

**ROUNDTABLE ON SMALL BUSINESS
HEALTH PLANS**

HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND
RETIREMENT SECURITY

OF THE

COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING SMALL BUSINESS HEALTH PLANS

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JANUARY 30, 2018
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ROUNDTABLE ON SMALL BUSINESS HEALTH PLANS

Tuesday, January 30, 2018

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND RETIREMENT
SECURITY,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:30 p.m. in room SD-430, Dirksen Senate Office Building, Hon. Michael Enzi, Chairman of the Subcommittee, presiding.

Present: Senators Enzi [presiding], Alexander, Sanders, Murphy, Warren, Hassan, and Jones.

OPENING STATEMENT OF SENATOR ENZI

Chairman ENZI. I will go ahead and call to order this Subcommittee meeting on Primary Health and Retirement Security roundtable.

A roundtable is a little bit different than a hearing. We are mostly interested in gathering information from more presenters than we might normally have, and have some people who actually have done something in the areas that they will talk about, and that is very, very helpful.

I am pleased to be able to open this roundtable. We have before us a policy that I have worked on for nearly 20 years, small business health plans. Sometimes it is called Association Health Plans.

I would like to thank the Ranking Member, Senator Sanders and his staff, for working with me to put together an outstanding group of individuals to explore this policy issue, and inform us about both their individual experiences in this area, as well as their thoughts on the small business health plan rule proposed on January 5, 2018 by the Department of Labor.

One thing that I hope we can all keep in mind is the idea that this is not a theoretical discussion. This is a conversation about a real change in policy that an agency is considering under their existing statutory authority. Nothing that they propose requires any Congressional action; they already have it and we have already given it to them.

But this is an important shift in the Department of Labor's view on Association Health Plans. As policymakers, we need to make sure that the agency is appropriately considering the impact of what they proposed.

There are some key considerations that have informed how I have looked at the proposed rule.

First, protections from discrimination. There should be strong protections from discrimination that ensure that employees are not excluded from coverage inappropriately.

Second, there must be accountability to beneficiaries. These plans should have accountability to an individual beneficiary, ideally in the state in which he or she lives. That kind of accountability may take different forms, and I know the ERISA does include various methods of recourse for beneficiaries.

Third, the regulations around these plans must try to protect small business, and their employees, from fraud. The proposed rule contemplates several protections, but I hope to hear more from you about whether you view those as appropriate.

Last, parity. It is important that the Department, as much as practicable, applies the same standards for benefits and other requirements to these plans as to other ERISA plans. The Department should not create a new, separate class of plans with different rules. Large employers and associated health plans, or small business health plans, should have comparable requirements and responsibilities.

Senator Sanders, and then I will have Senator Alexander speak.

STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you very much, Mr. Chairman.

Before I go further, let me thank the witnesses that we have, two of whom come from the State of Vermont.

Tess Kuenning is the President and CEO of Bi-State Primary Healthcare Association. I think she is going to express her concerns. We are 4 months into the fiscal year. Community health centers, which provide coverage for 27 million Americans, have still not been reauthorized.

We also have with us Jen Kimmich, who is the co-owner of The Alchemist Brewery, and they make very good beer—but she did not bring it—and is a medium sized employer in the State of Vermont who does a very good job in trying to provide healthcare to all of her employees.

I thank both of them for being here.

Before I get into the thrust of my remarks, Mr. Chairman, I will tell you what I think, you already know that I believe.

I believe that it is an international embarrassment that the United States of America remains the only major country on Earth not to guarantee healthcare to all people as a right.

Today, we have some 31 million people who have no health insurance. And, as I am sure will be discussed today, we have far more than that who are underinsured with high deductibles and high co-payments.

We pay the highest prices in the world for prescription drugs. The cost of healthcare continues to soar. And despite spending twice as much per capita as do the people of any other country, our healthcare outcomes are not particularly good.

The bottom line is you have a failing healthcare system and everybody who has spent 5 minutes thinking about it, understands it. In my view, the time is long overdue for us to move to a Medi-

care for all, single payer program. I think the American people are catching on.

Today, as you may have read, three major employers, and they are some of the most significant companies in this country—Amazon, Berkshire Hathaway, and JPMorgan Chase—have indicated that they are going to move in their own direction to a simple, non-profit type of system. I would hope that becomes an indication to other businesses that when we talk about a Medicare for all system, we are not just talking about the needs of ordinary Americans and consumers. We are talking about what is good for the business community as well.

We are making progress on that, and I hope the day comes, sooner or later, where the United States does not remain the only major country not to guarantee healthcare to all people as a right.

In terms of this hearing, we know that small businesses, and self-employed individuals, face unique challenges with purchasing health insurance coverage. This is why, in response to the President's October 12 Executive Order, the Department of Labor published proposed rules to expand the availability and flexibility of health coverage sold to small businesses and self-employed individuals through Association Health Plans. This proposed rule also would make fundamental changes to short term plans and health reimbursement arrangements.

Now, on the surface, this seems like a step in the right direction. In fact, it was described as a way to encourage competition, expand choice for small businesses and self-employed individuals, while also lowering their exorbitant and cumbersome administrative costs.

However, as is always the case, the devil is in the details. And the details in this proposed rule would take efforts to improve aspects of our Nation's healthcare system in a very wrong direction.

The proposed rule does indeed offer more flexibility. However, that flexibility comes in the form of opening the door for plans to limit coverage for those with pre-existing conditions, to deny covering the current list of Essential Health Benefits, and to strip maximums that consumers would be charged in out of pocket costs.

It would also allow short term plans, which currently do not offer comprehensive health insurance coverage and do not include any real consumer protections, to be sold as long term alternatives to what we all know is health insurance coverage under the Affordable Care Act.

We have a lot of concerns with some of the rules that are being proposed.

Thank you, Mr. Chairman.

Chairman ENZI. Thank you, Senator Sanders.

This is a Subcommittee hearing. I am the Chairman and Senator Sanders is the Ranking Member of that Subcommittee, but we are honored today to have the Chairman of the Committee, Chairman Alexander, here. I know that he has been engaged on this issue, if you have any remarks to share, please feel free to do so.

STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. Thanks, Senator Enzi.

I want to thank you and Bernie for doing this, and thank the witnesses for coming. I am going to try to listen to what you have to say.

I remember one time when I was on that side of the table. I concluded that these things are more of a "talking," than a "hearing," so I want to be a listener today.

I can think of two things to talk about.

I think this is a very intriguing rule, because all of us who have worried about the individual insurance market see that it is very small. Really, 6 percent of all the people who have insurance in the country have it and half of those have subsidies to help pay for it. The people who are really left out are the people who pay for their own insurance.

I was in a Chick-fil-A in Nashville, and a lady named Marti came up to me and said her policy had gone from \$300 to \$1,300 a month in the last few years. She could not afford it. She is self-employed.

As I understand this proposal, it could benefit her. It could give her the opportunity to have the same kind of insurance that an employee of a large company has. And, of course, what that does to begin with, is lower the cost because employees of large companies get roughly a benefit of about a \$5,000 tax break per individual that self-employed people do not get. That lowers her cost. And being part of a larger pool would lower her cost.

The second thing is, I am glad to see the protections that the regulation has. If you have the same sort of consumer protections that employees who receive healthcare from large companies have that means that Association Health Plans like this cannot charge a premium that is higher because you have a pre-existing health condition.

You cannot deny coverage of a pre-existing health condition. You have to offer coverage to children up to age 26. You cannot cancel an employee's plan because the employee gets sick. You may not impose annual or lifetime limits on benefit coverage. You must cover preventive health services free of charge to the patient.

I do not hear a lot of complaints about insurance that large employers have in terms of their protection, Mr. Chairman. If this really does offer an opportunity to lower the cost by about one-third, and to offer many of the same guardrails and protections that employees of IBM and other large companies have, I think it is a real opportunity for that self-employed farmer that I saw at Chick-fil-A. I am glad that the Secretary has proposed it.

I look forward to the hearing.

Chairman ENZI. Thank you, Mr. Chairman.

I want to thank the participants for the testimony they submitted; extremely helpful. I will be encouraging everybody to take a look at that. It will also all be a part of the record.

I will invite each of you to give a brief statement of your testimony.

Senator Sanders and I are so appreciative of your willingness to give your time to be here. We know that some of you had significant travel to get here, but your contribution to this discussion is something that we think is important.

I particularly appreciate the people from Wyoming who came because I make that trip almost every week and know how difficult that is.

First, I would like to introduce Brad Johnson. Brad is the owner of the Covenant Insurance Group, which was started in 1996 in Casper, Wyoming. Covenant specializes in employee benefits, and manages the Wyoming Chamber Health Benefits Plan. Covenant operates in all parts of the State of Wyoming and works with employers ranging from groups of two to employers with over 2,000 employees.

