnly swear to affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record reflect the witnesses answered all in the affirmative.

Before I recognize you to provide your testimony, let me briefly explain the lighting system. It's just like rules of the road. Green, keep on going; when your five minutes hits yellow, you have a minute to wrap up; and when it hits red, please wrap up as quickly as you can. We will try to do the same as members ask questions as well.

And so now, I welcome Ms. Monson, and recognize you for your five minutes of testimony.

TESTIMONY OF CATHERINE MONSON, CEO, FASTSIGNS INTERNATIONAL, INC., TESTIFYING ON BEHALF OF THE INTERNATIONAL FRANCHISE ASSOCIATION

Ms. MONSON. Thank you very much.

Chairwoman Foxx, it's great to see you again.

Chairman Walberg, great meeting you.

Ranking Member Blunt Rochester, thank you so much for your kind words last week at the minority and franchising event. And I hope you met FASTSIGNS franchisee Howard James at the event. He was one of the speakers.

And members of the Committee, my name is Catherine Monson. I'm here on behalf of FASTSIGNS International, our 604 FASTSIGNS franchisees in the U.S., with others in other countries, and another 37 franchisees in the U.S. about to open their businesses.

I'm here also with the International Franchise Association. I'm the second vice-chair of that association, and we represent over 733,000 franchise businesses employing 7.6 million employees in the U.S. today.

I have made my career in franchising. I love franchising. I've seen it build wealth for families, create jobs and opportunities. It is an amazing ladder of opportunities for women, minorities, and immigrants. And our recent IFA minority study shows a 50 percent increase in minority ownership of franchises since 2007, up to 30.6 percent, something we're very, very proud about.

For each of you, there are about 2,000 franchise businesses in each of your districts, and franchising is perfectly built for association health plans. We use economies of scale to help businesses deliver affordable products and services.

I guarantee you the Dunkin' Donuts franchisee in your district pays less for flour and eggs and coffee than an independent donut business does, and the FASTSIGNS in your district pays less for printers and inks and substrates. And we want to bring that same

negotiating power and economies of scale to association health plans.

Small business health plans are great. If I talk about FASTSIGNS franchisees, the average has five to seven employees. In that very difficult 10 or fewer employees small business health care market where they have no negotiating power, they can go to Blue Cross Blue Shield and ask for better rates, and at 10 employees or less, they don't get it. They come back to their employees. Their employees can't afford their part of it. Some employees are on their spouses' or parents' plan. It's very, very challenging.

IFA recently surveyed its franchisee members, and 65 percent do not provide health care coverage. 92 percent of that group do not provide it because they just can't handle the cost burden. But, 100 percent would look for health coverage and provide it if they could get it through an association health plan.

The IFA strongly supports the administration's rule. We know we can pull resources. And here's the key: It's getting quality health care. It is not about skinny plans. My franchisees and other franchisees want to have the best labor available. They want to have the best employees. It's about competing with large companies for the best employees. Skinny plans are not going to be considered at all.

Under the proposed rule, businesses can band together either by commonality of interest or commonality of region, and the broader the definition of commonality of interests, the better -- the larger the pool, the lower the prices, the better quality full coverage health care.

Franchises know how to do this. We know how to pull resources. We know how to negotiate with vendors bringing across -- if we will, think about the International Franchise Association. 7.6 million employees could be covered by quality affordable health care. It's all about a level playing field. We want the same exemptions to be able to buy large group health insurance coverage as the labor unions have, as large companies have.

The IFA is urging the Department to look at franchising as a commonality of interest too, and the Federal Trade Commission definition and state laws provide for great guidelines here.

We've also urged the Department of Labor to include a joint employer safe harbor, and this is really, really critical for franchising to get involved and to really get the maximum benefit out of association health plans. We support the adoption of safe harbor in the final rule so that we would not be deemed to joint employers just because there was an association health plan.

Without the safe harbor, we feel it's very unlikely that the benefits of this important health care policy will really take hold. And we're really thankful for the bipartisan coalition of members of Congress, including Chairman Walberg, who've echoed our request.

In closing, I want to say thank you very much for having me here. The International Franchise Association and FASTSIGNS strongly support the administration's rule and urge swift implementation. Franchising can and will be a willing partner in the effort to expand access to affordable quality health care -- that's the key. It's not skinny plans -- bringing more options to our very important working families.

Thank you so much.
[The statement of Ms. Monson follows:]

CATHERINE MONSON

CEO, FASTSIGNS® INTERNATIONAL, INC.

TESTIMONY BEFORE THE U.S. HOUSE SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

HEARING ENTITLED "EXPANDING AFFORDABLE HEALTH CARE OPTIONS: EXAMINING THE DEPARTMENT OF LABOR'S PROPOSED RULE ON ASSOCIATION HEALTH PLANS"

MARCH 20, 2018

Introduction

Good morning Chairman Walberg, Ranking Member Sablan, and distinguished members of the Subcommittee. My name is Catherine Monson, and I'm the Chief Executive Officer of FASTSIGNS® International. I am appearing before you today on behalf of both my company, our FASTSIGNS franchisees, the International Franchise Association (IFA) and the over 733,000 franchised establishments employing 7.6 million workers in the United States. Thank you for the invitation to share our views on Association Health Plans.

I have been in franchising for over 30 years, working for multiple franchisors, starting with Sir Speedy Printing Centers in 1980. I worked for Copies Now, TeamLogic IT, PIP Printing & Marketing Services and then became CEO of FASTSIGNS in 2009. FASTSIGNS, founded in 1985, is a sign and visual graphics company and is the sign industry's leading franchise system. Our network of sign centers includes 604 locations in the United States with another 37 in the process of opening, 31 locations in Canada, plus locations in the United Kingdom, Mexico, Brazil, the Caribbean, Saudi Arabia, UAE and Australia, for a total of 675 locations worldwide.

I'm passionate about franchising, primarily because over the last 30 years I've seen franchising transform lives. I've seen franchising help thousands of Americans achieve their dream of business ownership and build wealth for their families and many more find stable jobs in their communities. I have seen franchising create economic output and jobs. I have seen franchise ownership allow minorities and immigrants to create wealth and opportunity. That's why for more than two decades, I've been an active member of IFA, serving for ten years on the Board of Directors.

As many of you know, the IFA is the oldest and largest trade association in the world devoted to representing the interests of franchising. Its membership includes franchisors, franchisees and suppliers. IFA's membership currently spans more than 300 different business lines, including more than 11,000 franchisee, 1,100 franchisor and 575 supplier members nationwide. In total, IFA's members form a network of 733,000 small business establishments across the country – there are IFA members in all of your districts. They support their local economies, give back to their communities, and build businesses that provide local jobs.

Overview of AHP Impact on Franchising

I am here today to help advocate for making it easier and more affordable for local business owners to provide quality, affordable health insurance coverage to their employees. Specifically, I'm here to ask that you move forward with allowing franchise businesses and associations to form Association Health Plans, consistent with the Administration's recently proposed rule. Taking this important step will allow trade associations or multiple small employers to come together and pool their employees in order to buy quality health insurance, generating similar quality and savings as organized labor and large corporations do in the large group insurance

market. Allowing small business to band together will help lower costs, create greater flexibility, increase access, and reduce administrative expenses.

As many of you know, small businesses, such as franchises, bear a larger financial and administrative burden when providing quality health insurance benefits for their employees. Indeed, franchises and small businesses have historically struggled to provide quality health insurance benefits to employees given the constraints of the small market rules, as well as financial and administrative expense.

But if we use many of the same principles that have allowed franchising to provide economic opportunity to millions of Americans, we can also provide greater opportunities for quality, affordable health insurance coverage and health care.

Franchising is perfectly built for AHPs. Franchising uses economies of scale to help small business owners deliver affordable services and products to their customers through efficient and established distribution channels, communication protocols, and common business practices. Similarly, AHPs use a larger pool of enrollees to streamline costs and more effectively deliver quality, affordable health insurance and health care.

Based on my 30 plus years in the franchising world, I can say with confidence that the structure of the franchise model makes it uniquely suited to implement and manage quality AHPs. Franchises can effectively utilize AHPs through their intra-brand structures, vertical distribution models and regionally among multiple small business brands – or they can also take advantage of AHPs through the IFA. The end result will be that millions of American franchisees' employees, including my own, will gain access to quality health care coverage.

So, let me explore the problems franchisers are facing, the specifics of my position in more depth, and the support this program has with franchisors and franchisees and their employees in your communities across the country.

The Problem

As many of you know, while employer-sponsored coverage remains the most common source of healthcare coverage in the United States, a smaller proportion of people are covered by employers than a decade ago. There's also a bigger gap today between the health insurance large firms can access and afford for their employees and what small firms can provide. That gap means that that workers at small firms are more often responsible for paying both a larger share of family premiums, as well as higher cost sharing than workers in large firms. In addition, small group market rules under the Affordable Care Act (the "ACA") make it more difficult for small businesses to provide affordable health insurance without the purchasing power of a large group. That's mainly because insurance companies charge higher rates for smaller risk pools.

The franchise community has been hard hit by this reality. In fact, to measure the impact of the expense and administrative challenges faced by franchisee employers in providing health care coverage to their employees, the IFA conducted a member survey of both franchisors and franchisees to measure the challenge on the ground. The results speak for themselves. The survey found that:

- 65% of respondents do not provide any health coverage at all for their employees, only 35% do;
- 92% of respondents that do not provide health coverage refrain from doing so due to the cost burden;
- And, most importantly, 100% of respondents indicated they would provide health coverage to their employees if they could provide coverage through an AHP.

As an expert in the franchising system, I have seen first-hand how small businesses and franchisees are challenged in offering competitive health benefits. The federal Employee Retirement Income Security Act, which currently permits large corporations and labor organizations to "self-insure" and offer insurance with certain exemptions from state law, does not provide small business with the same advantage. The law must be reformed to empower small employers with the ability to obtain and offer quality, competitively priced health insurance.

The Administration has recognized this problem. That's why they directed the Department of Labor to propose regulations or revise guidance that will expand access to coverage for more Americans by allowing employers to form AHPs.

More specifically, the Secretary of Labor has been directed to consider expanding the conditions that a group of employers must satisfy to act as an "employer." The IFA believes that the current definition and its interpretations unduly limit groups of small employers from forming AHPs, preventing them from providing quality, affordable health care benefits to employees. Accordingly, we believe that a broad interpretation of the definition should consider the franchise business model as a "commonality of interest".

We're confident that we're on strong ground to make this suggestion. The franchise business model is a federally recognized and defined category of businesses that uniquely contributes to the United States economy. Franchise businesses have a strong and sufficient "commonality of interest," based on the FTC definition and governing state laws, that will give structure to AHPs limiting participation to a specific group of employer-members. Broadening the commonality of interest rule to include the franchise business model across industry sectors will allow larger risk pools, greater negotiation of rates, and administrative efficiencies. It will also exponentially

increase the affordability and accessibility of health insurance to working Americans who need it most.

I also strongly support the adoption of a safe-harbor provision in the final rule clarifying that the establishment and participation in an AHP does not create or imply joint employer liability. Allowing franchises to participate in an AHP, while not simultaneously including a safe harbor provision, would undermine the policy goals of expanded health care coverage and lowered rates. Without such a safe harbor, the franchise industry would be faced with even greater uncertainty about joint employer liability and would therefore be highly unlikely to offer the benefits of this important health care policy. We are thankful that a bipartisan coalition of members of Congress, including several committee members, have echoed our request.

We also suggest that the final rule clarify that AHPs will be considered the "employer" for purposes of sponsoring a single large group health plan and will not be considered multiple employer welfare arrangements ("MEWAs") subject to state MEWA requirements. For AHPs to effectively provide affordable, quality health insurance to the association member employees, AHPs that meet the regulations requirement should effectively be treated as a single "association" plan subject to the same State and Federal regulatory structure as other ERISA-covered employee welfare benefit plans.

If AHPs are considered MEWAs and if they are to effectively provide health insurance coverage as intended by the Executive Order and the Proposed Rule, the Department must use its authority to provide a uniform, consistent framework for AHP operation and pre-emption of state MEWA regulations.

We also recognize and support the need for non-discrimination requirements applicable to AHPs to prevent stacking of risk pools which could undermine the affordability and accessibility of health coverage for those who need it most and recognizes the need for the Proposed Rule's nondiscrimination requirements for AHPs.

Finally, the Proposed Rule would not allow associations to treat different employer-members as different bona fide employment classifications (i.e. no employer-by-employer risk rating). The IFA supports this requirement because it protects against AHPs cherry-picking only healthy employee populations thus defeating the purpose to spread risk among larger diverse populations. We believe that the Proposed Rule strikes the right balance between risk selection issues with the stability of the AHP market.

AHPs will allow small business employers, including franchise owners like my own 604 (soon to be 641) US franchisees, the ability to obtain and offer health insurance benefits through membership in a trade association, including a franchise system. With rising medical costs being

a top concern of both individuals and employers, the impact of this increased availability of quality, affordable health insurance would be significant across all of your districts.

Conclusion

Mr. Chairman, thank you again for allowing me to share FASTSIGNS' and IFA's views on the Association Health Plan proposed rule. Franchise businesses are hiring and expanding at a rapid pace, and in order to continue that growth and ensure that businesses can provide employees with quality and affordable health insurance, we strongly support finalization and implementation of this rule. FASTSIGNS and IFA looks forward to working with the Department of Labor, your Subcommittee, and the Administration on this important new policy.

I would be happy to answer any questions you may have.

Chairman WALBERG. Thank you.

I recognize Mr. McGrew for your five minutes of testimony.

TESTIMONY OF MICHAEL MCGREW, CEO, MCGREW REAL ESTATE, TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF REALTORS

Mr. MCGREW. Good morning, Chairman Walberg, Ranking Member Blunt Rochester, and members of the Subcommittee. Thank you for holding this hearing today and the opportunity to testify on behalf of the National Association of Realtors' 1.3 million members.

My name is Mike McGrew. I'm a third-generation realtor and CEO of McGrew Real Estate, an independent real estate brokerage with 70 independent realtors and 14 salaried employees in Lawrence, Kansas.

I'm the immediate past treasurer of the National Association of Realtors and a member of the executive committee, which establishes NAR's governing policies and oversees NAR's member benefits program.

As a practicing realtor since 1982, I know firsthand how hard it is to find and keep health insurance when you're a sole proprietor and you have no employer coverage. I also know how hard it is to find affordable health coverage for your employees when you're the boss.

The challenges facing the nation's small business and independent contractor community when searching for affordable health insurance continues to grow each year as costs rise and options diminish.

The Department of Labor's proposed rulemaking seeks to make it possible for the self-employed and small employers to purchase health insurance through a trade association. Access to more health insurance options is key for realtors, a group that now purchases coverage primarily in the struggling individual markets.

To understand the insurance challenges we face, it's important to know a bit about the structure of our industry. My company is a good example of a typical independent real estate firm. All of our agents are independent contractors. They have broad freedom to build their business as they choose under our state-mandated legal supervision responsibilities, and they value that independence. They have no limits on what they can earn, but they have no guaranteed paycheck. They wake up every morning unemployed and have to hunt for their next deal.

While we provide health insurance to our salaried support staff, we do not provide health insurance to our independent agents. When real estate agents and brokers forego health insurance, the primary reason cited is cost, and it's this experience that has driven NAR to seek additional health insurance options for our membership.

NAR has long supported legislation that would allow trade associations to create association health plans, including Chairman Walberg's *Small Business Health Fairness Act*. NAR also supports the Department of Labor's proposal that will provide more small businesses, as well as independent contractors, with access to an association health plan.

It is essential that any final rule makes self-employed individuals with no employees or working owners eligible to participate in an AHP. It is also important to note that, under the rule, association health plans would still be subject to consumer protections under the ACA, ERISA, and state benefit mandates. In fact, it would not be in NAR's interest to offer a benefit program that is not a quality product because it would fail to attract members, and our demographics are much older in NAR.

Additionally, since our surveys indicate that realtors' top priorities are affordability and access to preferred doctors, any association plan must achieve those goals as well.

The Association has questions about the rule, as it remains unclear how state regulation would impact association plans, especially those of national groups, like NAR, whose members can be found in all 50 states.

If an AHP cannot overcome barriers that states might implement to prohibit it from being classified as a large group plan, NAR may not be able to provide a nationwide plan for its members who are asking for more insurance options.

It is essential that the final rule clarify that while states may continue to regulate association health plans as they do now, they may not use existing authorities to undermine the final rule.

NAR also believes that the Department should reconsider eligibility criteria to be considered a working owner, especially the disqualification of those who have an offer of a subsidized coverage from a spouse's employer.

The rule's current restrictions could drastically limit the potential pool of members that may be eligible for an NAR health plan. More importantly, this restriction could bar these individuals from an association plan that could provide better or more affordable coverages.

To close, reducing the cost of health insurance while maintaining quality coverage is a top priority for NAR, a priority that is shared by the growing number of small businesses and self-employed Americans who are part of every sector of our economy.

NAR is encouraged by the administration's focus on making improvements in this area and the Committee's attention to the health insurance challenges that face self-employed real estate professionals across the country.

Thank you again for this opportunity to represent the realtors' health care concerns.

[The statement of Mr. McGrew follows:]

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HEARING BEFORE THE HOUSE EDUCATION AND THE WORKFORCE - SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

ENTITLED

"EXPANDING AFFORDABLE HEALTH CARE OPTIONS: EXAMINING THE DEPARTMENT OF LABOR'S PROPOSED RULE ON ASSOCIATION HEALTH PLANS"

WRITTEN TESTIMONY OF

MICHAEL C. MCGREW.

ON BEHALF OF

THE NATIONAL ASSOCIATION OF REALTORS®

MARCH 20, 2018

Chairman Walberg, Ranking Member Sablan, and Members of the Subcommittee, thank you for giving me the opportunity to talk with you about the challenges that face the nation's small business and independent contractor community as they search for accessible and affordable health insurance coverage. My name is Michael McGrew. I am the CEO of McGrew Real Estate, an independent company located in Lawrence, Kansas. My company has 70 independent contractor sales associates affiliated with the firm, as well as 14 salaried employees.

I am here on behalf of members of the National Association of REALTORS® (NAR). I am a member of NAR's Executive Committee and Board of Directors that is responsible for governing the Association.[1] I served as the 2016 Treasurer of NAR and in addition to my national responsibilities, I am also a member of the Kansas Association of REALTORS® Board of Directors and served as the President of the association in 1998.

As a practicing real estate professional since 1982, I know very well how hard it is to find and keep health insurance when you are a sole proprietor with no employer-provided coverage. I also know how hard it is to find affordable health coverage for your employees when you're the boss.

My experience is shared not only by my real estate colleagues but by the growing number of small businesses and self-employed Americans who are part of every sector of our economy. The real estate sales professionals' search for health coverage is a microcosm of the challenges that the self-employed and small business face today.

Real estate agents are not employees of the realty office with which they are affiliated. They are independent contractors, a separate legal business entity - the smallest of small firms. More REALTORS® work with an independent company than any other type of firm. Real estate firms, the offices with which these independent agents are affiliated, typically have one office and a small number of salaried employees – a receptionist, office assistant, or, perhaps, a transaction coordinator - and two independent contractor sales agents. Only a very small percentage of realty firms offer coverage to their salaried staffs and none offer coverage to their independent contractor agents.

According to NAR research, the percent of NAR's members that are uninsured have ranged as high as 33 percent in 2005. When asked why they do not have health insurance coverage, an overwhelming majority of our members cite cost as the primary reason. A majority of members are paying for their entire premiums without any financial help and cite affordability and access to preferred doctors as top priorities when selecting a plan. Consequently, reducing the cost of health insurance while maintaining quality is a top priority for the nation's REALTORS®.

It is this experience that has driven NAR to continually seek health insurance solutions for its membership. To this end, the Association was an early supporter of House bills to allow bona fide trade associations to create association health plans (AHPs); these included Representative Johnson's (R-TX) 2003 H.R. 660 and 2005 H.R. 525, the *Small Business Health Fairness Act.* On the Senate side, NAR worked with Senators Snowe (R-ME) and Byrd (D-WV) in support of their *Small Business Health Fairness Act of 2005.* This effort was followed by our work with Senators Enzi (R-WY) and Nelson (D-FL) in drafting S. 1955, the *Health Insurance*

[1] NAR's Board of Directors has the authority to approve expenditures of the Association; establish governing policies of the Association; develop public policy positions as they pertain to the real estate industry; approve member programs products, and services; and approve amendments to the bylaws.

Marketplace Modernization and Affordability Act of 2006, and a later effort with Senators Durbin (D-IL), Snowe (R-ME), and Lincoln (D-NE) to draft the *Small Business Health Options Program Act (SHOP)* in 2008. Most recently, NAR along with a number of other trade associations has indicated its support for Representatives Johnson and Walberg's bill, H.R. 1101, the *Small Business Health Fairness Act.*

Along with its long history of support for AHPs or Small Business Health Plans, NAR supports the Department of Labor (DOL) notice of proposed rulemaking (NPRM).[2] The Department's removal of regulatory barriers that make it possible for self-employed individuals and small employers to purchase health insurance through a professional or trade association has the potential to expand much needed access to AHPs. Affording more freedom to individuals to choose from a variety of insurance providers offering quality coverage plans should be supported across all industries and will be key to cultivating a deep participant pool and strong marketplace.

While REALTORS® satisfy the DOL's "commonality of interest" requirements when it comes to related industry, NAR has never been able to overcome the geographical limitations that prohibit the association from being able to offer an affordable AHP health plan to all members nationwide. The prospect of complying with 50 different state insurance laws is a major barrier. Also, since the majority of members are self-employed individuals with no employees, NAR has not been traditionally considered a "bona fide group or association of employers" for purposes of sponsoring an AHP. The Department of Labor's rule addresses many of these concerns, which NAR supports.

However, NAR is concerned that the proposed rule purports to limit AHP eligibility for many real estate professionals and may not adequately protect against state regulation, threatening AHP development and sustainability. As explained in NAR's comment letter, the Department must consider the following when finalizing the proposed rule:

- Ensuring that self-employed individuals with no employees (referred to as a "working owner") can participate in group health plan coverage under an AHP, which are still subject to important consumer protections;

- Removing arbitrary and unnecessary eligibility criteria for being considered a working owner; and,

- Clarifying that while states may continue to regulate AHPs, states may not use existing authorities to undermine the intent of this rule which is expand access to AHPs (e.g., by simply re-characterizing large group AHPs as "small group" health plans).

While the final terms of the proposed rule and the specifics of NAR's member demographics will govern the feasibility of any efforts by NAR to offer an AHP for its members, there are some of the considerations that NAR has raised which are explained in further detail below, and in the attached addendum.

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[2] Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 314 (Jan. 5, 2018) (to be codified at 25 C.F.R. pt. 2510).

I. Working Owners Should Benefit From More Affordable Options In An AHP, Which Are Also Subject To Important Consumer Protections

NAR is encouraged by the Department's inclusion of self-employed individuals with no employees (i.e. "working owners") as eligible to participate in "group health plan" coverage through an AHP. NAR has long-advocated for policy changes that would provide additional health coverage options for working owners like the independent contractor real estate sales professionals. Currently, working owners have limited options when it comes to accessing health insurance. If a working owner happens to have a spouse who is offered group health plan coverage through the spouse's employer, the working owner may be eligible for coverage. However, not all employer plan subsidizes coverage for workers' family members, and in some cases, this "family" coverage may be unaffordable for the working owner, their spouse and dependents.

If a working owner is not married[3] – or their spouse's employer does not offer group health plan coverage – the only health care option available to them is coverage in the fully-insured individual market. This can dramatically limit a working owner's ability to access affordable health coverage.[4] In today's individual market, finding a health plan that provides an adequate level of coverage at an affordable price is difficult.[5] NAR research indicates that median monthly premium cost in the individual market for members is $670, while those members eligible for coverage through an employer (spouse's or former employer for example) is $500. Allowing working owners to access health coverage through an AHP – either a fully-insured large group or self-insured AHP – will dramatically improve their ability to find comprehensive health coverage that may be more affordable than their current options.

AHPs would fall in this large group market that typically enjoys lower costs than the individual and small group market. Some critics have asserted that this lower price point is often times the product of less comprehensive – or "skinny" – coverage. In fact, large group plans tend to offer more comprehensive coverage than small group or individual health insurance plans. Contrary to the assertions, the lower costs in the fully-insured large group market – relative to the individual and small group markets – are driven by administrative efficiencies. In other words, the same administrative costs that drive up the cost of individual and small group coverage are not present in the fully-insured large group market, such as enrollment volatility.

Explained further, individuals and small employers often times drop in and out of the insurance markets and routinely change insurance carriers, sometimes every year. This volatility adds significantly to insurers' already very high administrative costs for small-group coverage,

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[3] According to the NAR 2017 Member Roughly 30 percent of NAR's members are unmarried. NAR 2017 Member Profile. https://www.nar.realtor/research-and-statistics/research-reports/member-profile

[4] For example, the Congressional Budget Office ("CBO") found that premiums in the individual market were 27 percent to 30 percent higher in 2016 than they would have been in 2009. *See* *https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.* Others have argued that many healthy individuals experienced rate increases of 100 to 200 percent. *See* https://www.finance.senate.gov/imo/media/doc/12FP2017Rop.STMNT.pdf.

[5] According to Avalere Health, 73 percent of the individual market plans offered through an ACA Exchange had restrictive (i.e., narrow) networks. *See* http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market.

especially as greater resources are devoted to underwriting, and dis-enrolling and re-enrolling small groups. In the case of existing fully-insured large group AHPs, the health coverage is traditionally superior to coverage a small employer independently might find in the commercial insurance market, and as a result, there is limited turn-over among small employer members.

In addition, prices in the individual and small group markets are typically higher on account of the *Affordable Care Act's* (ACA's) risk adjustment program.[6] In other words, insurance carriers typically price any potential risk adjustment "charges" into their premiums, which arbitrarily increases costs. Because the ACA's risk adjustment program does not apply to the fully-insured large group market, these added costs are not present, thus resulting in a lower costing health plan relative to individual and small group plans.

The requirement to cover the ACA's Essential Health Benefits (EHBs) and the ACA's adjusted community rating rules also have cost implications for individual and small group plans, which are also not present in the fully-insured large group market. For example, fully-insured large group premiums may be developed based on the "health claims experience" of all of the employees employed by a large employer, while this type of under-writing practice is prohibited in the individual and small group markets (i.e., premiums in the individual and small group market cannot be based on health status). In addition, age rating in the individual and small group markets is more limited, while age rating in the fully-insured large group market may produce a more "actuarially fair" premium rate.

NAR recognizes that other stakeholders will sound the alarm over the fact that fully-insured large group and self-insured AHPs are not subject to these ACA requirements, however these concerns are misplaced due to existing applicable consumer protections and State regulations.

- There are existing consumer protections under the ACA that require a fully-insured large group and self-insured AHP – as a group health plan – to provide a comprehensive level of coverage. For example, according to the ACA, a fully-insured large group or self-insured AHP (1) *cannot* deny an eligible plan participant health coverage if they have a pre-existing condition,[7] (2) *cannot* refuse to cover certain government-approved preventive services (rather, the AHP must provide free coverage for these preventive services),[8] and (3) *cannot* impose annual and lifetime limits on the "essential health benefits" covered under the plan.[9] Other ACA requirements including – (1) covering adult children up to age 26, (2) free access to emergency care, and (2) the prohibition against rescinding coverage absent fraud – apply.[10]

- Under the *Employee Retirement Income Security Act* (ERISA), there are specific notice and disclosure requirements,[11] and also fiduciary responsibilities that apply,[12] requiring the AHP

[6] *See* ACA section 1343.
[7] Public Health Service Act ("PHSA") section 2704.
[8] PHSA section 2713.
[9] PHSA section 2711.
[10] PHSA sections 2714, 2719A, and 2712.
[11] ERISA, Title I, Subtitle B Part 1.
[12] ERISA, Title I, Subtitle B Part 4.

and its employer members to act in the best interest of the plan participants. Participants also have a private right of action to sue the AHP if there is wrongdoing,[13] and there are detailed procedures for filing health claims,[14] and rigorous internal and external appeals processes.[15] In addition, continuation of coverage requirements under COBRA apply,[16] and according to the *Health Insurance Portability and Accountability* Act (HIPAA), premiums for an AHP plan participant *cannot* be developed based on the participant's health condition.[17]

- In the case of a fully-insured large group AHP, State benefit mandates also apply, meaning specified benefits and services that a particular State requires insurance contracts to cover must be included in the AHP plan.[18] Many industry experts suggest that most State's benefit mandates are as good as the ACA's EHB requirement, even in cases where a State does not cover all of the 10 medical services that make up the Federal EHB standard. The drafters of the ACA recognized that fully-insured large group plans traditionally offer a comprehensive set of benefits similar to the ACA's EHBs, which led Congress to exempt fully-insured large group plans from the EHB requirement entirely. AHPs would still be subject to these State benefit mandates that would not be preempted by ERISA.

  Finally, NAR exists solely to serve its members. As a member organization led and governed by a leadership compose of members since its inception in 1908, it would not be in NAR's best interest to offer a member benefit product that is not a quality product. As mentioned previously, REALTORS® top health coverage priorities are affordability and access to preferred doctors, so any AHP must strive to achieve those goals and cultivate a deep participant pool.

II. DOL Should Remove the Provision That Would Disallow Participation In an AHP If a Working Owner Is Eligible for Subsidized Health Coverage Through Their Spouse's Employer

NAR believes that the eligibility criteria for qualifying as a working owner under the Department's proposed rule is overly constraining and will limit the number of self-employed individuals who may be eligible to participate in an AHP. Such a provision appears directly contrary to the Department's policy goal of expanding health coverage to these individuals.

According to the NPRM, a self-employed individual with no employees who is eligible for subsidized health coverage through their spouse's employer would *not* be considered a "working

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[13] ERISA section 502.
[14] ERISA section 503.
[15] PHSA section 2719.
[16] ERISA, Title I, Subtitle B Part 7.
[17] ERISA section 702.
[18] According to the National Conference of State Legislatures, traditionally States have enacted health mandate laws to include required categories of up to 70 distinct "benefits" as well as "health providers" (such as acupuncturists or chiropractors) and "persons covered" (such as adopted children, handicapped dependents, or adult dependents). Adding up these laws, there are more than 1,900 such statutes among all 50 states; another analysis tallies more than 2,200 individual statute provisions, adopted over more than 30 years. *See* "State Insurance Mandates and the ACA Essential Benefits Provisions," National Conference of State Legislators (Oct. 2017). http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx, Appendix I.

owner" for purposes of participating in an AHP. Based on a survey of membership, 32 percent of NAR's members are covered under their spouse's employer plan.[19] It should be noted, however, this statistic does not account for those members who may be "eligible" for subsidized health coverage through their spouse's employer, but who have not enrolled.

If close to half of NAR's membership fall in this category and are therefore preemptively excluded from AHPs, it may be difficult for NAR to attract enough members to offer an affordable, better quality plan than the individual market. As currently structured, the proposed rule could inadvertently prevent NAR from even establishing an AHP, contrary to the intent of the rule.

It appears that this eligibility factor is intended to protect the small group market "risk pool" by limiting the number of working owners who may seek health coverage under an AHP (and therefore, exit the small group market and enroll in AHP coverage). However, if a working owner has access to subsidized health coverage through their spouse's employer, enrolling in such health coverage will – in many cases – be in the working owner's best economic interest. In these instances, working owners should have the choice and decide whether or not to exit the small group market.

There may also be instances where even though the "family" coverage is subsidized with employer contributions (and tax-free employee contributions), the coverage may still be "unaffordable" to the working owner and his or her spouse (because, for example, the employer subsidy is minimal or the employer imposes a costly "spousal surcharge"). In this case, a working owner should not be arbitrarily forced to choose between (1) no health coverage and (2) "unaffordable" health coverage. Instead, this working owner should be given another "choice," and the freedom to seek coverage under an AHP.

There might be instances also where coverage under an AHP would be superior to subsidized health coverage through the working owner's spouse's employer. One such example would be when a family's preferred health providers are participants in the AHP plan but not the spouse's employer plan. NAR strongly believes that working owners should *not* be precluded from enrolling in the superior AHP coverage that may better meet their families' needs.

III. State Regulation of AHPs Concerns

While nothing in the proposal alters a State's ability to regulate insurance, there is concern in the association community that States may attempt to enact legislation or promulgate rules to re-characterize a fully-insured large group AHP as a "small group" health plan, thereby subjecting the fully-insured AHP to the insurance rules applicable in the small group market. Such state action could frustrate the intent of the rule, which is to expand access to AHPs in order to offer more affordable, better quality health plans.

NAR is sensitive to this type of State regulation because of the interest in offering fully-insured large group or self-insured AHP coverage on a nationwide basis to all members and the ability of

[19] About 32 percent receive health insurance through a spouse, partner, or family member. NAR 2017 Member Profile.

state associations to offer coverage on a regional basis. If, however, States set up barriers to the formation of AHPs, NAR – along with other national trade associations – and its members would surely be disadvantaged, potentially to the point that it would not be able to offer its 1.3 million members with an alternative health insurance option that might better meet their needs. This would be an unfortunate outcome, especially in those states where the existing individual market has suffered from a declining number of insurers participating in the market and premiums have and are anticipated to continue to surge higher.

Conclusion

On behalf of NAR's 1.3 million members, I thank the Subcommittee for holding this hearing and looking into this important Department of Labor proposed rule that NAR believes would potentially provide the tools necessary to enable REALTORS® to have more flexibility and freedom in choosing a health insurance plan that best fits their needs.

APPENDIX

NATIONAL ASSOCIATION of REALTORS®

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March 6, 2018

Mr. Alexander Acosta
Secretary of Labor
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Re: "Definition of Employer under Section 3(5) of ERISA - Association Health Plans"; RIN 1210-AB85 or Docket ID No. 2017-28103 (submitted electronically)

Dear Secretary Acosta:

On behalf of the 1.3 million members of the National Association of REALTORS® (NAR), I write in support of the Department of Labor's Notice of Proposed Rulemaking (NPRM) clarifying the definition of "employer" under Section 3(5) of the *Employee Retirement Income Security Act* (ERISA) for purposes of establishing an Association Health Plan (AHP). The Department of Labor's (the Department's) efforts to expand health insurance options for more Americans is greatly welcomed, especially by real estate professionals that do not typically have access to employer provided coverage.

For well over a decade, NAR has advocated for reforms to the health insurance markets to provide better coverage to the self-employed and small employers that support the real estate industry – one of the country's biggest economic sectors, making up more than 16 percent of the U.S. Gross Domestic Product. NAR's 1.3 million members are involved in all aspects of real estate, as residential and commercial brokers, salespeople, property managers, appraisers, and counselors, all with varying health care concerns. The overwhelming majority of NAR members are not employees of the realty offices with which they are affiliated; they are independent contractors autonomous from the real estate company itself, paying for their business expenses and health insurance coverage out of their own pockets. NAR has long documented the challenges of finding affordable health insurance coverage and historically the rate of uninsured members has ranged between 20 and 30 percent. It is therefore critical that the Department of Labor support the needs of the real estate industry to have affordable health care options so that these individuals can continue to focus their role on boosting America's economic growth.

While some real estate professionals are able to obtain health insurance from a spouse, former employer, or government program, such as Medicare, many are purchasing health insurance on their own, through an exchange or with the help of a broker, in the individual insurance market. Passage of the *Patient Protection and Affordable Care Act* (ACA) resulted in significant

regulatory changes to the individual insurance market (and the small group market), some of which have benefited REALTORS®.[1] However, such changes have also resulted in significant increases in health care costs.[2]

While REALTORS® understand the importance of having health insurance, affordability continues to be a primary barrier to obtaining and maintaining coverage.[3] More than half of REALTORS® describe their existing insurance premiums as too expensive, costing more than $6,000 per year.[4] Numerous reports project rising costs for 2018, more so than in previous years. According to the Kasier Family Foundation, the average increase in the lowest-cost premium will range between 17 and 32 percent for 2018.[5] For REALTORS®, with a nationwide median individual gross income of $42,500, such increases could have a significant impact on whether they can afford to purchase health insurance.[6]

To promote uninterrupted market participation, there must be enough insurance options available at affordable prices that provide necessary coverage of care. NAR supports the Department of Labor's efforts to expand these options and help REALTORS® across America struggling to find cost-effective health insurance plans. Ensuring the freedom to choose from a variety of insurance providers offering quality coverage plans with enough premium support is key to cultivating a deep participant pool and strong marketplace.

However, the proposed rule purports to limit AHP eligibility for many working owners, including real estate professionals, and may not adequately protect against state regulation, threatening AHP development and sustainability. As such, NAR's comments focus on the following aspects of the NPRM that the Department must consider when finalizing the proposed rule:

1. Ensuring that self-employed individuals with no employees (referred to as a "working owner") can participate in group health plan coverage under an AHP;

2. Removing arbitrary and unnecessary eligibility criteria for being considered a working owner; and,

3. Clarifying that while states may continue to regulate AHPs, states may not use existing authorities to undermine the intent of this rule, which is to expand access to AHPs (e.g., by simply re-characterizing large group AHPs as "small group" health plans).

NAR has long championed legislative efforts to promote AHPs or Small Business Health Plans and support the Department's actions today.[7] The Department's removal of regulatory barriers that make it possible for self-employed individuals and small employers to purchase health insurance through a professional or trade

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[1] For example, with many real estate professionals falling in the baby boomer generation, maintaining protections for pre-existing conditions and ensuring guaranteed availability of coverage have been top priorities when considering health insurance options.
[2] *See* Ashley Semansee et al., *How Premiums Are Changing in 2018*, Kasier Family Foundation (Nov. 2017), https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/. [Hereinafter KFF 2018 Premiums.]
[3] Eighty-four percent of REALTORS® plan to continue buying coverage even in light of the recent change to the individual mandate penalty. National Association of REALTORS® Research Division, 2018 Health Insurance Survey, (February 2018).
[4] *Id.*
[5] KFF 2018 Premiums. Figures are based on metal levels for a 40-year-old before a tax credit would apply.
[6] National Association of REALTORS® Research Division, 2017 Member Profile, (May 2017), https://www.nar.realtor/reports/member-profile. [Hereinafter NAR 2017 Member Profile].
[7] *E.g.*, Letter from the Nat'l Ass'n of REALTORS® to Congressmen Johnson & Walberg in support of H.R. 1101, *the Small Business Health Fairness Act* (Feb. 28, 2017), http://narfocus.com/billdatabase/clientfiles/172/2/2847.pdf.

associations will expand much needed access to AHPs. NAR's members and I thank the Department for proposing a rule that has the potential to provide REALTORS® across the country with more flexibility and the freedom to choose a health insurance plan that best fits their needs.

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I. Finalize the Proposals That Would Allow NAR To Offer AHP Health Coverage To Members

A. Background on the Current Treatment of AHPs

1. *Currently, the Formation of AHPs Is Limited Due To Department of Health and Human Services Guidance*

Prior to the enactment of the ACA, small employers often times banded together to create a fully-insured or self-insured AHP. In the case of a fully-insured AHP, most States treated the AHP as a "large group" plan, subject to a State's large group market insurance regulations. In other words, small employers that participated in the AHP were not subject to the State's "small group" market insurance requirements.

The ACA enacted new coverage requirements applicable to fully-insured plans sold in the "individual," small group, and large group markets, as well as to self-insured group health plans. However, certain insurance market reforms that are otherwise applicable to individual and small group plans do *not* apply to fully-insured "large group" and self-insured plans. These reforms include the ACA's essential health benefits (EHB) requirements,[8] actuarial value (AV)[9] requirements, the adjusted community premium rating rules,[10] and the single risk pool requirement.[11]

Shortly after the enactment of the ACA, State and Federal regulators were concerned that small employers may choose to join an existing fully-insured AHP to avoid the ACA's small group market reforms. To address this concern, in 2011, the Department of Health and Human Services (HHS) issued guidance that essentially prohibited small employers from forming a fully-insured "large group" health plan.[12] This meant that the ACA's small group market insurance reforms *would* apply to fully-insured AHP employer members with 50 or fewer employees.

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[8] Required by the ACA, individual and small group health plans must cover a list of 10 medical services that make up the "Federal EHB standard:" ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. ACA section 1302(b).

[9] AV is a measure of how much the health plan pays for a covered benefit or service, and how much the policyholder must pay. According to the ACA, the minimum AV that may be provided for under an individual or small group plan is 60 percent (i.e., the "bronze" plan). (ACA section 1302(d)(1)(A)). The ACA also establishes a "silver" plan, which must provide 70 percent AV, a "gold" plan that must provide 80 percent AV, and a "platinum" plan that must provide 90 percent AV. ACA section 1302(d)(1)(B)-(D).