The Wyoming Chamber Health Benefits Plan is an Association Health Plan and is available to members of the Wyoming Chambers of Commerce, and has been in operation for the last 12 years.

I appreciate you making the trip. I know it is not easy to pop over to Washington from Casper for the afternoon. We are glad to be able to hear from you about how you work with the Chambers to provide a good and competitive health insurance option.

Next, I welcome Mike Sturm of Milliman. He is an actuary and consultant who has experience working with a variety of clients including associations and trusts on health plan issues and employer sponsored insurance.

He has insight into how these policies may affect broader health insurance markets, and how they can be structured to provide affordable options for small employers and employees.

We appreciate your time and expertise on the current law related to AHP's and the potential implications of the proposed rule.

Chris Condeluci of CC Law & Policy is an employment law expert with deep experience in understanding the regulatory structure that AHP's and ERISA plans have to comply with today, as well as what is contemplated under the proposed rule.

He also served as a staffer for the Senate Finance Committee during the passage of the Affordable Care Act.

Jennifer Kimmich, the co-owner of The Alchemist Brewery in Vermont, is also joining the roundtable today.

I have heard really excellent things about your product and I am glad to have you here to share your experience as a small business owner and providing a health benefit to your employees. It is something I know that you and so many other small business owners value, but it has become increasingly expensive to provide.

I appreciate your willingness to take time away from your business to be with us today.

I would also like to welcome Tess Stack Kuenning, the President and Chief Executive Officer of Bi-State Primary Care Association, which is a community health center in Vermont.

I am glad to have your insight as a provider on the importance of healthcare access as a critical value for our communities.

I appreciate all of you being here and for your time and expertise.

Mr. Johnson.

STATEMENT OF BRAD JOHNSON, REPRESENTING THE CASPER AREA CHAMBER OF COMMERCE AND THE WYOMING CHAMBER HEALTH BENEFITS PLAN, CASPER, WYOMING

Mr. JOHNSON. Mr. Chair and Ranking Member.

Thank you for the opportunity to be here today. I appreciate it. In Wyoming, is a little bit of a unique state. We have various—as Senator Enzi can tell you, a lot of small employers.

I was approached about 14 years ago by three chambers of commerce in three smaller towns asking about how to put together a benefit program that would give small employers the same options as large employers, kind of repeating a theme here today.

After about a year and a half of legal work, we were able to put a plan together that now functions with 15 chambers across the state, available to all chamber members.

It is a plan that does comply with all parts of the ACA, meaning that it has all Essential Health Benefits in the list. It meets all of the requirements. It works out very well, and we are proud of that program and how it has functioned.

Thank you for the opportunity.

[The prepared statement of Mr. Johnson follows:]

PREPARED STATEMENT OF BRAD JOHNSON

Over the past 20 years, we have worked with 7 different MEWA (Multiple Employer Welfare Arrangement) programs. We have also worked with two that did not succeed, and assisted in either working through the insolvency issues of a shutdown or merging with a “new” program to make sure coverage continued for participants.

Wyoming Chambers Health Benefit Plan

In early 2002, we were approached by three different small-town Chambers of Commerce to design and implement a benefit program whose goals were:

- Have the same benefit options as large employer plans,
- Have the same funding options as large employer plans,
- Have a benefit program that focuses on “health” rather than just accident and sickness,
- Have a program with multiple plan design options for participating employers (one size does not fit all),
- Be available for Wyoming employers from any industry sector (excepting public entities)

After about 18 months of setting the stage, establishing a legal entity and laying the groundwork, the program began on July 1, 2005. It started with 18 employers and 183 employees. It grew to over 770 participants, then throughout the economic downturn, receded to 285 participants, and recently has grown back to over 585 participants (11 new employers added since July 2017). There are 15 Chambers in Wyoming involved for their membership.

The success of this program is reflected in:

- The reserves held are at 400 percent of minimal reserve needs as determined by the underwriters,
- For the last three renewal cycles, the rates have not increased (0 percent rate change). This means participating employers have had the same rates for 4 years for their plans.
- Has remained ACA compliant offering all Essential Health Benefits as required (e.g.: no pre-existing waiting period, unlimited maximum, full maternity coverage, etc.)

The success of the program has to do with several component factors. These include:

- A privately developed software that handles the eligibility, billing and on-line quoting. This system allows the MEWA to be treated by interested administrators and reinsurance carriers as “one” employer instead of multiple employers.
- A reinsurance carrier, who also provides underwriting and limited actuarial services, who keeps the program stable. All employers are subject

to limited medical underwriting and either the entire group is accepted or denied into the Plan.

- Have a “drop box” at a Wyoming Bank, where premiums are deposited directly from employers. The account is reconciled regularly and audited annually from a Wyoming CPA firm. Audit reports and financial reports are available to all employers and submitted monthly to the Board of Directors.
- All employers pay the “same” premium regardless of when they joined the plan. Claim loss-ratios are not tracked or reported by employer. All employers receive the same renewal rate change. Age-based or composite participant rates are available for employer choice.
- The plan encourages wise consumption of services. There are included programs such as:
 - Centers of Excellence (medical providers that exceed in quality and pricing) where travel costs are covered.
 - Annual Wellness programs. If 80 percent of participating adults do the annual blood draw and risk assessment, the employer receives an 8 percent lower rate.
 - Telemedicine programs available.
 - Bill audit features. If a participant audits their bill(s), finds any errors and gets them corrected, the plan shares in the amount saved.
 - Extensive annual educational opportunities.

The proposed DOL regulations may assist in Association plan development, especially across state lines, but there are provisions which would hinder plans as well. In order to develop accurate and sufficient rates, quality underwriting is important, which the regulations appear to take away. The ability for MEWAs to choose some of the available benefit options would be crucial (similar to Medi-share programs). The regular and ongoing reporting and oversight by an outside party is crucial; there can be no secrets from participating employers and actively involved administrators.

Chairman ENZI. Thank you.
Mr. Sturm.

**STATEMENT OF MIKE STURM, PRINCIPAL AND CONSULTING
ACTUARY, MILLIMAN, MILWAUKEE, WISCONSIN**

Mr. STURM. I am from Milwaukee, which is about, I am guessing, somewhere close to halfway between Wyoming and Vermont. I am in the middle, probably in more ways than one.

All Senators and everyone in the room that works for the Federal Government, thank you for your service.

My name is Mike Sturm. I am a consulting actuary with Milliman. I have been in the business for 30 years, 27 of them spent in healthcare.

Milliman serves a variety of clients in the healthcare market including insurers, health systems, pharmaceutical manufacturers, employers, and many others.

One of the reasons these diverse clients look to us for advice is because we are independent. That is, we are wholly owned by our employees. This independence is important to us because it allows us to advise our clients without the influence of outside interests. As such, we are not required to, nor do we take, political positions on any topic, including healthcare legislation or proposed legislation.

I am not here to convince you the proposed Association Health Plan rule should or should not be implemented. Rather, my goal is provide unbiased, fact-based information to help inform the discussion with the hope that it will improve our healthcare financing system.

Association Health Plans have the potential to change the healthcare marketplace. As with most regulatory actions, there are advantages and disadvantages, there will be intended and unintended consequences, and there will be those who are financially better off and those who are not. This is also the case with the Association Health Plan proposed rule.

One needs to consider a number of factors when thinking about whether AHP's will achieve the Administration's stated goals of creating stable risk pools for small employers, and the ability for consumers to purchase policies at prices similar to the large group market without adversely impacting the current healthcare market.

These factors include, but are not necessarily limited to, how rating rules for AHP's vary from the current rating rule. Different rating rules create the possibility of risk pool segregation between more expensive and less expensive members in a given market.

I am going to repeat that because these are very important words.

Different rating rules create the possibility of risk pool segregation between more expensive and less expensive members in a given market.

The proposed rule as written appears to allow, and in some cases require, AHP's to vary rates differently than allowed in the current healthcare market to their benefit and to their detriment.

For example, I believe they are allowed to rate differently for age, geography, family composition, gender, group size, and health status. Specifically on health status, AHP's will be required to rate the 51-plus, large group market without health status, which will lead to AHP's attracting less healthy risks versus the current market. The current market is allowed to rate for health status in the 51-plus market.

In addition, benefits and nonparticipation in the risk adjustment mechanism should be considered when talking about AHP's and their risk segregation. In summary, all of these differences lead to the potential for segregation of the current risk pool.

With that said, the million dollar question is: how much segregation will occur? It is difficult to tell.

In addition, given that AHP's will be allowed to form around industry, it is likely that morbidity differences by industry will further segregate the risk pool between the healthy and less healthy populations.

At this point, I am going to say, be mindful. There are many factors. There are savings. There is a trust issue when you buy from people in your own industry. There are the benefits whether they offer the same or less than the current marketplace, health insurance expertise, and the people running the AHP's, et cetera.

I look forward to discussing these issues, and others, as we work together today to improve our healthcare financing system.

Thank you.

[The prepared statement of Mr. Sturm follows:]

PREPARED STATEMENT OF MIKE STURM

My name is Mike Sturm, and I am a Consulting Actuary with Milliman. I am 30 years into my career with 27 of them spent in health care.

Milliman serves a variety of clients in the health care market, including health insurers, health systems, pharmaceutical manufacturers, employers, and many others. One of the reasons these diverse clients look to us for advice is because we are independent (i.e., we are wholly owned by our employees). This independence is very important to us because it allows us to advise our clients without the influence of outside interests. As such, we are not required to (nor do we) take political positions on any topic, including healthcare legislation. I am not here to convince you the proposed Association Health Plan rule should or should not be implemented. Rather, my goal is to provide unbiased, fact-based information to help inform the discussion with the hope that it will improve our health care financing system.

Association Health Plans have the potential to change the healthcare marketplace. As with most regulatory actions, there are advantages and disadvantages, there will be intended and unintended consequences, and there will be those who are financially better off and those who are not. This is also the case with the AHP proposed rule.

One needs to consider a number of factors when thinking about whether AHPs will achieve the administration's stated goals of creating stable risk pools for small employers and the ability for consumers to purchase policies at prices similar to the large group market without adversely impacting the current healthcare market.

These factors include, but are not necessarily limited to:

- How rating rules for AHPs vary from current rating rules. Different rating rules create the possibility of risk pool segregation between more expensive and less expensive members in a given market. The proposed rule as written appears to allow (and in some cases require) AHPs to vary rates differently than allowed in the current healthcare market. For example, AHPs appear to be allowed to rate differently for:

Age

AHPs appear to be able to use age relativities wider than the 3:1 restriction in the individual and small group markets

Geography

AHPs appear to have more flexibility in both area factors and the area definitions themselves than is present in the individual and small group markets

Family composition

The ACA requires carriers to consider at most the three oldest dependent children when determining individual and small group premiums

Gender

AHPs appear to be able to vary premiums by gender

Group size (e.g., 1-5, 6-10 vs. 11-50)

The current market requires self-employed individuals to participate in the individual market, while premiums cannot vary by group size for other small employers

Health status

AHPs appear to be able to experience rate based on the aggregate risk of the association, while the current market requires rating for market average risk for small employers and the experience of the specific employer in the large group market

Benefits

AHPs appear to have more flexibility in benefits, as the current market prevents small employers from purchasing coverage leaner than bronze/coverage that does not provide EHBs.

Avoidance of risk adjustment mechanism in the current market

All of these differences lead to the potential for segregation of the current risk pool. With that said, it is difficult to determine the extent of the segregation that might occur.

In addition, given AHPs will be allowed to form around industry, it is likely that morbidity differences by industry will further segregate the risk pool between healthy and less healthy populations. The younger and healthier industries will likely find AHPs attractive and the older and less healthy industries are unlikely to find AHPs attractive.

Other factors to consider whether AHPs will meet their stated goals, include:

How much savings are achievable and at what cost. Savings will depend on whether the AHPs are fully insured or self-funded. Fully insured plans might be able to achieve some small administrative savings and possibly benefit limitations. Self-funding will likely generate greater administrative savings, but will likely require the AHP to raise a significant amount of (what we refer to in the industry as) risk based capital, to achieve the savings.

Allowing AHPs to offer “less than EHB” coverage will generate additional savings if they so choose to do so. One benefit they might not offer is maternity given its elective nature. However, I can tell you that most large employers cover all the EHBs, including maternity.

Will the fact that AHPs are subject to state laws create a regulatory compliance scenario so onerous such that it limits the formation of new AHPs?

The health insurance expertise of the AHP’s leadership will likely play a large part in whether the association will succeed long-term and protect its members.

Regarding stable risk pools, insurance companies and at least one current AHP I am aware of have stable pools. It may be difficult for new AHPs to garner enough members to create a stable pool in the first few years. Much of this will depend on whether they can get historical data on new association members to rate them accurately. A less stable risk pool could result if AHPs cannot gain access to this data. With that said, if AHPs are fully insured, the insurance carrier they select may already have the data needed to estimate an accurate rate.

In my experience, trust is an important factor in consumers’ purchasing decisions. AHP members may prefer to buy from their industry leaders (given they have common goals) whether or not the AHP is a more efficient funding vehicle than their current health care payer.

What will the role of insurance companies be in an AHP? I suspect insurance companies will have much to offer AHPs given their deep provider discounts, current abilities to administer health care claims, and large amounts of reserves to protect a new AHP.

I look forward to discussing these issues and others as we work together today to improve our healthcare financing system.

Chairman ENZI. Mr. Condeluci.

**STATEMENT OF CHRIS CONDELUCI, CC LAW & POLICY,
WASHINGTON, DC**

Mr. CONDELUCI. Thank you, Chairman Enzi, Ranking Member Sanders, and Members of the Committee for the opportunity to speak with you today.

My comments will focus on three areas: consumer protections, coverage options, and state regulations of AHP’s.

Unfortunately, much of the news coverage relating to AHP’s is inaccurately described consumer protections that apply to health coverage.

You will be interested to know that both fully insured and self-insured AHP’s as group health plans cannot deny a plan participant health coverage if they have a pre-existing condition, cannot refuse to cover certain Government-approved preventive services, cannot impose annual lifetime limits on the Essential Health Benefits covered under the plan.

Other requirements like covering adult children up to age 26, free access to emergency care, and the prohibition against rescinding coverage absent fraud apply.

Under HIPAA, premiums for AHP plan participants cannot be developed based on the participant’s health condition.

For example, the health status point, that the gentleman earlier brought up, a particular plan participant's premiums cannot vary based on the health condition of that participant. The HP regulations actually add important nondiscrimination rules that further protect workers that have health conditions.

According to ERISA's consumer protections, there are specific notice and disclosure requirements, fiduciary responsibilities, and there are detailed procedures for filing health claims and rigorous internal and external appeals processes.

Will AHP's offer more healthcare options to workers? Currently, self-employed individuals with no employees, like independent contractors, only have one healthcare option available to them: fully insured individual market health coverage.

Based on my observations, both Democrats and Republicans, would like to give independent contractors more choice when it comes to healthcare. And the proposed AHP regulations aim to do just that by allowing these working owners to participate in a group health plan subject to all of the consumer protections that I just described.

Now, when it comes to small employers, data shows that fewer small employers are offering health coverage today relative to 4 years ago. AHP health plans could provide more affordable coverage options for small employers and we could see many instances where employees do not have to go uninsured. It is important to emphasize that IRS data tells us that 18 million Americans are going without health insurance because they are either paying a penalty tax or claiming an exemption from the tax.

AHP health coverage at affordable price and with its consumer protections could allow workers to once again access comprehensive health coverage even in the absence of an individual mandate.

Last, state regulations; the proposed AHP regulations do not change or inhibit a state's ability to regulate insurance. Some states, however, are looking to enact laws that would re-characterize a fully insured large group AHP as a small group plan, but the statute of ERISA may preempt this state law because ERISA does not allow a state to regulate the plan, even a fully insured plan, in this manner.

A self-insured AHP would be considered a Multiple Employer Welfare Arrangement, or a MEWA. Currently, self-insured AHP's as a MEWA must comply with each state MEWA law where the AHP health coverage is offered.

Now, this patchwork of regulation could be streamlined if the Department of Labor issued a class exemption that would exempt self-insured AHP's from the non-solvency requirements of a MEWA statute.

Issuing a class exemption is advisable to promote uniformity in the law and to allow self-insured AHP's to offer coverage in multiple states. And policymakers can take comfort because state solvency requirements would continue to apply to self-insured AHP's because these requirements cannot be exempted under a class exemption that could be under consideration.

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

[The prepared statement of Mr. Condeluci follows:]

PREPARED STATEMENT OF CHRISTOPHER E. CONDELUCI

On January 4, 2018, the Department of Labor (DOL) released proposed regulations relating to “association health plans” (AHPs). Below is a brief discussion of the current treatment of AHPs, a description of the DOL’s current definition of a “bona fide group or association of employers” for purposes of the Employee Retirement Income Security Act (ERISA), and an explanation of the coverage requirements and consumer protections applicable to AHPs as a “group health plan.” The following also examines various legal challenges that may arise.

Current Treatment of “Association Health Plans” (AHPs)

In 2011, the Obama administration issued guidance that essentially prohibited small employers from forming a fully insured “large group” health plan. This meant that the ACA’s “small group” market reforms applied to fully insured AHP employer members with 50 or fewer employees.

One exception to the 2011 guidance: If the “group” of employers forming a fully insured AHP is considered a “bona fide group or association of employers” for purposes of ERISA, the fully insured AHP could still be treated as a “large group” plan, meaning the ACA’s “small group” market reforms would not apply.