[10] The ACA prohibits an insurance carrier from developing premiums for individual and small group plans based on health status. Premium rates may only vary by (1) age (but by no more than a 3 to 1 ratio), (2) tobacco use (but by no more than a 1.5 to 1 ratio), (3) single or family coverage, and (4) geography. ACA section 2701(a)(1).

[11] The ACA requires that the health risks of policyholders in the individual market must be pooled together into one, single risk pool by the insurance carrier underwriting their coverage. Similarly, the health risks of employees of small employers must be pooled together by the carrier underwriting the coverage for the small employers. ACA section 1312(c).

[12] *See* https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

The 2011 guidance dramatically reduced the number of fully-insured AHPs that operate today, but did not apply or impact self-insured AHPs. In addition, fully-insured AHPs sponsored by a "bona fide group or association of employers" as defined under ERISA were not impacted by HHS's guidance. In other words, if a group of employers sponsoring a fully-insured AHP is considered a "bona fide group or association of employers," the fully-insured AHP would continue to be considered a "large group" plan (and thus, small employer members participating in the AHP would *not* be subject to the ACA's small group market reforms).

2. *Currently, the Formation of AHPs Is Also Limited Due to Department of Labor Guidance*

The formation of AHPs is also limited by the Department of Labor's existing guidance on the factors that must be satisfied to be considered a "bona fide group or association of employers" for purposes of sponsoring a fully-insured "large group" or self-insured AHP. Specifically, to be considered "bona fide," a group of employers must meet (1) the "commonality of interest" and (2) the "control" tests.

Under the "control" test, the employer members of the group must exercise "control," both in form and substance, over the activities and operations of the AHP.[13] The "commonality of interest" test is a facts and circumstances test that is not always easy to satisfy. According to existing Department guidance, a group of employers would *not* be considered "bona fide" *unless* (1) the employer members are "related" (i.e., the employers are in the same industry) and (2) the employer members are located in the same State or tri-State area.[14] Also, a group of employers would *not* be considered "bona fide" if self-employed individuals with no employees are a part of the group.[15]

3. *These Limitations Have Barred NAR From Offering AHP Health Coverage To Members*

For decades, NAR – as a member-run organization – has been interested in establishing an AHP to offer health coverage to our 1.3 million members nationwide, or supported local and state associations to provide coverage on a regional basis. Although the REALTORS® satisfy the first component of the "commonality of interest" test (because all members are "related"), NAR at the national level is unable to meet other aspects of the "commonality of interest" test, like the geographical limitation.

More specifically, because the "commonality of interest" test confines an employer group to offering health coverage within the four-corners of a particular State (or in a tri-State area), NAR is unable to offer AHP health coverage to all members across the country. In addition, because the majority of members would be considered self-employed individuals with no employees, NAR would not be considered a "bona fide group or association of employers" for purposes of sponsoring an AHP. Lastly, there is an existing Department regulation that also prohibits a self-employed individual with no employees (and their spouse) from participating in an ERISA-covered plan.[16]

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[13] DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 2005-24A (Dec. 30, 2005), DOL Adv. Op. 2003-17A (Dec. 12, 2003), DOL Adv. Op. 2001-04A (Mar. 22, 2001), DOL Adv. Op. 96-25A (Oct. 31, 1996).
[14] *Gruber v. Hubard Bert Karle Webber, Inc.*, 159 F.3d 780 (3rd Cir. 1998) (citing *Steen v. John Hancock Mutual Life Ins.*, 106 F.3d 904 (9th Cir. 1997)); *National Ben Administrators, Inc., National Business Ass'n By and Through v. Morgan*, 770 F. Supp. 1169 (W.D.KY 1991); *see also*, DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-24A (Dec. 30, 2005), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 2003-17A (Dec. 12, 2003).
[15] *Marcella v. Capital Dist. Physicians' Health Plan, Inc.* v. 293 F.3d 42 (2nd Cir. 2002); *see also*, DOL Adv. Op. 2003-13A (Sept. 30, 2003), DOL Adv. Op. 98-08A (Oct. 9, 1998), DOL Adv. Op. 94-07A (Mar. 14, 1994), DOL Adv. Op. 90-19A (June 15, 1990).
[16] DOL Reg. section 2510.3-3(b), (c).

B. The NPRM May Enable NAR To Offer AHP Health Coverage To Members

The NPRM proposes to change existing Department guidance and regulations in such a way where NAR may finally be able offer health coverage through a fully-insured "large group" or self-insured AHP. This flexibility would be provided through the Department's modifications to the "commonality of interest" test and also because self-employed individuals with no employees (hereinafter referred to as "working owners") would be able to participate in AHP "group health plan" coverage.

The Department explains its requisite authority to supersede its previous interpretations as articulated in non-binding Advisory Opinions – as well as supersede a prior interpretation by a Federal court – to address marketplace developments and new policy and regulatory issues.[17] Based on this precedent, many stakeholders believe the Department does indeed have the requisite authority to reinterpret its own rules to address new issues presented in an ever-evolving economic environment, especially considering the fact that courts have deferred to Federal agencies provided there is a rational basis for the decision and it is explained through the normal rulemaking process under the *Administrative Procedure Act*.[18]

1. *REALTORS® Support the Modifications to the "Commonality of Interest" Test*

In the NPRM, the Department has opted to modify its interpretation of the various factors that must be present to satisfy the "commonality of interest" test. Under the proposal, a group of employers would meet the "commonality of interest" test if (1) the employers (and working owners) are in the same industry, line of business or profession or (2) the employers (and working owners) have a principal place of business in a particular State or metropolitan area (that may span more than one State).

With respect to the first test noted above, the Department has chosen to eliminate the geographical limitation for "related" employers. This would allow national trade associations – like NAR – to establish a fully-insured large group or self-insured AHP, and offer such AHP health coverage to the Associations' members regardless of their geographic location. In other words, so long as the members of the group are "related" – a test which NAR's members satisfy – AHP health coverage could be offered to members located in all 50 States, or members located in a particular region of the country (e.g., New England, the Southeast States, or the Pacific Northwest, to name a few). As stated above, NAR strongly supports this modification, and urges the Department to finalize this proposal.

2. *REALTORS® Support Allowing Working Owners to Participate in an AHP*

The Association commends the Department for allowing working owners to participate in "group health plan" coverage through an AHP. NAR has long-advocated for policy changes that would provide additional health coverage options to working owners and currently, working owners have limited options when it comes to accessing health insurance. If a working owner happens to have a spouse who is offered group health plan coverage through the spouse's employer, the working owner may be eligible for coverage. However, in some cases this "family" coverage may be unaffordable to the working owner and his or her spouse.

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[17] *See Perez v. Mortgage Bankers Ass'n.* 135 S. Ct. 1199 (2015); *see also, National Cable & Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967 (2005).

[18] *See Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Company*, 463 US 29 (1983).

If a working owner is not married – or their spouse's employer does not offer group health plan coverage – the only health care option available to them is health coverage in the fully-insured individual market. This can dramatically limit a working owner's ability to access affordable health coverage.[19] And, in today's individual market, finding a health plan that provides an adequate level of coverage at an affordable price is difficult.[20]

For the reasons discussed more fully below, NAR urges the Department to finalize the proposal to allow working owners to participate in a fully-insured "large group" or self-insured AHP. As stated, providing this flexibility in the law may enable NAR to offer group health plan coverage to its members nationwide, and/or on a regional basis.

II. Working Owners Will Benefit From Participating In a Fully-Insured Large Group or Self-Insured AHP

A. Working Owners Can Find Comprehensive Health Coverage Through a Fully-Insured Large Group or Self-Insured AHP

Allowing working owners to access health coverage through an AHP – either a fully-insured large group or self-insured AHP – will dramatically improve their ability to find comprehensive health coverage that best fits their needs.

1. *Consumer Protections Under ERISA and the ACA Apply to an* AHP

As the Department is well aware, existing consumer protections under ERISA and the ACA require a fully-insured large group and self-insured AHP – as a group health plan – to provide a comprehensive level of coverage.

For example, according to the ACA, a fully-insured large group or self-insured AHP (1) *cannot* deny an eligible plan participant health coverage if they have a pre-existing condition,[21] (2) *cannot* refuse to cover certain government-approved preventive services (rather, the AHP must provide free coverage for these preventive services),[22] and (3) *cannot* impose annual and lifetime limits on the "essential health benefits" covered under the plan.[23] Other ACA requirements including – (1) covering adult children up to age 26, (2) free access to emergency care, and (2) the prohibition against rescinding coverage absent fraud – apply.[24]

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[19] For example, the Congressional Budget Office ("CBO") found that premiums in the individual market were 27 percent to 30 percent higher in 2016 than they would have been in 2009. *See https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.* Others have argued that many healthy individuals experienced rate increases of 100 to 200 percent. *See* https://www.finance.senate.gov/imo/media/doc/12EP2017RoySTMNT.pdf.

[20] According to Avalere Health, 73 percent of the individual market plans offered through an ACA Exchange had restrictive (i.e., narrow) networks. *See* http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market.

[21] Public Health Service Act ("PHSA") section 2704.

[22] PHSA section 2713.

[23] PHSA section 2711.

[24] PHSA sections 2714, 2719A, and 2712.

Under ERISA, there are specific notice and disclosure requirements,[25] and also fiduciary responsibilities that apply,[26] requiring the AHP and its employer members to act in the best interest of the plan participants. Participants also have a private right of action to sue the AHP if there is wrongdoing,[27] and there are detailed procedures for filing health claims,[28] and rigorous internal and external appeals processes.[29] In addition, continuation of coverage requirements under COBRA apply,[30] and according to the *Health Insurance Portability and Accountability* Act (HIPAA), premiums for an AHP plan participant *cannot* be developed based on the participant's health condition.[31]

Importantly, the NPRM does *nothing* to change ERISA's and the ACA's consumer protections.

2. *State Benefit Mandates Apply to Fully-Insured Large Group* AHPs

In the case of a fully-insured large group AHP, State benefit mandates apply, meaning specified benefits and services that a particular State requires insurance contracts to cover must be included in the AHP plan.[32] Many industry experts suggest that most State's benefit mandates are as good as the ACA's EHB requirement, even in cases where a State does not cover all of the 10 medical services that make up the Federal EHB standard. The drafters of the ACA recognized that fully-insured large group plans traditionally offer a comprehensive set of benefits similar to the ACA's EHBs, which led Congress to exempt fully-insured large group plans from the EHB requirement entirely.

3. *State MEWA Laws and Solvency Requirements Apply to Self-Insured* AHPs

With respect to a self-insured AHP, this arrangement would be considered a self-insured "multiple employer welfare arrangement" (MEWA). As the Department knows, Congress specifically amended ERISA's preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State.[33] Since that time, many States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. These laws often times impose specific coverage and/or premium rating requirements on self-insured MEWAs. In addition, State MEWA laws typically impose the same solvency – or reserve – requirements that apply to insurance companies operating within the State. Other States outright prohibit self-insured MEWAs.

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[25] ERISA, Title I, Subtitle B Part 1.
[26] ERISA, Title I, Subtitle B Part 4.
[27] ERISA section 502.
[28] ERISA section 503.
[29] PHSA section 2719.
[30] ERISA, Title I, Subtitle B Part 7.
[31] ERISA section 702.
[32] According to the National Conference of State Legislatures, traditionally States have enacted health mandate laws to include required categories of up to 70 distinct "benefits" as well as "health providers" (such as acupuncturists or chiropractors) and "persons covered" (such as adopted children, handicapped dependents, or adult dependents). Adding up these laws, there are more than 1,900 such statutes among all 50 states; another analysis tallies more than 2,200 individual statute provisions, adopted over more than 30 years. *See* "State Insurance Mandates and the ACA Essential Benefits Provisions," National Conference of State Legislators (Oct. 2017), http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx, Appendix I.
[33] ERISA section 514(b)(6)(A)(ii).

4. *AHPs Will Provide Adequate Health Coverage*

NAR recognizes that other stakeholders will sound the alarm over the fact that fully-insured large group and self-insured AHPs are not subject to the ACA's EHB and AV requirements, and also the ACA's adjusted community premium rating rules and the single-risk pool requirement. However, these concerns are misplaced due to the applicable consumer protections and existing State regulation discussed above.

B. Working Owners Can Find Lower Costing Health Coverage Through an AHP

Allowing working owners to access health coverage through fully-insured large group or self-insured AHP will dramatically improve their ability to find comprehensive health coverage at an affordable price.

1. *Costs Are Typically Lower for Fully-Insured Large Group Plans*

Prices in the fully-insured large group market are typically lower than individual and small group market plans. Some have asserted that this lower price point is often times the product of less comprehensive – or "skinny" – coverage. In fact, large group plans tend to offer more comprehensive coverage than small group or individual health insurance plans. Contrary to the assertions, the lower costs in the fully-insured large group market – relative to the individual and small group markets – are driven by administrative efficiencies. In other words, the same administrative costs that drive up the cost of individual and small group coverage are not present in the fully-insured large group market. For example, individuals and small employers often times drop in and out of the insurance markets. In addition, individuals and small employers routinely change insurance carriers, sometimes every year.[34] This volatility – which drives up administrative costs – is not present in the single employer fully-insured large group market, as well as among existing fully-insured large group AHPs (e.g., in the case of existing fully-insured large group AHPs, the health coverage is traditionally superior to coverage a small employer might independently find in the commercial insurance market, and as a result, there is limited turn-over among small employer members).

In addition, prices in the individual and small group markets are typically higher on account of the ACA's risk adjustment program.[35] In other words, insurance carriers typically price any potential risk adjustment "charges" into their premiums, which arbitrarily increases costs. Because the ACA's risk adjustment program does not apply to the fully-insured large group market, these added costs are not present, thus resulting in a lower costing health plan relative to individual and small group plans.

The requirement to cover the ACA's EHBs and the ACA's adjusted community rating rules also have cost implications for individual and small group plans, which are also not present in the fully-insured large group market. For example, fully-insured large group premiums may be developed based on the "health claims experience" of all of the employees employed by a large employer, while this type of under-writing practice is prohibited in the individual and small group markets (i.e., premiums in the individual and small group market cannot be based on health status). In addition, age rating in the individual and small group markets is limited to a 3-to-1 ratio (which increases costs for younger individuals), while age rating in the fully-insured large group market is typically based on a 5-to-1 ratio, which many argue produces an "actuarially fair" premium rate.

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[34] For example, industry experts have explained that volatility in the small group market adds significantly to insurers' already very high administrative costs for small-group coverage, as greater resources are devoted to underwriting, and dis-enrolling and re-enrolling small groups.

[35] *See* ACA section 1343.

2. *Costs Are Traditionally Lower for Self-Insured Plans*

Self-insured group health plans are not subject to the ACA's risk adjustment program, as well as the ACA's EHBs and adjusted community rating requirements, which – as discussed above – means that these plans will have a lower cost relative to individual and small group plans. In addition, self-insured plans are not subject to State premium taxes, and therefore, unlike fully-insured plans (e.g., individual, small group, and large group plans), there is no tax liability that is passed through to the participant. Self-insured plan premiums also do not include a "risk" and "profit" load that insurance carriers traditionally build into their costs to employers and their employees.

3. *Costs Will Be Lower for Fully-Insured and Self-Insured AHPs*

Based on the foregoing, regardless of whether an AHP is a fully-insured large group or self-insured plan, the cost of coverage will primarily be lower than individual and small group health plans. And contrary to what may critics of AHPs may say, such lower costs are *not* driven by the plans offering limited benefits.

C. Allowing Working Owners to Participate In an AHP Will Not Materially Impact the Existing Individual Market

Critics of AHPs argue that the allowing working owners to participate in these arrangements will adversely affect the individual health insurance market. While it is true that some working owners may seek to exit the individual market and opt for health coverage offered through an AHP, the impact on the individual market will not be as severe as these critics suggest. Rather the proposed rule would provide another choice for more consumers to seek out more affordable coverage.

1. *Working Owners Eligible for the ACA's Premium Tax Credit Will Likely Remain In the Individual Market*

To determine how AHPs may impact the individual market, it is important to first examine the type of working owners purchasing an individual market plan. For example, a working owner with income between 100 percent and 400 percent of the Federal Poverty Level (FPL) will qualify for the ACA's premium tax credit if the working owner enrolls in an individual market plan sold through an ACA Exchange. In most if not all cases, working owners in this income cohort are likely to remain in the individual market because any coverage they may access through an AHP would *not* be subsidized.[36]

It is true that if a working owner in this income cohort enrolls in an AHP, they would be able to deduct 100 percent of the cost of the AHP coverage as an above-the-line deduction as permitted under section 162(l) of the Internal Revenue Code ("Code"). But, this tax benefit will likely be lower than the value of an ACA premium tax credit, and therefore, it would be in a working owner's best economic interest to remain covered under an ACA Exchange plan (instead of exiting the individual market and enrolling in AHP coverage).[37]

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[36] In the NPRM, the Department indicates that 906,000 working owners (and their dependents) are enrolled in an individual market Exchange plan and receiving a premium tax credit.

[37] Note, if a working owner enrolls in an individual market plan through an ACA Exchange – and they receive a premiums tax credit – the working owner *cannot* also take an above-line-deduction under section 162(l) (i.e., no "double-dipping").

2. *Working Owners Not Eligible for the ACA's Premium Tax Credit May Seek Coverage Under an AHP*

For those working owners with income above 400 percent of FPL, these individuals do not qualify for subsidized individual market plans. As a result, these working owners must pay for the full-cost of an individual market plan out of their own pocket. A working owner may deduct 100 percent of the cost of the individual market plan as an above-the-line deduction under Code section 162(l). However, it is unlikely that this tax benefit will make the individual market coverage affordable. As a result, it is likely that a working owner in the "un-subsidized" individual market will exit that market and seek coverage under an AHP.

3. *For Those Working Owners Exiting the Un-Subsidized Individual Market, They May Be Healthy or They May Be High Medical-Utilizers*

The fact that working owners may exit the un-subsidized individual market does not – in and of itself – mean that the individual market will be adversely affected. For example, AHP coverage may be equally attractive to both a "healthy" working owner or a working owner that utilizes a significant amount of health care (i.e., a "high medical-utilizer"). As a result, while a healthy working owner may exit the individual market thereby having a negative effect on the overall risk pool, a high medical-utilizer may also exit the individual market thus having a positive impact on the overall risk pool. This would occur in instances where a high-medical-utilizer would find that the AHP coverage is superior to any un-subsidized individual market coverage. And, it would occur in cases where the AHP is less costly than any un-subsidized individual market coverage.

NAR's members are a case-in-point, where average membership age 53 years old.[38] While information about the specific health risks of our membership remains private – as required under HIPAA (and thus unknown to us) – objective data indicates that older individuals tend to use more health care than younger individuals.[39] And, while it is too soon to determine whether the health insurance coverage NAR may offer through an AHP will cost less for members who are currently covered by an un-subsidized individual market plan, if the AHP coverage does indeed have a lower cost, then it is likely that many members – who skew older and thus may be high medical-utilizers – will exit the individual market. This action will likely have a positive impact on the overall individual market risk pool.

It is difficult to determine whether there will be a one-for-one trade-off between healthy working owners and high medical-utilizers who may exit the un-subsidized individual market, even for skilled actuaries. However, the assertion that the existence of AHPs will "siphon off" healthy risks from the individual market is similarly not a well-founded claim that can be objectively verified. A stronger argument can be made that high-medical utilizers will find AHP coverage attractive, and thus, exit the individual market.

III. Remove the Proposal That Would Disallow Participation In an AHP If a Working Owner Is Eligible for Subsidized Health Coverage Through Their Spouse's Employer

As stated above, the National Association of REALTORS® has long-advocated for policy changes that would provide additional health coverage options to working owners. The Association applauds the Department for finally providing the flexibility that this organization has long sought – allowing working owners to participate in group health plan coverage offered through an AHP. However, NAR feels that the eligibility criteria for qualifying as a working owner is overly constraining. The proposed eligibility criteria that must be met to be

[38] NAR 2017 Member Profile.
[39] *See* Dale H. Yamamoto, *Health Care Costs – From Birth to Death*, Society of Actuaries (June 2013), http://tinyurl.com/q5z2zb9.

considered a working owner will limit the number of self-employed individuals who may be eligible to participate in an AHP, which seems contrary to the Department's policy goal of expanding health coverage to these individuals.

A. Disallowing Participation In an AHP Due To Eligibility for Subsidized Health Coverage Through a Working Owner's Spouse Will Limit the Formation of AHPs

According to the NPRM, a self-employed individual with no employees who is eligible for subsidized health coverage through their spouse's employer would *not* be considered a "working owner" for purposes of participating in an AHP. Based on a survey of membership, 32 percent of NAR's members are covered under their spouse's employer plan.[40] This statistic does not account for those members who may be "eligible" for subsidized health coverage through their spouse's employer, but who have not enrolled, which would likely be higher.

If close to half of NAR's membership fall in this category and are therefore preemptively excluded from AHPs, it may be difficult for NAR to attract enough members to offer a more affordable, better quality plan than the individual market. As currently structured, the proposed rule could inadvertently prevent NAR from establishing an AHP, contrary to what the intent of the rule.

B. Disallowing Participation In an AHP Due To Eligibility for Subsidized Health Coverage Through a Working Owner's Spouse Is Arbitrary, Constraining, and Against Good Public Policy

It appears that this eligibility factor is intended to protect the small group market "risk pool" by limiting the number of working owners who may seek health coverage under an AHP (and therefore, exit the small group market and enroll in AHP coverage). However, if a working owner has access to subsidized health coverage through their spouse's employer, enrolling in such health coverage will – in many cases – be in the working owner's best economic interest. In these instances, working owners should have the choice and decide whether or not to exit the small group market.

For example, health coverage offered through an AHP will *not* be subsidized in any way (other than through the Code section 162(l) above-the-line deduction). In contrast, if a working owner's spouse is offered "family" health coverage that is subsidized through employer contributions (and also through tax-free employee contributions that may be made), the cost of this coverage will be cheaper than the un-subsidized AHP coverage. As a result, it would not be in the working owner's economic best interest to opt-out of their spouse's employer plan to enroll in AHP coverage. Meaning, it is unlikely that the working owner would exit the small group market.

However, there may be instances where even though the "family" coverage is subsidized with employer contributions (and tax-free employee contributions), the coverage may still be "unaffordable" to the working owner and his or her spouse (because, for example, the employer subsidy is minimal or the employer imposes a costly "spousal surcharge"). In this case, a working owner should not be arbitrarily forced to choose between (1) no health coverage and (2) "unaffordable" health coverage. Instead, this working owner should be given another "choice," and the freedom to seek coverage under an AHP.

[40] About 32 percent receive health insurance through a spouse, partner, or family member. NAR 2017 Member Profile.

Suggesting what form an appropriate "affordability" test could take – or suggesting what constitutes "subsidized" coverage – is beyond the scope of this comment letter. However, this situation is not an uncommon case where a working owner and his or her spouse are faced with employer coverage that they cannot afford, and also individual market coverage that is too costly and/or does not provide adequate health coverage. If this proposed eligibility factor is finalized, this working owner would be blocked from accessing what could be affordable and comprehensive coverage through an AHP (even if such coverage is un-subsidized). Again, a result that the Department does not intend.

Referring back to the example above: Even if the subsidized "family" coverage is "affordable," a working owner should still be given the option to enroll in an AHP even if it is not in the working owner's best economic interest. For example, there may be instances where coverage under an AHP is superior to subsidized health coverage through the working owner's spouse's employer such as when a family's preferred health providers are participants in the AHP plan but not the spouse's employer plan. And, even though the coverage under the AHP is un-subsidized, the working owner should *not* be precluded from enrolling in the superior AHP coverage.

The over-arching goal is that working owners should have as many choices available to them as possible. And, any concern over the impact AHP coverage may have on, for example, the small group market risk pool should not drive the development of an eligibility factor that is arbitrary and constraining. In addition, a working owner should not be put in a position where they have to choose between a spouse and affordable/quality health coverage, a reasonable concern that that this type of eligibility factor is anti-marriage.

C. Disallowing Participation In an AHP Due To Eligibility for Subsidized Health Coverage Through a Working Owner's Spouse Is Modeled After a Section of the Internal Revenue Code That Does Not Share a Parallel Provision Under ERISA

NAR understands that this eligibility criteria is modeled after a requirement set forth under Code section 162(l) – in particular Code section 162(l)(2)(B) – which denies the above-line-deduction for health care costs if a self-employed individual is eligible for subsidized health coverage through his or her spouse's employer. There is virtually no implementing guidance on this provision of the Tax Code and there is no history on why Congress included this rule in the Tax Code in the first place. It is reasonable to conclude that Congress did *not* develop this provision to serve as a factor for determining eligibility to participate in a group health plan. While there are a number of parallel provisions in both the Tax Code and ERISA, Code section 162(l)(2)(B) is not one of those parallel provisions. As a result, there is no reason why an unrelated section of the Tax Code should be used as precedent for limiting working owners' ability to participate in an AHP.

As discussed above, suggesting what constitutes "subsidized" coverage is beyond the scope of this comment letter. However, ever since 1986 – when section 162(l)(2)(B) was first added to the Tax Code – neither Congress nor the Department of Treasury has defined what the term "subsidized" coverage means for the purposes of this limitation. Attempting to develop a definition at this point is an ill-advised exercise that will merely add complexity to an already complex issue area.

IV. Comments on the "Hours Worked" Eligibility Requirement and the Nondiscrimination Protections

A. The "Hours Worked" Requirement for Qualifying as a Working Owner

Another eligibility factor for qualifying as a working owner requires that an individual work at least 120 hours per month providing personal services to a "trade or business." Real estate professionals do not have a traditional work schedule relative to workers in other industries and as independent contractors, such hours are not readily tracked like in an employer-employee relationship. The Department should modify this "hours worked" eligibility criteria, taking into account that there are many industries – like real estate – where workers may not have a defined schedule that leads to working 120 hours in a particular month.[41]

B. The Nondiscrimination Protections

The NPRM establishes four different nondiscrimination protections applicable to AHPs. Under the first proposed nondiscrimination protection, an employer group cannot deny other employers and/or working owners membership in the group – and by extension participation in an AHP – on account of any "health factor"[42] of an employee, a former employee, or the working owner. Under the second and third proposed nondiscrimination protections, the premiums for AHP health coverage – and eligibility for benefits covered under the plan – cannot vary based on a particular participant's health factor. And under the fourth proposed nondiscrimination protection, an AHP cannot develop different premiums for different employer groups or working owners based on their health claims experience.

With regard to the first nondiscrimination protection, NAR supports this proposal, as no employer or working owner should be denied membership in an organization because of a person's health status. In our opinion, denying membership based on a health factor is against public policy and is merely a subterfuge to denying a person health coverage under an AHP, which is currently prohibited by the ACA.

With respect to the second and third nondiscrimination protections, the Association is also supportive of these provisions. As the Department knows, these are requirements that currently apply to existing group health plans. And – as a group health plan – any AHP that NAR may sponsor will comply with this current law requirement and therefore, will not develop premiums or define eligibility for benefits based on any health factor of a particular plan participant.

While NAR strongly supports the other provisions, NAR is concerned that the inability to develop different premiums for different employer groups based on health claims experience may adversely affect existing AHPs that are currently sponsored by other trade associations and employer-run organizations. This is because like single employers that sponsor fully-insured large group and self-insured plans, most existing AHPs engage in the practice of "experience-rating" to develop their premiums. And, the inability to engage in this commonly used practice may be disruptive to current AHP plan participants. In addition, the inability to experience-rate employer members may limit the formation of AHPs in the future.

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[41] Around 16 percent of NAR members work fewer than 30 hours per week and make less than $10,000. NAR 2017 Member Profile.
[42] A "health factor" is defined as: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

V. State Regulation of AHPs

The preamble of the NPRM explains that – in the Department's opinion – nothing in the proposal alters a State's authority to regulate insurance. NAR agrees.

It should be noted however, that States may attempt to act upon their authority to regulate insurance and enact legislation or promulgate rules to re-characterize a fully-insured large group AHP as a "small group" health plan, thereby subjecting the fully-insured AHP to the insurance rules applicable in the small group market. In addition, States adverse to self-insured AHP health coverage may seek to enact reserve requirements that are so high that the requirement is prohibitive. Either state action could frustrate the intent of the rule, which is to expand access to AHPs in order to offer more affordable, better quality health plans.

NAR is sensitive to this type of State regulation because of the interest in offering fully-insured large group or self-insured AHP coverage on a nationwide basis to all members and the ability of state associations to offer coverage on a regional basis. If, however, States set up barriers to the formation of AHPs, NAR – along with other national trade associations – would be severely disadvantaged.

A. Fully-Insured Large Group AHPs

As the Department knows, a fully-insured large group AHP is subject to State benefit mandates that apply to insurance contracts sold within a respective State. This means that even as an ERISA-covered plan – which in some cases enjoy ERISA's preemption powers – State benefit mandates are *not* preempted by ERISA. There is, however, question as to whether a State law or regulation that re-characterizes a large group fully-insured AHP as a "small group" plan *would* be preempted by ERISA (and therefore, would *not* apply to an ERISA-covered fully-insured AHP).

On the one hand, an argument can be made that because States have the authority to regulate the insurance contracts sold within their State, a State could indeed enact a law or regulation to re-characterize a fully-insured large group AHP as a "small group" plan, and this law/regulation would be "saved" from preemption under ERISA's "savings clause" (and therefore, the law/regulation would *not* be preempted).[43] But, a legal argument can be made that this "re-characterization law" is directly impacting the ERISA-covered plan (and not the insurance contract), and even though the plan is fully-insured, any State law directly impacting an ERISA-covered plan *is* preempted under ERISA's "deemer clause."[44]

In addition, the statute of ERISA itself states that a fully-insured MEWA (i.e., a fully-insured AHP) may be subject to any State insurance law "to the extent that such law…requires the maintenance of specified levels of reserve and specified levels of contributions."[45] A legal argument can be made that a State law or regulation that re-characterizes the "large group" fully-insured AHP as a "small group" plan is *not* a law that "requires the maintenance of specified levels of reserve and specified levels of contributions."

While the Department is currently not in a position to opine on (1) whether a State law or regulation purporting to re-characterize a fully-insured large group AHP as a "small group" plan is preempted under ERISA's "deemer clause" or (2) whether this law or regulation has no effect on a fully-insured AHP because the

[43] *See* ERISA section 514(b)(2)(A).
[44] *See* ERISA section 514(b)(2)(B).
[45] ERISA section 514(b)(6)(A)(i)(I).

law/regulation is not one that "requires the maintenance of specified levels of reserve and specified levels of contributions," NAR urges the Department to consider clarifying this issue soon after final regulations are released.

There are various steps that the Department could take to address this issue. For example, the Department could issue informal guidance in the form of a Technical Release, explaining that – in the Department's opinion – a State law purporting to re-characterize a fully-insured large group AHP as a "small group" plan is indeed preempted or the law simply does not apply (because this State action is *not* a law that "requires the maintenance of specified levels of reserve and specified levels of contributions"). Alternatively, the Department could submit proposed legislation that would amend ERISA's preemption provisions, allowing fully-insured large group and self-insured AHPs to operate free from State law, provided specific Federal requirements are satisfied.

B. Self-Insured AHPs

As noted above, a self-insured AHP would be considered a self-insured MEWA, and ERISA explicitly gives States the authority to impose any State insurance law requirement on self-insured MEWAs. As also discussed above, many States have acted on this authority by enacting State MEWA laws.

The Association agrees with the Department that the proposed regulations in no way impact a State's ability to regulate self-insured AHPs through their State MEWA laws. As a result, a self-insured AHP must satisfy each State MEWA law in each of the States in which the AHP coverage is offered. Unfortunately, however, this fact may limit the extent to which self-insured AHPs are formed. This is because a self-insured AHP wanting to offer health coverage in multiple States must navigate the different legal requirements and licensing practices in each State in which the coverage may be offered. The cost and time associated with complying with this "patchwork" set of regulations and licensing rules is often times prohibitive. Some States may choose to enact requirements as a back-door way of preventing self-insured AHPs from operating within the State. If the Department believes that this is inconsistent with ERISA, the Department could submit proposed legislation that would amend ERISA's preemption provisions, to clarify this issue.

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Thank you in advance for considering these comments. Please do not hesitate to contact me with any questions, or if REALTORS® can serve as a resource on these very important matters.

Sincerely,

Elizabeth J. Mendenhall

Elizabeth Mendenhall
2018 President, National Association of REALTORS®

Chairman WALBERG. Thank you.

Now I recognize Mr. Arensmeyer for your five minutes of testimony.

TESTIMONY OF JOHN ARENSMEYER, FOUNDER AND CEO, SMALL BUSINESS MAJORITY

Mr. ARENSMEYER. Good morning, Chairman Walberg, Ranking Member Blunt Rochester, members of the Subcommittee. I'm the founder and CEO of Small Business Majority. Our mission is to empower America's 28 million entrepreneurs to build a thriving and inclusive economy. Working from nine offices across the country, we work closely with more than our network of 55,000 small business owners and over 1,000 local business organizations.

Over the past six years, the ACA has provided health care to more than 20 million individuals who otherwise couldn't access coverage, millions of whom work for small employers or are themselves business owners or self-employed individuals.

Equally important, the small group market has seen rates stabilized under the ACA, with an average cost increase of 5.2 percent, down from a rate of more than 10 percent prior to the ACA.

It should come as no surprise that scientific polling we conducted last year found that six in 10 small business owners favor retaining and strengthening the ACA. That's why we're so concerned about the proposed changes in the Department of Labor's rules governing AHPs.

In order for small businesses to receive affordable coverage, the small group market's risk pool must be robust and well balanced. The proposed rule would allow associations to operate as a single large employer, thus creating separate risk pools for different types of small businesses, particularly when it comes to things like essential health benefits, age rating, actuarial value, adjusted community rating, the single-risk pool requirement, and risk adjustment.

While this might mean that some small businesses with younger, healthier employees can purchase cheaper plans, the remaining risk pool becomes unbalanced, causing rates to soar for everybody else.

What's more, the proposed rule suggests that current protections against discriminatory marketing practices would not apply to AHPs, which would allow these plans to discourage enrollment from companies with employees that have expensive or complicated health issues.

Under this proposed rule, AHPs would also offer fewer consumer safeguards. It's concerning that the proposed rule is ambiguous about whether it will block states' abilities to regulate AHPs. It's unacceptable to prevent state insurance commissioners from enforcing rules they deem to be in the best interest of their state's small businesses and consumers.

Small business owners may turn to AHPs in search of lower-cost options. But without protections in place to prevent fraud, they can find themselves the victims of scams, on the hook for costly medical expenses for issues they thought their plan covered. As Adam Rochon, the owner of a small independent insurance agency says, "The bottom line is AHPs are only good as long as you don't get sick."

Importantly, AHPs are not a new idea. In fact, states have already experimented with these plans with disastrous results. An Urban Institute analysis of Oregon's regulations of AHPs prior to the ACA found that policies and lack of regulatory oversight increased the potential for adverse selection in the remaining small group market in the state.

This issue, as well as the concerns outlined above regarding fraud and abuse, is why a coalition of 17 attorneys general recently submitted comments to the Labor Department opposing the proposed rule. As noted in their comments, the proposed rule undermines the intent and structure of the ACA and is also contrary to the Labor Department's longstanding interpretation of ERISA, which, among other things, requires that large groups have a, quote, "common economic or representational interest," close quote, unrelated to the provision of benefits.

Finally, much has been made of the proposed rule's inclusion of independent contractors or so-called working owners. This is a group that has dramatically benefited from the ACA's individual market, with as many as one-third of participants in California's exchange being sole proprietors. As such, enacting this rule would significantly weaken the individual markets.

Rather than pursuing policies to undermine the ACA, we encourage lawmakers to advance legislation that would stabilize health care marketplaces and protect the robustness of covered options for small business owners, employees, and independent business owners.

Legislations like the bill that was recently introduced by the ranking members of the Energy and Commerce, Ways and Means, and Education and Workforce Committees would be an important step in lowering premiums and stabilizing markets.

Thank you. And I look forward to answering your questions.

[The statement of Mr. Arensmeyer follows:]

TESTIMONY BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON

"EXPANDING AFFORDABLE HEALTH CARE OPTIONS: EXAMINING THE DEPARTMENT OF LABOR'S PROPOSED RULE ON ASSOCIATION HEALTH PLANS"

March 20, 2018

John Arensmeyer

Founder & CEO, Small Business Majority

Thank you, Chairman Walberg, Ranking Member Sablan, Congresswoman Blunt-Rochester and members of the Subcommittee on Health, Employment, Labor, and Pensions.

As a leading representative of the 28 million small businesses in America, Small Business Majority is pleased to offer testimony today regarding options to expand access to affordable healthcare and the detrimental effects the U.S. Department of Labor's proposed changes to Association Health Plan (AHP) regulations would have on small businesses.

Small Business Majority's mission is to empower America's entrepreneurs to build a thriving and inclusive economy. We actively engage small business owners and policymakers in support of public policy solutions, and deliver information and resources to entrepreneurs that promote small business growth. Our extensive scientific opinion polling, focus groups and economic research help us educate and inform policymakers, the media and other stakeholders about key issues impacting small businesses and freelancers, including healthcare, access to capital, taxes, retirement and critical workforce issues.

Small Business Majority has a network of more than 55,000 small business owners across the country, with nine offices in Washington, D.C. and seven states. We work closely with our network and with more than 1,000 local business groups to create a strong small business voice in Washington and state capitals, and deliver critical education and resources to America's job-creating entrepreneurs. A key part of our work over the past 12 years has been to advocate for policies that help small businesses, their employees and self-employed entrepreneurs access affordable and comprehensive health coverage.

Over the past six years, the Patient Protection and Affordable Care Act (ACA) has provided healthcare to 24 million individuals nationwide who otherwise couldn't access coverage, many of whom work for small employers or are themselves business owners or self-employed individuals. Unfortunately, prior to the law's enactment, small businesses and their employees comprised a disproportionate share of the working uninsured. What's more, small employers faced greater instability in their health costs and coverage options, and when they could access health coverage, small businesses paid on average 18% more than their larger counterparts, usually for less comprehensive coverage.

Critically, many small businesses have seen their health insurance rates stabilize under the ACA. Since 2010, the increase in small business healthcare costs has been at the lowest level in years, following regular double-digit increases prior to the law's enactment. In fact, between 2008 and 2010, the

average yearly premium increase in the small group market was 10.4% according to the Centers for Medicare and Medicaid Services. Between 2011 and 2015, the average increase dropped in half to just 5.2%. It should come as no surprise then that scientific opinion polling we conducted last year found 6 in 10 small business owners support retaining and strengthening the ACA.[1]

More recent data from the Kaiser Family Foundation's 2017 Employer Health Benefits Survey shows that premiums continue to be stable for small businesses that offer employer-sponsored coverage to their employees. For all firms between 3-199 employees, the average premium increase from 2016 to 2017 was less than 1%. This is lower than the average premium rate increases from 2016 to 2017 across all firm sizes, which were 4% for singles and 3% for families.[2] Employee contributions for employer-sponsored coverage have also stabilized, reversing a pre-ACA trend of double-digit increases in insurance costs for small businesses that they often had to pass off onto their employees. This has made a significant impact on small businesses' bottom lines.

However, national efforts to chip away at the healthcare law, or repeal it entirely, threaten this progress. Recent efforts to undo key provisions of the ACA through legislation and executive action threaten to disrupt the marketplaces and in turn harm small business owners, their employees and self-employed individuals. While we believe certain provisions of the ACA can and should be improved, undermining the ACA eradicates hard-won benefits for America's entrepreneurs, causing a rapid rise in healthcare costs and creating tremendous economic instability.

That's why we're so concerned about the proposed changes to the Department of Labor's rules governing AHPs. In order for small businesses to be able to receive affordable coverage, the small group market's risk pool must be robust and well balanced. It's important to note that the small group market is where most small businesses currently purchase health coverage, which is why it's crucial to protect this market and ensure it's as strong as possible. The proposed rule would allow associations to operate as a single large employer, which would in turn allow them to be regulated as a large group health plan.

We believe this proposed change would result in disruptions in the small group market by creating separate risk pools for some employers, which would have the unintended consequence of raising premiums for other small businesses. When firms with healthy employees exit the small group market, the risk pool becomes unbalanced, causing rates to soar for the remaining employers and employees. Indeed, the National Small Business Association, in its submitted comments to the Labor Department on the proposed rule, emphasized the importance of "ensuring that the millions of smaller companies not purchasing coverage through an AHP do not see their insurance costs further escalate as a result of selection issues that create price disparities based on health status rather than the reduction of actual healthcare costs." We believe allowing self-employed individuals to enroll in AHPs will have similar repercussions for the individual marketplace.