The 2011 guidance does not apply to self-insured AHPs. However, ERISA’s definition of a “bona fide group or association of employers” is important: If a “group” of employers forming the self-insured AHP fails to meet this definition, ERISA’s preemption of state benefit mandates would not apply.

“Bona Fide Group or Association of Employers” For Purposes of ERISA

To be considered a “bona fide group or association of employers” for purposes of ERISA, the “group” must meet (1) the “commonality of interest” test and (2) the “control” test. The control test requires the employer members to have a say over the plan design and operation. The “commonality of interest” test, on the other hand, is a facts and circumstances test which is not always easy to satisfy. According to 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 geographical area. Also, a group of employers would not be considered “bona fide” if self-employed individuals with no employees are a part of the group (which means self-employed individuals with no employees are forced to find health care coverage in the fully insured “individual” market).

The DOL’s Proposed AHP Regulations

The DOL’s proposed regulations endeavor to make it easier for small employers to form a fully insured “large group” or self-insured AHP. For example, the proposed regulations would allow employers in the same industry or profession (i.e., “related” employers) to form an AHP, and offer “large group” fully insured or self-insured AHP health coverage to the employees of these “related” employers, regardless of the employers’ geographic location. 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).

In addition, self-employed individuals with no employees (referred to as “working owners”) could 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. Working owners in the same industry/profession could also establish an AHP solely for “related” working owner members. And last, 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.

Some of the Affordable Care Act’s “Individual” and “Small Group” Market Insurance Reforms Would Not Apply to Fully Insured and Self-Insured AHPs

Small employers and/or working owners forming a “bona fide” group and establishing a fully insured “large group” or self-insured AHP would not be subject to the Affordable Care Act’s (ACA) “essential health benefits” (the Federal EHBs) and “ac-

tuarial value” (AV) requirements. The AHP would also not be subject to the new adjusted community premium rating rules and the single-risk pool requirement.

It is important to note that the drafters of the ACA specifically decided against imposing these 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 percent AV plan. And, the practice of “experience rating” to determine premium rates for a group of employees worked relatively well.

The Affordable Care Act’s “Group Health Plan” Requirements Would Apply to Fully Insured and Self-Insured AHPs

Several industry stakeholders were recently quoted as saying that fully insured and self-insured AHPs (1) can deny a person coverage if they have a pre-existing condition, (2) can refuse to cover preventive services, and (3) can avoid imposing annual and lifetime limits. Unfortunately, these statements are incorrect.

As a “group health plan,” a fully insured and self-insured 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 EHBs covered under the plan.

All three of the above stated requirements were enacted under the ACA—fully effective in 2014. 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

The recently quoted stakeholders also overlook the consumer protections under HIPAA. 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.

ERISA and Its Requirements

Under ERISA, there are specific notice and disclosure requirements, and also fiduciary responsibilities that apply, requiring the AHP and its employer members to act in the best interest of the participants. Participants also have a private right of action to sue the AHP or employers if there is wrong-doing. And, there are detailed procedures for filing health claims, and rigorous internal and external appeals processes.

State Benefit Mandates Apply to Fully Insured AHPs

In the case of a fully insured AHP, the plan is subject to state benefit mandates. Most state benefit mandates are as good if not better than the Federal EHB standard. As a result, a strong argument can be made that fully insured AHPs are by definition required to provide adequate health coverage, in addition to meeting all of the rules, requirements, and consumer protections discussed above.

State MEWA Statutes Applicable to Self-Insured AHPs

A self-insured AHP must meet all of the same rules, requirements, and consumer protections discussed above. However, a self-insured AHP may not be subject to state benefit mandates on account of ERISA preemption.

Importantly, self-insured AHPs will by definition be considered “multiple employer welfare arrangements” (MEWA). ERISA explicitly gives states the authority to regulate self-insured MEWAs (i.e., a self-insured AHP). Many states have already enacted “state MEWA statutes,” which impose specific requirements on self-insured AHPs that offer health coverage within the state. Some states have an outright prohibition against self-insured AHPs operating within the state (e.g., California and New York have enacted this type of prohibition). Other states impose the state’s benefit mandates and/or specific premium rating requirements on self-insured AHPs.

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 requirements on self-insured AHPs.

Will the Proposed Regulations Face Legal Challenges?

A number of stakeholders have suggested that the proposed regulations are ripe for legal challenge. In my opinion, if any such legal challenges are filed, I believe they will be unsuccessful. Why?

The “commonality of interest” test—which is the test that the proposed regulations modify—is not specifically defined in the statute of ERISA itself. Rather, the “commonality of interest” test was born—and further developed—through DOL Advisory Opinions, meaning that the law in this area was solely created by Interpretive Guidance.

Currently, there is no prohibition against a Federal Department changing its interpretation of the law. More specifically, so long as a Federal Department is not re-writing the statute, the Federal Department can make changes to its own interpretation of the law.

This is also true in the case of allowing self-employed individuals with no employees to participate in an AHP. Currently, a DOL regulation prohibits self-employed individuals with no employees (and their spouses) from participating in an ERISA-covered plan. This rule, however, is not explicitly set forth in the statute, rather, this is an interpretation of the law developed by the DOL and memorialized in a regulation. Which means, the DOL can change its own interpretation of the law, and thus, change the regulation, provided the change in the regulation goes through the normal rulemaking process (e.g., proposed regulations, with a public comment period, prior to finalization).

ERISA Preemption Challenges to Certain State Laws

If a health plan is considered an ERISA-covered plan, state laws that have a direct impact on “the plan” will be preempted by ERISA (meaning, the state law would not apply). One exception to this preemption rule is if the state law is an “insurance law” that has a direct impact on the underlying “insurance contract.” If a state law directly impacts the “insurance contract,” then this law will be “saved” from ERISA preemption (i.e., the law would not be preempted).

The best example of a state insurance law that directly impacts the “insurance contract” is a state’s benefit mandate law, which requires the insurance contract to cover a specified medical service or benefit. In this case, the state’s benefit mandate law would not be preempted, and the fully insured health plan providing coverage to employees must cover these mandated services or benefits (even an ERISA-covered fully insured plan).

But, in cases where a state law attempts to “re-characterize”—or “deem”—the ERISA-covered plan as an “insurance contract” in the state’s attempt to regulate “the plan,” a court of law may find that this law is not “saved” from ERISA preemption. Why? Because ERISA provides that a state cannot back-door its way into regulating “the plan” by calling “the plan” an “insurance contract” and then arguing that the state law is an “insurance law” that is “saved” from ERISA preemption.

One example of a state law that may be found to have a direct impact on “the plan” is a law that re-characterizes a “large group” fully insured AHP as a “small group” plan. In this case, a state will likely argue that this law is an “insurance law” that has a direct impact on the “insurance contract” (and therefore, this law is not preempted by ERISA). But, an argument can be made that what the state is trying to do is to “re-characterize”—or “deem”—the fully insured AHP as an “insurance contract” and back-door its way into regulating “the plan.” A court of law may find that this law is not “saved” from ERISA preemption, but instead, the law is indeed preempted (and therefore would be null-and-void, thus preserving “large group” status for a fully insured AHP).

There is another legal argument that could lead a court to rule that any law that attempts to re-characterize a “large group” fully insured AHP as a “small group” plan does not apply. The statute of ERISA itself states that a fully insured MEWA—which is synonymous with 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.” An argument can be made that a state law 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.”

An examination of these legal arguments is important because a number of states are considering enacting a state law that re-characterizes a “large group” fully insured AHP as a “small group” plan. Some states already have a similar law on the books.

Chairman ENZI. Thank you for your information.
Ms. Kimmich.

**STATEMENT OF JENNIFER KIMMICH, CO-OWNER, THE
ALCHEMIST BREWERY, STOWE, VERMONT**

Ms. KIMMICH. Thank you, Chairman Enzi, Ranking Member Sanders, and the Members of the Subcommittee for inviting me here today to discuss the importance of access to healthcare for our employees and their families.

My husband and I started our craft brewery 15 years ago. The day we opened our small business in 2003, we had \$20 left in the bank and no health insurance. Through lots of hard work and determination, we grew our business and our brands. Today, our gross annual sales are \$20 million and we have 50 employees.

We offer full health insurance to all of our employees and their children. We also pay 50 percent for their spouses, and we spend over \$300,000 annually on health insurance. This is about 15 percent of our gross payroll.

The plan that we provide is considered a good one. It is a silver plan. The cost is \$560 per month for each employee, and almost \$1,600 per month for families. The deductible is \$2,600 per person.

We provide this health insurance to our employees because it is a good business decision. We know that when our employees and their families are healthy, our business thrives. Productivity goes up, morale goes up, and we are successful with recruitment and retention.

Although premiums increase each year, the small employer health insurance market has been relatively stable over the past decade. Our health insurance plan may not be perfect, but we are able to ensure that every one of our employees, young and old, has access to the care that they need.

Modern medicine has allowed many people to live and thrive with access to care and medication, so that our employee with Type 1 diabetes or our colon cancer survivor can each take good care of their health.

But healthcare is not just for those with chronic or past illness. We need to make sure that our healthiest employees continue to see their primary care doctors and that they can prevent and detect future illness.

I believe the proposed rule, and Association Health Plans, is a step in the wrong direction. We have significant concerns about several provisions that would undermine stability in the health insurance programs in which we have already invested so heavily.

The Executive Order indicated an interest in allowing short term plans to be sold for longer periods than the current limit of 3 months. These plans are not required to meet the standards that are applied to individual market health plans. Short term plans do

not have to cover the Essential Health Benefits and they may deny people who have pre-existing medical conditions.

If we allow these short-term benefits to be sold as a long-term alternative to regular health insurance, they will attract healthier consumers away from the regular insurance pool. This will endanger everyone's access to comprehensive coverage.

We need to seriously consider the adverse effects of expanding and extending short term, limited duration health plans, increasing enrollment in Association Health Plans, and relaxing rules for employer health reimbursement arrangements.

Businesses and their employees are most successful when there is a long term and comprehensive approach to healthcare so that providing and accessing health insurance is not a constantly changing and uncertain process for worker and business owner alike.

Thank you.

[The prepared statement of Ms. Kimmich follows:]

PREPARED STATEMENT OF JENNIFER KIMMICH

Thank you to Chairman Enzi, Ranking Member Sanders and the Members of the Subcommittee for inviting me to discuss the importance of access to health care for our employees and their families.

My husband and I started our craft brewery 15 years ago. The day we opened our small business in 2003, we had 20 dollars left in the bank and no health insurance. What we did have was a dream and a vision for our future. Through lots of hard work and determination, we were able to successfully grow our business and our brand. Today our gross annual sales are about \$20M and we have fifty full-time employees.

We offer full health insurance to all our employees and their children without any employee contribution. We also pay for 50 percent of the premium for employee spouses. We spend over \$300,000 annually on health insurance coverage—this is about 15 percent of our gross payroll. We also commit a significant amount of time and money to the administration of this plan. We spend many hours explaining the plan to our employees and helping them navigate the mysteries of coverage, co-pays and out-of-pocket expenses.

The plan that we provide is considered a good one—it is a “Silver” plan. The cost is \$560 per month for each employee and almost \$1,600 per month for families. The deductible is \$2,600 per person (\$5,200 per family), but in many cases, once the deductible is met, out-of-pocket expenses continue. For example, once the full deductible is met, our employees are still responsible for a 40 percent contribution toward all in-patient billing, and they are also responsible for 50 percent of non-generic prescriptions.

We provide health insurance to our employees because it is a good business decision. We know that when our employees and their families are healthy, our business thrives. Productivity goes up, morale goes up, and we are successful with recruitment and retention. Having healthy employees who are financially stable and not stressed is good for our bottom line. Although premiums, deductibles, co-pays and out-of-pocket expenses increase each year, the small employer health insurance market has been relatively stable over the past decade. Even with increasing costs, we know that the coverage we provide is vital to the well-being of our employees and the long-term sustainability of our business. Our health care plan may not be perfect, but we are able to ensure that every one of our employees, young and old, has access to the care they need. Modern medicine has allowed many people to live and thrive with access to care and medication, so that our employee with Type 1 diabetes, or the colon cancer survivor, can each take good care of their health and maintain their positive quality of life. But healthcare is not just for those with chronic or past illness. We need to make sure that our healthiest employees continue to see their primary care doctors so that they can prevent and detect future illness.

Our employees are our strongest asset and we need to make sure they are able to prioritize their health and well-being. I believe the proposed rule on Association Health Plans is a step in the wrong direction and would adversely affect small businesses like ours. We have significant concerns about several provisions that would

undermine stability in the health insurance programs in which we have already invested so heavily.

The Executive Order indicated an interest in allowing short-term plans to be sold for longer periods than the current limit of 3 months. Short-term plans are not comprehensive health insurance and could be exempt from consumer protections. These plans are not required to meet the standards that are applied to individual market health plans. Short-term plans don't have to cover the essential health benefits and they may deny people who have pre-existing medical conditions. They can also limit the amount of benefits covered under these policies. If we allow these short-term plans to be sold as a long-term alternative to regular health insurance, they will attract healthier consumers away from the regular insurance risk pool. This will endanger everyone's access to comprehensive coverage, especially the most vulnerable. We need everyone to be in the regular insurance risk pool so we don't limit more people's access to comprehensive coverage.

I am extremely concerned about the potential impact of the policies put forward in the recent Executive Order on health care. By allowing Association Health Plans to become exempt from consumer protections, there is increased risk for higher premiums and fewer plan options on the individual market. In the past, when we have had association health plans that offered minimal benefits, consumers have suffered. We need to seriously consider the adverse effects of expanding and extending short-term, limited-duration health plans, increasing enrollment in Association Health Plans (AHPs), and relaxing rules for employer Health Reimbursement Arrangements. In a challenging labor market, providing quality health insurance coverage is a competitive advantage. Businesses and their employees are most successful when there is a long-term and comprehensive approach to healthcare, so that providing and accessing health insurance is not a constantly changing and uncertain process for worker and business owner alike.

Chairman ENZI. Thank you.
Ms. Kuenning.

STATEMENT OF TESS STACK KUENNING, CNS, MS, RN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BI-STATE PRIMARY CARE ASSOCIATION, MONTPELIER, VERMONT

Ms. KUENNING. Thank you, Senators Enzi and Sanders, for the opportunity, and the Subcommittee Members for the opportunity to talk about the importance of health insurance coverage for patients at community health centers.

My name is Tess Kuenning. I am the President and CEO of Bi-State Primary Care Association, and we are a not-for-profit, non-partisan, charitable organization that works to promote access to effective, affordable, comprehensive primary care including medical, behavioral health, mental health, including substance use disorders, and medication assisted treatment, oral health, pharmacy services in an interdisciplinary team approach regardless of the person's ability to pay.

In New Hampshire and in Vermont, there are 29 community health centers caring for 302,000 people. Nationally, there are 1,400 community health centers serving 27 million people in more than 10,000 locations.

Community health centers are the Nation's largest primary care network holding the promise to assure access across our Nation's communities with a track record of quality care serving as a health home for whole person care.

Important to community health center patients are assuring that they have robust, affordable insurance coverage. Insurance coverage is what makes access real.

People with insurance coverage have greater ease in accessing community health center services without delays. Coverage allows

for not only primary care, but specialty care including beyond the walls of the health center.

Not having coverage, or being uninsured, or underinsured puts a strain on the patient and on the provider. Coverage should be affordable and a robust plan design allowing patients access to care that they need in preventive services acute care without barriers. Coverage eases financial barriers on the community health center Federal grants that go toward covering the cost of delivering care.

I would be remiss to not mention the outstanding issue that is in Congress' hands right now. Community health center patients hang in the balance. The funding for community health centers, and the National Health Service Corps, ended September 30, 2017. Without this funding, community health centers do not have 70 percent of their grant funds.

In the HELP Committee, you represent 23 states, nearly 500 community health centers, and 8.6 million patients, which is about one-third of the total patients served by community health centers. You have a lot of power in this Committee.

In Vermont, a 70 percent loss is \$14 million and in New Hampshire, \$16 million. No community health center can withstand those kinds of reductions without a corollary reduction in critical health services. Your urgent action would be gratefully appreciated, especially at a time when we are in a public health crisis with an opioid crisis, with a flu crisis, with the Zika virus. Community health centers are where patients go.

I have read the proposed rule by the Department of Labor that was issued on January 4 and the proposed rule gives me pause in a number of areas. I would like to share with you just the topics that I am concerned about and then through our discussion, to give you a little bit more detail.

What gives me pause are the consumer protections; the states' authority to regulate; the market instability and fragmentation; the lack of adequate coverage; no limits on premium variation based on age; geography, especially in two rural states; gender; women of childbearing age; network adequacy; and the issue of churn.

There are some protections in this rule that need to be addressed and I would like to be a part of the conversation to address those.

Thank you very much.

[The prepared statement of Ms. Kuenning follows:]

PREPARED STATEMENT OF TESS KUENNING

Thank you to Chairman Enzi, Ranking Member Sanders, and the Members of Subcommittee for the invitation to discuss the importance of health insurance coverage for patients of federally Qualified Health Centers (FQHCs or Health Centers).