Moreover, regulations for such plans do not require that they cover certain essential health benefits while also not requiring protections that typically prevent insurers from charging higher fees based on factors like gender, occupation and industry, age and group size. While this might mean that some small businesses with younger, healthier employees can purchase a cheaper plan, these plans won't provide the coverage they need if someone gets sick, thus undermining the goal of ensuring that most healthcare is covered and that the long-standing phenomenon of uncompensated care is reduced.

Additionally, we're concerned about the impact the proposed rule would have on small businesses as their workforce ages, as it is unclear whether the rule prevents insurers from charging more based on age than is allowed by the ACA. This is a particular concern for small businesses, as many have employees that work with them for years. As their employees age and potentially face health risks, small businesses could find themselves with few or no options for affordable health coverage.

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[1] http://smallbusinessmajority.org/our-research/healthcare/small-businesses-support-aca-over-replacement-plan

[2] Kaiser Family Foundation, 2017 Employer Health Benefits Survey, September 2017, http://www.kff.org/report-section/ehbs-2017-summary-of-findings/

As noted above, these plans are also not required to cover essential health benefits and could use this exemption to design health plans that intentionally exclude certain individuals. For example, the plans could exclude services for maternity coverage or mental health treatment, preventing small businesses with employees that need such services from enrolling. What's more, the proposed rule suggests that current protections against discriminatory marketing practices would not apply to AHPs, which would allow these plans to use marketing techniques to discourage enrollment from companies with employees that have expensive or complicated health issues, including pre-existing conditions, or small businesses that employ a high number of females or older workers. These discriminatory practices would exacerbate the problem of creating separate risk pools and further disadvantage small business owners or employees with the most critical need for affordable, quality healthcare.

In addition to providing less comprehensive coverage, these multi-state plans would offer fewer consumer safeguards. In fact, employees covered by these association plans would not actually be protected in the state where they live since the regulations created for a specific plan could supersede state laws that protect consumers from rate increases and poor coverage. It's also concerning that the proposed rule is ambiguous about whether it will block states' ability to regulate AHPs. It's unacceptable for the Administration to prevent state insurance commissioners from enforcing rules they deem to be in the best interest of their state's small businesses and consumers.

State regulation of multiple employer welfare arrangements (MEWAs) has shown that such regulation is critical to protecting consumers from fraud or insolvency, and weakening states' abilities to enforce consumer protections could threaten the health and financial security of small business enrollees. Small business owners may turn to these types of association plans in search of lower cost options, but without protections in place to prevent fraud, they can find themselves the victim of scams, on the hook for costly medical expenses for issues they thought their plan covered.

Importantly, AHPs are not a new idea. In fact, states have already experimented with these plans with disastrous results. Claims that AHPs will be a boon to small employers are based on little evidence and in fact, much evidence exists to the contrary. An Urban Institute analysis of Oregon's regulation of AHPs prior to the ACA found that policies and lack of regulatory oversight increased the potential for adverse selection in the remaining small group market in the state.[3] This issue, as well as the concerns outlined above regarding fraud and abuse, is in part why a coalition of 17 state attorney generals recently submitted comments to the Labor Department opposing the proposed rule. As noted in the comments authored by state attorney generals, the proposed rule is also problematic in that it is contrary to and undermines the intent and structure of the ACA, and is also contrary to the Labor Department's longstanding interpretation of ERISA, which has been ratified by Congress.

Lastly, we are concerned about the proposed rule because we've heard directly from small business owners who are worried about the effects of AHPs on their insurance. Adam Rochon is the owner of Sequoia Employee Benefits and Insurance Solutions, a small independent insurance agency with fewer than 10 employees. Mr. Rochon says, "The bottom line is AHPs are only good as long as you don't get sick—your entire group could find itself without coverage if one person is faced with an illness or a medical condition. What's worse, if one small portion of the small group market gets these low rates, everyone else's rates go up in the existing insurance markets." As an insurance broker, Mr. Rochon has personally witnessed small businesses losing insurance on an association health plan when one employee got sick, such as an entire medical practice being kicked off their plan when just one employee fell ill.

Rather than pursuing policies that undermine the ACA, we encourage lawmakers to advance legislation that would stabilize healthcare marketplaces and protect the robustness of coverage options for small business owners and their employees. Legislation like the Undo Sabotage and Expand Affordability of Health Insurance Act, which was recently introduced by the ranking members of the Energy and Commerce, Ways and Means and Education and the Workforce Committees, would be an

[3] https://www.urban.org/sites/default/files/publication/33721/413279-Federal-and-State-Policy-Toward-Association-Health-Plans-in-Oregon.PDF

important step in lowering premiums and protecting consumers. The legislation would extend the eligibility and size of tax credits that offset premiums, expand cost-sharing subsidies and prevent rules that would allow for AHPs or other types of junk insurance. It would also restore marketing funds for open enrollment, provide additional funding to states for educational outreach and creates a national reinsurance program to further stabilize marketplaces. These are some of the many common-sense solutions we support and believe legislators should pursue to stabilize and strengthen health coverage for the small business community.

In conclusion, the ACA is the first meaningful healthcare reform to help address the disparities in access to affordable, quality healthcare, and it's been particularly important for America's small businesses and self-employed entrepreneurs. However, we believe proposals like the proposed rule change will undo these hard-fought gains for our nation's job creators. We must do everything we can to ensure small businesses can access quality, affordable health coverage so they can focus on running their businesses. This means strengthening the small group and individual exchanges, rather than enacting rules that undermine the ACA and create instability in the health insurance markets. These policies make it easier for small businesses to offer health insurance, keeping themselves and their employees healthy and productive, which in turn benefits their bottom line. Access to affordable healthcare ensures that small business owners can continue to do what they do best—generate economic growth and create jobs.

Thank you for the opportunity to comment on this important issue for America's small business community. I would be happy to answer any questions.

Mrs. FOXX. [Presiding.] Thank you very much.
Mr. Condeluci, you're recognized for five minutes.

TESTIMONY OF CHRISTOPHER E. CONDELUCI, PRINCIPAL AND SOLE SHAREHOLDER, CC LAW & POLICY, PLLC

Mr. CONDELUCI. Thank you, Chairwoman, Ranking Member Blunt Rochester, and members of the Subcommittee, for this opportunity. My name is Chris Condeluci, the sole shareholder of CC Law & Policy, a legal and policy practice that focuses on issues relating to the *Affordable Care Act*. I am also an ERISA attorney by training.

I want to start today by saying association health plans, or AHPs, are not the same as short-term health plans. For months now, critics of AHPs have publicly stated that similar to short-term health plans, AHPs can deny a person coverage if they have a preexisting condition, can refuse to cover preventive services, and can impose annual lifetime limits. I want to say unequivocally and emphatically that these statements are incorrect.

AHPs as a group health plan under the law are subject to the ACA's coverage requirements, meaning they cannot deny a person health coverage if they have a preexisting condition, cannot refuse to provide free coverage for certain preventive services, and cannot impose annual lifetime limits on the federal essential health benefits covered under the plan. Other notable ACA requirements like coverage for adult children up to age 26, free access to emergency care, and the prohibition against rescinding coverage absent fraud all apply.

ERISA's notice and disclosure requirements, fiduciary responsibilities, and health plan procedures all apply to AHPs. COBRA continuation coverage applies, and HIPAA prohibits an AHP from developing premiums based on a particular participant's health status. State benefit mandates to -- state benefit mandates apply to fully insured AHPs, and state solvency requirements will apply to self-insured AHPs.

So now that we've established that AHPs are subject to existing law that requires the provision of comprehensive coverage, I will turn to the Department of Labor's proposed regulations.

The proposed rules would allow employers in the same industry to offer AHP coverage to their members nationwide or on a regional basis. Currently, these related employers can only offer AHP coverage within a particular state. This proposed change is critical for national trade associations, franchisees, and companies with cooperative members.

The proposed regulations would also allow employers in different industries but located in the same state or metropolitan area to form an AHP. This change is critical for local chambers of commerce and other employer-run organizations made up of multiple unrelated employers.

Prior to 2011, many of these organizations offered AHP coverage, but were forced to discontinue their plan due to guidance issued by the Obama administration. The proposed regulations would also allow self-employed individuals with no employees, referred to as working owners, to get health coverage through an AHP. This change is critical because working owners have limited options

when it comes to accessing health insurance. Some may be able to access coverage through their spouse, but in cases where family coverage is unaffordable or a working owner is not married, the option -- the only option is the ACA's individual market, which has proven problematic for those not eligible for a premium subsidy.

Lastly, the Department of Labor should issue a class exemption that would exempt self-insured AHPs from the nonsolvency requirements of state MEWA laws. A class exemption is advisable because there's a patchwork set of state laws with different rules and licensing requirements. And the lack of uniformity in the law will likely limit the formation of self-insured AHPs.

As a former Republican counsel to the Senate Finance Committee who had the opportunity to draft portions of the ACA, I wish the ACA worked better. I wish the individual and small group markets would have evolved into balanced markets where comprehensive coverage is available. But the reality is that did not happen, and the reality is the status quo is not working for many Americans.

One way to improve the status quo is by coming up with alternatives to the ACA that will continue to provide comprehensive coverage at a lower cost. And that is exactly what the AHP proposal is. It is an alternative that is going to help millions of employers to offer health coverage to attract and retain talented workers. It is an alternative that is going to help a large number of national trade associations, franchisees, and cooperative-run companies to provide additional benefits to their members and attract new members. And it is an alternative that's going to help working owners who have been struggling to afford health coverage in the ACA's unsubsidized individual market. This alternative will cost less than individual and small group plans, but the coverage will continue to be comprehensive as required under the ACA, ERISA, HIPAA, COBRA, and state law.

Thank you for your time. I look forward to answering any questions you may have.

[The statement of Mr. Condeluci follows:]

CC Law & Policy

Testimony Before the Committee on Education and the Workforce, Subcommittee on Health, Employment, Labor, and Pensions

Hearing on Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans

Christopher E. Condeluci, Esq.
Principal and Sole Shareholder
CC Law & Policy PLLC

March 20, 2018

Thank you Chairman Walberg, Ranking Member Sablan, and members of the Subcommittee for the opportunity to speak with you today. My name is Chris Condeluci. I am the principal and sole shareholder of CC Law & Policy, a legal and policy practice that focuses on issues relating to the Patient Protection and Affordable Care Act ("ACA"). Prior to starting my own practice, I served as Counsel to the Senate Finance Committee. During my time on the Finance Committee, I participated in drafting portions of the ACA, including the ACA Exchanges, the State insurance market reforms, and all of the taxes under the law.

In my current practice, I provide legal counsel on the statutory and regulatory requirements impacting stakeholders ranging from employers and health IT companies to the ACA Exchanges and private exchanges. I also provide policy analysis relating to the manner in which the ACA is being implemented. This includes observing and analyzing the evolution of the ACA's reformed "individual" and "small group" health insurance markets, and the impact the ACA is having on large fully-insured and self-insured "group health plans."

Organization of Testimony

My written testimony is organized into four parts. First, I distinguish association health plans ("AHPs") from short-term limited duration plans (referred to as "short-term health plans") by describing the ACA's "coverage requirements" that apply to AHPs, in addition to consumer protections applicable under the Employee Retirement Income Security Act ("ERISA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Second, I explain the current treatment of AHPs under existing law, including a description of the "bona fide group or association of employers" definition under ERISA. Third, I discuss various proposals included in the Department of Labor's ("DOL") proposed AHP regulations. And fourth, I examine issues relating to State regulation of fully-insured "large group" and self-insured AHPs.

I. Association Health Plans Are Not the Same As Short-Term Health Plans – AHPs Provide Comprehensive Coverage As Required Under the ACA, ERISA, HIPAA, and COBRA

I want to start with this top-line statement: Association health plans – or AHPs – are *not* the same as short-term health plans.

It is important to make this distinction because ever since President Trump issued Executive Order 13813,[1] the media and critics of the current Administration have inaccurately explained the rules applicable to AHPs. In short, the media and these critics have conflated AHPs and short-term health plans, and they have described these health plans as being one-in-the-same. AHPs and short-term health plans are vastly different.

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[1] Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," directed the Department of Labor ("DOL"), the Department of Health and Human Services ("HHS"), and the Department of Treasury ("Treasury") to issue regulations relating to (1) association health plans ("AHPs"), (2) short-term health plans, and (3) expanding the use of Health Reimbursement Arrangements ("HRAs").

A. Short-Term Health Plans Are Exempt from the ACA's Insurance and Coverage Requirements

Under existing law, short-term health plans are *not* considered "health insurance" offered in the individual insurance market,[2] and therefore, short-term health plans are *not* subject to the ACA's insurance and coverage requirements.[3] As a result, short-term health plans *can* deny a person coverage with a pre-existing condition (because the ACA's pre-existing condition protections do *not* apply). Also, a short-term health plan *can* develop premiums based on a person's health condition (because the prohibition against developing premiums based on health status does *not* apply). And, a short-term health plan *can* impose annual and lifetime limits on benefits and medical services covered under the plan (because the prohibition against imposing annual and lifetime limits does *not* apply).

On the other hand, AHPs – as a "group health plan"[4] – *are* subject to the ACA's coverage requirements.[5] Again, this distinction is important to understand because a number of stakeholders have publicly stated that – similar to short-term health plans – AHPs (1) can deny a person coverage if they have a pre-existing condition, (2) can develop premiums based on a participant's health condition, and (3) can impose annual and lifetime limits. These statements are *incorrect*.

B. AHPs Are Subject to the ACA's Coverage Requirements

According to the ACA, a fully-insured "large group" and self-insured AHP – as a "group health plan" – *must*:

- Eliminate all pre-existing condition exclusions for all plan participants.[6]
- Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan.[7]
- Provide coverage for certain preventive health services with no cost-sharing.[8]
- Cover "adult children" up to age 26.[9]
- Stop rescinding coverage absent fraud or misrepresentation.[10]
- Include new internal and external appeals processes (and provide notice).[11]
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.[12]

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[2] Section 2791(b)(5) of the Public Health Service Act section ("PHSA"), providing that the term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

[3] Section 1551 of the Affordable Care Act ("ACA") incorporates the definitions under the PHSA – including PHSA section 2791(b)(5) – into the ACA's insurance and coverage requirements.

[4] Section 733(a)(1) of the Employee Income Retirement Security Act ("ERISA") and PHSA section 2791(a)(1) provide that a "group health plan" is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents…directly, or through insurance, reimbursement, or otherwise.

[5] ERISA section 715 incorporates by reference the ACA's coverage requirements applicable to a "group health plan" into ERISA.

[6] *See* PHSA section 2704.

[7] *See* PHSA section 2711.

[8] *See* PHSA section 2713.

[9] *See* PHSA section 2714.

[10] *See* PHSA section 2712.

[11] *See* PHSA section 2719.

[12] *Id.*

- Provide direct access to emergency services.[13]
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.[14]
- Limit the plan's cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account ("HSA") rules for 2014.[15]
- Eliminate waiting periods that exceed 90 days.[16]
- Cover the cost of clinical trial participation.[17]
- Provide participants with a summary of benefits and coverage.[18]
- Provide annual reports describing the plan's quality-of-care provisions.[19]

C. Consumer Protections Under ERISA, HIPAA, and COBRA Apply to AHPs

Under ERISA, there are specific notice and disclosure requirements that a fully-insured "large group" and self-insured AHP must comply with.[20] In addition, ERISA's fiduciary responsibilities apply,[21] requiring the AHP and its employer members to act in the best interest of the plan participants. AHP plan participants also have a private right of action to sue the AHP if there is wrong-doing,[22] and there are detailed procedures for filing health status.[23]

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,[24] and according to HIPAA, premiums for an AHP participant *cannot* be developed based on the participant's health condition.[25]

D. The Proposed AHP Regulations Do Not Change the Requirements Under ERISA, HIPAA, COBRA, and the ACA

Importantly, the proposed AHP regulations do *nothing* to change the requirements under ERISA, HIPAA, COBRA and the ACA that otherwise apply to a "group health plan." As a result, it is important to once again emphasize that AHPs are *not* short-term health plans free from the above described Federal law requirements. Rather, AHPs are required to provide a comprehensive level of coverage with adequate consumer protections that both Republicans and Democrats in Congress have enacted into law over the past decades.

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[13] *See* PHSA section 2719A.
[14] *See* PHSA section 2705.
[15] *See* PHSA section 2707(b).
[16] *See* PHSA section 2708.
[17] *See* PHSA section 2709.
[18] *See* PHSA section 2715.
[19] *See* PHSA section 2717.
[20] ERISA, Title I, Subtitle B Part 1.
[21] ERISA, Title I, Subtitle B Part 4.
[22] ERISA section 502.
[23] ERISA section 503.
[24] ERISA, Title I, Subtitle B Part 7.
[25] ERISA section 702.

E. State Benefit Mandates Apply to Fully-Insured "Large Group" AHPs

Another important layer of coverage requirements that is often times overlooked by critics of AHPs is this: A fully-insured "large group" AHP will be subject to State benefit mandates. State benefit mandates require an insurance contract sold within a particular State to cover specified benefits and medical services. The State benefit mandates applicable to fully-insured "large group" plans in most States are as good as the ACA's Federal "essential health benefits" ("EHB") requirement. Even in States where their benefit mandates do not cover all of the 10 medical services that make up the Federal EHB standard,[26] the drafters of the ACA observed that most if not all fully-insured "large group" plans comply with the Federal EHBs, which led Congress to exempt fully-insured "large group plans" from the EHB requirement entirely.

F. State MEWA Statutes Apply to Self-Insured AHPs

In the case of a self-insured AHP, this arrangement is by definition a "multiple employer welfare arrangement" ("MEWA").[27] In the case of a self-insured MEWA, Congress specifically amended ERISA's preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State.[28] Since that time, many States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. These laws often times impose specific coverage and/or premium rating requirements on self-insured MEWAs. In addition, State MEWA laws typically impose the same solvency – or reserve – requirements that apply to insurance companies operating within the State. Other States outright prohibit self-insured MEWAs. States that have yet to enact a State MEWA statute are not prohibited from doing so in the future. In addition, States with existing State MEWA statutes are free to amend those statutes to impose specific coverage, rating, and/or solvency requirements on self-insured AHPs.

G. What ACA Requirements Do Not Apply To AHPs?

As discussed more fully below, while the ACA imposes the same coverage requirements on individual, small group fully-insured, large group fully-insured, and self-insured plans, the ACA does *not* impose certain insurance market reforms otherwise applicable to individual and small group plans to fully-insured "large group" and self-insured plans. These reforms include the ACA's EHB[29] and "actuarial value" ("AV")[30] requirements, and also the ACA's adjusted community premium rating

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[26] According to the ACA, individual and small group health plans must cover a list of 10 medical services that make up the "Federal EHB standard:" ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. [ACA section 1302(b)].

[27] *See* ERISA section 3(40).

[28] ERISA section 514(b)(6)(A)(ii).

[29] The Department of Health and Human Services ("HHS") issued regulations implementing the EHB requirement, effectively permitting States to designate an "essential health benefits-benchmark" plan. [*See* 78 Fed. Reg. 12834 (Feb. 25, 2013)]. In most States, the "essential health benefits-benchmark" plan is the most popular health plan in the State's small group market by enrollment.

[30] According to the ACA, the minimum "actuarial value" ("AV") that may be provided for under an individual or small group plan is 60% (i.e., the "bronze" plan). [ACA section 1302(d)(1)(A)]. The ACA also establishes a "silver" plan, which must provide 70% AV, a "gold" plan that must provide 80% AV, and a "platinum" plan that must provide 90% AV. [ACA section 1302(d)(1)(B)-(D)]. AV is a measure of how much the health plan pays for a covered benefit or service, and how much the policy-holder must pay.

rules[31] and the single risk pool requirement.[32] In addition, the ACA's "risk adjustment" program does not apply to fully-insured "large group" and self-insured plans.[33]

As mentioned, the drafters of the ACA specifically decided against imposing the above described insurance requirements on fully-insured "large group" and self-insured plans. Why? Because the ACA drafters felt that these plans covered benefits that were as good if not better than the Federal EHBs. The drafters also discovered that the typical group health plan was an 80% AV plan. And, the practice of "experience rating" to determine premium rates for a group of employees worked relatively well (because as a best practice, most if not all "group health plans" develop premiums based on the "health claims experience" of the entire group of employees, and then charge each employee the same dollar amount).

II. Background on the Current Treatment of AHPs

To better understand the DOL's proposed regulations – and the policy reasons for changing the law – it is important to discuss the current law treatment of AHPs, which includes a description of guidance issued by the Department of Health and Human Services ("HHS") in 2011, along with the existing definition of a "bona fide group or association of employers" for purposes of ERISA.

A. Employer Groups Forming AHPs Pre-ACA

Prior to the enactment of the ACA, small employers often times banded together to create a fully-insured or self-insured AHP. In the case of a fully-insured AHP, most States treated the AHP as a "large group" plan, subject to a State's large group market insurance regulations. In other words, small employers that participated in the AHP were *not* subject to the State's "small group" market insurance requirements.

B. The Enactment of the ACA

The ACA enacted new "coverage requirements" applicable to fully-insured plans sold in the individual, small group, and large group markets, as well as to "self-insured" group health plans. However, as discussed above, certain insurance market reforms that are otherwise applicable to individual and small group plans do *not* apply to fully-insured "large group" and self-insured plans. As stated, these reforms include the ACA's EHB and AV requirements, the ACA's adjusted community premium rating rules, the single risk pool requirement, and the ACA's "risk adjustment" program.

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[31] The ACA prohibits an insurance carrier from developing premiums for individual and small group plans based on health status. Premium rates may only vary by (1) age (but by no more than a 3 to 1 ratio), (2) tobacco use (but by no more than a 1.5 to 1 ratio), (3) single or family coverage, and (4) geography. [ACA section 2701(a)(1)].

[32] The ACA requires that the health risks of policyholders in the individual market must be pooled together into one, single risk pool by the insurance carrier underwriting their coverage. Similarly, the health risks of employees of small employers must be pooled together by the carrier underwriting the coverage for the small employers. [ACA section 1312(c)].

[33] *See* ACA section 1343.

C. HHS Guidance Relating to AHPs Issued In 2011

Shortly after the enactment of the ACA, State and Federal regulators were concerned that small employers may choose to join an existing fully-insured AHP to avoid the ACA's small group market reforms. To address this concern – in 2011 – HHS issued guidance that essentially prohibited small employers from forming a fully-insured "large group" health plan.[34] This meant that the ACA's small group market insurance reforms *would* apply to fully-insured AHP employer members with 50 or fewer employees.

The 2011 guidance dramatically reduced the number of fully-insured AHPs that operate today, as many existing fully-insured AHPs had a choice to make: (1) discontinue the plan or (2) shift to a self-insured AHP (because HHS's 2011 guidance does *not* apply to a self-insured "group health plan" sponsored by an employer group).[35] While some AHPs chose to shift to a self-insured arrangement, a greater number of existing AHPs discontinued their health coverage.

D. An Exception Under HHS's 2011 Guidance: AHPs Sponsored By a "Bona Fide Group or Association of Employers" For Purposes of ERISA

There was another option available to fully-insured AHPs in the wake of the release of HHS's guidance: The "group of employers" sponsoring the AHP could satisfy the definition of a "bona fide group or association or employers" for purposes of ERISA. More specifically, in HHS's 2011 guidance, the Department explained that if a group of employers sponsoring the AHP satisfied ERISA's the definition of a "bona fide group or association or employers," the fully-insured AHP *would continue* to be considered a "large group" plan (and thus, small employer members participating in the AHP would *not* be subject to the ACA's small group market reforms). In this case, the arrangement would be considered a "large group" plan because – as HHS further explains – the employees of all of the individual employer members of the "bona fide" group will be aggregated together for purposes of determining the size of the overall group of employees covered under the plan.[36]

For example, if an ERISA "bona fide" group included 100 employer members with 25 employees each, the AHP sponsored by this "bona fide" group would be deemed to cover 2,500 employees, which makes this plan a "large group" plan (because existing law provides that a "large group" plan is one that covers 51 or more employees).[37] As a result, each individual employer member with 25 employees would *not* be subject to the ACA's small group market reforms. Instead, the entire plan would be subject to the "large group" market requirements.

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[34] *See* https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

[35] *Id.* at footnote 1, page 1, explicitly stating that, "CMS does not have authority over self-insured association coverage." It is important to note that PHSA section 2791(b)(1) provides that "health insurance coverage" is offered by a "health insurance issuer." A health insurance issuer – as defined under PHSA section 2791(b)(2) – means an "insurance company, insurance service, or insurance organization…which is licensed to engage in the business of insurance in a State…" A self-insured plan is by definition not offered by a health insurance issuer, and HHS regulations confirm this (i.e., the regulations implementing PHSA section 2718 state that "[s]elf-insured plans are not a health insurance issuer, as defined by section 2791(b)(2) of the PHS Act").

[36] *Id.* at Section III.B, page 2-3.

[37] PHSA section 2791(e)(2), (3).

E. ERISA's "Bona Fide Group or Association of Employers" Definition

To be considered a "bona fide group or association of employers" for purposes of ERISA, a "group" of employers must meet (1) the "commonality of interest" and (2) the "control" tests. Under the "control" test, the employer members must exercise "control," both in form and substance, over the activities and operations of the health plan the group is sponsoring.[38]

The "commonality of interest" test is a facts and circumstances test that is not always easy to satisfy. According to court decisions and existing DOL guidance, a group of employers would *not* be considered "bona fide" *unless* (1) the employer members are "related" (i.e., the employers are in the same industry) *and* (2) the employer members are located in the same State or tri-State area.[39] Also, a group of employers would *not* be considered "bona fide" if self-employed individuals with no employees are a part of the group.[40]

F. Existing HHS and DOL Guidance Limits the Formation of AHPs

Based on the existing definition of the "commonality of interest" test, a significant number of employer groups fail to meet the test because, for example, they include members in multiple industries (i.e., the membership is made up of "unrelated" employers). Other employer groups include "independent contractors" (i.e., self-employed individuals with no employees) as members. In each of these cases, the employer-run organization would fail to be considered a "bona fide group or association of employers" for purposes of ERISA, and therefore, any fully-insured AHP that they would choose to sponsor would *not* be considered a "large group" plan, meaning the employer members of the organization *would* be subject to the ACA's small group market reforms (which has discouraged the formation of fully-insured AHPs).

In many cases, the demographics of these employer-run organizations is not conducive to sponsoring a self-insured plan. As a result, forming a self-insured AHP has not been an option either.

In addition, many employer groups that include employer members in the same industry (and thus would meet the first component of the "commonality of interest" test because they are "related") would like to provide health coverage to their employer members located in multiple States. However, these groups are constrained by the "commonality of interest" test's geographical limitation, and therefore, they are unable to form any type of AHP (e.g., a fully-insured or self-insured AHP) and offer AHP health coverage nationwide, or on a regional basis.

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[38] DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 2005-24A (Dec. 30, 2005), DOL Adv. Op. 2003-17A (Dec. 12, 2003), DOL Adv. Op. 2001-04A (Mar. 22, 2001), DOL Adv. Op. 96-25A (Oct. 31, 1996).

[39] *Gruber v. Hubard Bert Karle Webber, Inc.*, 159 F.3d 780 (3rd Cir. 1998) (citing *Steen v. John Hancock Mutual Life Ins.*, 106 F.3d 904 (9th Cir. 1997)); *National Ben. Administrators, Inc., National Business Ass'n By and Through v. Morgan*, 770 F. Supp. 1169 (W.D.KY 1991); *see also*, DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-24A (Dec. 30, 2005), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 2003-17A (Dec. 12, 2003).

[40] *Marcella v. Capital Dist. Physicians' Health Plan, Inc.* v. 293 F.3d 42 (2nd Cir. 2002); *see also*, DOL Adv. Op. 2003-13A (Sept. 30, 2003), DOL Adv. Op. 98-08A (Oct. 9, 1998), DOL Adv. Op. 94-07A (Mar. 14, 1994), DOL Adv. Op. 90-19A (June 15, 1990).

III. The DOL's Proposed AHP Regulations

Recognizing these constraints, the DOL proposes to modify ERISA's "bona fide group or association of employers" definition by reinterpreting the factors that must be satisfied to meet the "commonality of interest" test. The DOL also proposes to allow self-employed individuals with no employees (referred to as "working owners") to elect to (1) act as an "employer" for purposes of sponsoring a "group health plan" and (2) act as an "employee" for purposes of participating in AHP health coverage. In my opinion, these two changes to current law are the cornerstones of the proposed rule, and they are intended to not only allow small employers and working owners to band together to create (1) negotiating leverage based on economies of scale and (2) a bigger "risk pool," but the rules are designed to allow the formation of a fully-insured "large group" or self-insured AHP, which would be exempt from some of the ACA's insurance market reforms.

A. Proposed Modifications to the "Commonality of Interest" Test

As discussed above, to meet the existing "commonality of interest" test, an employer group must be (1) "related" (i.e., in the same industry) *and* (2) located in the same State or tri-State area. Under the proposed regulations, however, a group of employers would meet the "commonality of interest" test if (1) the employers are in the same industry, line of business or profession *or* (2) the employers have a principal place of business in a particular State or Metropolitan area (that may span more than one State).

1. *"Related" Employers*

With respect to the first component of the test, the Department has chosen to eliminate the geographical limitation for "related" employers. In other words, the proposed regulations would allow employers in the same industry or profession (i.e., "related" employers) to form an AHP, and offer fully-insured "large group" or self-insured AHP health coverage to the employees of these "related" employers, regardless of the employer members' geographic location.

This change is critical for national trade associations, franchisees, and companies with "cooperative" members. For decades, these types of employer groups have wanted to offer some type of health coverage to their employer members through a fully-insured or self-insured AHP on a nationwide, or a regional basis. And, although these organizations typically satisfied the first component of the existing "commonality of interest" test (because all of their members are "related"), these organizations have never been able to satisfy other aspects of the "commonality of interest" test, like the geographical limitation. But, if the proposed regulations are finalized, these employer groups would finally be able to offer health coverage through a fully-insured "large group" or self-insured AHP to their members located in multiple States.

2. *"Unrelated" Employers*

With respect to the second component of the proposed "commonality of interest" test, the DOL maintains the geographical limitation, but eliminates the requirement that the employer members be "related." In other words, the proposed regulations would also allow employers in different industries and professions (i.e., "unrelated" employers) to form an AHP, *but only if* these "unrelated" employers are located in the same State or Metropolitan area (that spans a tri-State area).

This change is critical for local Chambers of Commerce and other employer-run organizations that are made up of multiple "unrelated" employers that want to offer fully-insured "large group" or self-insured AHP health coverage to their employer members in a specific geographic locale. This change is particularly important because many of the employer groups adversely impacted by HHS's 2011 guidance are organizations like local Chambers of Commerce that were forced to discontinue their plan because (1) the plan was fully-insured and (2) the Chambers could not meet the definition of a "bona fide group or association of employers" for purposes of ERISA.

While stakeholders are supportive of the DOL's modifications to the "commonality of interest" test, reasonable questions have been raised over why the geographical limitation was eliminated for "related" employers, but this limitation continues to apply to "unrelated" employers. A strong argument can be made that "unrelated employers" should *not* be limited to a geographic location.

It is important to emphasize that the most critical component of a "bona group or association of employers" sponsoring an AHP is "control" over (1) the operations of the employer group and (2) the provision of health coverage through the AHP. Thus it follows that if the employer members of a particular group have the requisite "control" over the employer-run organization and the AHP, it should *not* matter whether the group is made up of "related" or "unrelated" employers offering health coverage in one State or multiple States. As a result, it is reasonable to suggest that the geographical limitation for "unrelated" employers should be eliminated in cases where these "unrelated" employers can adequately show to the DOL that they have the requisite "control" over (1) the operations of the employer group and (2) the provision of health coverage through an AHP.

If the DOL continues to believe that some sort of geographic constraint should apply in cases of "unrelated" employers, it is reasonable to allow "unrelated" employers located in three contiguous States to meet the "commonality of interest" test (based on precedent set forth in proposed Department of Treasury ("Treasury") regulations relating to the "geographic locale" restriction for participation in a Voluntary Employees' Beneficiary Association ("VEBA"), governed by the rules set forth under Section 501(c)(9) of the Internal Revenue Code ("Code")).[41] The Assistant Secretary of the Employee Benefits Security Administration ("EBSA") could also be given the authority to recognize larger areas as a geographical limitation for purposes of the "commonality of interest" test on a case-by-case basis upon application by an AHP seeking to offer health coverage to members located in multiple States.

B. Proposal to Allow Working Owners to Participate In an AHP

1. *Proposed Changes to DOL Reg. Section 2510.3-3*

The DOL proposes to allow self-employed individuals with no employees (i.e., working owners) to participate in an AHP. In this case, according to the proposed changes, working owners in the same industry/profession and located in different geographic locations could participate in an AHP established by other "related" employer members. For example, working owners who are Widget-Makers and who are members of the National Widget-Maker Association could participate in the Association's AHP alongside the Widget-Maker employer members. In addition, other working owners like self-employed farmers who are members of an agricultural "cooperative" could participate in an AHP sponsored by a "cooperative"-based company to which these "cooperatives" (which include the self-employed farmers) are members. This would allow AHP health coverage to be offered to self-

[41] *See* 57 Fed. Reg. 34,886 (Aug. 7, 1992).

employed farmers, along with other "cooperative" members with employees, located in multiple States. The greater plan participation would provide greater financial security and reduce administrative costs.

In addition, according the proposed rules, working owners in the same industry/profession could also establish an AHP solely for "related" working owner members. This would allow, for example, Uber drivers to establish an AHP in which Uber drivers all across the country could receive fully-insured or self-insured AHP health coverage. Again, the greater plan participation would provide greater financial security and reduce administrative costs for the AHP.

Lastly, pursuant to the proposed changes, working owners in different industries and professions (i.e., "unrelated" working owners) could join, for example, a local Chamber of Commerce AHP, provided the working owners are located in the same State or Metropolitan area as the local Chamber's employer members.

2. *The Proposed Definition of "Working Owner"*

For purposes of participating in an AHP, the proposed regulations would define a working owner to mean an individual who:

1. Has an ownership right in a "trade or business," regardless of whether the "trade or business" is incorporated or unincorporated.
2. Earns wages or self-employment income from the "trade or business."
3. Is not eligible to participate in any subsidized "group health plan" maintained by any other employer of the working owner or of the working owner's spouse.
4. Works at least 120 hours per month providing personal services to the "trade or business" or earns income from the "trade or business" that at least equals the working owner's cost of the AHP health coverage.

Arguments have been made that that the eligibility criteria for qualifying as a working owner is overly constraining. These arguments claim that the proposed eligibility criteria will limit the number of self-employed individuals who may be eligible to participate in an AHP, which seems contrary to the DOL's policy goal of expanding health coverage to these individuals.

For example, according to the proposed rule, a self-employed individual with no employees who is eligible for subsidized health coverage through their spouse's employer would *not* be considered a "working owner" for purposes of participating in an AHP. Interestingly, it appears that this eligibility criteria is modeled after a requirement set forth under Section 162(l) of the Internal Revenue Code ("Code"), which denies a self-employed individual an above-line-deduction for health care costs if the individual is eligible for subsidized health coverage through his or her spouse's employer. Unfortunately, there is no clear implementing guidance or legislative history on why this rule was included in the Tax Code in the first place. But, it is reasonable to conclude that Congress did *not* develop this provision to serve as a factor for determining eligibility to participate in a "group health plan."

Another eligibility factor for qualifying as a working owner requires that an individual work at least 120 hours per month providing personal services to a "trade or business." However, there are a number of industries where working owners do not have a traditional work schedule. As a result, these

working owners may work at least 120 hours in a particular month, but there may be other months where their hours fluctuate such that they do not meet the proposed hours threshold. An argument can be made that the DOL should modify this "hours worked" eligibility criteria, taking into account that there are many industries where workers do not have a defined schedule that leads to working 120 hours in a particular month.

3. *The DOL's Authority to Modify DOL Reg. Section 2510.3-3*

The DOL points out that "the touchstone of ERISA is the provision of benefits *through the employment relationship*." The DOL further points out that a "participant" in an ERISA-covered group health plan "is an employee of an employer who may receive benefits from that employer's own benefit plan." And, that "individuals" who are *not* participants (i.e., individuals who are not employees or former employees of an employer sponsoring a particular plan) "are ineligible to be covered by an ERISA plan." However, as stated above, the DOL has opted to modify its current regulations to allow working owners (1) to act as an "employer" for purposes of sponsoring a "group health plan" and also (2) to be treated as an "employee" for purposes of being covered by an AHP.

The DOL justifies this modification to current law, explaining that "this approach is consistent with advisory opinions in which the Department has concluded that working owners may be 'participants' in ERISA plans. For example, Advisory Opinion 99-04A reviews various provisions of ERISA and the Code that specifically address working owner issues in ERISA plans, and concludes that, taken as a whole, they reveal a clear Congressional design to include working owners within the definition of participant for purposes of Title I of ERISA."

The DOL also acknowledges that the U.S. Supreme Court in *Yates v. Hendon*,[42] concluded that "under ERISA, a working owner may have dual status (i.e., he can be an employee entitled to participate in a plan, and, at the same time, the employer (or owner or member of the employer) who established the plan." And, the DOL notes that section 401(c) of the Internal Revenue Code ("Code") "generally treats a sole proprietor as both an employer and an employee."

Based on this analysis and interpretation of ERISA, the Code, and court decisions, the DOL proposes to allow working owners to participate in group health plan coverage through an AHP (sponsored by groups of employers and/or groups of working owners). The DOL explains that it has the authority to supersede its previous interpretations as articulated in non-binding advisory opinions – as well as supersede a prior interpretation by a Federal court – to address marketplace developments and new policy and regulatory issues.[43]

Based on this precedent, many stakeholders believe that the DOL does indeed have the requisite authority to re-interpret its own rules to address new issues presented in an ever-evolving economic environment. And while other stakeholders argue that the DOL has exceeded its authority – thereby setting up a legal challenge – it is important to understand that DOL Reg. section 2510-3.3 is *not* a codification of the statute. Rather, the regulation is an interpretation of the statute developed by the DOL and memorialized in administrative guidance. Which means, the DOL can change its own interpretation of the statute, and thus, change the regulation, provided the change in the regulation goes

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[42] 541 U.S. 1 (2004).

[43] *See Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199 (2015); *see also, National Cable & Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967 (2005).

through the normal rulemaking process (e.g., proposed regulations, which the public can comment on, prior to finalizing the change).

C. The Proposed Nondiscrimination Protections

The proposed regulations establish four different nondiscrimination protections applicable to AHPs. Under the first proposed nondiscrimination protection, an employer group cannot deny other employers and/or working owners membership in the group – and by extension participation in an AHP – on account of any "health factor"[44] of an employee, a former employee, or the working owner. Under the second and third proposed nondiscrimination protections, the premiums for AHP health coverage – and eligibility for benefits covered under the plan – cannot vary based on a particular participant's health factor. And, under the fourth proposed nondiscrimination protection, an AHP cannot develop different premium rates for different employer and/or working owner members based on the members' "health claims experience" (i.e., the AHP cannot "experience-rate" premiums for different employer/working owner members). If an employer group fails to satisfy any of these nondiscrimination protections, the group would fail to be considered a "bona fide group or association of employers," even in cases where the employer group satisfies the "commonality of interest" and "control" tests.

1. *Allowing AHPs to "Experience-Rate" Premiums Will Not Render the Nondiscrimination Protections Ineffective*

A vast majority of stakeholders have raised concerns over the fourth nondiscrimination protection, and they have argued that the DOL should remove this nondiscrimination protection from the final regulations. The DOL, however, explains that if this fourth nondiscrimination protection is not finalized, the first three nondiscrimination protections discussed above could be rendered ineffective (because an employer group could offer membership to all employers meeting the requisite membership criteria, but then charge specific employer members higher premiums based on their health-claims experience). Stakeholders disagree.

For example, in cases where a prospective employer member may employ employees who utilize a significant amount of health care (i.e., "high-medical-utilizers"), this employer may benefit by finding more affordable health coverage through an AHP, due to the fact that this employer *cannot* be denied membership in the employer group sponsoring the plan on account of these high-medical-utilizers. More affordable premium rates will likely be available to an employer with high-medical-utilizers because – on account of experience-rating – the AHP will be able to attract employer members with "healthy" employees (by offering these employers a lower premium rate). The fact that these healthy risks may now be a part of the AHP, these healthy risks are able to offset the exposure the high-medical utilizers may pose to the risk pool. This allows the AHP to develop competitive premium rates for the employer with high-medical-utilizers, notwithstanding the fact that this employer's premiums may be higher than employer members with healthy employees.