My name is Tess Kuenning, and I am the President and CEO of Bi-State Primary Care Association located in Montpelier, Vermont, and Bow, New Hampshire. Bi-State is a non-partisan, non-profit 501(c)(3) charitable organization that promotes access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations. On behalf of the Bi-State and the 29 Community Health Centers, which provide care for nearly 302,000 Vermonters and New Hampshire residents, I thank you for the opportunity to participate in the Roundtable discussion today before the Committee regarding the effects of a recently released Department of Labor Proposed Rule regarding Association Health Plans¹ on Health

¹ The proposed rule was released on January 5, 2018 and is available for comment until March 6, 2018. Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 Fed. Reg. 614 (January 5, 2018) (to be codified at 29 CFR 2910).

Centers as they provide and expand access to comprehensive primary care services in medically underserved communities.

I have served as the President and CEO of Bi-State for nearly 23 years and just prior worked for the U.S. Public Health Service and HCFA, now CMS. I am a clinician by training and have worked in tertiary ICU and primary care both in the United States and in Nepal. My background as a Clinical Nurse Specialist and experience across government agencies, as well as private health care sectors, have shown me that barrier-free access to comprehensive primary and preventive services is the difference between a robust healthy life or not.

In New Hampshire and Vermont, as well as across the Nation, Health Centers are the Nation's largest network of comprehensive primary and preventive health care practices. Health Centers are and continue to hold the promise to fulfill access to care for our Nation's communities. Health Centers historically have, and will continue to care for all patients in their community, extending their expertise in caring for our most vulnerable: the uninsured and underinsured.

Association Health Plans

The Department of Labor recently released a Notice of Proposed Rulemaking (NPRM) related to Association Health Plans. Association Health Plans are a type of health coverage for qualifying employers. The rules defining when Association Health Plans can be used have changed over the past several years, with this latest NPRM intending to expand access to this type of health coverage. According to President Trump's Executive Order signed in October 2017, this change related to Association Health Plans is meant to encourage competition and choice for small businesses and lower their administrative and other costs.² Some states, like Vermont, also have laws that impact Association Health Plans (see 8 V.S.A. s. 3368 and 8 V.S.A. s. 4079(2)).

The proposal intends to adopt a new definition of "employer" for purposes of determining when employers can join together to offer or enroll in an Association Health Plan that is treated as a group health plan under ERISA. Depending on the type of Association Health Plan, which state it operates in, and the number of individuals covered, the benefits covered and the costs incurred may be different than those currently required by Federal law for the small group and individual market. By design, the NPRM allows for more flexibility around benefits covered by Association Health Plans. The benefits impacted include: limitations on pre-existing conditions, essential benefits, and out-of-pocket maximums. Under current law, these benefits are standardized for the small business and individual health insurance markets.

Concerns have been raised by organizations like the National Association of Insurance Commissioners, National Governors' Association, American Academy of Actuaries, and the NCSL National Conference of State Legislators regarding health coverage options, like Association Health Plans, that could fragment existing health insurance markets.³ Fragmentation is considered to be bad for health insurance markets. The fragmentation would occur when employers and individuals leave the general small group and/or individual health insurance market and join an Association Health Plan. Those leaving would join an Association Health Plan because the cost is lower (the cost is lower because those in the Association Health Plan would either be healthier than those in the general insurance market and/or the coverage would be different-without maternity or mental health for example). If healthy individuals leave the general insurance market, that leaves those who are less healthy and more expensive. Over time, the balance between health and unhealthy can shift so much that the general insurance market goes into a 'death spiral' where the coverage becomes increasingly more expensive and potentially unattainable.

Other concerns harken back to past Association Health Plans that left a legacy of insolvency and fraud with millions of unpaid claims. These issues along with Federal preemption of state regulation of AHPs are noted among the reasons why some

² Exec. Order No. 13813, 3 C.F.R. 48385 (2017) Executive Order found here: <https://www.whitehouse.gov/Presidential-actions/Presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>.

³ "The Association Health Plan Proposed Rule: What It Says And What It Would Do," Health Affairs Blog, January 5, 2018. Accessed 1/11/2018 at: <https://www.healthaffairs.org/doi/10.1377/hblog20180104.347494/full/>.

state governments, labor, provider groups and even consumers have expressed apprehension.⁴

In Vermont, Association Health Plans are regulated by the Department of Financial Regulation⁵ and this regulation can serve to mitigate potential market fragmentation and ensure Vermont consumers are protected. This regulation could also potentially be used to ensure that the coverage offered is similar to that offered in the general health insurance market and there are no exclusions for services like mental health or maternity. In Vermont, these Association Health Plans would be considered a type of Multiple Employer Welfare Arrangement (MEWA) and thus subject to state insurance laws and regulation including solvency and reserve contributions to ensure payment of plan benefits. However, Vermont's authority is limited to policies that have a minimum of 100 persons at the time of incorporation if formed outside the state, and a minimum of 25 persons at the time of incorporation if formed in the state. Association Health Plans that are created in another state, or are below the thresholds specified by Vermont law, may not be able to be regulated by Vermont and Vermonters could purchase plans that have different consumer protections than those offered within the state. Vermonters in the general health insurance market could end up with more expensive plans as those individuals would need Vermont's consumer protections.

Health Centers—General Background

By way of background, Health Centers are community owned, not-for-profit organizations that receive Federal funding under the Public Health Service Act to provide primary medical, dental, behavioral and mental health services—including Medication Assisted Treatment (MAT) to treat substance use disorders—and pharmacy services to all patients, regardless of their ability to pay. Health Centers also provide a variety of enabling and support services. To date, there are over 1,400 Health Centers located at more than 10,000 locations nationwide⁶, both urban and rural, serving as patient-centered health homes for more than 27 million patients.⁷ Every Health Center has relationships with their community partners such as hospitals, mental health centers, and home health agencies, to assure patients have the full continuum of care.

Health Centers are funded through a myriad of resources. Primarily, just under 20 percent of Health Center revenues are from Federal grants; 65 percent are from patient related revenues, which includes Medicaid, Medicare, and private or commercial insurance; and just over 15 percent is from other revenues, which may include competitive state and local grants, contributions from county and municipalities as well as foundations and philanthropy.⁸

In their communities, Health Centers are more than a safety net, as they have a demonstrated track record of improving the health and well-being of their patients using a locally tailored health care home model designed to coordinate care and manage chronic disease. They employ skilled providers who chose to work at Health Centers given the multidisciplinary team approach to comprehensive all-inclusive whole person care. Numerous published studies over many decades have demonstrated that Health Centers are a proven cost saver. Studies have also shown that Health Centers improve the health status in communities, reduce emergency room use, and eliminate barriers to health care.

The distinctive model of care delivered by Health Centers allows them to save the entire health system, including the government and taxpayers, approximately \$24 billion annually by keeping patients out of costlier health care settings, such as

⁴ "The Association Health Plan Proposed Rule: What It Says And What It Would Do," Health Affairs Blog, January 5, 2018. Accessed 1/11/2018 at: <https://www.healthaffairs.org/doi/10.1377/hblog20180104.347494/full/>.

⁵ Short Term—Limited Duration Insurance and Association Health Plans. (2018). Vermont Legislature, House Health Care Committee. Retrieved from <https://legislature.vermont.gov/assets/Documents/2018/WorkGroups/House-Health-Care/Executive-Orders-Regarding-Health-Insurance/W?Emily-Brown?Short-Term-E2-80-93-limited-duration-insurance-and-Association-health-plans?1-9-2018.pdf>.

⁶ Bureau of Primary Health Care. Uniform data system. U.S. Department of Health and Human Services. 2016.

⁷ NACHC. "The Number of Patients Continues to Grow at Community Health Centers," September 2017. <http://www.nachc.org/news/the-number-of-patients-continues-to-grow-at-community-health-centers/>.

⁸ Bureau of Primary Health Care. Uniform data system. U.S. Department of Health and Human Services. 2016.

emergency departments.⁹ As a result of their timely and appropriate care, Health Centers save \$1,263 per person per year, lowering costs across the delivery system from ambulatory care settings to the emergency department to hospital stays.¹⁰

Nationally, approximately 49 percent of health center patients are covered by Medicaid and another 23 percent are uninsured.¹¹ In return, Health Centers bring significant value to the Medicaid program, serving 1 in 6 Medicaid patients^{12, 13} for only 1 percent of Medicaid spending.¹⁴ Additionally, studies have shown that Health Centers save 24 percent per Medicaid patient compared to other providers.¹⁵

In addition to reducing health care costs, Health Centers serve as small businesses and economic drivers in their communities. Health Centers employ over 207,000¹⁶ individuals and generate \$45.6 billion in total economic activity in urban and rural communities.¹⁷

For today's discussion on Association Health Plans, what is most important to the Health Centers is that their patients have access to the best coverage available to them. Whether that be through Association Health Plans, the Marketplace, Medicare or Medicaid, or some other form of insurance, we believe that coverage is an important element in providing good health care. Studies have long shown that people with health insurance have greater ease in accessing health care services and fewer delays in receiving care when needed.

Coverage does not just mean holding an insurance card, but rather the ability to access preventive services and care coordination, in addition to primary care needs. This also includes access to specialty care—including that beyond the walls of the Health Center. Too often we see Health Center patients that have an insurance card, but their options for care are limited, meaning that he or she must travel miles and miles to find a covered provider, or includes a prohibitively high deductible, making the coverage essentially useless to its holder. This under-insurance puts a strain not just on the patient, but on the Health Center too, who is required to provide the care, regardless of the patient's ability to pay. It is important that any proposal to create a new form of coverage offer affordable and robust coverage, allowing patients to access the care that they need, primary and preventive as well as acute, in their communities and without barriers to care.

From a financial perspective, when our patients have good coverage, that in turn eases the financial burden on our Federal grant dollars that go toward covering the costs of delivering care effectively to our medically underserved patients and communities. Comprehensive coverage allows patients to access the care they need and frees up those much-needed grant dollars for those with no insurance at all.

This is even more important because of an outstanding issue that is in Congress' hands. On September 30, 2017, Health Centers went over the "funding cliff," because Congress had not yet renewed the Community Health Center Fund. Without action, Health Centers face a 70 percent reduction in funding, which would be detrimental to all Health Centers across the country. As we are here today discussing new insurance alternatives for our patients, I would be remiss if I did not mention the importance of renewing that funding. Our patients need both access to meaningful insurance coverage and restoration of full Community Health Center funding. In Vermont, a 70 percent loss in Federal funding equates to a \$14M loss, and in New Hampshire, the loss would be nearly \$16M. No health care system can withstand this reduction in funding and not have a corresponding reduction in critical health care services. The Health Centers have indicated they would reduce their services on average by 40 percent severely effecting access and care to our communities.

⁹ Ku L, et al. Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform. Geiger Gibson/RCHN Community Health Foundation Collaborative at the George Washington University. June 30 2010. Policy Research Brief No. 19.

¹⁰ Ku L, et al, 2010.

¹¹ Ku L, et al, 2010.

¹² Bureau of Primary Health Care. Uniform data system. U.S. Department of Health and Human Services. 2016.

¹³ Kaiser Family Foundation. "Total monthly Medicaid and CHIP enrollment", December 2016. <https://www.kff.org/health-reform/state-indicator/total-monthly-Medicaid-and-chip-enrollment/?currentTimeframe=10&sortModel=-7B-collId-:-Location-,-sort-:-asc-7D>

¹⁴ Nocon R.S. et al. "Health care use and spending for Medicaid enrollees in federally qualified health centers versus other primary care settings." American Journal of Public Health 106, No. 11 (November, 2016): 1981–1989.

¹⁵ Nocon R.S. et al. 2016.

¹⁶ Bureau of Primary Health Care. Uniform data system. U.S. Department of Health and Human Services. 2016.

¹⁷ Capital Link. "Infographic: Health centers have a powerful national impact." 2016.

Nationwide, Medicaid and CHIP make up the majority of most Health Center patients. While Health Centers see everyone in their community, they are experts in caring for low and moderate income families. In Vermont, many Medicaid beneficiaries have annual income contributing to their families' well-being.¹⁸

Vermont's Community Health Centers

Like their counterparts nationwide, Vermont's Community Health Centers provide comprehensive primary care and prevention to Medicaid, Medicare, commercially insured, and uninsured patients. Vermont Medicaid covers 183,000 Vermonters and the Health Centers serve nearly one-third of them.¹⁹ The majority of Vermonters on Medicaid are children, the elderly, pregnant women, and working adults. By serving these patients, and over 106,000 Medicare and commercially insured Vermonters, Vermont's Health Centers assure access to care a reality. Insurance coverage makes access real. By providing access to comprehensive, high-quality primary care, Vermont's Health Centers ensure Vermonters get necessary services.

In 2000, Vermont had only 2 Community Health Centers with 7 sites serving just over 18,000 patients. Currently, Vermont has 12 federally funded Community Health Centers with 64 clinical sites in every county caring for the whole family from prenatal care to pediatrics, to adult and elder health care, providing a medical or health home to more than 172,000 Vermonters. Vermont Health Centers have a significant market share serving 1 in 4 Medicaid, 1 in 2 uninsured, 1 in 3 Medicare enrollees and 1 in 5 commercially insured Vermonters. Over the past 10 years in New Hampshire, Health Centers have grown to 16 organizations across the state serving approximately 113,000 patients in underserved areas.

Community Health Centers are also directed by patient-majority boards. This unique model ensures care is locally controlled, responsive to each individual community's needs and, at the same time, reduces barriers to accessing health care through various services. Health Centers provide or arrange for transportation to ease the geographic barriers. Throughout Vermont, Health Centers work to bring fresh food, pharmacies, and classes for the elderly to their communities. They are more than just a doctor's office, Health Centers are a driving force to support the economic development and communities in more rural parts of Vermont. As well, Health Centers provide care targeted to reduce various cultural barriers by providing culturally competent care including translation services.

At the Community Health Center of Burlington, which is the community provider of choice for adult refugee health care, they serve a diverse population of patients that communicate in nearly 30 different languages. Interpreter-assisted visits accounts for 18 percent of our patient visits. CHCB's New American Health Program was founded to offer a solution to improve the health status of new arrivals, build relationships to establish a long-term Health Care Home, provide social services assistance, and offer education leading to better health and well-being. The Health Center provider teams have specific experience with multi-cultural health and cultural competency; all services are offered with interpreter services; essential informational materials have been translated to their language; a Limited English Proficiency Specialist provides in person education along with in house produced videos (made possible by a state grant) both help provide health literacy and how to navigate a western health practice. Participants are also connected to dental care, mental health counseling and psychiatry as needed.

It is noteworthy that CHCB cares for over 5,000 Vermonters who identify as LGBTQ. This is testimony to their compassion, nonjudgmental and matter-of-fact attitudes and excellent quality care that we have developed into the provider of choice for these Vermonters. The Health Center specifically offer a Transgender Health Clinic, and, new this year, an LGBTQ Health Clinic. CHCB also purposefully hires to reflect their community. CHCB staff consists of French speaking Africans, Nepali, Bosnian, gay, lesbian and transgender individuals.

In New Hampshire, attention to cultural competency is a high priority as well. At the Manchester Community Health Center, of their 17,000 patients, over 7,600 patients (45 percent) spoke a language other than English as their primary lan-

¹⁸ Vermont: Health Coverage & Uninsured. (2016). Kaiser Family Foundation State Health Facts. Retrieved from <https://www.kff.org/state-category/health-coverage-uninsured/?state=vt>.

¹⁹ DVHA SFY18 Budget Adjustment Act (BAA). (2018). Vermont Legislature, House Health Care Committee. Retrieved from [https://legislature.vermont.gov/assets/Documents/2018/WorkGroups/House-Care/Bills/H.633/BUDGETADJUSTMENT?Cory-Gustafson?DVHA-SFY-18-Budget-Adjustment-Act-\(BAA\)?1-10-2018.pdf](https://legislature.vermont.gov/assets/Documents/2018/WorkGroups/House-Care/Bills/H.633/BUDGETADJUSTMENT?Cory-Gustafson?DVHA-SFY-18-Budget-Adjustment-Act-(BAA)?1-10-2018.pdf).

guage. There are 62 languages spoken and of the 223 staff, approximately 50 percent are either bilingual, bicultural, immigrants or refugees.

Health Centers work collaboratively within their local communities to support the needs of their patients. Working with hospitals, community mental health agencies, nursing homes, and others, Health Centers and their committed staff combat opiate addiction, diabetes, and other chronic conditions day in and day out. Vermont's Community Health Centers also serve as economic engines and community anchors alongside other business leaders in their communities. Vermont Community Health Centers employed 1294 FTE and generated nearly \$178 million in total economic benefits; while New Hampshire Community Health Centers employed 896 FTE and generated over \$114 million in total economic benefits in their communities.^{20, 21}

Impact of Association Health Plans on Community Health Centers and Bi-State

There are two main ways that Association Health Plans can impact Community Health Centers/Bi-State Primary Care Association: 1. Health Centers/Bi-State as employers; and 2. Health Centers as health care providers. This section will address each in turn:

- 1. As employers, Health Centers experience rising health care costs like every other business. Depending on their size, Vermont's Community Health Centers provide either fully insured coverage or self-insured coverage. Regardless of the type of coverage, the cost has increased significantly over the past several years. Health Centers, like other employers could opt to select an Association Health Plan if one were available for them.

Vermont Health Centers' experience:

Our Health Centers in Vermont over the last years have had significant increases to premiums and deductibles with increases to both the employee and employer.

One Health Center self-insured with 145 employees covering nearly 200 lives in their insurance plan are paying for a single deductible \$6,350 and family \$12,700. Their premiums this year are 20 percent higher and they have learned from their insurer that premiums will go up at least this amount yearly. They have multiple plans for employees to choose from given the high costs. They note they can't absorb and new increases in the medical premium costs. They have attempted to join other risk pools without any success.