In other words, by allowing an AHP to develop different premiums for different employers, the AHP will be able to offer competitive premium rates that *both* employers with healthy employees *and* employers with high-medical-utilizers may find attractive, which not only benefits the employer

[44] A "health factor" is defined as: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

member (from a financial perspective), but also its employees (especially those employees who may be high-medical-utilizers because they may now have access to affordable and quality health coverage subject to ERISA's and the ACA's consumer protections).

With respect to the prohibition against varying premiums and eligibility for benefits based on any health factor, these are requirements that currently apply to existing "group health plans" under HIPAA. As the Department knows – currently – self-insured and fully-insured "large group" health plans develop their premium rates based on experience-rating, which is not prohibited under HIPAA. Importantly, this current law prohibition against varying premiums or eligibility for benefits based on any health factor of a particular participant is in *no* way rendered ineffective by virtue of the existing experience-rating practice adopted by these plans. Allowing employer-run organizations sponsoring an AHP to engage in the practice of experience-rating will similarly do *nothing* to change or inhibit the effectiveness of these nondiscrimination protections.

2. *Experience-Rating Would Be Done To Maintain the Solvency of the AHP, Which Is "Acting In the Best Interest" of Employees*

As discussed above, one of the most important components of a "bona group or association of employers" sponsoring an AHP is "control" over (1) the operations of the employer group and (2) the provision of health coverage through the AHP. This "control" is critical because it ensures that the employer members sponsoring the AHP are "acting in the best interest" of their employees. Importantly, developing different premiums for each employer member based on their health claims experience is actually is done in furtherance of "acting in the best interest" of the employees covered under the AHP. For example, if the AHP did not develop different premium rates for particular employer members, the solvency of the AHP might be called into question, which could adversely affect the health coverage offered to plan participants.

As a result, to ensure that affordable and quality health coverage is consistently made available to employees of the sponsoring employer members, the AHP is required to experience-rate employer members to maintain its solvency. Engaging in practices that would ensure the long-term viability of the AHP is by definition "acting in the best interest" of employees participating the plan because without experience-rating, the employer-run organization may no longer be able to offer health coverage.

In addition, by experience-rating different employer members, an AHP has a better chance to attract employer members with "healthy" employees who are then able to offset the health risks associated with high-medical-utilizers. This means that high-medical-utilizers can enjoy a competitive premium rate for affordable and quality health coverage. And, healthy employees can also enjoy a competitive rate relative to, for example, the small group market.

3. *AHPs Would Be Placed At a Competitive Disadvantage If AHPs Cannot Develop Different Premiums for Different Employer Members*

Without the ability to experience-rate employer members, AHPs would be placed at a competitive disadvantage relative to commercial insurance carriers. It appears, however, that commercial insurance carriers have argued that if AHPs were permitted to develop different premiums for different employer members, that commercial insurers would be the entities placed at a competitive disadvantage, especially as it relates to selling health plans to small employers. In addition, it appears

that the commercial carriers argued that if AHPs could engage in a premium rating practice that commercial carriers in the small group market were prohibited from adopting, AHPs would "segment" the market, leaving only employers with high-medical-utilizers for commercial carriers to cover.

It is important to point out that the ACA's small group market reforms prohibit the development of premiums based on the health claims experience of a small employer. Instead, premiums for small group plans may only vary by age, tobacco, geography, and family size. Based on these new rules – and in response to the commercial carriers' arguments – it appears that the DOL developed a nondiscrimination protection that essentially mirrors the premium rating practices now required in the ACA's small group market.

Unfortunately, by imposing similar premium rating practices that apply to commercial insurers selling small group plans to AHPs, the DOL is detrimentally impacting existing AHPs, and calling into question whether AHPs will be formed in the future. This is due in large part to the fact that commercial insurance carriers have greater scale relative to AHPs. In other words, AHPs can only cover a finite number of "lives" under their plan. Which means, the risk pool of AHPs are going to be small relative to commercial carriers who have access to a much greater number of lives on account of under-writing coverage for small employers that are not members of a "bona fide group or association of employers."

More specifically, if an AHP is not permitted to develop different premium rates for different employer members, the AHP would not be able to compete with the commercial carriers, and therefore, the plan would not be able to attract enough lives – especially "healthy" lives – to create a sustainable risk pool. As discussed above, the practice of experience-rating will help an AHP attract employer members with "healthy" employers, which is critical to offsetting the exposure of employer members with high-medical-utilizers that will likely seek health coverage through an AHP (especially because employer groups cannot deny membership based on the health status of an employer's employees).

Even if AHPs become the preferred choice for health coverage among small employers in a particular State's small group market, many stakeholders do *not* believe that the ability to experience-rate employer members will result in "cherry-picking" small employers with good health risks over small employers employing high-medical-utilizers (a scenario that it appears the DOL is trying to prevent through the development of this nondiscrimination protection). This is because – as stated – the employer members sponsoring the AHP (as an employment-based arrangement) will be "acting in the best interest" of their employees, taking the necessary steps to provide affordable and quality health coverage to each and every employer member. In other words, an AHP is not going "price" its employer members out of the AHP coverage, thereby leaving small employers with high-medical-utilizers to the commercial insurance carriers.

IV. State Regulation of AHPs

The preamble of the proposed regulations explains that – in the DOL's opinion – nothing in the proposal alters a State's authority to regulate insurance. I agree.

However, policymakers must be mindful that States may attempt to act upon their authority to regulate insurance and enact legislation or promulgate rules, providing that any fully-insured "large

group" AHP operating within the State must comply with the ACA's "small group" market rules. States may also choose to enact a solvency requirement (i.e., a specified reserve level) that is so high that even well-run, well-capitalized self-insured AHPs cannot satisfy.

Any such State actions would be counter the policy goals that the DOL is trying to achieve. And, any such State actions are arguably inconsistent with ERISA. If left standing, these barriers to the formation of AHPs would surely disadvantage national trade associations, franchises, "cooperative"-run companies, and working owners who are currently struggling to afford health coverage in the ACA's "un-subsidized" individual market.

1. *Fully-Insured "Large Group" AHPs*

As discussed above, a fully-insured "large group" AHP is subject to State benefit mandates that apply to insurance contracts sold within a respective State. This means that even as an ERISA-covered plan – which in some cases enjoy ERISA's preemption powers – State benefit mandates are *not* preempted by ERISA.

There is, however, question as to whether a State law or regulation that re-characterizes a large group fully-insured AHP as a "small group" plan *would* be preempted by ERISA (and therefore, would *not* apply to an ERISA-covered fully-insured AHP).

On the one hand, an argument can be made that because States have the authority to regulate the insurance contracts sold within their State, a State could indeed enact a law or regulation to re-characterize a fully-insured large group AHP as a "small group" plan, and this law/regulation would be "saved" from preemption under ERISA's "savings clause" (and therefore, the law/regulation would *not* be preempted).[45] But, a legal argument can be made that this "re-characterization law" is directly impacting the ERISA-covered plan (and not the insurance contract), and even though the plan is fully-insured, any State law directly impacting an ERISA-covered plan *is* preempted under ERISA's "deemer clause."[46]

In addition, the statute of ERISA itself states that a fully-insured MEWA (i.e., a fully-insured AHP) may be subject to any State insurance law "to the extent that such law...requires the maintenance of specified levels of reserve and specified levels of contributions."[47] A legal argument can be made that a State law or regulation that re-characterizes the "large group" fully-insured AHP as a "small group" plan is *not* a law that "requires the maintenance of specified levels of reserve and specified levels of contributions."

At this point, it does not appear that the DOL is in a position to opine on (1) whether a State law or regulation purporting to re-characterize a fully-insured "large group" AHP as a "small group" plan is preempted under ERISA's "deemer clause" or (2) whether this law or regulation has no effect on a fully-insured AHP because the law/regulation is not one that "requires the maintenance of specified levels of reserve and specified levels of contributions." But, it is advisable for the DOL to clarify this issue soon after final regulations are released.

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[45] *See* ERISA section 514(b)(2)(A).
[46] *See* ERISA section 514(b)(2)(B).
[47] ERISA section 514(b)(6)(A)(i)(I).

There are various steps that the DOL could take to address this issue. For example, the DOL could issue informal guidance in the form of a Technical Release, explaining that – in the DOL's opinion – a State law purporting to re-characterize a fully-insured large group AHP as a "small group" plan is indeed preempted or the law simply does not apply (because this State action is *not* a law that "requires the maintenance of specified levels of reserve and specified levels of contributions"). Alternatively, the DOL could submit proposed legislation that would amend ERISA's preemption provisions, allowing fully-insured large group and self-insured AHPs to operate free from State law, provided specific Federal requirements are satisfied.

2. *It Is Imperative That the DOL Issue a "Class Exemption" From the Non-Solvency Requirements of State MEWA Laws*

As discussed above, an AHP is by definition a MEWA. In the case of a self-insured MEWA, ERISA gives States the exclusive authority to impose any State insurance law requirement on these arrangements. Over the years, States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. This has created a "patchwork" set of rules and requirements that self-insured MEWAs must meet if an employer-run organization sponsoring this type of arrangement wants to offer health coverage to employees located in multiple States.

As a result, a self-insured AHP (as a self-insured MEWA) must satisfy each State MEWA law in each of the States in which the AHP coverage may be offered. Unfortunately, however, this fact may limit the extent to which self-insured AHPs are formed. This is because a self-insured AHP wanting to offer health coverage in multiple States must navigate the different legal requirements and licensing practices in each State in which the coverage may be offered. The cost and time associated with complying with this "patchwork" set of regulations and licensing rules is often times prohibitive.

Congress enacted ERISA to avoid the multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans. Consistent with the purpose of ERISA, developing a "class exemption" would provide a level of "uniformity" that would allow self-insured AHPs to offer health coverage in multiple States free from the burden of complying with a set of regulations that differ State-by-State.

Please note, I am not suggesting that self-insured AHPs should be freed from regulation. What I am suggesting is that such regulation should be uniform. And such uniformity can be accomplished through developing a "class exemption" that would include specific Federal rules that must first be met prior to a self-insured AHP availing itself of any exemption from a State MEWA law's non-solvency requirements.

Providing specific suggestions on what may be considered "reasonable" and "appropriate" regulation of a self-insured AHP through a "class exemption" is beyond the scope of my testimony. However, I believe the DOL should consider developing a "class exemption" that codifies an existing State MEWA statute that the Department – and outside stakeholders – believe provides an appropriate level of regulation and oversight. The "class exemption" may also require a specified number of lives be covered under the self-insured AHP – as well as a requirement to meet a reasonable solvency requirement – as conditions to qualifying for the "class exemption."

I understand that even if a "class exemption" is developed (so that self-insured AHPs may be exempt from the non-solvency requirements of State MEWA laws), State insurance laws regulating reserve and contribution levels will continue to apply. I believe this is good policy (not to mention a statutory requirement under ERISA) because I believe a defined set of solvency requirements are imperative to ensure the viability of self-insured AHPs. However, while the DOL does not have the authority to dictate the type of reserve requirement a State may put into place, consideration must be given to the fact that States may choose to enact prohibitive reserve requirements as a back-door way of preventing self-insured AHPs from operating within the State. An argument can be made that such State actions are inconsistent with ERISA.

Make no mistake, I am well aware of the history of self-insured MEWAs, which include fraudulent arrangements and arrangements which have experienced solvency deficiencies. But, it is important to emphasize that policymakers at both the Federal and State level have taken steps to ameliorate the problems that have plagued self-insured MEWAs in the past. As stated, Congress specifically amended ERISA's preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State. Since that time, States have enacted their own State MEWA laws with varying degrees of regulation.

Most recently, Congress strengthened the DOL's ability to monitor self-insured MEWAs through increased notice and disclosure requirements as part of the ACA.[48] The ACA also enhanced the DOL's enforcement authority by providing extended civil and new criminal penalties,[49] and the ACA now allows the DOL to stop a MEWA's operations or seize its assets in certain circumstances without a court order.[50] Congress is free to further augment the DOL's enforcement authority – either through increased funding for enforcement or additional enforcement tools – if concerns over fraudulent self-insured AHPs remain.

V. Conclusion

A. AHPs Will Provide Adequate Health Coverage At a Lower Cost

I recognize that other stakeholders will sound the alarm over the fact that fully-insured "large group" and self-insured AHPs are not subject to the ACA's EHB and AV requirements, and also the ACA's adjusted community premium rating rules and the single-risk pool requirement. However, a strong argument can be made that these concerns are mis-placed due to the applicable consumer protections and coverage requirements, as discussed above.

I also recognize that stakeholders will argue that the lower costing health coverage that fully-insured "large group" and self-insured AHPs will likely provide is a proxy for less comprehensive – or "skinny" – coverage. I once again disagree.

It is important to emphasize that lower costs in the fully-insured "large group" market are driven by administrative efficiencies. In other words, the same administrative costs that drive up the cost for fully-insured individual and small group coverage are not present in the fully-insured large group market. For example, individuals and small employers often times drop in and out of the insurance markets. In addition, individuals and small employers routinely change insurance carriers,

[48] ACA section 6606.
[49] ACA section 6601.
[50] ACA section 6605.

sometimes every year. This volatility – which drives up administrative costs – is not present in the fully-insured large group market.

In addition, prices in the individual and small group markets are typically higher on account of the ACA's "risk adjustment" program. In recent years, insurance carriers have engaged in "defensive pricing" by loading any potential "risk adjustment" payments under the program into their plan premiums. This results in increased costs for the consumer, regardless of whether the carrier is required to pay a "risk adjustment" charge under the program or not. Unfortunately, in cases where the carrier ultimately receives a "risk adjustment" payment, the carrier does not "rebate" premiums back to the policyholders. As stated above, the ACA's risk adjustment program does not apply to the fully-insured "large group" plans, which means the added costs from "defensive pricing" are not present in the "large group" market, which means that costs are by definition lower than individual and small group plans.

The Congressional Budget Office has indicated that the ACA's EHBs and the ACA's adjusted community rating rules increase costs for individual and small group plans.[51] In particular, the requirement that premiums for individual and small group market plans can only vary by a 3-to-1 ratio has been shown to increase cost for younger individuals.[52] In contrast, age rating in the fully-insured "large group" market is typically based on a 5-to-1 ratio, which actuaries suggest produces an "actuarially fair" premium rate (which is lower than premiums in the individual and small group market).

Self-insured group health plans are not subject to the ACA's risk adjustment program, as well as the ACA's EHBs and adjusted community rating requirements, which – as discussed above – means that these plans will have a lower cost relative to individual and small group plans. In addition, self-insured plans are not subject to State premium taxes, and therefore, unlike fully-insured plans (e.g., individual, small group, and large group plans), there is no tax liability that is passed through to the participant. Self-insured plan premiums also do not include a "risk" and "profit" load that insurance carriers traditionally build into their costs to employers and their employees.

As a result, regardless of whether an AHP is a fully-insured "large group" or self-insured plan, the cost of coverage will primarily be lower than individual and small group health plans. And contrary to what critics of AHPs may say, such lower costs are *not* driven by the plans offering limited benefits.

B. Employer Members Will Seek to Offer Comprehensive Health Coverage to Attract and Retain Talent

It is important to emphasize that one of the main reasons why employers offer health coverage to their employees – even through an AHP – is to attract and retain talent. A strong argument can be made that to remain competitive among their peers, employers – especially those offering health coverage through an AHP – are going to make sure that their plan offers a comprehensive level of health coverage so they can attract and retain talented workers.

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[51] Congressional Budget Office, Private Health Insurance Premiums and Federal Policy, February 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums_OneCol.pdf, page 25 - 29.

[52] *Id.*

Employers also offer health benefits to their employees to promote healthy lifestyles and "presenteeism" in the workplace (and to combat "absenteeism"). If given the flexibility to develop plan designs that may not fit neatly into the "standardized" EHB framework – for example, value-based insurance designs ("VBID") that provide coverage for high-value services that is actuarially equivalent to an EHB plan – I believe more employers (especially small employers) will want to offer health coverage that provides a level of coverage that is as comprehensive as the EHBs. And, as discussed above, the cost of these types of comprehensive plans will likely be more affordable than ACA-compliant small group and individual market plans.

[10:34 a.m.]

Mrs. FOXX. Thank you very much. And, again, I want to thank all of our witnesses for being here today.

Mr. Condeluci, I will come back to you in a minute, but I do want to thank you very much for setting the record straight in your testimony. I think that is extraordinarily important.

Ms. Monson, in your testimony you mentioned that because AHPs have a larger pool of enrollees they can more effectively balance the risk associated with providing health insurance coverage to their employees. For many small businesses, if an employee gets sick the individual company or franchise may have to bear the increased costs in premiums alone. Do AHPs provide more financial stability for small business faced with higher claims?

Ms. MONSON. Absolutely. AHPs will provide financial stability to small business owners. The biggest complaint of all small business owners is the cost of providing quality health insurance to their employees. Many can't afford to. With AHPs bringing down the cost because of the greater pool and lower administrative costs, it will definitely help financially those small business owners. And it really all comes down to competition for great employees. Nobody wants to hire bad employees, but to keep the best employees you've got to have great benefits. And too many small employers can't afford to have the same similar quality insurance that labor unions and large companies do. AHPs will solve that.

Mrs. FOXX. Thank you very much. Mr. Condeluci, we have heard from a number of small business and employer groups that small group market costs continue to increase and the number of small employers offering health insurance, especially for very small businesses, continues to decrease.

How is small group market size currently defined in the states? Is there significant difference in cost or offer rates between groups that are fewer than five or 10 and those that are over 50 or 100?

Mr. CONDELUCI. Thank you for the question, Chairwoman. First, the states typically define the small group market as an employer employing at least two and up to 50 employees. As you may recall, the ACA actually changed that definition and moved that up to 100, but that change in the law from the ACA was changed by Congress back to 50. So it is two to 50 is the definition.

To your question with regard to the cost as it's—let's say the price for groups that are smaller in size versus those that are 51 and above, the ACA, as many know, reformed the small group market, or enacted reforms to the small group market, and in particular, the adjusted community rating rules, the single risk pool requirement, essential health benefits, and actuary value all apply to small group market plans. So typically the prices are not that different between the various groups because even if you're a small group of five, relative to a small group of 45 still in a small group market, the prices are typically going to be the same.

When you look at the large group market, which is 51 and above, often times the cost in the large group market is lower. There are administrative efficiencies in the large group market that is not present in the small group market. Or stated differently, the small group market has a lot of volatility. A lot of small employers dropping out of the market, in and out of the market, there's under-

writing issues. And that just drives up administrative cost. And that volatility is not quite present in the large group market, and therefore large group often times has a lower cost associated with it.

So those are just some factors between the differences between small group and large group market plans.

Mrs. FOXX. Thank you very much. Mr. McGrew, as you know firsthand, health care costs are just one of the many budget line items that small business owners have to balance while running their companies. Operating costs, payroll, maintenance, marketing, and many other duties compete for limited time and resources. Can you describe the other costs your business incurs and how health care costs factor into strategic decisions, including hiring and expansion?

Mr. MCGREW. Thank you, Madam Chairwoman. There is no question that when you're a small business owner you wear a lot of hats and we don't have an extensive HR department in our company. Therefore, we rely a lot on outside advisors. We have to count on them for their expertise, and those are costs associated with having them help advise us with regard to these things.

If I could spend more time helping my agents create more opportunities and help more consumers, my time is better spent than spending it on regulations and searching for health care options.

In the state of Kansas, there are two health care insurance plans available in the whole state. We don't have a lot of choices. And so we spend a lot of time trying to figure out if there's a better way to do things. Unfortunately, that's spinning our wheels because we really at this point have only very limited choices.

Thank you.

Mrs. FOXX. Thank you very much. And, again, thanks to all of you. Mr. Scott, you are recognized for five minutes.

Mr. SCOTT. Thank you. Mr. Arensmeyer, do the AHPs reduce the overall cost of health insurance for everybody, or just move it around so that different people pay different rates?

Mr. ARENSMEYER. They do not decrease the overall costs. The cost factors in the health insurance market are governed by many underlying issues. And you're right, they just move it around.

Mr. SCOTT. Okay. So if you allow healthy people to form their own AHPs what happens to everybody else?

Mr. ARENSMEYER. Everybody else gets left in a group that's forced to raise prices, and most people are going to have their prices go up.

Mr. SCOTT. And what happens to stability if healthy people start forming their own associations?

Mr. ARENSMEYER. Well, stability of the market decreases. Congress decided we've got three basic groups, risk groups. You've got large groups, small groups, and individual and each one of those needs to be as robust as possible. If you start to weaken any one of them you weaken the whole system.

Mr. SCOTT. Now, if you form an AHP and people in your program start getting sick what can they do?

Mr. ARENSMEYER. If they're in an AHP? If they start getting sick and the AHP starts to incur losses, the AHP could go away. Unlike a large group, which is there because everyone's got a common eco-

nomic interest, you know, in a big company. You know this is a group that's just set up for health insurance purposes only and it could just disintegrate.

Mr. SCOTT. That means they can go back into the normal individual or small market pool?

Mr. ARENSMEYER. They would ultimately have to back into it, yes. But you're talking about destabilizing a market in the process.

Mr. SCOTT. Now, what is the history of insolvency in AHPs?

Mr. ARENSMEYER. There's been a tremendous history of insolvency. And as I said, again, if you set up an entity for the sole purpose of providing health coverage you don't have the foundation that you have in the large group market with a large company that's there for many reasons beyond health insurance. So once something starts to go wrong, there's absolutely no incentive for people to stay in the system.

Mr. SCOTT. So if the cost go up because a few people got sick, everybody will start bailing? Is that right?

Mr. ARENSMEYER. That's right.

Mr. SCOTT. Is it possible to design a benefit package that attracts healthy people rather than average people?

Mr. ARENSMEYER. Absolutely. I mean if you don't have the same rules regarding essential health benefits you create different rules of the road. The reason that—and I should add, as I said in my testimony, the small group market, unlike some of what you've heard, has actually been relatively stable. In fact, between three and 199 employees it has only gone up one percent in the last year. So that's how you have a stable market is you have as much risk spread out as possible.

Mr. SCOTT. But if you had designed a program that you did not have services for diabetes, did not have chemotherapy, you did not have AIDS medicine on your formulary, you would discourage people with those diseases from joining the pool. Is that right?

Mr. ARENSMEYER. That's correct.

Mr. SCOTT. And you would have a healthier pool as long as they stayed healthy, and everybody would be happy until somebody got sick?

Mr. ARENSMEYER. That's correct.

Mr. SCOTT. Can you give some examples of what happened—you mentioned fraud. What happened? Can you mention what happens when people get defrauded in this situation?

Mr. ARENSMEYER. Well, if they think they're signing up for comprehensive health benefits and then all the sudden the AHP weakness, then they are out of luck.

Mr. SCOTT. What happens when the AHP goes insolvent?

Mr. ARENSMEYER. The people don't have coverage anymore.

Mr. SCOTT. We have heard that nobody is going to really sell these skimpy plans because nobody would want to buy it. Doesn't a skimpy plan have the advantage of a very low price?

Mr. ARENSMEYER. Absolutely. I mean it becomes very attractive on the surface and all of the sudden you find out it's not covering what you need it to cover.

Mr. SCOTT. And so the whole point of this is to lower the prices. And if you can get a low price then people would be attracted to it until they get an illness that is not covered. Nowhere they have

done these, has the cost of the residual market, those that didn't get into an AHP, have you seen the cost go up for everybody else?

Mr. ARENSMEYER. Absolutely. I mean the cost increases in the small group market prior to the ACA, particularly when you had AHPs in the system, were much higher. I mean the growth was higher, the rate of increase was higher.

Mr. SCOTT. Is there any problem with discriminating based on gender or designing a pool that has traditional male employees?

Mr. ARENSMEYER. You can certainly design a pool, design a set of benefits to intentionally exclude, or at least implicitly exclude certain people by not having maternity coverage, not having coverage for things that people who are older tend to get. Again, it's about having separate rules of the road than the small group market. The whole point of the small group market, as we just heard from Mr. Condeluci, it's actually you get pretty common costs across the entire small group market because you have a common set of rules and a common risk pool.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman WALBERG. I thank the gentleman and, again, thank you for the panel for being here. I apologize for having to leave to go to two other subcommittee hearings that are going on at the same time for me.

Mr. Condeluci, there has been a lot of discussion about whether AHPs will provide adequate consumer protections to their members. Some fear that expanding AHPs will lead to discrimination against employees who are older, sicker, or more expensive than other workers. That has been brought out this morning already.

Can you discuss which nondiscrimination requirements apply to AHPs and how those compare to requirements applicable to existing plans in the large group market?

Mr. CONDELUCI. Thank you for the question. In the Department of Labor's proposed regulations, there's a nondiscrimination protection that says that members seeking to join an employer group, or a group that is going to sponsor an AHP, cannot deny membership based on the health status of that employer member's employees. So there is a nondiscrimination protection when it comes to membership in the employer group, which almost by extension is a nondiscrimination protection as it relates to participation in the AHP.

When it comes to the AHP there are current law nondiscrimination protections, as I discussed, and they're built into the proposed regulations, which say that an AHP cannot vary premiums based on a particular participant's health condition, nor can they vary eligibility for benefits based on a particular employee's or a particular participant's health condition. So those are current law, nondiscrimination protections that again are built into the proposed regulations.

Chairman WALBERG. Okay. And group market plans are required to cover preexisting conditions as well?

Mr. CONDELUCI. Yes, sir. Large group plans, self-insured plans, as well as small group plans and individual market plans are subject to the ACA coverage requirements. And those ACA coverage requirements, which apply to all plans in all of those markets, have a prohibition against denying someone coverage based on a health

condition or discriminating against a particular participant based on the health condition of that individual.

Chairman WALBERG. Okay, great. Thank you. Ms. Monson, you briefly talked about the cost of providing health insurance to your employees, as well as the challenges that franchised businesses can face when obtaining health insurance coverage. How does the ability to offer great health insurance coverage affect your franchisees' ability to attract and retain talent? And what impact do you think that offering an AHP would have?

Ms. MONSON. Thank you for the question. Every business requires the best employees to be the most successful that they can be. And small employers have really struggled, franchise businesses with small staffs have really struggled to find that same level of quality care, quality health insurance, at a reasonable price. My franchisees, every day, compete for the same employee candidates as large corporations do.

Chairman WALBERG. So competition is real?

Ms. MONSON. Competition is real for great employees. And we need to help those small business owners and those franchise business owners have access to quality, affordable health insurance—AHPs will bring that—so that they can have a level playing field when competing for the best employees, hiring the best employees, and keeping the best employees.

Chairman WALBERG. Okay. Thank you. Mr. McGrew, cost is a significant concern for small employers who want to offer health insurance. Do you believe that AHPs can offer the independent contractors you work with more affordable health plans and they can find it and purchase it today?

Mr. MCGREW. Thank you, Mr. Chairman. Absolutely. I am very confident, in my case, that the National Association of Realtors would be able to provide an option for my independent contractor realtor family members. There are so few choices when you're in the individual market that are good choices. And to have another option from a valued trusted business partner, as the National Association of Realtors is, would I think be a very valuable and viable option for my realtor family.

Chairman WALBERG. Okay. Mr. Condeluci—excuse me, Ms. Monson. I want go to back to her. Can you describe how an AHP would help small employers manage the administrative costs of their plan?

Ms. MONSON. If I take a look at the International Franchise Association representing, you know, 733,000 franchise businesses, with the stability of great coverage and an affordable price, there's not going to be the small businesses joining and leaving all the time. That reduces the administrative cost. There's a certain administrative cost that goes over one company, no matter if it's small or if it's very, very large. And so then we can spread the administrative costs over millions of employees or thousands of employees or hundreds of employees, rather than just 10 or 15 or 20.

Chairman WALBERG. Thank you. I see my time has expired. Thank you.

I recognize Ms. Blunt Rochester for her five minutes of questioning.

Ms. BLUNT ROCHESTER. Thank you, Mr. Chairman. And, again, thank you to the panel. You know, as I listened to the conversation one of the things that becomes clear to me is that we all value affordable, quality health care and access to it. I think one of the concerns, and one of the reasons why my focus has been on strengthening the *Affordable Care Act* is because to me this is kind of going backwards. It is saying we are piecemeal as a country instead of all in this together.

So I start with that premise and I thank the panel for your testimony.

Mr. Condeluci, I will probably ask you some questions later based on the new testimony, so I will come back to you with some of that later. But I would like to ask a question, starting with the fact that the *Affordable Care Act*, what was really powerful about it was that it afforded protections to older consumers, particularly as more people are living longer and staying longer in the workforce. And I worry that older business owners and older workers who could be left with fewer options or even more expensive coverage under this rule. AARP states in a comment letter that the rule could "greatly increase the likelihood that working Americans, especially those age 50–64, would face higher insurance premiums and the loss of access to critical health insurance coverage".

Mr. Arensmeyer, are you concerned about the impact that the rule could have on older workers?

Mr. ARENSMEYER. Absolutely. I mean if you just look at the large group market now, the age banding between the most expensive for older workers and the least expensive is five to one, whereas in the small group markets, as you know, it's three to one. So you're automatically talking about a situation where you would have relatively higher prices for older people, which would then create problems for small businesses with older workforces.

Ms. BLUNT ROCHESTER. And another thing that concerns me about the rule is that it could discourage businesses with employees who have preexisting conditions and health issues, or even people with disabilities, from enrolling in association health plans. For example, right now small group plans must cover rehabilitative services, but under the rule this requirement would not apply.

In your position, would a plan without that coverage be attractive to, for example, a small business owner with a physical disability?

Mr. ARENSMEYER. No, it wouldn't. And, again, it gets back to the fact that you've got different rules of the road. We've heard a lot about the fact there would still be certain prohibitions against overt discrimination, but that doesn't stop you from setting up a plan that has different benefits than the essential health benefits required in the small group market, and thereby discouraging people who might be higher health risks from joining that plan.

Ms. BLUNT ROCHESTER. Right. And my last question, earlier this week the President announced his plan to combat the opioid crisis. And while I don't think we are going to debate the plan here, I will mention that I think it is really encouraging that the President and Congress are having this important conversation and actually having it in a bipartisan way. But I am a little nervous about the rule and that impact on association health plans to avoid covering need-

ed services for substance use disorder. Entirely counterproductive to what we are saying that we are trying to do with stemming the opioid crisis.

Would you comment on the importance of substance use disorder treatment and why maintaining coverage for essential health benefits is important?

Mr. ARENSMEYER. Again, it gets back to the fact that you have different rules for different risk pools here. And there's no question you could again design plans that had less coverage for drug abuse treatment and you'd then be skewing the market accordingly. So, again, I'm going to stress that in the large group market, where you have common economic interest in a company, there's an interest in covering everybody, you know, with the best benefits as you can in that company. When you set up a plan that—or an organization or association is purely for the purpose of providing health coverage, you don't have that and you don't start off with a pool of people that you want to cover. You're saying we're going to set up this particular plan, then we're going to attract people to come into it. By definition, you're then skewing the risk pool that's in that market, making it not only different from the small group market, but different from a large group that's actually representing a company.

Ms. BLUNT ROCHESTER. I am just going to close out by saying the Committee knows I have served as Deputy Secretary of Health and Social Services, Secretary of Labor, State Personnel Director. This issue of health care cost and quality has been one that has plagued us for many, many years. We need to all be on the same page and be doing it as one country, not a lot of different separate groups.

Thank you. And I yield back.

Chairman WALBERG. I thank the gentlelady. And now I recognize my friend from Tennessee, Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman. And I have been in the small group market when we started our practice and grew now to the large group market. I have also served as a mayor of my local community where we did self-insurance plans. So I have a fairly good understanding of the market. I also have the *Affordable Care Act* and have had two major operations in the last 18 months, one for cancer, and I would have been better off with each of them just to have written a check. It would have been cheaper. In my district, almost as many people paid the penalty last year as got a subsidy. So it isn't working like a charm in the First Congressional District of Tennessee. I will just start by saying that.

Now, secondly, I could not agree more that we want to increase the access to care to people, lower cost, and increase quality. I have a good friend of mine I won't mention, he has over 15,000 employees in his business. He has been able to put a health maintenance plan in that business. And we know what the drivers are, hypertension, diabetes, obesity, smoking, cancer, we know what those are. And with a large group like that, you can manage your health care costs. And he has been able to keep those at one percent level for the last several years. Why in the world would we put a roadblock up to keep these small business owners from doing the same thing? I know you are absolutely right, Ms. Monson, one of the hardest things to do and one of the most valuable people in my of-

fice are my employees in a doctor's office or in a realty office. Good people are hard to find. They need this coverage for their families and themselves and they need it affordable. And the way you can provide that is getting a larger risk pool. And, look, we had great employees who had serious health benefits, we wanted to—as an employer, I wanted to take care of those people, not only in a small business. These are not just employees, they are your friends. You may have worked with them for 25–30 years, which I did routinely. And I found out when we got older things happen to us. We didn't abandon those people. And it is offensive to me when people come up here and say that I would do that, that small business owners would do that.

So I know them, I work around them, and, by the way, we had this Christian sharing ministries that has grown dramatically after the *Affordable Care Act* simply because coverage costs went down. And, Ms. Monson, you made a comment—and I think you will find this with all small business owners—if they could find a product that was affordable and offered quality coverage for their employees, they would buy it. The problem is cost, and that is how do you get the cost down. And I agree with you all, how do you provide quality product.

So I think, Mr. Condeluci, I read your testimony last night and you made some incredibly good points in here, is that this is not a fly by night plan, these are quality plans that are governed by ERISA, they are in a different silo, agreed, than the small group market. And one of the comments, Mr. McGrew, that you made, was that there are two insurers in the state of Kansas. Well, if I were those two insurers, I wouldn't want any competition in the state of Kansas. I certainly wouldn't want an association health plan where my people there could buy insurance from somewhere else. And in Alabama, I know there is a dominant player in that market. In Tennessee there is a dominant player in the market. So I bring these up.

And Ms. Monson, back to you. I want you just to again comment on the importance of your employees in your franchise business. And quite frankly, if 10 percent of franchise employee workers would get health insurance, you would have an incredibly large 700,000–1,000,000 people in a market. And, believe me, you can control costs doing that.

Ms. MONSON. Thank you. It all comes down to competition and competing for the best employees. And the best employees are smart, they understand. You know, I keep hearing this, we're going to provide skinny plans or poor coverage. That's not the case. People today are educated. The employment candidate is going to ask questions about the health insurance, they're going to know what it covers. There is no upside for any employer to offer subpar health insurance because we do, we care about our employees, we want them to be healthy, we want them to continue and grow within the organization and to remain. There's no incentive to have lousy coverage, only good coverage.

And thinking about the 7.6 million employees that work for the 733,000 franchise establishments in the U.S., what an amazing large pool. Think about the buying power. It's all buying power.

Mr. ROE. Well, the last thing I will say before I close up, one of the things I wish the ACA had worked as well, and it has for some people, but it has failed a lot of people. And what we are seeing in our practice is with the out of pockets and co-pays so high, people come get a preventive service, but then if you find anything wrong with them and you have to send them down to the hospital or wherever, to a diagnostic center to get testing, all of that is on their nickel. And if you have got a $4-5-6-7000 out-of-pocket, you just don't get it done.

So I think this is an incredible opportunity. I am excited about this. I think it will be fun to see if this could work. I know it will.

Thanks and I yield back my time.

Chairman WALBERG. I thank the gentleman. I recognize the gentleman from New York, Mr. Espaillat.

Mr. ESPAILLAT. Thank you, Chairman Walberg, for this opportunity. I ask for unanimous consent to enter a comment letter submitted by state attorneys general in opposition to the Department of Labor's proposed association health plan rule.

Chairman WALBERG. Without objection; hearing none it will be submitted.

Mr. ESPAILLAT. Thank you, Mr. Chairman. Mr. Chairman, as I have said, 16 state attorneys general and the attorney general from the District of Columbia, have submitted this comment that stipulates in fact that they have great concerns with this proposed action.

Mr. Chairman, here we are again, talking about association health plans, an idea which has failed time and time again. As our attorney generals have said, their state and respective offices have the duty and experience of protecting consumers from predatory practices associated with AHPs, but this proposed rule will threaten those very protections and open up consumers in states and regions across the country to the real potential of fraud and catastrophic wrongdoing.

Almost 75 pieces of legislation dealing directly with AHPs have consistently been introduced in Congress, dating all the way back to the 103rd Congress. Let me repeat this again, almost 75 pieces of legislation dealing with these issues have been consistently introduced in the U.S. Congress dating back to the 103rd Congress. Of those almost 75 pieces of legislation, nine bills have passed at least one of the Chambers of Congress, and of those nine, not one—not one has been signed into law. Additionally, during that time, then-Secretary of Labor Elaine Chao's testimony on AHPs in 2013, it was clear that the Department of Labor did not have the authority to act on AHPs without legislative action from Congress.

This effort will lead to segregating the insurance pool into one that has healthy young people, people with preexisting conditions, and the others will have seniors, people with catastrophic illnesses, people with preexisting conditions, poor people. That is what this actually will do.

This tells me two things, one, there has never been enough support of confidence in this kind of association health plan proposal to actually authorize them through federal legislation, and, two, until now the Department of Labor has never believed it had the authority to establish these kinds of AHPs on its own. In fact, this

proposal is directly opposed to the ratified Congressional intent of both ERISA as well as the intent of the ACA.

Aside from the massive enforcement issue, potential for widespread fraud and abuse, and as well as the constant legal battles that will be attached to AHPs, it seems to me that the Department of Labor requires Congressional authority to implement these rules and the Department quite simply lacks that authority.

My question is—recognizing Mr. Condeluci found it acceptable to submit a brand new testimony this morning, which I am going to completely ignore—I am going to ask Mr. Arensmeyer this question. I represent New York's 13th Congressional District, which is home to many small businesses that are critical to the local economy, our neighborhoods, and workforce. If implemented, what exactly does this proposed rule mean for those small businesses and the health of their employees?

Mr. ARENSMEYER. What it means is if they don't find the AHPs that have access to—if they don't have the kind of benefits they want they are left in the core small group pool, but by pulling out the participants in that pool that are healthier and younger, their costs are likely to go up. Or, if they chose to join an AHP, they're at risk they don't have coverage for certain needs that they might have.

Mr. ESPAILLAT. One last quick question, as I am running out of time, how does this impact the ultimate risk factors that are considered for any pool of insurers?

Mr. ARENSMEYER. Well, again, I mean it comes down to you want as broad and robust a pool as possible. And there's—operating with the same rules of the road. So when you start to play with that and you start to pull certain people out of a pool, you start to create instability in the whole marketplace. I mean we're all for competition and we'd love it if there were more group plans participating in the small group market. So, again, if they come in playing by the same rules that would be great. We all are concerned about costs, there's underlying costs in the system we need to deal with. It's a question of people in the common pools that are joined by common economic interests.

Mr. ESPAILLAT. Thank you, Mr. Chairman.

Chairman WALBERG. I thank the gentleman. I recognize the gentlelady from Oregon, Ms. Bonamici.

Ms. BONAMICI. Thank you very much.

Chairman WALBERG. Oh, excuse me, excuse me. I saw you hustling around there and—can't keep track of the players here. So take your time, take your time, get in place. And now I recognize the gentleman I never want to slight, the gentleman from Minnesota, Mr. Lewis.

Mr. LEWIS. Thank you, belatedly, Mr. Chairman. You know, I am a little perplexed as to the opposition to expanding these small business pools. For many, many years we have had large businesses operate under the notion of say a self-insured plan to get out from under very onerous state mandates. They obviously had purchasing power advantages and large networks that small businesses didn't have. So the idea of granting in the association health plans that same purchasing power, economies of scale that self-insured plans had or that larger businesses had, seems to me to be

something that wouldn't generate much opposition, especially since you look at the status quo. And as the Committee has pointed out, since 2008, the share of small businesses with fewer than ten employees offering coverage at all has dropped nearly 40 percent. In my home state of Minnesota, just since 2013 and the implementation of the *Affordable Care Act*, some 7000 more small businesses have dropped coverage. So we do have a crisis here.

It seems to me, Mr. Condeluci, that therefore the fallback revision of the opponents of this is well, if you allow these pools to form, why, they will be offering these skimpy plans. Now, you know, my parent used to buy something called major medical. When we understood what real insurance models looked like, we realized that your automobile insurance doesn't cover the tires, doesn't cover the oil change. If so, it would be sky high. And therefore health insurance for many, many years used to cover a catastrophic event that could bankrupt a family, but if you took Johnny or Susie to the annual physical, you paid it. We now with the *Affordable Care Act* gone the other way. We ought to have first dollar coverage on everything, I don't want any co-pays, I don't want any deductibles. And we put the system on the market and all we are left with are spiraling out of control premiums.

But, isn't it true, Mr. Condeluci, that for many, many years, businesses, especially self-insured, were trying to get out from under very costly state mandates, for that very reason, right?

Mr. CONDELUCI. Yes. Self-insured plans have ERISA preemption protections and therefore the state benefit mandates do not apply to those self-insured plans. And therefore, the costs associated with the self-insured plan is typically lower. While employers, be it small, be it large, they're sponsoring those self-insured plans, offer comprehensive coverage that are almost as comprehensive as the essential health benefits, as well as many of the state benefit mandates that would otherwise apply for ERISA preemption.

Mr. LEWIS. And those people under self-insured plans weren't shortchanged, they had very good health insurance. But the fact is there were costly mandates in my home state of Minnesota that some larger corporations wanted to get out from under to tailor a health insurance plan to fit their employees. And they had that option, but small business didn't have the option. But it is also true that the *Affordable Care Act* wanted to limit that, and therefore came up with these essential health benefit plans. So the notion that they could get out from under those under the ACA simply by an association health plan is erroneous, is it not?

Mr. CONDELUCI. Yes, it is, sir. And it's important to understand that employers offer health coverage to attract and retain talented workers. And small employers compete with large employers for talent as well as they compete with their own small employer peers. And those small employers are going to seek to offer comprehensive coverage. And virtually every large employer out there offers coverage that includes the essential health benefits or offers coverage that is actuarially equivalent to the essential health benefits. So the claim that these association health plans will offer skimpy plans I think is difficult to accept, just basically seeing what large employers out there are offering. And I will note, the drafters of the ACA specifically exempted large group, fully insured

plans and self-insured plans from the essential health benefits requirement, as well as some of the other insurance market reforms because the drafters accepted the notion that these large employers were offering comprehensive enough coverage. And therefore, the drafters said why should we impose these requirements when these employers are already doing the right thing?

Mr. LEWIS. So if it is good enough for those large employers, it is probably good enough for small business, isn't it?

Mr. CONDELUCI. Yes, sir.

Mr. LEWIS. Having said all of this, isn't it true, however, that we have got to get back to the notion of a catastrophic health insurance policy that allows people to buy coverage that starts, quite frankly, with a very low deductible, but that wouldn't bankrupt their family. Instead, we have gone down this road of prepaid medicine, thinking about that first dollar coverage, and that is an impossibility in most insurance markets, isn't it?

Mr. CONDELUCI. Yes, sir.

Mr. LEWIS. Thank you so much. I yield back.

Chairman WALBERG. I thank the gentleman. And now I recognize, again, the lady from Oregon, Ms. Bonamici.

Ms. BONAMICI. Thank you very much, Mr. Chairman, and Ranking Member, and thank you to our witnesses for being here.

I used to do financial counseling at Legal Aid and I would work with clients who were devastated often times by health care costs. And some of them just could not afford insurance and some of them had insurance but it didn't cover them when they needed it. Also, when I was in private practice, I represented franchisees, and I know how hard they work, often family owned businesses. And I know they want to do right by their employees. And even before that my first job was in my mom's small business. I understand and know how important small businesses are to our communities, to our economy, and of course we all want small business owners and employees to have access to affordable, accessible health care.

But I am very concerned because we have seen a great deal of evidence suggesting that association health plans do not work as intended. I think back to before the *Affordable Care Act*, which passed before my time in Congress. We knew that people who could not afford insurance would get their health care in emergency rooms, which is the least effective, most expensive way to get health care. Those costs would get passed along to everyone. And even Dr. Roe recognized the ACA works for some people.

What we should be doing is, we should be strengthening the *Affordable Care Ac*t by providing certainty for insurers, we should be strengthening and stabilizing the individual and small group markets. That is what would really make a difference.

Mr. Chairman, I would like to introduce into the record a letter addressed to Secretary Acosta from the AARP, in which they note the proposed rule's expansion of AHPs could greatly increase the likelihood that working Americans, especially those age 50–64, would face higher insurance premiums and the loss of access to critical health insurance coverage.

Chairman WALBERG. Without objection; and hearing none, it will be introduced.

Ms. BONAMICI. Thank you, Mr. Chairman. Mr. Arensmeyer, you referenced a letter signed by 17 state attorneys general, including Oregon Attorney General Ellen Rosenblum, from my home state. Could you explain why these attorneys general are so concerned about this rule and their ability to enforce state regulations on association health plans?

Mr. ARENSMEYER. Well, based on the letter I think they're concerned about a lot of the concerns that I've raised here about separate risk pools. They're concerned that, particularly on the interpretation of ERISA, that ERISA is based upon regulating plans that may not have the same rules as the small group market, but they are based on a common economic interest in the—you know, among the participants in that plan.

So, again, we've heard a lot about comparing large group plans with the AHPs. I mean large companies, like General Motors, IBM, Google, they have an interest in providing comprehensive coverage. We've heard that most of them provide essential health benefits because they have an economic in doing that. There's no common economic interest in an association health plan that is set up purely to provide coverage and could go away tomorrow. That's not the case with a large group plan. Google is not going to get rid of its large group plan tomorrow because, you know, there's some issues with risk in it.

So, again, they're concerned that ERISA, the way it was written and the way it's been interpreted, that this flies in the face of that. It's also concerned that it flies in the face of the intent of the *Affordable Care Act*.

Ms. BONAMICI. Thank you. And I noticed in your testimony you mentioned an Urban Institute analysis of association health plans in Oregon prior to the ACA. That analysis found there was increasing potential for adverse selection in the state's remaining small group market. Could you just briefly summarize that study and comment on whether this proposed rule might lead to adverse selection?

Mr. ARENSMEYER. Well, again, it gets back to what I'm saying. If you have something that's set up with a separate set of rules, it's purely to provide health coverage, you don't have the built in protections, just sort of market protections, that you have with a normal large group plan. So there's a tendency to maximize, you know, to try to keep the cost down by reducing benefits and by—you know, at some point then people start to get sick and they're not covered and the whole system—

Ms. BONAMICI. Thank you. I wanted to get one more quick question in. Mr.—I know you said Condeluci, I want to say Condeluci—it has been referenced before, there has been a long and well documented history of health insurance scams promoted through AHPs. According to the GAO, between 1988 and '91 operators of multiple employer entities left about 400,000 people with medical bills. There is just a whole history here. The Department of Labor does not address the fraud that is prevalent in this market. There is not clear indication of how the rule would protect consumers. So what would the Department of Labor need to do to prevent fraud and protect legitimate Associations or small businesses or self-employed individuals from being scammed?

Mr. CONDELUCI. It's a very fair question. And it's important to note, because a lot of folks overlook the fact that the ACA, driven by the GAO report and the investigation on fraudulent activity, led to actually enactment under the ACA additional enforcement authority for the Department of Labor. So the Department of Labor now can actually impose civil and criminal penalties if there's fraudulent activities in these self-insured and/or fully insured AHP type plans. In addition, the DOL can go in and seize assets if there's solvency concern without a court order. So there are now enforcement tools that are in the law that have been offered to the Department of Labor, which many would argue have contained many of the fraudulent activity that occurred in, let's say, the early 2000s to the 2004 timeframe. And Congress does have the ability to provide additional funding to the Department of Labor to increase that enforcement authority and/or provide additional tools to ensure that there are not fraudulent activities, and therefore containing much of the concern and much of the fraudulent activity that has happened in the past.

Ms. BONAMICI. Thank you. I see my time has expired. Thank you, Mr. Chairman.

Chairman WALBERG. Very adeptly done, to get that last question in. Thank you. I thank the gentlelady. I recognize my good friend and colleague from Michigan, Mr. Mitchell.

Mr. MITCHELL. Thank you, Mr. Chair. Let me start briefly, Mr. Arensmeyer, with a comment for you. I led a couple of small businesses, one that evolved into a fair sized business; I was chair of an association of those small businesses. I am astonished, and frankly a little offended, with your comment that somehow there is not a joint economic interest, that we do not have the same level of economic interest in the wellbeing and health of our employees as large businesses do. And I think it is based on the very premise with which you go forward with your testimony. So your position, of course, you are welcome to it, it is noted, but I think it is based on some false premises. I was extremely concerned with the health and wellbeing of our employees.

Let me go through a little history. As with Dr. Roe, I was in a large group plan with Chrysler Corporation and a self-insured plan. We had a business that grew to 650 employees and we had part-time employees that were teachers and instructors that worked less than—some less than 15 hours a week because they were instructors. During the economic downturn we created a health insurance plan for employees that were regularly scheduled at least nine hours a week, because frankly in many cases they were female employees, their husbands were losing jobs in the auto industry and they had no health insurance.

Along came the ACA, which by definition, because we had this plan as an option that we created for our part-time employees, created obligations that frankly we couldn't afford for part-time employees, some of which worked as little, as I said, 12 hours a week. It created obligations that we had to make a choice between continuing insurance for employees, which we did because we thought it was necessary for them and their families, or telling them to go to the *Affordable Care Act*. Huge obligations that no one seemed to care much about.

I met with a large employer recently, a hospital, who told me two-thirds of their ER cases should go to primary care—still primary care or urgent care but still come to the ER. The *Affordable Care Act* has failed to deal with the fundamental problems which we are kicking around today, a lack of transparency of cost and choice. Try to find out what the cost of an MRI at a clinic versus an MRI at the hospital—let me know how that works for you. Second, is a lack of user input and involvement in the cost and choice. And, third, is the lack of the competition on what the cost is. We have disassociated the user from the cost, and now we are trying to paper it over with one reg. after another.

Until we fundamentally deal with the *Affordable Care Act*, fundamentally deal with what we are not talking about, which is the cost of health care in this nation, and people having a choice in understanding what their costs are, we are going to continue to try to move costs around from one group to another. And then, hope the government will pay for it, the taxpayers.

So, while we talk about this plan today, the longer we sit here and hope that the federal government is going to somehow find a way to milk the taxpayer to pay costs for someone that doesn't know what their cost is, that goes to the emergency room for care they could go to urgent care. Because that is what they have done their entire life, our health care costs will spiral. And we should do that, we should actually take the effort to do that here in Congress.

A couple of quick questions. I am running out of time, and I apologize, but it frankly frustrates me.

Ms. Monson and Mr. Condeluci—I apologize for the pronouncement, sir.

Mr. CONDELUCI. Quite all right.

Mr. MITCHELL. Is there some reason there wasn't some explicit language put in place on the joint employer to exclude them or to clarify the exclusion so in fact it doesn't create a further risk as being defined as joint employer? Can you help me with that?

Ms. MONSON. I know that the International Franchise Association has made a request that we have a safe harbor because we do not want to have the risk of being deemed joint employers just because there is this valuable affordable quality health care plan available, whether it's through the FASTSIGN sister or whether it's through the International Franchise Association, it's certainly a request we've made.

Mr. MITCHELL. Well, given all the conversation we have had, including with the Secretary of Labor, both here and in meetings about the joint employer rule, I am frankly astonished that there wasn't something done in the regulation to in fact address that. I don't understand why and I think by letter I may well participate in making a comment on that because I don't understand why it is they didn't address that. It has been a huge conversation around here, yet it is ignored by the Department frankly.

One more quick question because I know I am going to run out of time, but I am going to see if I can use my colleague, Ms. Bonamici's, time. You note, Mr. Condeluci, a potential conflict between potential state law and the redefinition of large group AHPs

by state law saying the small groups are causing issues there. How do you propose they resolve that?

Mr. CONDELUCI. First, the proposed regulations do nothing to change state regulation. So therefore, states could, if they so choose, enact a law that re-characterizes a large group, a large group fully insured AHP, as a small group plan, therefore subject to the small group market rules. And there is an argument that could be subject to an ERISA preemption challenge.

And, in addition, there is certain language in ERISA that requires states to impose certain regulation on fully insured MEWAs or fully insured AHPs. And a re-characterization law such as this is arguably inconsistent with the ERISA statute as it relates to regulating fully insured MEWAs as the state level.

Mr. MITCHELL. Thank you, sir. One quick comment, Mr. Chair, is I did review really quickly the letter from the 16 attorneys general opposing this regulation. It won't shock you to know, Mr. Chair, that all 16 attorneys general have explicitly expressed in no small manner their support for the current *Affordable Care Act*, such states as New York, Massachusetts, and California. So that will state a great deal their rational.

Thank you, sir.

Chairman WALBERG. I thank the gentleman for doing your homework. And I recognize the gentlelady from Florida, Ms. Wilson.

Ms. WILSON of Florida. Thank you. I want to begin by thanking our subcommittee Chairman Walberg and Ranking Member Sablan for holding today's hearing. And I would like to thank our witnesses for your testimony and for being here today. I ask unanimous consent to enter into the record a comment letter in response to the proposed rule from the American Cancer Society Cancer Action Network.

Chairman WALBERG. Hearing no objection, and I hear none, it will be entered.

Ms. WILSON of Florida. I strongly believe that if the Department of Labor's proposed rule is to expand association health plans goes into effect it would seriously undermine many of the benefits offered under the *Affordable Care Act*, mainly by weakening consumer protections and shifting cost onto working people. Indeed, underlying effects of association health plans limit access to comprehensive health coverage, increase costs for consumers, and threaten coverage for people with preexisting conditions. Moreover, they leave consumers with even fewer protections against fraud.

Certainly, without guaranteed coverage for essential benefits such as maternity care, mental health treatment, and substance use treatment, many people may be left with inadequate coverage that neither gives them access to the care they need, nor offers adequate financial protection against serious medical conditions. And, in fact, the proposed rule goes so far as to explicitly state that some association health plans might thrive by delivering savings to members by other means, such as by offering less comprehensive benefits.

In addition, these plans would increase cost and threaten coverage for people with preexisting conditions, as healthier and lower cost consumers get cheaper plans with less benefits that may not meet their health care needs. Association health plans would leave

older, sicker, and higher cost consumers or consumers with pre-existing conditions behind in a traditional market with sky-rocketing costs, making it outright difficult to obtain coverage.

I want to ask a few questions of our witnesses.

Mr. John Arensmeyer, you state in your testimony that because most small businesses currently purchase coverage in the small group market, it is important to protect the stability of this market. In your opinion, does the proposed rule contribute to stability or does it undermine it?

Mr. ARENSMEYER. We believe it undermines it. And, again, as I said before, by removing certain participants in that market who are likely to be at a lower risk, thereby leaving higher risk folks in the small group market and increasing costs and increasing instability.

Ms. WILSON of Florida. Under the proposed rule associations tied together by the same industry or geographic area can form solely for the purpose of offering coverage. This means employers could form a new organization for the sole purpose of achieving savings, avoiding many of the *Affordable Care Act's* consumer protections. But what about small businesses and workers that want these protections? If they choose to stay in the traditional market, what could the rule mean for them?

Mr. ARENSMEYER. Well, obviously, if they choose to stay in the existing market and you remove lower risk out of the small group market, you're going to end up with higher costs, more instability in what's left and it's going to jeopardize the protections that they have. Again, it's really about, you know, we welcome competition and there's been a lot of talk about cost reduction. Absolutely, there is a lot of need to reduce health care costs in the whole system, but at the same time if we're going to be talking about coverage and robust and stable markets, we have to have everybody playing by the same rules.

Ms. WILSON of Florida. What role do you think states should play in regulating these health plans?

Mr. ARENSMEYER. Well, traditionally states have played a very significant role in regulating health coverage. And right now it's unclear, and as Mr. Condeluci said, you know, states may believe they can still regulate these or re-characterize these groups as small group, but there would be a likely challenge under ERISA. So it again creates legal instability on top of the economic instability.

Ms. WILSON of Florida. Mr. Michael McGrew, in its proposal DOL speculates that associated health plans will generate substantial inefficiencies that result in cost savings for their members, but provides no evidence and no actual numbers to support its assertions. What specific administrative functions will you perform more efficiently than an insurer, and what percent savings does that yield?

Mr. MCGREW. Thank you, Madam Congresswoman. I am not an insurance expert, but I would say that from the standpoint of the National Association of Realtors, if they were given the opportunity to provide an AHP plan to our 1.3 million members, we would certainly benefit from the fact that the National Association of Realtors has a robust value proposition to offer the rest of us who are

small, independent, and individual company owners who do not have the time and the ability to do the kind of work that you're suggesting.

Chairman WALBERG. I thank the gentlelady; her time has expired. I recognize the businessman and gentleman from Pennsylvania, Mr. Smucker.

Mr. SMUCKER. Thank you, Mr. Chairman. Mr. McGrew, your testimony underscores what I heard just recently in a meeting with realtors and their association in the district that I represent. I think top concern for them was health care. And I think all of them in the room, or almost all of them in the room, were covered through the individual marketplace and were experiencing the kinds of things that we have been hearing here, high cost, prohibitive premium costs, and very high deductibles.

I know in other situations I have heard individuals who really wanted to go into business for themselves but saw the costs of health care as a barrier to entry essentially. Are you finding that with realtors as well? Are they making decisions not to go into real estate because of the cost of health care?

Mr. MCGREW. Absolutely. There are career decisions being made every day based on your ability to get health insurance. And it's interesting to me. The entrepreneurial spirit that is embodied in the realtor community is prevalent around the United States as well. And why is it that individual sole proprietors that have this spirit are discriminated against, if you will, from having the ability to access the more affordable health care markets?

Mr. SMUCKER. That is the way I see it. It was mentioned earlier that we want to ensure that everybody can get to play by the same rules. And I think, you know, we have seen tremendous opportunities, tremendous prosperity in our country because of unleashing individuals' ability to start a business, to grow their businesses.

And I was an owner of a large enough business with several hundred employees that could self-insure. First of all, we had a large enough pool we could buy our own insurance, but as we continued to grow we were able to self-insure. And being able to attract employees from other businesses, the health insurance that we had available was often the deciding factor, being able to pull them away from another maybe potentially smaller business. So it really isn't a level playing field today, is it?

Mr. MCGREW. It does not feel like that, no, sir.

Mr. SMUCKER. And do you find that as well, Ms. Monson?

Ms. MONSON. I do find it as well that us as small employers don't have the same opportunities to get affordable health care for our employees as large employers and labor unions do. And it puts us at a competitive disadvantage.

Mr. SMUCKER. Mr. McGrew, back to the realtors. In the event that the Association could put together an AHP, what percentage of realtors do you think participate in that?

Mr. MCGREW. From the standpoint of viewing that as an option, I think virtually all of them would. Today 90 percent of our members are covered one way or another, many of them through their spouses. If they had the opportunity to see better options that are provided from a brand they trust, a brand they already do business

with, the National Association of Realtors, I believe many of them would seriously consider that as an option.

Mr. SMUCKER. Ms. Monson, one of the things that I have noticed as well is that small businesses, particularly businesses under maybe ten employees, have just simply given up on being able to provide health care for their employees. The employees go to the individual marketplace and then are faced with the kind of high cost that we are seeing. Are you finding that with your franchisees as well?

Ms. MONSON. Yes, I am. I find that with our FASTSIGN franchisees. And also, on a recent survey that the International Franchise Association conducted with its 733,000 other franchise location members, 65 percent don't provide health coverage, primarily because of the cost. But then, when they were asked the follow-up question, if quality affordable insurance was available through say an IFA AHP or some other AHP—and let me just clarify, IFA is a bona fide association. This is not a fly by night deal, we are not looking to make a quick buck by getting into the association health plan market, this is about taking care of our members and our members' employees. We have a fiduciary responsibility, we care about our brand. We would never do anything to hurt our brand. So when I hear accusations that it's fly-by-night, that we're just going to put something together to make a quick buck, nothing could be further from the truth. And in that survey of our members, 100 percent say they would be looking forward to offering that quality, affordable health care coverage through an AHP.

Mr. SMUCKER. Thank you.

Chairman WALBERG. I thank the gentleman and I recognize my friend from Connecticut, Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman. And as long as we are all doing homework around here, I just would note that the letter that was submitted from the National Association of Insurance Commissioners that made a forceful argument for retaining regaining state authority over the operation of MEWAs and these association health plans was actually a very bipartisan letter. We have the Commissioner of the Tennessee Department of Insurance, as well as the South Carolina Department of Insurance who signed this letter. And, again, I would ask that it be added to the record.

Chairman WALBERG. It has been already, and duly noted, and Mr. Mitchell and Dr. Roe will probably want to discuss that with you.

Mr. COURTNEY. Well, again, I think, you know, these are the folks who are closest to this issue on the ground. And they talk about the fact that, you know, these plans have been plagued by insolvencies. That is quote, unquote in terms of the letter that they submitted. And, again, they raised a whole series of questions because, frankly, the Department has been very kind of slippery in terms of just, you know, what is going to be the lines of authority here, as was stated by some of the other witnesses. And because of that, they say at a minimum this rule should be put off until 2020, until we get to a really clear understanding of this.

I would just say, you know, to Mr. Condeluci, that, you know, the track record of U.S. DOL in terms of enforcing pension problems

that, again, is their jurisdiction since ERISA was passed, is very, very spotty. And we have had casework in my office where we have struggled, even under the Obama administration, in getting actually help for people in terms of pensions. So the notion that, you know, not to worry, you know, that the U.S. Department of Labor is going to have jurisdiction over 311 million people in this country with, you know, all the other authorities that they have to do and take it away from the folks in the attorneys general's offices or the insurance commissioner's office, in my opinion is really a very risky proposition. And, again, we have amply experience to show that really is not, in my opinion, the way to go given, again, the real empirical history that we know about in terms of association health plans.

Now, we have heard some conversations here about the fact that, you know, we really should give people the option for the catastrophic coverage. Mr. Lewis talked about that earlier.

Again, Mr. Arensmeyer, you know, I actually just had a hip surgery eight weeks ago and, you know, after one night in the hospital it was, you know, get out of here, because, as we know, health care has shifted outside of hospitals now. I mean the notion that the old days of catastrophic coverage—actually, that was where the majority of health care was delivered, you know, back in the '60s and the '70s, in the heyday of catastrophic coverage. The essential health benefits, which was part of the *Affordable Care Act*, was grounded in the Institute of Medicine going out and analyzing, you know, what is health care, you know, where is it delivered. And that is really what was sort of the structure in terms of making sure that people are going to get the necessary care that they need.

And catastrophic plans, which just take care of hospitalization, that doesn't work in the 21st century. And I was wondering if you could comment on that.

Mr. ARENSMEYER. Well, absolutely. And I want to echo what the Ranking Member said, that the way we're going to—first of all, the ACA needs some fixes. I mean we're the first to argue that. But we need to do this on a common ground, working together with a common risk pool, with common rules of the road. And if you start to sort of Balkanize or break off different pieces of the market it makes it much harder.

Essential health benefits not only were put in place to cover, you know, what was generally perceived among professionals to be stuff that should be covered, there also was a common set of rules. And, again, to say it again, Mr. Condeluci said the small group market as a result doesn't have a lot of price differences in it because of that. So we would absolutely—we want to see more competition, we want to see fixes made to the *Affordable Care Act*, but we want that done with a common set of rules.

Mr. COURTNEY. Thank you. And, again, as a small employer myself before I was elected to Congress ten years ago, and saw what was happening to age rating pre-*Affordable Care Act*, I mean every time I had an employee who hit the age of 50 their rates went through the roof because age rating was about six to one back then under the market. The ACA contracted that down to three to one. And, again, I wasn't here earlier, but I just want to reinforce that point. We are opening the door here now to age rating, which I

have a lot of realtor friends back home, I mean they tend to be, you know, folks in their 50s and up and they tend to be frankly more women. And, you know, gender rating and age rating, you are reintroducing that. You know, careful what you ask for.

And I would just note again, lastly, that there are 652 operating association health plans in this country right now, so this is not like the ACA posed some existential threat to association health plans, they are out there and they are working. The question is how are they going to be organized. And we want to make sure that people get the care that they need in 21st century terms, not 20th century terms. And we also want to make sure that the benefits are going to be fair in terms of how they are allocated.

With that, I yield back.

Chairman WALBERG. I thank the gentleman. And now I am privileged to recognize the gentleman and hero from South Carolina, Mr. Wilson.

Mr. WILSON South Carolina. And thank you very much, Chairman, Tim Walberg. I appreciate your leadership to promote positive health care, to address that Obamacare has destroyed 300,000 business jobs and forced 10,000 small businesses to close.

And, Mr. McGrew, thank you for your testimony on behalf of the National Association of Realtors. As a former real estate attorney myself and a grateful dad of a realtor, I appreciate your service on the executive committee and board of directors of the Association.

You mentioned in your testimony that many of your real estate agents serve as independent contractors. Can you explain the system in the real estate industry and elaborate on the advantages that operating as an independent contractor provides for real estate agents and for the agencies they work?

Mr. MCGREW. Thank you, Mr. Congressman. Yes, independent contractors are a notion that not everyone understands. When you have the opportunity to make a living with the least number of restrictions on the way that you do your business, that is the spirit that most independent contractors, certainly realtor independent contractors bring. They want that opportunity to build their own brand within the confines of the required supervision that companies like mine provide for them, but they can build their own business with a minimum of interference. And that's the good news.

The bad news is, as I mentioned in my testimony, it's an eat what you kill business. They have to have something to hunt and we do not guarantee them a paycheck.

Mr. WILSON South Carolina. Well, I just want to point out, too, as Mr. Courtney, that we appreciate realtors in our community. They are leaders in the Chamber, the Rotary Club, the Lions Club, wherever you need a volunteer, there are realtors. So thank you very much for such professionals.

Mr. MCGREW. Thank you.

Mr. WILSON South Carolina. And, Ms. Monson, I want to thank you for being here today too on behalf of the International Franchise Association. Your organization is appreciated for providing entry-level jobs leading to extraordinary achievement for workers. What a great opportunity to provide for young people in particular to achieve.

You mentioned that the recently proposed rule to allow small businesses to band together to help lower cost, create greater flexibility, increase access, and reduce administrative expenses. You noted that many of the same principles have allowed the franchise model to be successful, having franchising especially suitable to the formation of association health plans. You say "franchising is perfectly built for AHPs." Can you explain how the franchise model utilizes its distribution communication and business practices that would complement an association health plan?

Ms. MONSON. Yes. Thank you very much. So if we take a look at just what FASTSIGNS International does for its franchisees, with over 600 locations in the United States and then another 30 in Canada, and in other countries as well, when we look at the supplies that they use every day, we negotiate with vendors. Because of the volume purchases, we get lower prices. Even for services like payroll processing, we have an amazing rate with some of the payroll processing companies, giving our franchisees lower cost compared to their independent competitors. And we do that with equipment, supplies, services, everything that a franchisee in our business would need. We have that expertise, we have a supply chain group that focuses just on lowering costs for franchisees through negotiating.

Likewise, the International Franchise Association could do the same, bringing that same knowledge and expertise of franchising, of group buying power, and negotiating. And so we are very confident that we can bring the cost down and compete for the same quality coverage that large companies and unions have, at a lesser price using that supply chain negotiating skill and experience.

Mr. WILSON South Carolina. And, again, I appreciate franchises. On Sunday, I was at a Wendy's and I couldn't believe how hard-working the people were as they were confronted with a baseball tournament at a next door park. A line as far as you could see. And then a bus full of Chinese tourists in West Columbia, South Carolina. And the people behind the counter had a smile the whole time, which was startling.

And then, Mr. Condeluci, in your written references to the 2011 guidance by the Department of Health and Human Services prohibiting forming a fully insured large group plan. What impact did this have on association health plans?

Mr. CONDELUCI. I first want to set the record straight that when I said that small group plans typically have uniform prices, that's based on the fact that there are uniform rules within a particular market. But different state, small group markets vary widely, so costs vary widely. And relative to the large group market, small group market costs are much higher. So I just want to set the record straight because Mr. Arensmeyer continues to point out the point that I had made earlier. So I just want to clarify that point.

Sir, to your question, thank you very much for that. The 2011 guidance had an adverse effect on employer-run organizations like local chambers of commerce and otherwise who are offering fully-insured association health plans. It essentially blew up their plan. They had a choice to either discontinue their plan or shift to a self-insured plan because the guidance required the insurance company to look through the association, the underlying size of the group,

to apply the ACA's new market reforms. And that had an adverse impact and discouraged these employer-run organizations offering these plans. And that is the adverse effect that the 2011 guidance had on those fully insured arrangements.

Mr. WILSON South Carolina. And thank you all for being here today.

Chairman WALBERG. I thank the gentleman. I want to at this time thank the panel for your competency and your commitment to presenting your case in the real worlds that you live in. So thank you for taking the time to be with us today.

So at this point I would ask my friend and colleague from Delaware, Ms. Blunt Rochester, for your closing comments.

Ms. BLUNT ROCHESTER. Thank you, Mr. Chairman. I want to first thank the Chairman and the witnesses for your testimony. Ms. Monson made a comment about caring about the brand and also about our people. And that is evident by the fact that you are all here on this panel. I think one of the challenges that we face as lawmakers, and the same with our attorneys general across the country, and our insurance commissioners, is that we are protecting folks because of folks that are not in this room, that do not care as much as you do, which reminds me of a clarification that we would like to share on the letter that Mr. Courtney referenced. It was not a duplicate, it was actually from the National Association of Insurance Commissioners. So we would like to submit that letter on his behalf.

Chairman WALBERG. Without objection, I hear none, it will be submitted.

Ms. BLUNT ROCHESTER. Thank you. And I opened this hearing by noting the eighth anniversary of the ACA, and just a reminder of the progress that we have made in ensuring that more Americans have access to affordable, comprehensive coverage. This anniversary also serves as a call to action to strengthen the ACA and to do more to increase access to coverage. Instead, it feels like we are again defending the health care system. And at the latest, we are now attacking this from the small business owners and their employers' perspective, their employees.

I just want to be clear that I fully support small business owners, both in my home state of Delaware and across the country. Small businesses are the driving force of our economy and it is critical that we work to ensure that owners have the resources they need to build thriving businesses of their own.

That is why I am deeply concerned about the potential impact of this proposed rule on small businesses and their workers. There is no doubt that the expansion of the association health plans as proposed under the rule would needlessly expose hardworking small business owners and their workers to inadequate coverage and out of pocket expenses. Many of the over 900 comment letters from legal experts and consumer advocates that were submitted to the Department have been mentioned here today, and many of these comments raised concerns that the proposed rule could destabilize the state regulated individual and small group markets, leaving consumers with less comprehensive coverage, undermining state's authority to regulate health insurance markets and protect con-

sumers, and exposing small businesses and workers to fraud and insolvencies.

As you are aware, there are serious doubts as to the Department of Labor's legal authority to make the policy changes envisioned in this proposed rule. Mr. Condeluci in his testimony characterized the rule as changes to the law.

If we want to help small businesses and their employees we should not advance a rule that would leave them with insufficient coverage that renders them unable to access vital health services, such as mental health treatment, maternity care, and substance use disorder treatment.

I do think the Committee would benefit from the opportunity to hear from the Department of Labor on this rule and I will look forward to working with Chairman Walberg to make that happen.

In the meantime, I think our time would be better spent talking about efforts to strengthen the *Affordable Care Act* and increase access to affordable, comprehensive health coverage.

I yield the remainder of my time.

Chairman WALBERG. I thank the gentlelady. And, again, this hearing has been just that, a hearing opportunity to have ideas and concerns raised to give us a better opportunity to address. Yes, eight years of the *Affordable Care Act* is coming to fruition. During the course of all of those eight years since the *Affordable Care Act* was passed in a non-bipartisan fashion and pushed through, we have had to deal with it. And multiple times, in fact, we have reformed portions, repealed portions that didn't work in the *Affordable Care Act*, and have done that to a great degree in a bipartisan fashion, with even President Obama signing some of those changes. We did pass in the House very significant comprehensive reform, to a great extent to repeal. We did our work on that. We continue to address concerns, and this indeed is one of those areas that we have to work toward.

As I listened today to the panel, it just reinforced my memory on the fundamental strength of this country that was developed as a result of small businesses, entrepreneurial efforts, people who took risks to provide goods and services to our developing nation that brought about a financial system, a finance system that was enabled to assist businesses, small businesses, entrepreneurs, in starting out their life and the opportunity to succeed in this great new formed country, which had an idea never before tried in the world. Doggonit, we have been pretty successful, haven't we? And I think our process is to continue that and to find means by which we can encourage, not simply corporations—and we love that, certainly in Michigan—but the auto industry and many other large corporations that have helped this country be what it is. We still go back to those small businesses, business men and women who take that risk and want to move forward, who don't want to be a part of a large corporation necessarily, but I would also state, want to acquire a workforce that makes them successful. And in this day and age, unlike not all that far back, there are communication abilities that allow individuals to know what is working and what will work better for them in another business opportunity. And so the competition has been ramped up.

And I think it is a moral obligation for us to be as least restrictive as possible with the basic preventative and protection requirements still put in place, yes, but least restrictive to allow these entities as well, small businesses, to compete on as level of a playing field as we can make it, by allowing them to offer and afford to their employees an equal opportunity to have the most important care that they feel for themselves, and that is health care, brought to them in a least restrictive way, in the fullest possible way.

And so that is the purpose of this hearing today. I think the issue will go on. I think we will continue to discuss it. We certainly want to hear from the Department of Labor. We want to know that they are doing good work to make sure that our people back in our Districts have that good work made available to them to continue to advance, to care for their employees, and to do it in the best way possible.

So, again, I thank you for our Committee's efforts, I thank the panel for being here today. But with no further agenda before the Subcommittee today, it stands adjourned.

[Additional submission by Ms. Blunt Rochester follows:]

NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

March 6, 2018

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

Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed regulation, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans" (83 Fed. Reg. 614 (Jan. 5, 2018)) (AHP Proposed Rule), which expands the criteria under ERISA for determining when employers may join together in an association that is treated as the ERISA "employer" of a single, multiple employer group health plan. We write as the chief insurance regulators of our respective states and members of the National Association of Insurance Commissioners.

Before turning to our specific comments on the proposed regulation, we think it is helpful to provide some experiential context as insurance regulators. As you know, states have a long history of regulating insurance in general and Multiple Employer Welfare Arrangements (MEWAs) in particular. MEWAs have had a colorful and troubling history since the enactment of ERISA in 1974. While the promise of MEWAs has always been to give small employers access to low cost health coverage on terms similar to those available to large employers, that promise has never been the reality for a number of reasons.

Pre-1983, MEWAs were plagued by insolvencies. Opportunistic third party promoters saw MEWAs as profit-making opportunities. They claimed ERISA preemption of state laws, whether or not the MEWA was a legitimate ERISA plan. MEWA promoters took advantage of the regulatory void and made money at the expense of their participants. These insolvencies, whether through malice or incompetence, resulted in significant sums of unpaid claims and the loss of health insurance for participants. In 1983, in response to these troubling market conditions, Congress enacted the Erlenborn-Burton Amendment to save state regulation from ERISA's preemption and deemer provisions. Congress recognized that it was both necessary and appropriate for the states to be able to establish, apply and enforce state insurance laws with respect to MEWAs.

Nevertheless, even after the 1983 ERISA Amendments expressly established that state regulation of MEWAs was not preempted, MEWA promoters and others continued to create confusion and uncertainty by falsely claiming ERISA coverage and protection from state regulation under ERISA's preemption provisions. The U.S. Department of Labor (DOL) recognized that this confusion did not serve consumers, as outlined in the current AHP Proposed Rule preamble.

Notably, fraud and abuse have not been the only issues with MEWAs. Even well-intentioned non-fully-insured MEWAs have been notoriously prone to insolvencies. Keeping the cost of coverage low tends to be the primary focus of MEWAs. In the past, some MEWAs became insolvent simply because the MEWA did not want to raise rates for its member employers and their employees. Solvency is also a challenge for MEWAs under the best of circumstances because they are, by their very nature, an unstable risk pool. They do not have the consistency of membership like a true large employer.

With this historical context, we turn to the proposed regulation. The DOL and the NAIC share the same goals – providing affordable options for consumers, while ensuring markets remain stable and consumers are protected. It is particularly important that the federal rule, as it is implemented, not threaten the states' ability to enforce existing laws or enact laws in the future that regulate insurance. States remain in the best position to monitor closely what is happening in their insurance markets and have the tools in place to respond quickly to any issues.

The AHP Proposed Rule clearly and rightly confirms that Association Plans created under the new rules are still MEWAs and are fully regulated by the states (largely indirectly in the case of fully-insured MEWAs; directly in the case of non-fully-insured MEWAs). The provisions in ERISA that preserve state regulatory authority over the MEWA and the plans it may purchase are not modified in this proposed rule and, therefore, existing state authority is not changed.

However, some entities have commented that the revisions proposed by DOL to the definition of employer could create ambiguity regarding the ability of states to regulate MEWAs: both MEWAs that are not fully insured, and the insurance products offered to MEWAs that are fully insured. To avoid potential confusion, and lawsuits, we recommend that DOL affirm in the final AHP Rule that these changes in no way limit the ability of states to regulate MEWAs, insurers offering coverage through MEWAs, and insurance producers marketing that coverage to employers.

Therefore, we encourage you to confirm that states retain full authority, as recognized by the Erlenborn-Burton amendment to ERISA, to set and enforce solvency standards for all MEWAs, and comprehensive licensure requirements and oversight for non-fully-insured MEWAs. The states' authority over non-fully-insured MEWAs includes benefit, rating and consumer protection standards, and laws specifying who is eligible to apply for licensure. We also encourage you to affirm that states retain full authority under ERISA's saving clause to regulate the terms of the insurance coverage that may be offered to fully insured MEWAs.

Given that bad actors have historically used any ambiguity regarding ERISA preemption as a shield to challenge state oversight and defraud consumers, it is critical that the final rule dispel any questions.

In addition to our overarching concerns, we provide the following comments:

- **Coordination between DOL and State Insurance Departments** – It is critical that the DOL focus efforts and resources on coordination with state insurance departments. The NAIC has enjoyed a long-standing cooperative relationship with the DOL, especially with respect to MEWAs. In the past, the DOL and states have worked together to identify bad actors and support the coordinated use of state and federal tools to prevent harm to consumers. We trust that this relationship will continue and look forward to renewed coordination with DOL to make sure that this expansion of AHPs doesn't lead to a new era of fraud, abuse and insolvencies that ultimately harm consumers.

- **Exception for certain not fully insured MEWAs** – Consistent with our desires to coordinate with the DOL and avoid repeating the troubled history of MEWAs, we strongly caution against an exception from state law for certain not fully-insured MEWAs. Granting such exceptions without first assembling all the resources and expertise necessary to carry out the regulatory functions currently exercised by the states would ignore the reasons (detailed above) for the preservation of the state regulation of MEWAs under current law.

- **Region not to Exceed State or Metropolitan Area** – The AHP Proposed Rule allows an AHP to satisfy the commonality requirement if its members have a principal place of business within a region that does not exceed the boundaries of the same state or metropolitan area. We suggest that DOL define a metropolitan area consistent with definitions developed by the Office of Management and Budget and used by the census bureau and other federal agencies. We are also concerned that the DOL commonality requirement does not include a definition of region. Without clear guidelines, an AHP could define a region or a metropolitan area to avoid areas that are less affluent and, therefore, more likely to have chronic health problems. States should continue to have the authority to set required service areas.

- **Working Owners** – The AHP Proposed Rule extends the ability to join an AHP as an employer and as an employee to "working owners" and requests comment on whether the rule should use different criteria than the number of hours of service per week or month or income that at least equals the cost of coverage. We suggest that the DOL should limit working owners to individuals who can substantiate the claimed income or work hours through tax filings as self-employed individuals or members of partnerships under the Internal Revenue Code (IRC). Using the IRC definition would ensure, consistent with the stated intent of the NPRM, that "working owners" who join an AHP are genuinely engaged in a trade or business and are performing services for the trade or business in a manner that is in the nature of an employment relationship.

- **Nondiscrimination** – The AHP Proposed Rule requests comment on the nondiscrimination provisions. We agree that nondiscrimination provisions are critical to preventing outright adverse selection against the individual and small group markets in a state. However, AHPs could also use benefit designs, membership requirements or dues structures to discriminate against employers with higher cost employees. This is another example of why it remains critical for states to be able to continue to regulate in this area.

- **Notice Requirements** – The AHP Proposed Rule asks for comment on whether there should be additional notice requirements to ensure that employers, their employees and beneficiaries are adequately informed of their rights and responsibilities with respect to AHP coverage. We support robust notice requirements; however, DOL must be sure to coordinate with the states on the contents of the notices to avoid confusion and undue administrative costs.

- **Timing** – The DOL should postpone the effective date of the rule to 2020 to give states time to review their rules and regulations and facilitate a smooth transition.

Thank you for this opportunity to comment, and for the efforts of Secretary Acosta and DOL leadership to engage with us constructively on this proposal. We are available to discuss these or other issues as the AHP Proposed Rule is finalized.

Sincerely,

Julie Mix McPeak
NAIC President
Commissioner
Tennessee Department of
Commerce & Insurance

Eric A. Cioppa
NAIC President-Elect
Superintendent
Maine Bureau of Insurance

Raymond G. Farmer
NAIC Vice President
Director
South Carolina Department of Insurance

Gordon I. Ito
NAIC Secretary-Treasurer
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[Additional submission by Ms. Bonamici follows:]

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March 6, 2018

Secretary R. Alexander Acosta
United States Department of Labor
200 Constitution Avenue, NW
Washington, DC 20120

Re: RIN 1210-AB85

Submitted electronically via regulations.gov

Dear Secretary Acosta:

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, and US Territories, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

We appreciate the opportunity to comment on the Department of Labor's (Department) proposed rule that would expand the availability of association health plans (AHPs) by expanding the definition of "employer" under section 3(5) of ERISA. We write to express our concerns that the proposed rule's expansion of AHPs could put consumers at risk of fraud and abuse, preempt state consumer protections and oversight of these insurance products, and greatly increase the likelihood that working Americans, especially those age 50-64, would face higher insurance premiums and loss of access to critical health insurance coverage.

AARP has long raised concerns with the lack of protections and benefits for consumers under AHPs, specifically since AHPs increase the fragmentation of risk pools, which drive up the costs for older Americans[1]. With the passage of the Affordable Care Act (ACA), consumers in both the individual and small group markets were guaranteed a basic set of benefits and protections, including the prohibition on discrimination in coverage based on preexisting conditions and limitations on pricing based on age, as well as access to essential health benefits (EHBs). We have serious concerns that the

[1] AARP letter to Sen. Enzi on S.1955, March 7, 2006

Department's proposed rule is a step backwards and will once again subject consumers unaffordable costs and to inadequate health insurance coverage.

Our biggest concerns are that, as a result of this proposal, older Americans in the existing small group market will see much higher costs. Specifically, the proposed rule would not apply the ACA's 3:1 age rating to AHPs. Prior to enactment, health insurers were allowed to discriminate against older workers and charge small businesses in some cases ten times higher for older workers than younger workers, effectively rendering coverage inaccessible for small businesses with older workers. The 3:1 age rating in current law is already a compromise that requires older Americans to pay three times more than younger individuals for health insurance coverage that protects older workers from being charged exorbitantly higher premiums than other people based solely on age.

Not only is AARP concerned about significantly higher insurance costs for older adults, but we are also concerned about the Department's lack of ability to police these new plans. Currently, the Department employs 400 investigators to monitor over 5 million plans[2]. The Department acknowledges that AHPs have had a history of fraud and abuse, and yet has no significant additional resources to assure that fraud will be minimized. For those employees who find out that their hard earned money is not there when they need health insurance coverage, this can only add to the stress when they are dealing with an illness.

Moreover, the Department's proposal lacks empirical analysis on the impact of AHPs in the current small group market. We are very concerned that the proposed rule's own impact analysis concedes a great amount of uncertainty in the impact of this rule on consumers, stating that while "the impacts of this proposed rule, and of AHPs themselves, are intended to be positive on net, the incidence, nature and magnitude of both positive and negative effects are uncertain."

Alternatively, we are supportive of the 2011 AHP guidance from the Centers for Medicare & Medicaid Services (CMS) that holds "in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules." This ensures that employees in the small group market are afforded protections in the ACA that prevent discrimination based on age and preexisting conditions. We encourage the Administration to maintain the view that employment based coverage be based on size alone. This would ensure that the ACA's consumer protections - most importantly the 3:1 age band and protections against preexisting condition discrimination -remain intact for small group coverage.

Consumer protections in health insurance markets are critical to ensuring that consumers can rely on the coverage they purchase and that it is there when they need

[2] Fact Sheet, *EBSA Restores $1.1 Billion to Employee Benefit Plans,* goo.gl/rQm7U6

it. The proposed rule itself provides examples (§2510.3 (d)(5)) that demonstrate the complexity of the proposal and the ability – despite the application of ERISA and HIPPA nondiscrimination standards- for discrimination based on a pre-existing condition in AHPs. The nondiscrimination standards that DOL relies upon are inadequate to providing meaningful consumer protection for older adults and people with pre-existing conditions. While an older worker may not be denied coverage outright based on their age or pre-existing condition, the proposed rule would allow AHPs to be formed and designed in such a way that would once again allow discrimination based on a pre-existing condition and higher costs for small employers that employ older workers. Accordingly, AHPs would attract and meet the needs only for a healthier pool making this coverage option unaffordable for employers with an older workforce and/or workers that have pre-existing conditions.

In addition, the Department requested comments on the types of consumer protections and disclosures that would be needed as part of any final AHP regulation. AARP strongly believes that DOL should clearly affirm that both the employer and AHP are fiduciaries with all of the attendant obligations that ERISA fiduciary duties include. The rule should make clear that employers must prudently select and monitor AHPs. The rule also must make clear that the AHP is required to serve as a named fiduciary. Given that AHP members are likely to be small employers, the AHP should be required to provide advance disclosure to employers of all fees and services, insurance contracts, and employer legal obligations under the contract. DOL also should make clear whether employers or the AHP will provide all required notices to participants and beneficiaries and DOL. Participants and beneficiaries should be provided understandable disclosure of the role of the AHP, all plan benefits and charges, and any penalties that may occur for employer, participant or beneficiary non-payment of premiums. If the AHP files the Form 5500, then the names and addresses of all participating employers must be included and searchable by employer name on the DOL website.

While the proposed rule asserts that AHPs may provide a useful service by helping small employers find insurers or pool administrative services and some risks, this proposal fundamentally undermines the quality, affordability, and availability of health insurance. Permitting an employer to contract for limited benefits will place a massive burden on older workers and their families every time a beneficiary develops a major illness such as cancer and finds out it is not covered. Current law requires employers to provide coverage that includes the EHBs. We cannot afford to take a step backwards and expose more Americans to unaffordable costs and inadequate health insurance coverage.

Once again, we thank you for the opportunity to comment on this proposed rule. If you have any questions, please do not hesitate to contact Brendan Rose on our Government Affairs staff at 202-434-3770 or brose@aarp.org.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director

[Additional submission by Mr. Espaillat follows:]

Attorneys General of New York, Massachusetts, California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Maine, Maryland, New Jersey, New Mexico, Oregon, Pennsylvania, Vermont, Virginia

March 6, 2018

Via Federal eRulemaking Portal
Director Joe Canary
Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW, Ste. N-5655
Washington, DC 20210

Re: Comments on Proposed Rule: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 614 (Jan. 5, 2018), RIN 1210-AB85; Request for a Public Hearing

Dear Mr. Canary:

The undersigned State Attorneys General submit these comments to oppose the Department of Labor's Proposed Rule: *Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans*, 83 Fed. Reg. 614 (proposed Jan. 5, 2018) (to be codified at 29 C.F.R. pt. 2510) ("Proposed Rule"). The Department of Labor ("Department" or "DOL") proposes to expand the criteria for determining when employers may join together in an association to purchase health coverage, allowing individuals and small employers unprecedented ability to group together as an association in order to exempt them from many of the Affordable Care Act ("ACA") protections that currently apply to individual and small group plans (including essential health benefit coverage and premium restrictions based on race and sex). These changes would increase the risk of fraud and harm to consumers; would undermine the current small group and individual health insurance markets; and are inconsistent with the text of the Employee Retirement Income Security Act ("ERISA") and the ACA.

Association Health Plans ("AHPs") have a long and notorious history of fraud, mismanagement, and deception. Over decades, Congress has legislated – including through ERISA and the ACA – to protect health care consumers from this fraudulent conduct. The Proposed Rule would reverse many of these critical consumer protections and unduly expand access to AHPs without sufficient justification or consideration of the consequences. Because the Proposed Rule is an unlawful attempt to accomplish by executive rulemaking changes in law and policy that lie within the power of Congress – and that Congress has refused or failed to adopt – we urge that the Proposed Rule be withdrawn. In addition, in light of the significant impacts this proposal would have on the States' consumers, health care markets, and

enforcement resources, we request that the Department hold a public hearing to receive input from affected stakeholders before any regulatory changes are finalized.[1]

I. Background

Section 3(5) of ERISA defines "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." 29 U.S.C. § 1002(5). ERISA allows an "association of employers" to manage employee benefit plans offering health insurance. To protect these associations from becoming mere commercial insurance arrangements that serve only a profit motive – instead of operating as legitimate employer/employee health benefit plan arrangements as ERISA intended – the Department has consistently required that members of such associations consist of a "bona fide" group of employers with a high degree of common interest, or *"commonality of interest,"* beyond solely purchasing or offering health insurance. The association's employer members must also themselves exercise "control," both in form and substance, over the activities and operations of the employee welfare benefit plan.

The Proposed Rule largely eliminates these current requirements, and instead would allow *any* group of employers in the same industry or the same geographic area to form employer associations under ERISA, even if their sole purpose is simply to purchase health insurance. In short, the Proposed Rule would make three substantial changes:

1. Eradicate longstanding ERISA definitions such that associations may form solely for the purpose of purchasing or providing health plans if the employers are in the same industry or the same geographic region;
2. Deem self-employed individuals to be both employers and employees such that they can participate in employer associations; and
3. Allow most associations to be single, large employers such that they may evade many ACA requirements (now imposed on small group and individual plans).

These changes would vastly expand the ability of AHPs to form in ways that would result in fewer protections for our citizens, increased fraud within our borders, and destabilization of our individual and group markets.

[1] *See, e.g.*, U.S. Dep't of Labor, *Hearing on Definition of the Term "Fiduciary"; Conflict of Interest Rule – Retirement Investment Advice and Related Proposed Prohibited Transaction Exemptions*, 80 Fed. Reg. 34,869 (June 18, 2015) (scheduling a four-day public hearing for August 2015 to consider issues related to the Department's proposed conflict of interest rulemaking under ERISA); U.S. Dep't of Labor, *Hearing on Definition of "Fiduciary"*, 76 Fed. Reg. 2142 (Jan. 12, 2011) (scheduling a two-day public hearing for March 2011 to receive input on the Department's October 2010 fiduciary rulemaking proposal under ERISA, "to ensure that all issues are fully considered and interested persons have sufficient time to share their views on this important regulation").

II. The Proposed Rule Would Facilitate Increased Fraud and Misconduct Relating to AHPs

AHPs and other multiple employer welfare arrangements ("MEWAs") have a lengthy and well-documented history of fraud and abuse. Although AHPs and other MEWAs are not uncommon, very few of these arrangements are covered by ERISA as they commonly fail to meet the requirements of ERISA and longstanding DOL regulations and guidance. By dramatically expanding the use of AHPs under ERISA, while also failing to include any provisions that would decrease the likelihood of future misconduct, the Proposed Rule would substantially weaken the current regulatory structure that safeguards against fraud and abuse.

A. There Has Been an Extensive History of Fraud and Mismanagement Associated with AHPs

By enacting ERISA in 1974, Congress federalized the regulation of employee benefits, including employee benefits plans. Immediately after ERISA's passage, various entities marketing MEWAs entered the health insurance market. The plans offered by these entities were rife with abuse and mismanagement and left behind a trail of unpaid claims.[2] When states sought to enforce their own insurance laws to regulate these plans, the entities argued that ERISA preempted state law, in many cases hindering efforts to stop fraudulent and illegal activity.[3] At the same time, the DOL claimed to lack authority over these insurance arrangements because most were not, in fact, ERISA plans.[4]

In response, Congress amended ERISA in 1982 to eliminate any doubt regarding ERISA preemption of state laws as to MEWAs, firmly declaring that MEWAs are subject to state insurance laws, *see* 29 U.S.C. § 1144(b)(6)(A), and recognizing that the federal government alone could not adequately protect consumers against the fraud and insolvency of MEWAs.[5]

Despite the unambiguous authority granted to the states to regulate MEWAs, entities seeking to market dubious AHPs have sought to exploit any regulatory gaps. These entities have an extensive record of fraud, gross mismanagement, and illegal activity in the marketing and operation of MEWAs and AHPs across the country.[6] In the late 1980s, scammers unleashed a

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[2] Mila Kofman, *Assoc. Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Health Policy Inst., at 2 (Summer 2005), https://hpi.georgetown.edu/ahp.html (providing history of attempts to regulate AHPs by state and federal governments).

[3] *Id.* at 7; *see also* U.S. Government Accountability Office ("GAO"), *Employee Benefits: States Need Labor's Help Regulating MEWAs*, GAO/HRD-92-40, at 8 (Mar. 10, 1992), https://www.gao.gov/assets/220/215647.pdf; U.S. Dep't of Labor, *MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Fed. and State Regulation*, at 3 (Aug. 2013), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

[4] Mila Kofman, *supra* note 2, at 7.

[5] The House of Representatives had earlier clarified the intended scope of ERISA through a resolution stating that plans marketed by entrepreneurs to employers and employees are not covered by ERISA. *See* H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).

[6] *See, e.g.*, GAO, *Private Health Ins.: Employers and Individuals Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312, at 3-5 (Feb. 27, 2004), https://www.gao.gov/assets/250/241559.pdf; GAO,

wave of fraud and misconduct through phony unions, relying on the ERISA exemption for collectively bargained union plans. From 1988 to 1991, failed MEWAs left thousands of people in dozens of states without health insurance and nearly 400,000 patients with medical bills exceeding $123 million.[7] Following a 1991 Senate Report finding that fraudsters attempted to use ERISA to avoid state oversight, Congress eventually required MEWAs to register with the DOL before operating in a state.[8]

A 2004 GAO Report again found that employers and individuals were vulnerable to unlicensed or "bogus" entities selling fraudulent health insurance coverage through, among other things, "associations they created or through established associations of employers or individuals."[9] In total, GAO identified 144 unauthorized entities that covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002.[10] These entities failed to pay at least $252 million in medical claims and state and federal regulators were able to recover only a fraction of this amount.[11] Although state insurance departments sought to stop these entities' activities in their states, nationwide enforcement was hampered because many of the promoters operated across state lines and the DOL was not able to effectively clamp down on these plans.[12]

The ACA, passed in 2010, aimed to provide comprehensive health coverage for all, and its provisions have worked to prevent MEWA fraud in a number of ways. AHP members benefit from the protections of the individual and small group health plan market, including requirements to cover essential health benefits and meet actuarial value requirements. These protections are vitally important in light of the extensive history prior to the ACA of skimpy health plans (of the sort that the DOL now seeks to encourage) causing significant harm to consumers through, for example, medical bankruptcies, failure to cover necessary benefits, and caps on coverage. In addition, the ACA incorporated a series of enforcement tools to prevent MEWA abuses. *See, e.g.*, Sections 4376 (imposing fees on applicable self-insured MEWAs); 6601 (prohibiting false statements in connection with the marketing and sale of MEWAs – subject to up to ten years of imprisonment or fine); 6602 & 10606 (amending definition of "federal health care offense" to include violation of MEWA-related provisions); 6605 (enabling the DOL to issue administrative summary cease and desist orders against plans, including MEWAs, that demonstrate financially hazardous conditions); 6606 (requiring MEWAs to register with the Secretary of Labor before operating in a state). These enforcement tools, which include fines and imprisonment, evidence the serious concerns Congress had with respect to MEWAs – plans that the Proposed Rule now seeks to proliferate.

Employee Benefits: States Need Labor's Help Regulating MEWAs, at 3-7; Mila Kofman, et al., *Proliferation of Phony Health Ins.: States and the Fed. Govt. Respond*, Bureau of Nat'l Affairs, at 13-15 (Fall 2003).

[7] GAO, *Employee Benefits: States Need Labor's Help Regulating MEWAs*, at 2-3.

[8] Mila Kofman, *Ass'n Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, *supra* note 2, at 12.

[9] GAO, *Private Health Ins.: Employers and Individuals Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, at 1-4.

[10] *Id.* at 4.

[11] *Id.*

[12] *Id.*

B. The Proposed Rule Would Dramatically Increase Problematic Use of AHPs by Weakening the Structural Safeguards Against Fraud and Abuse

As States and State Attorneys General, we have extensive experience protecting individuals and small employers within our states from predatory entities that seek to defraud or deceive customers through the use of AHPs. *See infra* Part VI. In light of this experience, we believe that the Proposed Rule would invite fraud and wrongdoing in the health insurance market that will threaten the health and financial security of consumers in our states.

First, by weakening the "bona fide association" requirement to allow unrelated employers to associate solely for health benefit purposes, the Proposed Rule would encourage fly-by-night associations to form, engage in misconduct, and disappear with employees' premiums. The Proposed Rule would transform the "bona fide association" conditions by (a) allowing the provision of health insurance to be the sole reason for an association's existence; (b) not requiring the association sponsoring an AHP to have been in existence for any length of time or to demonstrate its legitimacy its any other way; (c) eliminating the requirement that the association maintain substantive control over the AHP and, instead, require only that it have "formal" control by maintaining an organizational structure with by-laws and a board of directors; and (d) allowing geographic proximity alone to establish "commonality of interest." 83 Fed. Reg. 614, 635.

These changes would expand the treatment of "bona fide associations" to such an extent as to evade the statutory requirement that the association "act[] directly as an employer, or ... indirectly in the interest of an employer." 29 U.S.C. § 1002(5). Under ERISA, the employer or an association on its behalf is intended to serve as the guarantor of its employees' interests; but an association that is not truly a bona fide representative of its employer members cannot be counted on to protect them. It is the "representational link between employees and an association of employers in the same industry who establish a trust for the benefit of those employees" that provides the "protective nexus" that differentiates ERISA plans from other health insurance arrangements. *MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 186 (5th Cir. 1992). The Proposed Rule weakens the requirements to be a "bona fide association" so extensively that it would essentially eliminate any requirement of an underlying employer-employee relationship, without which small employers and employees are vulnerable to entities offering health insurance with whom they have no preexisting relationship at all. It is for this reason that Congress specifically did not include "commercial products within the umbrella of the employee benefit plan definition." *See* H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).

Second, the Proposed Rule would further weaken protections against fraud and mismanagement by allowing individuals who purport to own a business to join AHPs as employers even though they have no employees ("working owners"). 83 Fed. Reg. 614, 636. The Proposed Rule would not require the association sponsoring the AHP to obtain any evidence beyond the written representation of the working owner that he or she in fact owns a qualifying business. *Id.* This provision is particularly susceptible to abuse because it opens the door for fraudsters to market to individuals and then enroll them if they "check a box" confirming compliance with the written representation requirement in the Proposed Rule. The AHP could

then collect premiums, and, in the event that a policyholder submits claims, conduct an "audit" that results in the policy being cancelled or rescinded when it turns out that the individual did not, in fact, qualify as a "working owner" as defined in the Proposed Rule. AHP promoters have long marketed fraudulent or deceptive health plans to individuals through associations with whom the individuals have no relationship other than the provision of health insurance; if the Department grants them explicit permission to do so, they will again seize the opportunity to enroll untold numbers of individuals in similar plans.

The potential for fraud is particularly concerning given the characteristics of the "working owners" that AHP promoters are likely to target if the Proposed Rule is promulgated. For example, a business owner may require workers to establish their own LLCs so that the owner can misclassify these individuals as independent contractors even though they might otherwise meet the legal definition of employees. These employers would then very plausibly work with promoters to offer these employees access to AHPs that provide few benefits and little security, while nonetheless creating the impression that their employees are enrolling in comprehensive health care coverage. Workers in these situations, who are already subject to wage theft and other abuses, will be prime targets for unscrupulous AHPs when they should be considered employees eligible for employer-sponsored insurance in the first place. Similarly, "gig economy" workers could be taken advantage of through "employers" who promise health insurance, but arrange for skimpy AHP coverage instead, leaving these workers exposed to unexpected medical bills and without coverage for necessary medical services. Workers such as these are very likely to be harmed given the propensity of AHP promoters to engage in fraud and abuse or, at minimum, to offer skimpy plans with limited coverage.

Third, the Proposed Rule seeks to allow AHPs to provide coverage to a massively expanded universe of "employers" at the "association-level," rather than at the "employer-level." 83 Fed. Reg. 614, 618-19. The ACA's regulation of most AHPs at the "employer-level," generally as small groups, has reigned in much of AHPs' fraud and abuse.[13] By moving so many small employers and individuals out of these markets and into the large group market, the Proposed Rule would undermine the ACA's requirement of providing comprehensive coverage to individuals as well as to employees of small employers.[14] For example, the Proposed Rule would allow small employers and "working owners" who do not share a true commonality of interest and who do not belong to a bona fide association in any meaningful way to be regulated as a single large employer, outside of the individual and small group plan protections of the ACA, opening the door to fraud and abuse. 83 Fed. Reg. 614, 618-19. Moreover, the Proposed

[13] The Centers for Medicare & Medicaid Services in 2011 set forth: "[I]n most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules. In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the 'employer,' the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules." Memorandum from Gary Cohen, Acting Dir., Office of Oversight, Ctrs. for Medicare & Medicaid Servs., (Sept. 1, 2011) ("CMS 2011 Guidance"), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf. This guidance was also codified by New York. N.Y. Ins. Law § 4317(d)–(e).

[14] *Id.*

Rule's application will result in segmentation of the health care market into inexpensive plans with little coverage for the healthy and expensive full coverage for those with preexisting conditions.

III. The Proposed Rule Would Violate the Administrative Procedure Act Because It Is Contrary to ERISA, and Because It Is an Arbitrary and Capricious Change of Longstanding Agency Position

A. The Proposed Rule's Weakening of the "Bona Fide Association" Definition, if Finalized, Would Be Unlawful

The Department's proposal to change the "bona fide association" conditions is inconsistent with ERISA and several decades of case law applying ERISA, and would therefore be contrary to law and in excess of statutory authority. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."). Further, because the Proposed Rule is also inconsistent with the DOL's own longstanding position, this change would be arbitrary and capricious under the Administrative Procedure Act ("APA").

1. The Proposed Rule's New "Commonality of Interest" Requirements Are Contrary to ERISA

Section 3(5) of ERISA defines "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." 29 U.S.C. § 1002(5). When enacting ERISA, Congress's intent was clear: to maintain an employee benefit plan under ERISA, an association must be tied to the employees or the contributing employers by genuine economic or representational interests unrelated to the provision of health insurance benefits, and employer members participating in the plan must exercise actual control over the program.

Relying on a "plain reading of ERISA's language considered against the backdrop of express and implicit congressional intentions," Courts of Appeal have consistently held that the "definition of an employee welfare benefit plan is grounded on the premise that the entity that maintains the plan and the individuals that benefit from the plan are tied *by a common economic or representation interest, unrelated to the provision of benefits*." *Wis. Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1063, 1065 (8th Cir. 1986) (emphasis added) ("decision is premised on ERISA's language and Congress' intent"); *see also Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1998) ("commonality of interest requirement is well-established in the case law"); *MDPhysicians Inc.*, 957 F.2d at 185. This "common economic or representation interest" requires either that there be an "economic relationship between employees and a person acting directly as their employer" or a "representational link between employees and an association of employers in the same industry who establish a trust for the benefit of those employees." *MDPhysicians Inc.*, 957 F.2d at 185-86. Where the "only

relationship between the sponsoring [entity] and . . . recipients stems from the benefit plan itself," the "relationship is similar to the relationship between a private insurance company . . . and the beneficiaries of a group insurance plan," and is simply not covered by ERISA. *Wis. Educ. Ass'n Ins. Tr.*, 804 F.2d at 1063.

Moreover, under the Proposed Rule, AHPs would be allowed to organize for the sole purpose of offering health insurance coverage. Establishing an AHP for this purpose is the definition of a commercial insurance arrangement, rather than in service of an employer-employee relationship as intended by ERISA. This proposed change is inconsistent with Congress's intent of protecting ERISA plans from becoming mere commercial, for-profit insurance arrangements. *See Int'l Ass'n of Entrepreneurs of Am. Benefit Tr. v. Foster*, 883 F. Supp. 1050, 1057 (E.D. Va. 1995) (describing the circumstance of companies that market insurance products and characterize themselves as ERISA benefit plans to avoid state regulation, and noting that these plans "are no more ERISA plans than is any other insurance policy sold to an employee benefit plan") (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)).

Despite this uniform judicial interpretation of ERISA, the Department is proposing to redefine the bona fide association and commonality of interest requirements so that they no longer ensure that the association and the employees have a "common economic or representation interest unrelated to the provision of benefits." The Proposed Rule goes as far as allowing employers connected *only* by geography to satisfy the commonality of interest requirement, and for associations that exist for the sole purpose of providing health insurance to be deemed bona fide. 83 Fed. Reg. 614, 635. The DOL asserts that neither its "previous advisory opinions, nor relevant court cases, have ever held that the Department is foreclosed from adopting a more flexible test in a regulation . . . in determining whether a group or association can be treated as acting as an 'employer' or 'indirectly in the interest of an employer,' for purposes of the statutory definition." 83 Fed. Reg. 614, 617. However, the Department may not seek to issue a new regulatory interpretation that is counter to the unambiguous statutory language and the courts that have interpreted the statute. *See Public Citizen, Inc. v. Mineta*, 340 F.3d 39, 54-62 (D.C. Cir. 2003) (vacating rule because agency interpretation contravened legislative intent and plain reading of statute).

2. The DOL Does Not Offer Reasoned, Evidence-Based Rationales for Reversing Its Longstanding Position

The Proposed Rule would also be arbitrary and capricious because it would reverse several decades of consistent agency interpretation without reasoned support. *See Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015) (explaining that "the APA requires an agency to provide more substantial justification when 'its new policy rests upon factual findings that contradict those which underlay its prior policy'") (quoting *F.C.C. v. Fox Tel. Stations, Inc.*, 556 U.S. 502, 515 (2009)); *see also Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 57 (1983).

First, the Proposed Rule acknowledges but fails to address the long history of fraudulent and abusive conduct by AHPs and other MEWAs. The DOL concedes that "[h]istorically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving

participants and providers with unpaid benefits and bills." 83 Fed. Reg. 614, 631. The Department also acknowledges that "the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse, increasing potential oversight demands on the Department and State regulators." *Id.* at 632. In a footnote, the Department cites reports authored by the GAO and articles detailing the history of financial abuses associated with MEWAs. *Id.* at 614, n. 24. The DOL, however, does nothing else with these sources – whether to explain how the Proposed Rule would safeguard against the historical "financial mismanagement or abuse" it acknowledges, or to discuss any methods for preventing such fraud, or even mitigating the costs associated with a proliferation of abusive MEWAs. This is so despite the extensive records of this conduct maintained by the DOL, which may well show that entities that have engaged in fraud or gross mismanagement have operated in the very same ways that the Proposed Rule now seeks to encourage.[15] The justification provided by the Department – to allow more people to benefit from cheaper, less comprehensive plans – is woefully inadequate in the face of the clear history of fraud and abuse in the marketplace.

Second, the Proposed Rule allows AHPs to form on the basis of a "single industry or trade," *or* a common geographic region within a single state or multi-state metropolitan area, and dilutes the prior commonality of interest requirements to the point of elimination. The Proposed Rule now requires only formal association documents and the right of association members to elect the association's directors or officers that control the group or association. 83 Fed. Reg. 614, 620. Nothing in the Proposed Rule vests employer members with actual control over the directors or officers as is currently required by DOL guidance; instead, it appears to cede authority to govern the association to an elected body and *not* to the employer members. *See* DOL Adv. Op. 94-07A, 1994 ERISA LEXIS 11 (Mar. 14, 1994) (association's governing documents provided "no effective way for members to affect the Board or operations of" AHP and trust operating plan and thus failed the control requirements). There is nothing in the Proposed Rule that explains how employer members of the association can adequately guard against the adverse interests of those who would treat the AHP as a commercial enterprise, the purpose of which is to make money for its promoter, service providers and salesforce. The DOL's failure to provide reasoned and evidenced-based explanations for its departure from longstanding agency policy would be arbitrary and capricious if the Proposed Rule is enacted, and thus, the DOL should withdraw the Proposed Rule and start anew.

3. The Department's Failure to Include Any Quantitative Analysis of the Costs and Benefits of the Proposed Rule Is Unjustifiable

In addition, in proposing these extensive changes to how AHPs are defined and regulated, the Department has declined to include any quantitative analysis of the costs and benefits of the Proposed Rule. The failure to quantify the estimated costs to employees and health care consumers hinders the public's ability to comment on the Department's proposal, and is likely arbitrary and capricious under the APA.

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[15] As other commenters have observed, the DOL's failure to make public and to analyze in the Proposed Rule its extensive data concerning AHP fraud and abuse provides a sufficient basis alone to require that the DOL withdraw the Proposed Rule and fundamentally reconsider its approach to this issue.

The Department's Regulatory Impact Analysis acknowledges that this proposal is "economically significant," and that the Department was therefore required to assess – including by quantifying – the costs and benefits of the proposal. 83 Fed. Reg. 614, 625. But despite acknowledging AHPs' history of "financial mismanagement and abuse," the Department makes no effort to assess the economic impact of weakening the requirements for groups seeking to qualify as bona fide associations. *Id.* at 631. Nor does the DOL quantify the likely costs of a proliferation of AHPs in the form of the additional resources to be needed by state and federal agencies to monitor AHPs and enforce state and federal standards. The Department makes only the general assumption that AHPs "are an innovative option" that "can help reduce the cost of health coverage" because AHPs will "help small businesses ... to group together to self-insure or purchase large group health insurance." 83 Fed. Reg. 614, 615. In particular, the Department fails to quantify the likely attendant costs of a proliferation of AHPs on the existing individual and small group ACA markets.[16]

Agencies are obligated to provide reasons, not bare conclusions, to support an action. *Amerijet Int'l Inc. v. Pistole*, 753 F.3d 1343, 1350 (D.C. Cir. 2014) ("conclusory statements will not do; an agency's statement must be one of reasoning") (internal quotations omitted). Failing to quantify the costs of a proposal that could have as significant an impact on the health care market as this one would be arbitrary and capricious if absent in a final rule. *See Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin*, 538 F.3d 1172, 1201 (9th Cir. 2008) ("[T]here is no evidence to support [the agency's] conclusion that the appropriate course was not to monetize or quantify the value of carbon emissions reduction at all.").

B. The Proposed Rule's Dual Treatment of Sole Proprietors as Both Employers and Employees Is Unlawful

1. The Proposed Rule's Treatment of Sole Proprietors Is Contrary to ERISA

In a dramatic departure from judicial precedent interpreting ERISA, the Proposed Rule takes the unprecedented step of defining "sole proprietors" – referred to in the Proposed Rule as "working owners" – as both employers *and* employees. 83 Fed. Reg. 614, 621. This dual treatment of sole proprietors as employers and employees conflicts with ERISA and judicial interpretation of the statute's text. *See* 29 U.S.C. § 1002(5). This precise question was squarely before the Second Circuit in *Marcella v. Capital Dist. Physicians' Health Plan, Inc.*, 293 F.3d 42 (2d Cir. 2002). In *Marcella*, the court examined whether plaintiff, an independent contractor, could be a member of an AHP governed by ERISA. Membership in the plan at issue was open to "businesses with employees, but also to sole proprietorships without employees and to

[16] Projections forecast that the Proposed Rule, if finalized, will lead to 3.2 million enrollees shifting out of the ACA's individual and small group markets into AHPs by 2022 and that the Proposed Rule would increase premiums for those remaining in the individual ACA market by 3.5 percent. *See Association Health Plans: Projecting the Impact of the Proposed Rule*, Avalere (Feb. 28, 2018), http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf.

individuals such as plaintiff, *neither of which can logically be considered an 'employer'*...". 293 F.3d at 48 (emphasis added). The Second Circuit held that "[t]he plain language of the statute would, therefore, seem to preclude finding that the group is 'a group or association of employers,' because not all members of the Chamber are employers." *Id.* (quoting Section 3(5) of ERISA).

The Department cites *Yates v. Hendon*, 541 U.S. 1 (2004), to support its argument that self-employed working owners can participate in large group coverage through an association even if they have no employees, but *Yates* asked a different question. In *Yates*, the Court held that a working owner (*i.e.* the employer) can also qualify as a participant of an ERISA plan only "[i]f the plan covers one or more employees other than the business owner and his or her spouse." 541 U.S. at 6. In fact, the Court explicitly noted that "[c]ourts agree that if a benefit plan covers *only* working owners, it is not covered by Title I" of ERISA. *Id.* at 21, n. 6 (citing cases from the Second, Sixth, Ninth, and Eleventh Circuits) (emphasis added).

2. The DOL Does Not Offer Reasoned, Evidence-Based Rationales for Its "Working Owner" Definition as Both Employer and Employee

The Proposed Rule's expanded definition of "employer" to include sole proprietors also conflicts with well-established existing regulations. Most significantly, 29 C.F.R. § 2510.3-3(b) specifically excludes "any plan, fund, [and] program ... under which no employees are participants covered under the plan" from the definition of ERISA-covered plans, and uses the specific example of a plan where "only [] sole proprietor[s] are participants" as *not* covered by ERISA. *See id.* at (c)(1) ("[a]n individual and his or her spouse shall *not* be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse.") (emphasis added). The Proposed Rule, which newly defines sole proprietors as employers and employees subject to ERISA, does not provide adequate justification for this significant proposed change.

Indeed, the Department acknowledges the strain of defining "sole proprietors" as both employers and employees, and attempts to minimize this well-established regulation, asserting its application is limited to "narrow circumstance" despite its previously broad application. 83 Fed. Reg. 614, 621. Ultimately, the Department is forced to concede that an amendment of current regulation may be the only way to avoid this irreconcilable conflict:

> [T]o the extent the regulation could result in working owners not being able to participate as employees even in some circumstances, the Department believes the policies and objectives underlying this proposal support an amendment of the 29 CFR 2510.3-3 regulation so that it clearly does not interfere with working owners participating in AHPs as envisioned in this proposal.... Accordingly, and to eliminate any potential ambiguity regarding the interaction of this proposal with the regulation at 29 CFR 2510.3-3, this proposal also includes a technical amendment of paragraph (c) of 2510.3-3 to include an express cross-reference to the working owner provision in this proposal. 83 Fed. Reg. 614, 621-22.

The stated policies and objectives to support such a change do not provide adequate legal support. The Department ultimately invites comment on ways to ensure that working owners who join an AHP are genuinely engaged in a trade or business. 83 Fed. Reg. 614, 622. But similar to the loosening of bona fide association and commonality of interest requirements, the DOL does not support the proposition of working owners as both employers and employees with plausible justification for this significant – and illogical – change. Notwithstanding that this unprecedented dual treatment of working owners as employer and employee will open the door to negative consequences, the DOL has failed to present adequate explanation for its reversal of longstanding agency policy, judicial precedent, and existing regulations.

IV. The Proposed Rule Conflicts with the ACA's Statutory Scheme and Congressional Intent

The intent of the Proposed Rule is not covert: the President himself plainly cited the sabotage of the ACA as the clear purpose of the Proposed Rule. While signing the Executive Order directing this rulemaking, he stated he was "taking crucial steps towards saving the American people from the nightmare of Obamacare,"[17] and tweeted the following day that "ObamaCare is a broken mess. Piece by piece we will now begin the process of giving America the great HealthCare it deserves!".[18] Just days ago, the President reiterated these points, saying at the Conservative Political Action Conference that "piece by piece by piece, Obamacare is just being wiped out."[19] Given the President's goal to destroy – rather than faithfully execute – the ACA, the Proposed Rule unsurprisingly conflicts with the ACA in its attempt to undermine the Act through executive means, as set forth in detail below.

First, the Proposed Rule is contrary to and will undermine the ACA's individual, small group and large group structure. The ACA categorizes health plans as large group, small group or individual, offering the greatest protections to small group and individual plans.[20] In its simplest terms, the Proposed Rule seeks to expand the category of "large groups" so that the many consumers previously protected by the ACA's individual and small group provisions will, through AHPs, become members of large group plans outside of many of the ACA's protections. Specifically, the Proposed Rule provides that unrelated small employers and "working owners" may band together solely for the purchase of insurance to form a single large employer, thereby undermining the market structure set forth by the ACA, which defines these small employers as part of the small group market, and "working owners" as part of the individual market. 42 U.S.C. § 18024(a)(1)-(3). The ACA builds this small group and individual market structure into

[17] Donald J. Trump, President of the U.S., Remarks at Signing of Executive Order Promoting Healthcare Choice and Competition (Oct. 12, 2017), https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-executive-order-promoting-healthcare-choice-competition/.
[18] Zachary Tracer, *Trump Moving 'Step by Step' to Take Apart Obamacare on His Own*, Bloomberg (Oct. 13, 2017, 2:46 PM), https://www.bloomberg.com/news/articles/2017-10-13/trump-orders-an-end-to-key-obamacare-insurance-subsidies.
[19] Mathew Yglesias, *Donald Trump's CPAC Speech Is a Reminder That He's Not Really in Charge of His White House*, Vox (Feb. 23, 2018, 1:10 PM), https://www.vox.com/2018/2/23/17044770/trump-cpac-2018-speech.
[20] 42 U.S.C. § 18024(a); *see. e.g.*, 42 U.S.C. § 300gg–6 (requiring individual and small group health plans to provide coverage for ten essential health benefits); *see also* CMS 2011 Guidance, *supra*, note 13.

the ACA itself, as well as the Public Health Services Act ("PHSA") and ERISA.[21] The Proposed Rule, which candidly seeks to expand access to cheaper plans that do not have to abide by the ACA individual and small group rules, anticipates regulating these AHPs as large employers, and is thus in conflict with all three of these statutes. 83 Fed. Reg. 614, 615-16.

The ACA's individual, small group and large group market structure is clearly defined in 42 U.S.C. § 18024 and 42 U.S.C. § 300gg–91(e). Each market receives different ACA protections, with the individual and small group markets afforded the greatest protections. For example, the ACA requires small group plans to utilize adjusted community rating to calculate premiums, which prevents insurers from varying premiums within a geographic area based on age, gender, health status, or other factors.[22] 42 U.S.C. § 300gg(a). The ACA also requires individual and small group plans to cover ten essential health benefits, including pediatric services, maternity care, prescription drugs and coverage for mental health services. 42 U.S.C. § 18022(b). Large group plans, in contrast, are not subject to community rating or essential health benefit mandates, or many other requirements, including premium restrictions based on health status, gender or age.[23] 42 U.S.C. § 300gg(a).

These ACA market designations are also effectuated through amendments to the PHSA, and certain of these reforms are imported directly into ERISA. *See* 29 U.S.C. § 1185d (as amended by § 1536(e) of the ACA) (importing requirements of 42 U.S.C. §§ 300gg through 300gg–28 into ERISA "as if included" in that Act).[24] For example, the essential health benefits and community rating requirements of the ACA, applying only to individual and small group

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[21] *See, e.g.*, 42 U.S.C. §§ 300gg(a)-300gg–28 (applying PHSA requirements to group plans based on market size); 29 U.S.C. § 1185d (provision of ERISA enacted by the ACA importing PHSA provisions into ERISA); 42 U.S.C. § 300gg–91(e) (defining individual and very small group market levels for purposes of imported PHSA provisions).

[22] ACA; Health Insurance Market Rules; Rate Review; Final Rule, 45 C.F.R. §§ 144.101–144.214, 147.100–147.200, 150.101–150.465, 154.101–154.301, 156.10–156.1256 (2013), *available at* https://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf.

[23] Large employers are required to provide their employees with insurance coverage or pay a penalty ("the employer mandate"). Through the employer mandate, the ACA imposes standards on the employer itself, rather than regulating the plan offered by the employer or the insurance issuer selling the plan. These standards include that employers must offer coverage that achieves 60% actuarial value as measured against essential health benefits, or be at risk of paying a penalty of up to $3,000 per employee. 26 U.S.C. §§ 4980H(b), 36B(c)(2)(C)(ii). They must also provide a summary of benefits and coverage, and notice of the right to designate a primary care physician and gynecologist without prior authorization; set limits on out-of-pocket maximums; and comply with various reporting requirements. U.S. Senate, *The Patient Protection and Affordable Care Act as Passed Section-by-Section Analysis with Changes Made by Title X Included within Titles I - IX, Where Appropriate*, 1, 1-2, *available at* http://www.dpc.senate.gov/healthreformbill/healthbill53.pdf (last visited Mar. 5, 2018).

[24] 29 U.S.C. § 1185d (as amended by § 1563(e) of the ACA) inserted this language into ERISA: "[T]he provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart." Part A of Title 27 of the PHSA covers §§ 300gg through 300gg–28 of Title 42. *See* 29 U.S.C. § 1185d(a)(2) (as amended by § 1563(e) of the ACA) ("[T]o the extent that any provision of such part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.").

plans, are incorporated into ERISA. 42 U.S.C. § 300gg–6.[25] Thus, ERISA itself was amended to incorporate the market structure and protections of the ACA.

In addition, in direct conflict with the Proposed Rule, the ACA provides that only in very narrow circumstances can employers join together to be treated as a single employer. This is achieved through the ACA's incorporation of the "aggregation rules" from the Internal Revenue Code ("IRC"). These aggregation rules determine when multiple business entities should be treated as a single employer. The ACA incorporates the IRC's aggregation rules, which state that an employer "treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 [the Internal Revenue Code of 1986]" should be treated as "1 [single] employer" for purposes of the ACA" (the "aggregation rule"). *See, e.g.*, 42 U.S.C. § 18024(b)(4)(A). Pursuant to these rules, businesses may be treated as a single employer when they are in a controlled group of corporations or under common control.[26] The ACA employs these aggregation rules in **eight** provisions.[27] Most significantly, 42 U.S.C. § 18024(b)(4)(A) uses the aggregation rule in order to determine employer size for small group and large group definitions; 26 U.S.C. § 45R(e)(5)(A) (as amended by § 1421 of the ACA) requires entities that meet the aggregation rule be considered a single employer for purposes of determining health insurance credits for small employers; and 26 U.S.C. § 4980H(c)(2)(C)(i) (as amended by § 1513 of the ACA) requires application of the aggregation rule to calculate employer size for the purpose of the employer mandate. Many of the provisions incorporated into ERISA include these narrow aggregation rules as well because they depend on the distinction between large and small group plans.[28]

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[25] *See also* 42 U.S.C. § 300gg(a)(1) (adjusted community rating for individuals and small group employers); § 300gg–1 (guaranteed availability of coverage); § 300gg–2 (guaranteed renewability of coverage); § 300gg–3 (prohibition of preexisting condition exclusions or other discrimination based on health status); § 300gg–5 (non-discrimination in health care); § 300gg–11 (no lifetime or annual limits); § 300gg–13 (coverage of preventive health services).

[26] In defining a "single employer," the IRC looks to whether the employers operate under "common control," perform functions (e.g. management services) for one another, or demonstrate a shareholder or partnership relationship; the IRC limits the "single employer" designation to companies that have a "common owner or . . . are otherwise related." 26 U.S.C. §§ 414(b), (c), (m); *Determining If an Employer Is an Applicable Large Employer*, IRS, https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer (last updated Nov. 22, 2017).

[27] *See, e.g.*, 26 U.S.C. § 4980I(f)(9) (as amended by § 9001 of the ACA) (utilizing the aggregation rule to determine which entities are to be taxed for high cost employer-sponsored coverage); 26 C.F.R. 51.1 (describing regulations issued to "provide guidance on the annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs by section 9008 of the [ACA]", which uses the aggregation rule to identify these branded prescription pharmaceutical manufacturers and importers); 26 U.S.C. § 162(m)(6)(C)(ii) (as amended by § 9014 of the ACA) (requiring "two or more persons" to be treated as "single employers" when identifying the covered health providers to which the ACA's limitation on excessive remuneration applies); 26 U.S.C. § 125(j)(5)(D)(ii) (as amended by § 9022 of the ACA) (using a related aggregation rule for purposes of identifying eligible employers that maintain "simple cafeteria plans"); 26 U.S.C. § 48D(c)(2)(B) (as amended by § 9023 of the ACA) (identifying taxpayers that are eligible to receive the qualifying therapeutic discovery project credit by applying the aggregation rule).

[28] *See* 29 U.S.C. § 1185d (importing requirements of 42 U.S.C. §§ 300gg through 300gg–28 into ERISA "as if included" in that Act); 42 U.S.C. § 300gg–91(e) (defining market levels for purposes of 42 U.S.C. §§ 300gg through 300gg–28 in relation to aggregation rules); *see also* 42 U.S.C. § 300gg(a)(1) (describing community rating); § 300gg–6 (describing group plans that must cover essential health benefits).

Thus, the ACA - as well as the PHSA and ERISA itself – already have aggregation rules for determining when and for what purposes individuals and small employers should be grouped together to be considered a single large employer. The Proposed Rule – which seeks to allow *all* employers in common industry or close geographic location to form a "single large employer" – plainly conflicts with these narrow aggregation rules.[29] Such a vast new definition of "single large employer" far exceeds the ACA's aggregation rules, as applicable under ERISA, the IRC, the PHSA, and the ACA, and therefore clearly conflict with these statutes.

In addition, the Proposed Rule's new classification of "working owners" is directly inconsistent with the ACA. Under the ACA, including under provisions imported into ERISA by the ACA, sole proprietors without employees are treated as individuals – not as employers – protected by the individual market. *See, e.g.*, 42 U.S.C. § 300gg–91(d)(6), (e)(2), (e)(4) (defining "large employer" and "small employer," and then defining "employer" to include "only employers of two or more employees").[30] Moreover, the Proposed Rule offers neither justification nor evidence that the DOL considered the Rule's effect on these various statutory schemes, nor did it suggest ways that the Rule's conflict with law and prior guidance can be resolved (discussed *supra* Part III).

By enabling individual and small groups to be deemed large group plans, the Proposed Rule will allow associations made up of individuals and small employers to evade the ACA's individual and small group protections. This will fulfill the goal of the Proposed Rule to avoid comprehensive coverage and facilitate the sale of cheaper plans "across State lines." Exec. Order No. 13813, 82 Fed. Reg. 48385 (Oct. 17, 2017). In fact, AHPs formed pursuant to the Proposed Rule may be subject to even fewer requirements than large employers currently are, since there may be no *actual* employer – just an association created solely for the purpose of providing health coverage. Congress's intent in enacting the ACA could hardly have been clearer: it established definitions for participation in and protections for large group, small group, and individual plans, and narrow rules for determining when multiple businesses can be treated as a single employer. It then applied those standards under ERISA "as if included" in that Act. This blatant attempt by the DOL to avoid the clear text and purpose of the ACA is contrary to law.

Second, the Proposed Rule will undermine the fundamental ACA provisions that pool risk with the result of destabilizing small group and individual insurance markets. Section 1312(c) of the ACA, "Single Risk Pool," imposes rules on the individual and small group markets to create a diverse risk pool in order to ensure the provision of affordable health care for healthy

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[29] In particular, by crafting specific rules when applying ACA protections to group health plans under ERISA, Congress directly required the DOL to follow the IRC's narrow aggregation rules, barring the Department from applying another standard it prefers under more general ERISA language as a means to undercut the ACA. *See Rad.AX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012) (Scalia, J., for a unanimous court) (internal citations and quotation marks omitted) ("[I]t is a commonplace of statutory construction that the specific governs the general. That is particularly true where, as [here], Congress has enacted a comprehensive scheme and has deliberately targeted specific problems with specific solutions.").

[30] The ACA also amends the PHSA (42 U.S.C. § 300gg–91) by incorporating: "The term 'employer' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1002(5)], except that such term shall include only *employers of two or more employees*." (emphasis added). Thus, the PHSA also defines employer owners without any employees as individuals, and not as employers.

and sick alike. 42 U.S.C. § 18032(c).[31] The Proposed Rule, again, conflicts with this structure, as AHPs will likely attract healthy individuals out of the existing individual and small group markets, and leave the remaining offerings to turn into "sick" plans whereby premiums will dramatically increase. This will leave those whom the ACA was implemented to help – the sick, elderly, those with preexisting conditions – with unaffordable or inadequate coverage.[32]

For example, since most AHPs will not be required to offer the ACA's essential health benefits, they will opt not to include services that are more expensive or that are required by individuals with greater health care needs. For instance, while complying with the Proposed Rule's non-discrimination provisions, an AHP could opt not to include maternity coverage. This would naturally dissuade potential members who plan to have children from joining the AHP, and they will likely obtain coverage from an ACA-compliant exchange plan. Or an AHP could choose not to cover mental health and substance use disorder treatment, again with the expectation that individuals who need or are likely to need these services for themselves or their families will obtain coverage on the ACA exchanges. The same motivations will cause AHPs to exclude other expensive benefits such as cancer treatment or certain prescription drugs. This market segmentation will lower prices for healthier individuals and groups in the AHPs, but cause premiums to spike (likely out of reach) for people who need these essential health care services – in direct conflict with the ACA's goal of spreading risk, particularly within the small group and individual markets.[33]

The Proposed Rule will also encourage AHPs to form in those industries that attract a younger, healthier, and male workforce (*e.g.*, technology or engineering) or in those geographic areas that have healthier populations (*e.g.*, wealthy communities and/or non-rural areas). The Proposed Rule places no restrictions on this type of risk selection. The Proposed Rule dismisses these risks as speculative and argues that AHPs will also form in industries with older and less healthy workers by delivering sufficient administrative savings to offset the additional costs of insuring this population. 83 Fed. Reg. 614, 628-29. However, the DOL provides no evidence to support the proposition that AHPs can deliver administrative savings that an insurance company cannot. Indeed, all available evidence and analysis is to the contrary.[34]

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[31] The "single risk pool" provision is also referenced in the PHSA provisions imported into ERISA. *See, e.g.*, 29 U.S.C. § 1185d (importing 42 U.S.C. § 300gg, among other protections, into ERISA).

[32] Although the Proposed Rule's non-discrimination provisions are beneficial, they are inadequate to ensure that AHPs are unable to structure themselves to attract healthier individuals and groups while dissuading individuals who may have a greater need for health care services from enrolling in the AHP. Indeed, we have repeatedly seen AHPs that are designed to do precisely this. (*See, e.g.*, *supra* at Part II).

[33] The Proposed Rule speculates that because large employers do not offer skimpy coverage to their employees, AHPs likely will not do so either. 83 Fed. Reg. 614, 628. However, there are fundamental differences between large employers and AHPs that the Proposed Rule simply ignores. Large employer plans typically provide comprehensive benefits because large employers employ a diverse set of individuals with varying health needs and must offer benefit packages to satisfy all current and potential employees. AHPs, on the other hand, allow self-employed individuals and small businesses to pick their insurance plan based on the particular coverage that they need at the time given their current health needs. These individuals and small groups have every reason to enroll in skimpy, cheap coverage that appeals to their own narrow demographic group or health profile.

[34] *See, e.g.*, Mark Hall, et al., *HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed*, HEALTH AFFAIRS 20(1): 142-53 (2001), *available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.20.1.142 (identifying numerous alternative means to save on health care coverage costs); Kaiser Family Foundation et al., *Employer Health Benefits 2017 Annual Survey*, KAISER FAMILY FOUND. (2017), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017 (presenting findings on

These consequences are in clear violation of the language and purpose of the ACA. Also clear is the APA's prohibition against rulemaking in conflict with established law, and as such, the Proposed Rule violates the APA.

V. The Proposed Rule Is Contrary to Longstanding DOL Interpretation of ERISA That Has Been Ratified by Congress

Not only is the Proposed Rule contrary to the ACA in key respects, but it also is contrary to the DOL's longstanding interpretation of "bona fide association." Congress has ratified this longstanding interpretation over decades in a series of statutory schemes, including and most notably in the ACA, which was the capstone of Congress's decades-long efforts to address access to health care through individual and group insurance markets.

As the Supreme Court has explained, "[w]here an agency's statutory construction has been 'fully brought to the attention of the public and the Congress,' and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned." *N. Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 535 (1982) (citation omitted); *see, e.g.*, *Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 846 (1986) ("It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the 'congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress.'") (citation omitted).

As set forth *supra* in Parts I through III, the DOL has long maintained that only a "bona fide association" of employers bound by a "commonality of interest" can meet the definition of "employer" under 29 U.S.C § 1002(5).[35] The Department has consistently held that most MEWAs are not regulated by ERISA as employee welfare benefit plans, and indeed that ERISA itself forecloses such an interpretation, unless such entities qualify as "bona fide associations" under these well-established, narrow principles. *See e.g.*, Brief for Petitioner-Appellant DOL at *7, *Donovan v. Dillingham*, 668 F.2d 1196 (11th Cir. 1982) (No. 80-7879) ("[T]he statutory language of ERISA precludes a finding that a single, umbrella-like ERISA plan has been created in these cases."); *see also Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982) ("An issue in other cases has been whether a multiple employer trust – the enterprise – is itself an

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strategies that private and non-federal public employers have used to shift health care costs to employees and thus reduce employer costs of health care coverage provision).

[35] *See, e.g.*, DOL Adv. Ops., 80-40A, 1980 ERISA LEXIS 38 (July 9, 1980) ("bona fide" association depends on a number of factors, including control by employers over association, but does not cover "several unrelated employers" executing trust agreements as a means to fund benefits); 91-42A, 1991 ERISA LEXIS 49 (Nov. 12, 1991) ("[W]here several unrelated employers merely execute similar documents or otherwise participate in an arrangement as a means to fund benefits, in the absence of any genuine organizational relationship among the employers, no employer association, and consequently no employee welfare benefit plan, can be recognized."); 2008-07 A, 2008 ERISA LEXIS 8 (Sept. 26, 2008) (rejecting local chamber of commerce's request to be an ERISA employee welfare benefit plan); 2017-02 AC, ERISA LEXIS 2 (May 16, 2017) ("The Department has expressed the view that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of ERISA section 3(5).").

employee welfare benefit plan. The courts, congressional committees, and the Secretary uniformly have held they are not.").

The ACA directly included the phrase "bona fide association" in the components of the statute applicable under the PHSA and ERISA. As noted above, Congress imported key protections from Title 27 of the PHSA into ERISA "as if included in" that Act. *See* 29 U.S.C. § 1185d (as amended by § 1563(e) of the ACA). Among the imported provisions is a guaranteed-renewability protection, *see* 42 U.S.C. § 300gg–2, that relies on the phrase "bona fide association," defined with a series of elements, such as five years of active existence and being "formed and maintained in good faith *for purposes other than obtaining insurance*." *See* 42 U.S.C. § 300gg–91(d)(3) (emphasis added). As relevant here, the guaranteed-renewability provision requires a health insurance issuer in the large or small group market to "renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable," except in connection with a series of exceptions, one of which involves when an employer in the small or large group markets ceases to be a member of a "bona fide association." *Id.* § 300gg–2(b)(6). In short, Congress in the ACA imported into ERISA's plain text the phrase "bona fide association," along with its attendant narrow definition, effectively ratifying the DOL's longstanding interpretation of that term.

Even prior to the ACA's enactment, Congress had amended ERISA and the interlocking statutes related to health plans in the IRC and PHSA numerous times based on the DOL's firmly settled interpretation. *See, e.g.*, Consolidated Omnibus Budget Reconciliation Act ("COBRA"), Pub. L. No. 99-272, § 10001, 100 Stat. 82, at 222-23 (1986) (amending, *inter alia*, 26 U.S.C. § 106(b)); *id.* § 10002, 100 Stat. 82, at 227-31 (codified at 29 U.S.C. §§ 1161-69) (whereby Congress applied the narrow aggregation rules from the IRC, suggesting that Congress foreclosed a broad interpretation of "employer" that would group together many unrelated businesses in a single large group); and Health Insurance Portability and Accountability Act ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936, at 1964-66, 1982 (1996) (reflecting continued congressional judgment that unrelated small employers cannot simply be interpreted as one large employer at the DOL's discretion, including through a definition of "bona fide association").

Given these key statutory schemes creating health plan protections for consumers, and these statutes' reliance on DOL definitions, Congress has not left the Department with broad discretion to depart so drastically from a settled understanding of how business entities may be treated as one employer in these interlocking statutes.[36] In short, through a long line of enactments establishing and amending interlocking statutory regimes, Congress long ago ratified the DOL's narrow conception of "bona fide association" and accordingly barred the Department from so fundamentally altering the established edifice of federal regulation of individual and group health insurance.

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[36] For example, HIPAA enacted Section 2791 of the PHSA, which defined "large employer" as an employer with an average of at least 51 employees during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. Pub. L. No. 104-191, § 102, 110 Stat. 1936, at 1975-76. That section defined "small employer" as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year." *Id.* at 1976. Like provisions earlier enacted in COBRA, and later enacted in the ACA, this HIPAA provision relied on the IRC's narrow aggregation rules. *Id.*

VI. The DOL Should Not Exempt AHPs from State Regulation

The Proposed Rule also invites comment as to whether the DOL should seek to exercise its never-before-used authority to issue regulations that would exempt AHPs from most state insurance regulation and enforcement. 83 Fed. Reg. 614, 625. The history detailed above (in Part II) shows that this would be a tremendous mistake. Exempting AHPs from state insurance laws would allow fraudulent or improperly managed health plans to operate without fear of detection or punishment until after the damage has been done. The result would be policyholders with unpaid medical bills and health care providers who are not paid for their services. Since exercising this authority would require new regulations, if the DOL decides to explore this misguided idea further, it should issue a separate proposed rulemaking with an opportunity for notice and comment regarding the intended use of this exemption. *See* 29 U.S.C. § 1144(b)(6)(B).

To date, the DOL does not have, and has not sought, the regulatory or enforcement resources to step into the States' shoes and become the primary regulator of AHPs. Furthermore, the Department does not have, and has not proposed, federal financial or other insurance standards to protect beneficiaries from the serious consequences that result when an AHP cannot or does not pay medical claims. Exempting AHPs from state regulation would threaten the health and financial security of individuals and small employers throughout the country.

Indeed, States and State Attorneys General have extensive experience protecting individuals and small employers from predatory entities that seek to defraud or deceive customers through the use of associations. Some examples include:

- In 2007, the operators of an association that deceptively marketed its discount health plan products to Massachusetts residents as "Affordable Healthcare Plans" and "Top Rated Insurance" were ordered to pay restitution to the defrauded consumers, a substantial civil penalty and attorney's fees, and were permanently enjoined from engaging in various conduct in Massachusetts.[37]

- In 2009, pursuant to a consent judgment following Massachusetts' consumer protection lawsuit, HealthMarkets, Inc. and its subsidiaries were ordered to pay $17 million, resulting from unfair and deceptive practices through the sale of insurance products packaged with memberships in three different associations.[38]

- In 2011, the United States Life Insurance Company in the City of New York agreed to pay full restitution to consumers whom it required to join associations and to whom it misrepresented the terms, benefits, and (very limited) coverage

[37] Compl. at ¶ 19, Commonwealth of Mass. v. Nat'l Alliance of Assocs. Professional Benefit Consultants, Inc. et al., Compl. No. 09-1404B (Mass Super. Ct. Apr. 6, 2009).
[38] *See* Press Release, Att'y Gen. of Mass., *AG Martha Coakley Reaches $17 Million Settlement with Health Insurers Regarding Unfair and Deceptive Conduct* (Aug. 31, 2009), http://www.mass.gov/ago/news-and-updates/press-releases/2009/ag-reaches-17-million-settlement-with-health.html.

provided by its plans, as well as the fact that the policies had not been approved for sale in Massachusetts.[39]

- In 2015, Unified Life Insurance Co., agreed to pay $2.8 million in restitution and civil penalties as a result of its deceptive and unlawful selling of sold short-term health insurance that was not authorized for sale in Massachusetts, but which it deceptively marketed through a third-party association.[40]

- In 2001, the Maryland Insurance Administration fined and revoked the registration of a MEWA administrator that engaged in "illegal and dishonest practices" such as failing to register as an insurer as required by state law, failing to pay premiums for stop-loss insurance contrary to representations made to employer members (and thereby exposing these employers to unexpected losses), and failing to pay claims for insured employees. *Md. Ins. Admin. v. SAI Med Health Plan, LLC*, No. MIA-6-1/01 (Md. Ins. Admin. Jan. 16, 2001).

- In 2005, the Maryland Insurance Administration fined and revoked the licenses of a MEWA's administrator for failing to register with the state as required by law and making material misrepresentations regarding the relationship of the MEWA to the insured employees and, overall, engaging in conduct that was "dishonest and lacked ... trustworthiness and competence." *Md. Ins. Admin. v. Dennis Kelly, et al.*, No. MIA-2005-07-004 (Md. Ins. Admin. Mar. 30, 2007).

- From the 1980s through the early 2000s in California, AHP failures hurt employees across many different industries. For example, thousands of California farm workers suffered when a plan created by Sunkist Growers collapsed, leaving nearly 5,000 medical providers with an estimated $10 million in unpaid claims. Similarly, when Rubell-Helms Insurance Services went out of business, it reportedly left $10 million in legitimate medical claims unpaid.[41]

Over many years, state enforcement efforts and oversight have lessened AHP fraud. Since the ACA, this success combined with the development of our state and federally facilitated health exchanges has resulted in consumers having comprehensive and reliable health coverage. Relatedly, our states have made great strides in decreasing the uninsured rate since the ACA. This is largely due to the confluence of a range of affordable plans together with one single risk pool with the same premiums paid by all members of a plan. For example, in New York, the

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[39] *See* Press Release, Att'y Gen. of Mass., *Health Ins. Co. to Pay $760,000 for Unlawfully Selling Unauthorized Health Ins. in Mass. and Failing to Cover Mandated Benefits* (Apr. 25, 2011), http://www.mass.gov/ago/news-and-updates/press-releases/2011/health-insurance-company-to-pay-760000.html.

[40] *See* Press Release, Att'y Gen. of Mass., *Ins. Co. to Pay $2.8 Million to Resolve Claims of Unlawful, Deceptive Sales of Health Ins. Sold Across State Lines* (Apr. 4, 2017), http://www.mass.gov/ago/news-and-updates/press-releases/2017/2017-04-04-insurance-company-to-pay-2-8-million.html.

[41] *See* Melinda Fulmer & Ronald D. White, *Sunkist's Health Plan Collapses*, L.A. Times, Jan. 4, 2002, *available at* http://articles.latimes.com/2002/jan/04/business/fi-sunkist4; Robert L. Jackson, *Health Insurance 'Pyramid' Scams Examined: Hearing: Authorities Tell a Senate Panel That Irvine-Based Rubell-Helm Insurance Services Is among Firms under Scrutiny for Allegedly Taking Premiums and Not Paying Large, Legitimate Claims*, L.A. Times, May 16, 1990, *available at* http://articles.latimes.com/1990-05-16/business/fi-362_1_health-insurance.

uninsured rate dropped from 10% to 5%; in California, it dropped from 17% to 7%; in Illinois, from 14% to 6.5%; in Maryland, from 10% to 6%; and in Delaware, from 9% to 6%. In Massachusetts, the uninsured rate has dropped from more than 10% before it enacted health reform in 2006 to less than 4% today. The success of our state and federally facilitated exchanges, and our future success in decreasing the rates of uninsureds is likely to be impacted by any exemption from state regulations that govern the types of AHPs that are envisioned in the Proposed Rule.

VII. Conclusion

For the reasons set forth above, the States strongly oppose the Proposed Rule and urge that it be withdrawn.

Sincerely,

Maura Healey
Massachusetts Attorney General

Eric T. Schneiderman
New York Attorney General

Xavier Becerra
California Attorney General

George Jepsen
Connecticut Attorney General

Matthew P. Denn
Delaware Attorney General

Karl A. Racine
Attorney General for the District of Columbia

Russell A. Suzuki
Acting Attorney General, State of Hawai'i

Lisa Madigan
Illinois Attorney General

Tom Miller
Iowa Attorney General

Janet T. Mills
Maine Attorney General

Brian E. Frosh
Maryland Attorney General

Gurbir S. Grewal
New Jersey Attorney General

Hector Balderas
New Mexico Attorney General

Ellen F. Rosenblum
Oregon Attorney General

Josh Shapiro
Pennsylvania Attorney General

Thomas J. Donovan Jr.
Vermont Attorney General

Mark R. Herring
Virginia Attorney General

[Additional submissions by Chairman Walberg follow:]

March 20, 2018

The Honorable Tim Walberg
Chairman
Subcommittee on Health, Employment, Labor and Pensions
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

RE: Statement for the Record: Hearing on the Department of Labor's Proposed Rule on Association Health Plans

Dear Chairman Walberg:

Thank you for holding the hearing on March 20, 2018 on expanding affordable healthcare options that will examine the Department of Labor's (DOL) Proposed Rule on Association Health Plans (AHPs). We submitted a comprehensive response to the Proposed Rule and appreciate the opportunity to summarize our comments below.

The National Restaurant Association is the leading business association for the restaurant and foodservice industry, representing more than 14.7 million employees, nearly 10 percent of the nation's workforce. With one million locations across the country, the $798.7 billion in sales from the restaurant industry makes up four percent of the U.S. GDP.

Moreover, the restaurant industry is 90% small businesses, serving local communities and neighborhoods. Our small business members experienced the same difficulties obtaining health coverage as all small businesses - declining from an average of 63% in the ten years preceding the Patient Protection and Affordable Care Act ("PPACA") to 56%[1] in 2016.

We applaud the DOL's endeavor to execute Executive Order 13813 and accomplish its three goals, especially regarding AHPs. Having recently launched the Restaurant & Hospitality Association Benefit Trust (RHABT) we can validate the difficulties establishing an AHP. Allowing small businesses to gain the economies of scale and same benefit requirements as large employers will allow them to offer more affordable coverage and compete for talent on a level playing field.

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[1] Kaiser Family Foundation, *Employer Health Benefits Annual Survey (2016)*, Exhibit H

We particularly support the requirement that AHPs must have an organizational structure and be functionally controlled by its members. This is an important safeguard to ensure the AHP represents its members. We also support the Department's efforts to expand the offering to working owners who are often navigating the unsubsidized individual market.

While the Proposed Rule offers some regulatory relief, the non-discrimination components dramatically expand regulatory requirements resulting in a proposed rule diametrically opposed to the goal of the Executive Order. The proposed non-discrimination rules, specifically for varying premiums by employer, would effectively eliminate the creation of any startup AHPs and jeopardize the viability of existing AHPs. A startup's lack of experience, combined with onerous non-discrimination rules, would make carriers even less likely to support a new AHP.

The DOL's logic for this regulatory expansion is flawed on several levels:

- Much of the order is spent establishing the level of cohesion and commonality necessary to differentiate an AHP versus a commercial insurance company. The DOL then proposes expanding commercial insurance regulatory requirement to AHPs to distinguish them from being a commercial insurance company.

- The DOL writes employer-by-employer risk rating undermines "acting in the interest of employers." However, AHPs by regulation are run by and for the benefit of the employer members. It is illogical to say an entity run by and for the benefit of employer members is not acting in the interests of said employer members.

- The DOL treats employers as similarly situated individual employees, despite critical differences in how employers obtain health insurance versus individuals. Employers have real choices in the open market for health insurance where they can switch vendors if they do not like pricing, service, networks, or wellness program options. Employees effectively can only choose between heavily subsidized employer coverage or no coverage. Individual employees benefit from non-discrimination because they do not have choices. The ability to change vendors in an open market is a critical distinction for why it is incorrect to expand this regulation from individual employees to employers.

- The proposed non-discrimination rules would destabilize the existing AHP 51+ segment by creating adverse selection. The existing 51+ segment allows insurance carriers to vary premiums by employer whereas AHPs must offer the same rate to all employers. This creates a system where less healthy employers gravitate to AHPs driving up costs for remaining members. The resulting cost increases would quickly limit the ability of relatively small AHPs to attract moderately healthy groups. This would effectively force existing AHPs out of business or exiting the 51+ segment – resulting in increased consolidation in the marketplace and decreased competition.

Below are further suggestions we submitted for DOL's Consideration:

- **Grandfather Existing Multiple Employer Welfare Arrangements ("MEWAs") /AHPs.** If the DOL publishes the final rule, in substantially the same form, there needs to be a clearly stated option for existing MEWAs/AHPs to be grandfathered into the current regulatory structure or many existing AHPs will likely be put out of business. Reducing choice and competition in the market is the exact opposite of the Executive Order.

- **Promote transparency vs regulation.** Transparency to employers and consumers is critical to ensuring the tradeoff between premium reductions and benefit/financial protection reductions is clearly understood especially in the under 50-segment. To mitigate this possible issue the Association supports the creation of a simple, standard disclosure form that clearly states in plain language any differences in benefit coverage to Essential Health Benefits and if financial limits are higher than the PPACA limits.

Thank you for our leadership on this issue and the opportunity to comment further on the Proposed Rule to expand access to health coverage by allowing more employers to form AHPs and the Request for Information on self-insurance.

Respectfully submitted,

Clinton Wolf
Senior Vice President, Health and Insurance Services National Restaurant Association

Congress of the United States
Washington, DC 20515

March 23, 2018

The Honorable Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

RE: Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans RIN 1210-AB85

Dear Secretary Acosta:

We write to you regarding association health plans ("AHP") in the State of Indiana. We applaud the Administration for taking action to expand the benefits of AHPs to more small businesses. My home state of Indiana is fortunate to have a robust AHP market that provides value and choice to a significant number of employees and dependents. While we share the Administration's commitment to expand access for small businesses to AHPs, we encourage the Department take appropriate steps to ensure that new regulations do not adversely impact AHPs that have been successfully operating.

For a number of years, AHPs have offered valuable coverage options for small employers seeking alternatives to costlier products available in the traditional small group market. There are a number of fully-insured and self-funded AHPs successfully operating across Indiana, and their continued success demonstrates the demand among small businesses seeking to provide comprehensive coverage options to their employees. Importantly, these plans satisfy all state and federal benefit requirements, with some offering more generous coverage than required for ACA-compliant plans, while also offering important consumer protections like guaranteed issue and renewal of coverage.

While the Department's proposed rule would make several important changes to expand access to AHPs, the proposal could significantly alter the successful AHP market in Indiana by inhibiting AHPs from treating different employer members as distinct groups for rating purposes. This could threaten the comprehensive benefits currently available through AHPs in Indiana. By removing the ability to set premiums for each member employer based on the experience of their workforce and dependents, AHPs are left with fewer options to create affordable plans that can compete with products on the small group market. This could lead to AHPs reducing the benefits they currently provide, potentially forcing employees and their dependents off plans that are working for them.

The Department can avoid this outcome by modifying the regulation to permit AHPs operating prior to the date when the proposed rule was published in the Federal Register to continue

operating as they have been. We encourage the Department to consider grandfathering these plans and allowing them to set premiums for each of their employer members using the same approaches they have used for many years. A grandfathering approach could result in even more choice for small businesses by allowing them to choose from plans in the traditional small group market, the grandfathered AHP market, and the newly expanded AHP market.

We appreciate the Department's efforts to promote access to AHPs through this rulemaking. By carefully considering the needs of existing plans successfully operating in Indiana and other states, the Department can deliver on the promise of expanded coverage options for small businesses while ensuring that changes to current regulations and guidance do not adversely impact existing plans and the families they cover.

Sincerely,

Luke Messer
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Jackie Walorski
Member of Congress

Jim Banks
Member of Congress

Susan W. Brooks
Member of Congress

Multi-Association Health Plan Coalition

April 3, 2018

The Honorable Tim Walberg,
Chairman
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

The Honorable Gregorio Kilili Camacho Sablan,
Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

Re: Hearing on Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans

Dear Chairman Walberg and Ranking Member Sablan:

The Multi-Association Health Plan (MAHP) Coalition is pleased to submit this statement for the subcommittee's March 20 hearing on DOL's proposed rule on Association Health Plans (AHPs). Our coalition operates within the printing, publishing, communications and allied industries and was formed to obtain association health insurance for our small business members.

We believe AHPs can be part of the solution for America's healthcare, and are gratified by the proposed regulatory framework put forward from DOL's Employment Benefits Security Administration (EBSA).

Specifically, we support EBSA's proposed language to expand "commonality-of-interest" requirements and promote AHP formation on the basis of industry, and we have asked that the final rule clarify that a related group of associations can band together as a Multi-Association Health Plan and be considered an "employer" in order to provide a health plan to the MAHP's collective membership.

Bona fide associations in the same line of business should be able to form AHPs and MAHPs anywhere in the country and the full text of our comments to EBSA is attached.

Thank you,

Susan Rowell
President
National Newspaper Association and
Publisher, The Lancaster (SC) News

Michael Makin
President & CEO
Printing Industries of America

Hamilton Davison
President & Executive Director
American Catalog Mailers Association

Attachment: MAHP Coalition Comments to DOL/EBSA

Multi-Association Health Plan Coalition

March 1, 2018

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

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

To the Docket:

On behalf of the Multi-Association Health Plan (MAHP) Coalition, comprising the National Newspaper Association and Printing Industries of America, we enthusiastically support President Trump's Oct. 12, 2017, Executive Order (EO) 13813 "Promoting Healthcare Choice and Competition Across the United States," to expand healthcare options for America. Our coalition operates within the printing, publishing, communications and allied industries and was formed to obtain association health insurance for our small business members.

Our small business members have struggled before the Affordable Care Act (ACA) was passed as well as after its implementation to find affordable health plans. Most have long since been priced out of group plans for themselves and their employees. As such, they and their staffs either are attempting to purchase affordable insurance on the ACA exchanges or are going without coverage, at great risk to their health and productivity. Many report that even if they can find coverage on the exchanges, the choices are too limited for them to find what they need, and some of our members are in counties where no plans or only one plan have been offered for periods of time.

We believe association health plans (AHPs) can be part of the solution for America's healthcare, and are gratified by the proposed regulatory framework that has been put forward for comment from the Dept. of Labor (DOL). Specifically, we are pleased by proposed language that would expand the ability to meet "commonality-of-interest" requirements in DOL advisory opinions (AO 94-07A and AO 2001-04A) that interpret the definition of an "employer" under Section 3(5) of the Employee Retirement Income Security Act (ERISA). We are particularly pleased that this language would promote AHP formation on the basis of industry.

Definition of "Employer"

The proposed rule would amend the definition of "employer" to expand the types of groups and associations that would qualify as single employers for purposes of sponsoring an ERISA health plan.

Under current law, only a "bona fide" employer association can act as an employer and establish an ERISA plan. A bona fide employer association must consist of individual member employers who:

- Join together for reasons other than providing health coverage;
- Have one or more common law employees;
- Control the association; and
- Share a "commonality-of-interest," which generally means the member employers and the association share a sufficiently close economic or representational interest, such as operating in the same industry.

AHPs have been regulated under ERISA as multiple employer welfare arrangements (or MEWAs), which could be an employee benefit plan covering all members of an association. As stated, this has been defined as a bona fide group or association over which dues paying members exercise the requisite control. DOL would determine the existence of a bona fide association of employers based on criteria listed above per AO 2005-20A.

This criterion has prevented employers from joining together for the exclusive purpose of providing health coverage and prevented employers from joining together if they are not closely related, even if in the same geographic area. The rationale for this traditional definition is sound, as it discourages creation of risky plans, ensures that individuals with experience in their industries have a stake in the governance of the plans and lends credibility in the marketplace.

Bona fide employer associations also have another advantage over individual plans and small group markets (50 or fewer employees) under the Affordable Care Act in that they qualify for the large group market (51 or more employees) and are not required to provide ACA essential health benefits. Thus, a group health plan established and maintained by a bona fide employer association is considered a single plan and, assuming there are at least 51 employees in the aggregate among all member employers, the plan will fall into the large group market rather than having to comply with more costly rules in the smaller health plan regulatory structure.

We support the proposed rule's expanded definition of "employer" to allow more associations to qualify as bona fide and ask that the final rule clarify that a related group of associations can band together (as a Multi-Association Health Plan or MAHP) and be considered an "employer" in order to provide a health plan to the collective membership. This would be done consistent with current protections that are designed to prevent adverse consequences and to ensure that AHPs resemble employer-sponsored arrangements and not commercial insurance.

AHP Certainty

Many of us have desired the opportunity to develop health insurance plans for our small business members for more than two decades and have supported bipartisan legislation to that effect. In so doing, it has always been our goal to create a regulatory framework that fosters legitimate AHPs and precludes fraudulent activity that could leave participants in the lurch. For example, we are pleased that S. 1818, the Small Business Health Plans Act of 2017, establishes financial transparency and regulatory oversight for AHPs in Sec. 806 Requirements for Application and Related Requirements, including a bonding disclosure requirement to state officials where an AHP operates, and that these requirements are augmented in Sec. 3 Cooperation Between Federal and State Authorities.

Also, Sec. 801 Association Health Plans and Sec. 803 Requirements Relating to Sponsors and Boards of Trustees in H.R. 1101, the Small Business Health Fairness Act of 2017, provide criteria for sponsorship of

AHPs that we support. However, please note that we prefer the clarifying language in S. 1818 that a consortium of bona fide associations [a Multi-Association Health Plan or MAHP] qualifies as a plan sponsor, so that organizations with insufficient numbers of small members to form a favorable risk pool can join together for a more solvent and attractive offering.

Commonality-of-Interest

Among the factors considered by DOL for a bona fide group or association have been the purpose for which a group/association was formed and who controls and directs operations of the benefit program. Also, employers that participate in a benefit program must directly or indirectly exercise control over the program, and DOL further clarified that the person or group that maintains the plan must be "tied to the employers and employees that participate in the plan by *some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits.*"

The degree of commonality-of-interest has depended on the facts, but an association of employers in unrelated industries would most likely not meet the current criteria. However, a group of associations whose members comprise different facets of a common industry, such as a supply or distribution chain, would appear to meet the current criteria and definitely would appear to qualify under the proposed language's expanded view. As such, we support that aspect of the proposal and hope the Department (EBSA) makes clear that such a group would qualify.

Under the proposed rule, member employers can establish a commonality-of-interest if they "Are in the same trade, industry, line of business, or profession, regardless of state boundaries."

Accordingly, the MAHP Coalition urges consideration of these concerns:

1. Many associations are too small or have too few eligible plan participants to form a viable risk pool. We are not seeking a self-insured plan, but hoping to attract a qualified underwriter. One of the lessons from the Senate Health Education Labor and Pensions (HELP) and House Education and the Workforce Committees' thorough examination of healthcare over the past decade is that the widest possible pool of enrollees is necessary to enable insurers to underwrite viable plans. We believe the concept is sound to require associations to prove that they were formed and are in continuing existence for purposes other than providing health insurance. But DOL must allow bona fide associations to create umbrella entities that can serve a number of otherwise-qualified associations and allow them to combine their enrollees into a large, consolidated pool in order to attract competition for the plans.

2. We have worked with Sen. Mike Enzi to ensure that these networks (Multi-Association Health Plans or MAHPs) can be created, and his Small Business Health Plans Act of 2017 (S. 1818) includes language in Section 801(b)(4) that a qualified plan sponsor can be "a bona fide trade association or a consortium of such associations." This language ensures that smaller associations can band together to sponsor a health plan, thus creating a more attractive economy-of-scale for underwriters. For these reasons, we support the proposed rule's expanded view of "commonality-of-interest" and request that DOL's final regulations take the same approach.

Preemption of State Rules

Finally, the question of requiring nationally-based, federally-regulated health plans to comply with regulations of the various states must be carefully addressed. Simply put, states have two kinds of mandates in place: 1) health coverage mandates; and 2) financial solvency mandates.

While our organizations intend to seek plans that provide coverage of pre-existing conditions, the impossibility and expense of complying with each state's coverage mandates have defeated AHPs in the past. It is crucial that federal regulations provide flexibility for the market to offer plans that address various coverage needs, and for associations to shop for and provide the plans that best fit their members' needs.

Federal regulations will have to preempt state coverage mandates to some extent in order for AHPs to maintain the efficiencies that will translate to lower insurance costs for participants. The vast majority of AHPs, including the Multi-Association Health Plan we want, would be fully insured. Therefore, they would be based on insurance offerings already registered, regulated and routinely filed in every state (under the rubric of policy-holder protection), which lends itself to federal streamlining.

Also, the issue of "must offer vs. must provide" for coverage requirements should be addressed since "must provide" mandates are driving up the costs of health insurance. The ability of bona fide employer associations to qualify for the large group market and not be required to provide ACA essential benefits will need to be augmented with federal preemption over "must-provide" state coverage mandates.

One possibility would be modeled on the Health Insurance Marketplace Modernization and Affordability Act of 2006 introduced by Sen. Mike Enzi. Under that legislation, Small Business Health Plans (or AHPs) would have to offer at least one comprehensive benefit package modeled on a state employee plan in one of the five most populous states. AHPs that offer such a plan would be granted the flexibility to offer other benefit packages that are exempt from state mandated benefits laws (from which large corporations and unions are now exempt).

With regard to financial solvency mandates, states certainly have an interest in requiring a sound fiscal basis for plans operating within their borders. And, per ERISA's preemption rules, if a MEWA (including an AHP) is fully insured, state insurance regulations can require the MEWA to maintain specified levels of reserves and/or contributions. However, fifty varying mandates on other coverage requirements will be problematic to the viability of AHPs that want to cross state lines.

As stated, we support reasonable financial solvency and transparency requirements for AHPs, but the viability of nationwide AHPs will depend on their being able to maintain their economies-of-scale. The patchwork quilt of state mandates creates complex legal barriers that will thwart the promise of AHPs as envisioned in the proposed rule. Therefore, we recommend that federal regulations preempt these mandates perhaps by sweeping them into ERISA-level regulation, and we again also suggest language in S. 1818 and H.R. 1101 as possible templates for the proposed rule's interplay with state solvency and transparency requirements.

Conclusion

We note that White House talking points that accompanied President Trump's Executive Order state that a factor for regulatory action to allow AHPs across state lines is that, "A broader consumer-friendly interpretation of the federal law governing insurance (ERISA) could potentially allow employers in the

same line of business *anywhere in the country* to join together to offer healthcare coverage to their employees."

We agree that employers who belong to bona fide associations in the same line of business should be able to form AHPs and MAHPs anywhere in the country, and urge Secretary Acosta and EBSA to enable associations related by supply chain or other common interests to band together to offer such health plans.

Thank you,

Susan Rowell
President
National Newspaper Association and
Publisher, The Lancaster (SC) News

Michael Makin
President & CEO
Printing Industries of America

Hamilton Davison
President & Executive Director
American Catalog Mailers Association

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Government Affairs

James W. Tobin III
Executive Vice President & Chief Lobbyist
Government Affairs and Communications Group

March 20, 2018

The Honorable Tim Walberg
Chairman
Subcommittee on Health, Employment,
Labor, and Pensions
U.S. House of Representatives
Washington, DC 20515

The Honorable Gregorio Sablan
Ranking Member
Subcommittee on Health, Employment,
Labor, and Pensions,
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Walberg and Ranking Member Sablan:

On behalf of the approximately 140,000 members of the National Association of Home Builders (NAHB), I am writing to express NAHB's appreciation to the Subcommittee on Health, Employment, Labor, and Pensions for holding today's important hearing on the Department of Labor's (DOL) proposed rule expanding the ability of employers to join together to secure health care coverage through an association health plan (AHP). We thank this Subcommittee and the Committee on Education and the Workforce for their continued attention to this issue.

Smaller employers face significant challenges in negotiating high-quality care at costs that they and their employees can afford. In a 2015 survey, 72% of NAHB members saw premium increases of over 10% in the year prior, including 8% who saw more than a 50% increase. Small businesses are subject to higher premiums, and because of their size, limited in the types of plans to which they have access through the small group health insurance market.

NAHB has long advocated for association health plans as a means for smaller employers to provide group health benefits for their employees. Currently, only certain states allow employers to band together in AHPs, with regulations varying vastly from state to state among those that do. Even in these states, the barriers to successfully setting up and operating an AHP are high.

NAHB has welcomed recent proposals from Congress and the Trump Administration to loosen restrictions on the expansion of AHPs, including the House-passed *Small Business Health Fairness Act* (H.R. 1101) and the *Small Business Health Plans Act* (S. 1818). Earlier this month, we were pleased to submit comments on the Department of Labor's proposed rule to provide a regulatory framework for treating health plans sponsored by associations as large group health coverage for purposes of federal and state health care laws. This will enable more associations to provide affordable quality health benefits to their members.

NAHB is supportive of the proposed rule. We believe that associations such as ours are uniquely suited to provide comprehensive, affordable health care for their members through a single large group health plan by leveraging economies of scale and administrative efficiency. The proposed rule's expansion of the definition of

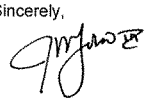
"employer" for purposes of Section 3(5) of ERISA will allow us to establish and operate an AHP across state lines, expand our member businesses' coverage options and rates, and also help attract and retain talented workers with competitive benefit offerings. Additionally, the proposed expansion of coverage under an AHP to "working owners" will help more workers in the residential construction sector to gain access to affordable health coverage by allowing independent contractors to sign up for a health plan offered by an association.

At the same time, we believe there is further opportunity to improve upon the proposed rule. Specifically, NAHB recommends that only a legitimate established organization, or a trust or other entity affiliated with such an organization, be permitted to sponsor an AHP to prevent fraud and abuse. Further, we urge further improvements to ERISA to ensure a smooth coordination between AHPs and state insurance laws.

NAHB's full comments to DOL are enclosed. We look forward to working with the Department of Labor and other agency stakeholders, the White House, and Congress to expand access to AHPs and further promote and expand health care options for small businesses.

Again, thank you for holding this important hearing and for considering our views.

Sincerely,



James W. Tobin III

Encl: NAHB Comments: Definition of Employer – Small Business Health Plans RIN 1210-AB85.

Office of Legal Affairs
James G. Rizzo
Executive Vice President & Chief Legal Officer
JRizzo@nahb.org

March 5, 2018

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

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

To Whom It May Concern:

On behalf of the National Association of Homebuilders ("NAHB") and its membership, I am pleased to submit comments in response to proposed rules issued by the Department of Labor (the "Department") that would broaden the criteria under Section 3(5) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") for determining when employers and individuals may join together to form a group or association treated as the sponsor of a single large group health plan (the "Proposed Rules").

Overview of NAHB

Since it was founded in the early 1940s, NAHB has worked to ensure that housing is a national priority and that all Americans have access to safe, decent and affordable housing. NAHB represents the largest network of craftsmen, innovators and problem solvers dedicated to building and enriching communities. Each year, NAHB's members construct about 80% of the new homes built in the United States, both single-family and multifamily. Comprised of a federation of more than 700 state and local builders' associations, NAHB represents more than 140,000 members. About one-third of NAHB's members are home builders and remodelers and the remaining members work in closely related specialties, such as, sales and marketing, housing finance, building trades and manufacturing and supply of building materials. We are dedicated to providing education and tools to our members, servicing their business needs and assisting them in navigating today's complex political and economic issues.

NAHB commends the Department on issuing the Proposed Rules to better enable associations to provide affordable quality health benefits to their members and to provide a regulatory framework for treating health plans sponsored by associations ("Association Health Plans" or "AHPs") as large group health coverage for purposes of federal and state health care laws. We believe that associations, such as NAHB, are uniquely suited to provide comprehensive, affordable health care for their members through a single large group health plan by leveraging economies of scale and administrative efficiency. We recognize that the Proposed Rules chart new territory for group health plans sponsored by associations and appreciate the opportunity to submit the following comments on the Proposed Rules.

Definition of Bona Fide Association (§2510.3-5(b)(1))

While NAHB supports the expansion of the definition of "employer" for purposes of Section 3(5) of ERISA, we are concerned that permitting an entity to form an association solely for the purpose of providing health benefits without any nexus or tie to an existing, legitimate association is problematic and subject to abuse.

We recommend that only a legitimate established organization, or a trust or other entity affiliated with such an organization, be permitted to sponsor an AHP and that the organization affiliated with or sponsoring the AHP have a legitimate business purpose separate and apart from the establishment of a health plan for its members. To that end, we recommend that the criteria to be a "bona fide association" be revised to require that the association be (i) organized under the laws of a state, (ii) recognized as a not-for-profit corporation with exemption from federal taxation; and (iii) established and operated for at least two years prior to the date the AHP is established. In addition, we recommend that the final rule be clarified to permit an association (as defined above), or multiple affiliated associations in the same industry, to join together to establish a trust or other legal entity for purposes of sponsoring an AHP. This clarification will ensure that AHPs are sponsored and administered by bona fide associations, or joint entities or trusts established by or affiliated with bona fide associations, and will protect consumers from commercial arrangements that are established solely for financial gain without any other connection to the members.

Further, the Proposed Rules make an assumption that the members of an association are either employers of common law employees or working owners with dual employer/employee status. We would like to highlight the fact that not all association membership consists solely of employer groups and working owners. In fact, membership in an association is often comprised of individuals who may be common law employees of employers that are not also members of the association. For example, membership in the NAHB consists of individuals who are members of their local affiliated building association (which can either be an employer or individual membership), sole proprietors working in the industry who meet membership criteria and students or apprentices sponsored by a member. Other associations where this membership structure is prevalent include professional associations, such as the American Bar Association. We encourage the Department to clarify that members of an association may participate in an AHP sponsored by that association even if their common law employer is not also a member of the association.

Commonality of Interest Test (§2510.3-5(c))

NAHB supports the first prong for satisfying the "commonality of interest" test set forth in §2510.3-5(c)(1) of the Proposed Rules, namely that the employers be in the same trade, industry, line of business or profession, regardless of geographic location. However, we have concerns about the second prong of the commonality of interest test set forth in §2510.3-5(c)(2) of the Proposed Rules that would permit single large group health plans to be established by regional associations without any common ties by trade, industry or profession. We believe the second prong of the commonality of interest test facilitates the establishment of commercial arrangements with no connection or ties to underlying participants (other than geography) and could result in an increase in sham arrangements that are susceptible to financial mismanagement and insolvency – arrangements which the existing MEWA rules are meant to discourage.

With regard to the meaning of the terms "trade", "industry" or "line of business", NAHB encourages the regulators to interpret these terms broadly to encompass related trades in the same industry. For example, while all NAHB members must serve the home building, multi-family development and remodeling industry, in

addition to builders and developers, members also include a wide variety of professionals, artisans and tradespeople, such as plumbers and electricians, who support the home building and development industry. In short, all members of a legitimate association (and their families) should be permitted to participate in an AHP sponsored by or affiliated with the association, provided they otherwise meet the criteria for membership. For this reason, we agree that it is important to maintain the organizational structure, participation, governance and functional control requirements of the Proposed Rules.

Expansion of AHP coverage to Working Owners and Definition of Working Owner (§2510.3-5(e)(1) and (2))

NAHB strongly supports the expansion of coverage under an AHP to "working owners", but has concerns about the way in which the term "working owner" is defined in the Proposed Rules. First, we recommend that the definition of "working owner" in §2510.3-5(e)(2) be modified to eliminate the requirement in subparagraph (iii) that the individual must not be eligible for other subsidized group health plan coverage under a group health plan sponsored by any other employer of the individual or the spouse's employer. This requirement unfairly disadvantages working owners and their spouses who have access to other employer sponsored health care and would also be administratively cumbersome for AHPs to monitor. Further, coverage through a spouse's or other employer's health plan may not be the most affordable or appropriate option for a working owner and his or her family and may cause undue hardship to an individual who is precluded from electing preferable AHP coverage on this basis.

In addition, we believe the hours requirement for purposes of meeting the definition of "working owner" in §2510.3-5(e)(iv)(A) should be modified to enable interns and apprentices of trades, such as the building trades, to qualify for health coverage under an AHP sponsored by an association of which they are members. Participation criteria could be based on hours worked performing services for a trade even if such individuals are not working a full-time schedule or paid for their work. Apprenticeship and internship programs are extremely common in many industries, including the building industry, and offer a career path to many individuals who choose not to attend a four-year college or university.

We do, however, support the provision in the Proposed Rules that would permit a group or association sponsoring an AHP to reasonably rely on a written representation from an individual that he or she meets the eligibility criteria for participation in the AHP as a working owner. A written representation will greatly relieve the administrative burden on the plan sponsor to request proof and verify eligibility and is consistent with other forms of written representations used in concert with group health plan administration.

Clarify that Participation in AHP is not a Basis for finding Joint Employment Status under other Federal and State laws

We believe it is important for the Department to add a safe harbor to the regulation to clarify that an employer's participation in an AHP with other unrelated employers may not be used as indicia of joint employment status for purposes of other sections of ERISA, such as Section 510 of ERISA, or other federal and state labor laws, or common law. The independent nature of small businesses and working owners should be preserved. The final rules should also clarify that the sponsor of the AHP cannot be sued as an "employer" under Section 510 of ERISA and should be treated as an "employer" solely for purposes of Section 3(5) of ERISA to enable an AHP to be treated as a large group health plan.

ERISA Preemption

NAHB supports broad ERISA preemption of state insurance laws as they may apply to AHPs. Subjecting AHPs to myriad state insurance laws will significantly hamper their adoption by legitimate associations. We believe that the organizational structure, participation and governance requirements applicable to AHPs under the Proposed Rules, in connection with the additional requirements for sponsorship by, or affiliation with, bona fide associations or groups of associations discussed in these comments, will put AHPs on the same strong structural and financial footing as single employer plans which enjoy broad ERISA preemption.

AHPS are already subject to sufficient federal and state regulatory oversight without additional regulation specifically aimed at multiple employer welfare arrangements, or MEWAs. Associations that are exempt from federal tax are required to file Form 990 with the Internal Revenue Service and are subject to audit. Associations are also accountable to their dues-paying members and governing boards and may also be subject to additional state laws and reporting requirements under state laws that govern not-for-profit or charitable organizations. Insurers that issue group health insurance policies to AHPs are subject to licensing, reserve requirements and regulation under federal and state law, and group health insurance policies issued to AHPs must comply with state mandated benefit requirements and be filed with the department of insurance in the state where the policy is delivered and/or situsted. In addition, fully-insured and self-insured MEWAs are subject to federal reporting on the Department's Form M-1 and Form 5500 (with related financial schedules for AHPs funded through trusts) and are also subject to oversight, audit and enforcement by the Department under laws applicable to MEWAs, recently strengthened under the Affordable Care Act.

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In conclusion, we support the Department's effort to expand the sponsorship of single employer large group health plans to legitimate associations for the benefit of their members and members' families and support affording such plans broad ERISA preemption from state insurance laws. We believe that AHPs, if properly structured, will result in lower costs and provide greater access to comprehensive health care for small employers and individuals through membership in an association.

Respectfully submitted,

James G. Rizzo

[Additional submission by Ms. Wilson follows:]

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March 6, 2018

Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
Department of Labor
Room N-5655
200 Constitution Avenue, NW
Washington D.C. 20210

Re: RIN 1210-AB85: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans Proposed Rule
83 Fed. Reg. 614 (January 5, 2018)

Dear Deputy Assistant Wilson:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the proposed rule implementing changes to the Employee Retiree Income Security Act's (ERISA's) definition of "employer" for purposes of determining when employers may join together to form an Association Health Plan (AHP). ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society and supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN supports efforts to reduce the number of uninsured Americans. Having adequate and affordable health insurance coverage is a key determinant in surviving cancer. Research from the American Cancer Society shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[1]

We have opposed previous federal initiatives to encourage the growth of AHPs because these plans promote the growth of products that do not provide comprehensive coverage, could damage the non-AHP individual and small group markets, and inadequately address issues of plan solvency and regulatory oversight, especially in light of the long record of AHP fraud and solvency problems. As discussed in more detail below, we outline several concerns we with have with the proposed rule in its current form. We believe this proposed rule should not be finalized until the needs of the patient community have been met.

AHP Coverage Could be Less Comprehensive: The health plans sold by AHPs are currently regulated mostly as either individual or small group coverage and are therefore subject to consumer protection

[1] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes," *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.

standards provided under the Affordable Care Act (ACA). The proposed rule could seriously erode the affordable comprehensive coverage now available in most states' individual and small group markets that is so critical to cancer patients and survivors. Exempt from any benefit and cost-sharing standards, AHPs could offer products lacking prescription drug coverage or rehabilitation services. These products could leave critical gaps in coverage (e.g., the plan could cover only generic drugs and a limited set of branded products) and could require very high deductibles and coinsurance.

Expanding AHPs Could Lead to Market Segmentation: Because the AHPs would no longer be subject to the Essential Health Benefit (EHB) requirements or the state benchmark requirements that define the scope of those benefits, these plans would fuel market segmentation. The premiums for AHP products would likely be lower than for ACA-compliant plans, not because of any AHP administrative efficiencies, but because of the more limited benefit packages. As a result, younger and healthier individuals would be attracted to enroll in AHPs, leaving older, sicker, and costlier individuals in the individual and small group products that are subject to the ACA's stricter consumer protection and other market requirements. The adverse selection spiral experienced by those non-AHPs, could lead the plans to charge increasingly higher premiums, making them unsustainable. It is for these reasons that the National Association of Insurance Commissioners,[2] the National Governors Association,[3] and the American Academy of Actuaries[4] have also been historically opposed to AHPs.

Past Experience with AHPs: We are also concerned about the proliferation of AHPs because of their history of fraud and financial instability. For a long time, these products were not traditionally subject to the same state insurance solvency and licensing requirements that allowed regulators to maintain necessary oversight.[5] If an AHP lacked the financial resources to pay claims, then enrollees were left with no coverage and high out-of-pocket costs. Even in cases of well-meaning AHP sponsors, insolvencies led to millions of dollars in unpaid claims.[6]

Our concern about the potential for a new wave of AHP fraud and solvency problems arises out of the open question regarding the authority of the federal government and the states to regulate AHPs under the Department's outlined policy framework, a critical issue that we discuss in further detail later. The preamble notes that the Department of Labor has enforcement authority to issue a cease and desist order when a Multiple Employer Welfare Arrangement (MEWA), a type of AHP, engages in fraudulent or other abusive conduct and to issue a summary seizure order when a MEWA is in a financially hazardous condition.[7] Called into question in the Request for Information and elsewhere in the proposed rule's preamble is the continuation of the existing state role in regulating MEWAs, especially those that are not fully-insured and thus more likely to encounter solvency and fraud problems. The Department

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[2] National Association of Insurance Commissioners, Consumer Alert: Association Health Plans are Bad for Consumers, available at http://www.naic.org/documents/consumer_alert_ahps.pdf.
[3] National Governors Association, Governors Oppose Association Health Plans, May 2004, available at https://www.nga.org/cms/home/news-room/news-releases/page_2004/col2-content/main-content-list/governors-oppose-association-hea.html.
[4] American Academy of Actuaries Letter to John Boehner, Chairman, House Committee on Education and the Workforce, April 28, 2003, available at http://www.actuary.org/pdf/health/ahp_042803.pdf.
[5] Kofman M, Bangit E, Lucia K, MEWAs: The Threat of Plan Insolvency and Other Challenges, Commonwealth Fund, May 2004, available at http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf.
[6] Id.
[7] 83 Fed. Reg. at 617.

appears to be considering a final rule that would provide a sweeping federal preemption of state authority in this arena. We are very concerned about any policy that would weaken the states' role in regulating AHPs.

The Department of Labor would need far greater resources than it has had in the past or currently exists to fully monitor AHPs in all 50 states and provide for effective enforcement where noncompliance issues arise. ACS CAN strongly urges the Department to follow current law and reaffirm the authority of the states to regulate AHPs more generally. We note that state regulators are often on the front lines of consumer complaints and can be in a better position to monitor what is happening in their markets.

PROPOSED REGULATION

A. Employers Could Band Together for the Single Purpose of Obtaining Health Coverage

The proposed rule seeks to allow employers to band together for the express purpose of offering health coverage if they are: (1) in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area.

We note that the preamble discusses at length how this proposed policy would help small businesses reduce their health care costs, but at the same time, the Department declined to limit the policy only to small employers. In fact, the preamble notes that it expects minimal interest from large employers given that they already enjoy market advantages, nevertheless "there may be some large employers that may see cost savings and/or administrative efficiencies in using an AHP as a vehicle for providing health coverage to their employees."[8] We are concerned that allowing large employers to join together to form an AHP – either with other large employers and/or a mixture of large and small employers – would segment the market further and would siphon younger, healthier individuals into these products and away from the individual market. We strongly urge the Department to disallow large employers from forming an AHP.

Under the proposed policy, an AHP could sell across state lines if the businesses to which membership was offered shared some common geographic area. It also seems likely, however, that AHPs could market across state lines to the extent that they meet the other commonality of interest provision, that is, that they are in the "same trade, industry, line of business or profession." To the extent that the rule was to permit a state to impose solvency and other standards on these plans, as we urge, it is unclear which state would have jurisdiction over the AHP. If an AHP were formed in the greater Washington, D.C. area, it is unclear whether the state insurance regulators in Maryland, D.C., and Virginia would have joint jurisdiction. If an AHP selling to real estate brokers across the country was domiciled in Georgia, would other states' insurance laws apply to that AHP? Or, as it appears possible under the preamble language, would any or all state laws be preempted from applying to the AHP coverage or would the application of state law be limited to only that state in which the AHP was primarily domiciled. The potential for problems to arise would be significant. AHP participants might discover that they have no recourse under state law to obtain benefits due under the terms of the AHP and federal law and oversight would seem to be minimal as outlined in the preamble.

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[8] 83 Fed. Reg. at 620.

B. The Group or Association Must Have an Organizational Structure and Be Functionally Controlled by Its Employer Members

The proposed rule would require that the group or association have a formal organizational structure with a governing body and have by-laws or other indications of formality and that the group control its functions and activities.

We are concerned that this proposal is not sufficient to address concerns regarding the financial solvency of the AHPs. The proposed rule does not impose any federal solvency requirements to ensure that entities have sufficient resources to prevent financial failure. These solvency requirements exist to ensure that a health insurer is able to pay claims when their enrollees experience high health care claims, such as when an enrollee is diagnosed with cancer. If an AHP has insufficient reserves to pay claims, the AHP risks folding, thus leaving enrollees suddenly with no health coverage and potentially liable for any medical expenses that have been incurred.

In the preamble the Department recognizes past solvency and fraud problems with Multiple Employer Welfare Arrangements (MEWAs) but glosses over the potential for these problems to multiply under the far less stringent organizational requirements specified in the proposed rule. This concern is magnified to the extent that states, which require issuers of insurance to meet capital and reserve requirements, are prevented from regulating AHPs.

C. Group or Association Plan Coverage Must be Limited to Employees of Employer Members and Treatment of Working Owners

The proposed rule would require that only employees and former employees (including dependents) may participate in the health plan sponsored by the association.

More concerning though is the inclusion in the proposed rule of working owners (self-employed individuals) as eligible entities for coverage under AHPs based solely on their self-certification. The proposed policy is inconsistent with ERISA as a law created to protect employees of private sector firms, since a working owner may not have any employees.[9]

In addition, the proposed policy could dramatically increase the likelihood that the individual insurance market, including the Qualified Health Plans (QHPs) selling through the ACA marketplaces, would experience severe adverse selection and become unsustainable. AHPs would draw healthier individuals away from the ACA-compliant individual market products, turning the latter into the coverage of last resort for those in need of more comprehensive benefits. Together with the repeal of the shared responsibility (individual mandate) requirement under the Tax Cuts and Jobs Act, signed into law in late 2017, this measure would make it impossible over a few years' time for ACA-compliant plans to retain sufficiently large and balanced risk pools to survive.[10] (Federal costs would also grow substantially to cover the increased QHP premiums for those eligible for the ACA's premium subsidies.)

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[9] Both ERISA regulation 29 CFR 2510.3-3 and the Public Health Service Act (42 U.S.C. § 300gg-91) make clear that employer-owners without any employees would not qualify as employees.

[10] The Congressional Budget Office (CBO) estimated 13 million additional people would be uninsured by 2026 as a result of the repeal of the individual mandate. CBO, "Repealing the Individual Health Insurance Mandate: An Updated Estimate," November 2017, available at https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

Moreover, because AHPs would be exempt from the current law requirement for a single risk pool and risk adjustment, no mechanism would exist to require their participation in the spreading of risk that helps offset the losses of ACA-compliant plans (including QHPs. As the ACA-compliant individual and small group markets became more expensive, less well-meaning entities would likely form AHPs in an effort to make a quick profit off of consumers seeking lower-cost alternatives.

D. Nondiscrimination Protections

The proposed rule would prohibit the group or association from restricting members in the association itself based on any health factor of an employee (including former employees and family members). Health factors include health status, medical condition (both physical and mental illness), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability.

We are pleased that the proposed rule would not allow the group health plan sponsored by the AHP group or the AHP to exclude enrollees based on a health factor, including their health history. We believe that an individual's health status and health history should not be taken into account for purposes of determining eligibility for health coverage or cost-sharing associated with benefits provided under the plan.

However, we are concerned that the while the proposal would prohibit health discrimination *within* groups of similarly situated individuals, it would not prohibit discrimination *across* different groups of similarly situated individuals.[11] For example an AHP could impose different rates based on age (the 3 to 1 limit under the ACA would not apply), gender, industry, group size and geography. It could also charge an employer with higher rates of females higher premiums or an employer with a relatively younger workforce lower premiums. An AHP seeking to achieve favorable selection would face few constraints on its ability to fashion and price products that attract the lowest-cost, lowest-risk enrollees. We are concerned that this provision provides a back-door way for an AHP to use health status to determine premiums.

The Department requests comment on whether its proposed non-discrimination rules would result in involuntary cross-subsidization across firms that would discourage AHPs from forming. We strongly urge the Department to ensure that guaranteed issue, guaranteed renewability, adjusted community rating, a single risk pool and risk adjustment, all required under the ACA's individual and small group markets and applicable today to most AHPs, continue to apply to AHPs. A separate and weaker set of federal minimum standards, such as envisioned by this proposed rule, would invite the kind of risk segmentation that we have already described, greatly limiting the affordable coverage options for individuals with preexisting health conditions like cancer or a history of cancer, or are older or have other risk factors, such as employment in a high-risk industry.

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[11] 83 Fed. Reg. at 624.

REGULATORY IMPACT ANALYSIS

1.3 AHP's Potential Impacts

The proposed rule's stated goal is to facilitate the establishment of more AHPs in order to make more, and more affordable, health coverage options available to more employees of small businesses and their dependents.[12] However, even the rule itself notes that "[w]hile the impacts of this proposed rule, and AHPs themselves, are intended to be positive on the net, the incidence, nature and magnitude of both positive and negative effects are uncertain. Among factors impacting uncertainty, as cited in the proposed rule, are legislative proposals to repeal and replace the ACA, state's ability to regulate AHPs, and interaction with related initiatives including the short-term limited duration policies."[13]

Given the amount of uncertainty, we question the wisdom of allowing the proliferation of AHPs or whether it would be wise to delay the implementation of any proposed changes until such time as efforts to provide more stability to the individual market have been permitted to take effect. We caution that the impact analysis conducted by the Department is incomplete. The repeal of the individual mandate penalty beginning in 2019 is expected to have a significant impact on the individual market and the proposed rule failed to include any analysis regarding the extent to which the interaction of those policies would affect the viability of the individual market.[14] In addition, we note that other efforts by the Administration – such as the recently released proposed rule on short-term limited duration policies[15] – will also have a profound impact on the individual market and should be taken into account for purposes of determining the impact on the individual market.

1.5 Increased Choice

The proposed rule notes that AHPs would not be subject to the individual and small group market rules, and thus "would enjoy greater flexibility with respect to the products and prices they could offer to small businesses."[16] We are concerned that the proposed rule would allow AHPs to offer coverage that does not include the Essential Health Benefits (EHBs) or the state EHB benchmarks that define their scope.

Moreover, it appears that AHPs may also be exempt from the ACA's Minimum Essential Coverage and maximum out-of-pocket cost limits by virtue of the proposed rule's definitional changes. As a result, an AHP could offer lower-cost coverage than non-AHPs simply by not covering expensive cancer drugs or any prescription drugs or could cap the number of hospital days or offer no inpatient hospital coverage. Exemption from the ACA's 60 percent minimum essential coverage requirement could give rise to AHP coverage that actually pays for very little of an enrollee's health care expenses.

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[12] 83 Fed. Reg. at 626.
[13] 83 Fed. Reg. at 627.
[14] Recent analysis by Avalere estimates higher premiums in both the individual and small group markets and an increase in the number of uninsured Americans relative to current law. Avalere, "Association Health Plans: Projecting the Impact of the Proposed Rule," Feb. 28, 2018, available at http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf.
[15] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, Short-Term, Limited Duration Insurance, Proposed Rule, 83 Fed. Reg. 7437 (Feb. 21, 2018).
[16] 83 Fed. Reg. at 628.

Thus, AHPs could impose high enrollee cost-sharing on benefits likely to be expensive to insure or to attract higher-risk enrollees. While technically enrollees might be insured, the insurance offered to them would be inadequate to meet their needs, leaving them exposed to a significant amount of out-of-pocket costs. Enrollees who signed up for an AHP assuming that they were healthy and in little need of health care could find themselves uninsured for critically-needed health care in the event of a serious illness, like a cancer diagnosis.

Moreover, to the extent that plans offered by AHPs do not meet the Minimum Essential Coverage requirements, an individual who needs or wants to leave their AHP to enroll in an ACA-compliant plan (for example to access more comprehensive coverage or because their AHP has become insolvent and stopped paying claims) would likely not be given a special enrollment period to do so, and would have to wait till open enrollment, thus resulting in a gap in coverage.

The selection dynamics created by this proposed rule would inevitably lead to a severe segmentation of the private insurance market, jeopardizing the adequacy and affordability of coverage for those Americans most in need of health care. Should the rule be finalized in its current form, the ACA-compliant plans, especially the QHPs, could be significantly weakened, experiencing declining numbers of participants that would undermine the spreading of risk. As stated earlier, to the extent that AHPs draw the healthier and younger enrollees, the non-AHPs (especially the QHPs selling through the marketplaces) would likely become insurers of last resort, vulnerable to a death spiral undermining their viability. Especially in the absence of the enforceable individual mandate, healthier individuals and small groups will either migrate to AHPs or go uninsured.

The proposed rule makes note of these concerns, yet dismisses them by stating that these risks "may be small, however, relative to the benefits realized by small businesses and their employees that gain access to more affordable insurance that more closely matches their preferences."[17] The Department is seemingly suggesting that a concern about the lack of adequate and affordable coverage options to those in the individual market is outweighed by lower premiums provided to small businesses (even though these premiums would be lower because coverage would not be as comprehensive). From a cancer perspective, affordable health insurance premiums are important but equally important are the adequacy of the benefits provided under the plan.

1.6 Risk Pooling

The proposed rule indicates that AHPs would not be part of the risk adjustment program that seeks to minimize risk for insurers in the individual and small group market. Rather, the Department suggests that such programs are not necessary given that AHPs would be subject to non-discrimination policies outlined above. However, we again note that non-grandfathered health insurance coverage and the insurers selling that coverage in the remaining individual and small group markets would have to meet federal minimum requirements related to rating, a single risk pool, the EHBs, and participation in the risk adjustment system. They would have to shoulder the effects of adverse selection through these risk pooling measures; AHPs, on the other hand, would be exempt from sharing in any of the costs associated with that adverse selection. The proposed application of a non-discrimination rule that allows AHPs to rate on factors other than those that are defined to be health-status related would create an extremely un-level playing field for insurers, likely leading most if not all to exit the marketplaces.

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[17] 83 Fed. Reg. at 628.

In response to concerns that AHPs could siphon younger and healthier individuals by offering lower-priced products, the Department suggests that pricing flexibility would be the only advantage provided to AHPs and suggests that an AHP may realize sufficient efficiencies that would enable it to offer lower premiums even to less healthy individuals. Yet the Department offers no evidence to support its theory.

The plans sold through the AHPs use the same network of healthcare providers as health insurers or third-party administrators (TPAs) and thus the likelihood is low that an AHP, even with a large number of participants, would be able to achieve more discounted prices than these issuers. If an AHP seeks to contract directly with providers in order to achieve discounted prices, it would require an enormous investment of resources to establish that network and again, seems unlikely to achieve deeper discounts than insurers or TPAs. Moreover, there are administrative costs associated with establishing and operating an AHP and they would have to be reflected in its premiums. For these reasons, when asked to estimate AHP proposals introduced in Congress, the Congressional Budget Office has concluded that they would not likely lead to significant increases in health insurance coverage, including for small businesses.[18]

1.7 Individual and Small Group Markets

We are concerned that the proposed rule seems to suggest that its intent is to shift individuals from marketplace coverage to coverage through an AHP, noting that many individuals who are enrolled in marketplace coverage could become eligible for an AHP. The proposed rule incorrectly suggests that "the ACA creates significant incentives for some people to wait to purchase insurance until an enrollment period that occurs after they have experienced a medical need." The ACA was designed to ensure that as many individuals as possible were enrolled in coverage and in fact contained a provision that imposed a fine on individuals who failed to maintain coverage. Also as the Department is aware, the Department of Health and Human Services has severely curtailed an individual's opportunity to enroll in marketplace coverage outside the annual open enrollment period, much less create a special enrollment period for individuals who have a medical need.

In fact, the proposed rule notes that the "Department considered the potential susceptibilities of individual and small group markets to adverse selection under this proposal" but notes the "ACA's requirement that essentially all individuals acquire coverage and the provision of subsidies in Exchanges may reduce that susceptibility."[19] The individual mandate was repealed in recent legislation, thus negating the Department's arguments.

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[18] Congressional Budget Office, Small Business Health Fairness Act of 2005 (H.R. 25), cost estimate (Apr. 2005), available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/62xx/doc6265/hr525.pdf; Congressional Budget Office "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts," (January 2000), available at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/18xx/doc1815/healthins.pdf.

[19] 83 Fed. Reg. at 630-631.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed rule. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Christopher W. Hansen
President
American Cancer Society Cancer Action Network

[Questions submitted for the record and their responses follow:]

April 10, 2018

Christopher E. Condeluci
Principal and Sole Shareholder
CC Law & Policy PLLC
1001 4th Street, SE
Washington, DC 20003

Dear Mr. Condeluci:

Thank you again for testifying at the March 20, 2018, Subcommittee on Health, Employment, Labor, and Pensions hearing on "Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans."

Enclosed are my additional questions following the hearing. Please provide written responses no later than April 24, 2018, for inclusion in the official hearing record. Responses should be sent to Alexis Murray of the Committee staff, and she can be contacted at (202) 225-7101.

We appreciate your contribution to the work of the Committee.

Sincerely,

Tim Walberg
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

CC: The Honorable Gregorio Kilili Camacho Sablan
Ranking Member, Subcommittee on Health, Employment, Labor, and Pensions

Questions for the Record
Hearing: "Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans"
Tuesday, March 20, 2018

Chairman Walberg (MI)

1. There have been reports in the past regarding beneficiary difficulties dealing with interstate insurance sellers. I am interested to know the steps this proposed rule will take to ensure consumers are confident they are dealing with legitimate insurance products and who or what entities will be responsible for advocating for the patient in purchase or coverage disputes?

2. State regulators have long been at the forefront of detecting fraudulent association health plan activity within their states, and are equipped to respond more quickly than those at the federal level in shutting down insolvent operations. What do you think is the proper role of states in regulating association health plans and how do you view this rule affecting that role?

Questions for the Record
Hearing: Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans
Tuesday, March 20, 2018

There have been reports in the past regarding beneficiary difficulties dealing with interstate insurance sellers. I am interested to know the steps this proposed rule will take to ensure that consumers are confident they are dealing with legitimate insurance products and who or what entities will be responsible for advocating for the patient in purchase or coverage disputes?

Can consumers be confident they are dealing with legitimate insurance products?

An "association health plan" (AHP) established pursuant to the proposed Department of Labor (DOL) regulations is considered a "group health plan" under the law. As a group health plan, a fully-insured and self-insured AHP will be subject to the Employee Retirement Income Security Act (ERISA), the Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act (HIPAA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Fully-insured and self-insured AHPs are subject to the ACA's "coverage requirements." This means that an AHP (1) *cannot* deny a person who is eligible to participate in the plan health coverage if they have a pre-existing condition, (2) *cannot* refuse to cover preventive services (rather, the AHP must provide free coverage for certain government-approved preventive services), and (3) *cannot* impose annual and lifetime limits on the Federal "essential health benefits" covered under the plan. Additional ACA requirements apply – most notably – coverage for adult children up to age 26, free access to emergency care, and the prohibition against rescinding coverage absent fraud.

HIPAA protections also apply to fully-insured and self-insured AHPs. For example, premiums for an AHP plan participant *cannot* be developed based on the participant's health condition. Instead, premiums are developed based on the "health claims experience" of the entire group. As a best practice, sponsors of a fully-insured or self-insured group health plan charge every participant the same premium rate.

Under ERISA, there are specific notice and disclosure requirements, and also fiduciary responsibilities that apply, requiring the plan sponsor of the AHP to act in the best interest of the plan participants. Participants also have a private right of action to sue the plan sponsor of the AHP if there is wrong-doing. And, there are detailed procedures for filing health claims, and rigorous internal and external appeals processes. In addition, continuation coverage rules under COBRA apply.

Who or what entities will be responsible for advocating for the patient in purchase or coverage disputes?

As stated above, a fully-insured and self-insured AHP is considered a group health plan under the law. As a result, the AHP will be governed by ERISA, which imposes specific fiduciary responsibilities on those individuals that exercise control over the AHP.

The proposed DOL regulations require the group of employers and/or self-employed individuals with no employees (referred to as "working owners") establishing an AHP to establish a formal organizational structure with a governing body (such as a Board of Directors or Trustees) to exercise control over the AHP. The proposed regulations also require that the employer and/or working owner members of the AHP must have the power to nominate, elect, and/or remove members of the Board of Directors or Trustees.

The elected members of the Board of Directors or Trustees – as fiduciaries of the AHP – are required to act in the best interest of the AHP participants. This includes advocating for AHP plan participants who may have purchase or coverage disputes with the insurance carrier under-writing the health coverage or the plan sponsor of a self-insured AHP, which is the Board.

In the event the purchase or coverage disputes are not resolved to the AHP participant's satisfaction by the insurance carrier or the Board, there are specific claims procedures and internal and external appeals processes that the participant may pursue. For example, a participant may seek an external review of any coverage dispute, which includes an independent review of outside experts (often times in accordance with a State's external review requirements that are consistent with the National Association of Insurance Commissioners' Uniform External Review Model Act).

The DOL is also responsible for ensuring that purchase or coverage disputes among ERISA-covered plan participants are adequately addressed. The DOL has Field Offices in which ERISA-covered plan participants (which include AHP participants) can contact with specific complaints about coverage disputes or benefit denials. In addition, in cases where the AHP is fully-insured, an AHP participant can contact the State Insurance Department with specific purchase or coverage disputes with the insurance carrier under-writing the coverage.

State regulators have long been at the forefront of detecting fraudulent association health plan (AHP) activity within their States, and are equipped to respond more quickly than those at the Federal level in shutting down insolvent operations. What do you think is the proper role of States in regulating AHPs and how do you view the proposed Department of Labor (DOL) regulations affecting that role?

The proposed DOL regulations do not impact a State's ability to regulate insurance. In other words, States have the exclusive authority to regulate insurance products offered within their State, and the DOL regulations do nothing to impact this authority. As a result, States will continue to serve as the primary regulator of AHPs – both fully-insured and self-insured AHPs – even after the DOL regulations are finalized.

It is important to note that an AHP is by definition a "multiple employer welfare arrangement" (MEWA). In the case of fully-insured MEWAs (i.e., fully-insured AHPs), States are permitted to impose specific reserve and contribution level requirements on these plans. In addition, State insurance regulations applicable to the insurance carrier under-writing the AHP will continue to apply. And, the State's benefit mandates will apply to the AHP's insurance contract.

In the case of self-insured MEWAs (i.e., self-insured AHPs), ERISA gives States the exclusive authority to impose any State insurance law requirement on these arrangements. Over the years, States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. For example, some States have an outright prohibition against self-insured MEWAs operating within the State, while other States allow self-insured MEWAs to operate free most of the State's insurance regulations. Because the DOL proposed regulations do nothing to inhibit a State's ability to regulate self-insured MEWAs (i.e., self-insured AHPs), States are free to amend their existing State MEWA laws to be more restrictive or permissive, as the case may be.

I personally believe that the States should continue to serve as the primary regulator of AHPs – both fully-insured and self-insured AHPs – because "health care is local." That is, States have a better understanding of the needs of their constituents and the issues that may directly impact their insurance markets. In addition, because State regulators typically are "closer" to activities that may go on within their borders, States have the ability to swiftly act in cases of fraudulent or abusive activities.

Having said that though, I also believe that the DOL should play a critical role in serving as a regulator of self-insured AHPs. In my opinion, critics of AHPs overlook the fact that – through the Affordable Care Act (ACA) – Congress strengthened the DOL's ability to monitor self-insured MEWAs (i.e., self-insured AHPs) through increased notice and disclosure requirements. The ACA also enhanced the DOL's enforcement authority by providing extended civil and new criminal penalties, and the ACA now allows the DOL to stop a MEWA's operations or seize its assets in certain circumstances without a court order. Congress is free to further augment the DOL's enforcement authority – either through increased funding for enforcement or additional enforcement tools – if concerns over regulating self-insured AHPs remain.

[Whereupon, at 11:55 a.m., the Subcommittee was adjourned.]

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