Another Health Center with 150 employees have a commercial product for their employees paired with a health reimbursement account. They note their greatest barrier to offering health insurance is controlling costs to the organization while trying to keep costs affordable to their employees. While they have tried to keep the employee premiums low, the deductibles have increased.

One of our largest Health Centers with 350 employees, is a "quasi self-insured", using a commercial insurer with \$45,000 deductible per covered life. Employees have a \$1,750 individual deductible and \$3,500 stacked family deductible (Employee pays first \$1,750 and the Health Center pays the next \$42,250 of the total for a total of \$45,000 for the individual deductible, after which the insurance pays the remainder of the claim). The Health Center has also has purchased and put in place individual and aggregate stop losses to control their financial exposure for individual and aggregate catastrophic events. Under this high deductible plan with purchased stop loss maximums the Health Center operates essentially like a self-insured, with less cost and catastrophic financial exposure. As well, the employee has to pay around 20 percent of the actual cost of the benefit through pre-tax payroll deductions and the Health Center provides employees the option of HSA's to pay for deductible and out of pocket costs. The Health Center reported the high and increasing cost of health care, especially over the last 4 years as grown in the neighborhood of 50 percent increase (going from \$25,000 to \$45,000), and this is the largest impediment to providing health insurance. The Health Center does this because it feels it is important to offer a robust health benefit program with in-

²⁰ 2016. Capital Link. The Economic Impact of New Hampshire's Community Health Centers.

²¹ 2016. Capital Link. The Economic Impact of Vermont's Community Health Centers.

cludes health, dental, vision, long term care, with options to purchase additional supplemental insurance for accidents and hospitalizations.

Bi-State experience:

Bi-State as a small business employer for 25 employees working in Vermont and New Hampshire. We have selected a plan that allows for a strong in-state network and a comprehensive package. Over the past 3 years, our premiums have been held to a 11–16 percent increase only because Bi-State chose to increase its deductibles from \$2,000 to \$5,000, added most notably co-insurance which is the cost above the deductible that employees must pay until the out of pocket maximum. There have also been an overhaul in the structure and pricing of prescription plans. The in-network out of pocket maximums are \$7,350 for individuals and \$14,700 for a family of two.

The summary of all these experiences have in common that Health Centers and our organization care deeply about assuring our employees have robust health insurance coverage.

As health care providers, Health Centers provide the necessary primary care services that reduce acute health care costs on a daily basis. Those services go far beyond annual check-ups. Managing patients and their conditions requires an array of tools including prescription drugs, dental services, access to mental health and addictions treatment services, and many others. Over 20 percent of Vermonters have a mental health condition, which can exacerbate their diabetes, hypertension, and other chronic conditions. For example, if an individual is in treatment of an opiate addiction, but their health plan does not cover the medication used in medication assisted therapy, Suboxone, that patient's chance of overcoming the addiction is dramatically reduced. Given that Association Health Plans can offer different benefits, the concern about specific benefit offering is very real to primary care providers who have appreciated consistency in benefits covered in Vermont under current insurance market rules.

Conclusion

Without their local Community Health Center, many communities and patients would often be without any access to primary care services. Community Health Centers have proven time and time again that access to a health center translated to improved health outcomes for our most vulnerable Americans and reduced health care expenditures for this Nation. Community Health Centers need assurances that their patients will continue to have insurance coverage that is comprehensive and allows them to get necessary treatment.

Mr. Chairman, we stand ready to meet the demand among those in need of primary care. However, Community Health Centers can only meet these primary care demands if we can provide access to care.

We look forward to working with you and the other Members of this Subcommittee to accomplish our shared goal of improving access to primary care while reducing overall health care costs across the country.

I thank you for this opportunity to share the importance of comprehensive and reliable coverage options for health center patients.

Thank you, Mr. Chairman.

Chairman ENZI. Thank you.

Now, we will go to questions. The way a roundtable works is that if any of you want to add something to a question that has been asked, if you will stand your card on end, we will give you a chance to comment on that too.

I am going to start with Mr. Johnson, who had the really clear, one-page testimony that I hope everybody will look at. It is seldom that we get one page and that it is as concise as that. You really shortened your remarks more than we needed you to.

Could you describe a little bit about the kind of participation you have in the health plan, the kind of plans that you offer, and what has made you competitive in the state?

Mr. JOHNSON. The plan itself is, again, available to any member of a participating Chamber. We have 15 Chambers across the state that participate in the program. Those can be groups of two to as large as wish to participate. From an employer size, they can be any employer size.

They are also multi-industry. We have accountants. We have trucking companies. We have oilfield companies, lawyers, lots of different industries in the plan. It is available to all.

The benefit program was requested. When we first started, it was similar to a large employer's plan in that it has multiple benefit plans from \$1,000 deductible on the low end to a \$5,000 deductible on the high end. There are six different benefit structures.

None of them, by the way, reach the required Affordable Care Act maximum of \$7,350 out of pocket; they are all under that as far as the out of pocket maximums.

They all provide extensive wellness coverage. They also provide for employer wellness participation. If the employer elects to do an annual screening, they get an 8 percent lower rate in their plan if 80 percent of their participating adults do the screening. It is a program that has worked very, very well. It is manifest in the fact we have a zero percent rate change for the past 3 years.

Chairman ENZI. Pretty amazing.

Mr. Condeluci.

Mr. CONDELUCI. Yes, sir. I was trying to flip it up, but I have too much liquid in front of me, so the last thing I want is an accident. Thank you.

I actually have a question for Mr. Johnson.

Is your plan a fully insured arrangement or a self-insured?

Mr. JOHNSON. Partial self-insured.

Mr. CONDELUCI. Partial self-insured. And the reason why I ask that question is it is important to understand the current treatment of Association Health Plans. If you are a fully insured Association Health Plan, CMS issued guidance back in 2011 that requires an insurance carrier to look through the Association to the underlying size of the employer member.

If you are an employer member of this fully insured Association Health Plan, and you are below 50 or fewer employees, therefore you are in the quote/unquote, "small group market," the rule says that the insurance carrier must impose the small group ACA insurance market reforms to that employer member.

That is distinguished from a self-insured Association Health Plan in which this 2011 CMS guidance does not apply to. In general, a self-insured Association Health Plan currently is not subject to this CMS guidance, yet fully insured Association Health Plans are.

But there is one exception to this 2011 CMS guidance and the reason I just wanted to bring this up, and I apologize if it is overly complicated, because there is an exception to this CMS guidance that says the 2011 guidance will not apply if the group is a bona fide group or association of employers as defined for purposes of ERISA.

The Department of Labor has developed the rules in and around what it means to be a bona fide group or association for purposes of ERISA. And it is, to a certain degree, what the proposed regulations are getting to with allowing small employers and sole propri-

etors to actually meet this definition of a bona fide group in order to be considered a large group health insurance plan. Therefore, many of the ACA reforms—Essential Health Benefits, actuarial value, adjusted community rating rules, and the single risk pool requirements—do not apply.

But the last comment, Senator, is the group health plan rules, that I articulated during my comments, do apply. And the consumer protections under HIPAA, ERISA, and otherwise apply in addition to many of the nondiscrimination rules that are included in the proposed regulations.

That is a long way of saying, there is a lot of kind of different moving parts here when it comes to trying to describe the different arrangements. I probably inartfully articulated some of these rules, but it is important to try to get a handle on the different aspects and the different rules that might apply because there is a lot of confusion that arises.

Chairman ENZI. Thank you.

Senator Alexander.

The CHAIRMAN. Thank you, Senator Enzi.

I would like to pick back up right there and make sure I understand. I carry around a card with me so Senators can know who has insurance; 18 percent have Medicare, 61 percent have employer insurance, 21 percent Medicaid, 6 percent individual in the country, something about like that.

Let us look at employer, for just a minute. That is what we are talking about.

178 million Americans have employer insurance; 61 percent employer. Now, Mr. Condeluci, you were saying that there are three groups of employer insurance. One is the ERISA; those are the self-insured.

Mr. CONDELUCI. Yes, sir.

The CHAIRMAN. Two is the fully insured, and three is the small group market.

Now, the small group market is basically the 50 or less employees, and the ACA protections and rules apply to that.

Right?

Mr. CONDELUCI. Yes, sir.

The CHAIRMAN. You were saying, I think, that even in the fully insured group, the next group up, that the ACA rules apply to that too?

Mr. CONDELUCI. Maybe I will attack the question this way, Senator.

Having been a part of the drafting of the ACA, the drafters of the law essentially said, "We want to reform the individual market," and therefore there are individual—

The CHAIRMAN. Yes, but without getting into all of that. Let me just skip that group. Let me go to ERISA.

ACA does not apply to ERISA. Right?

Mr. CONDELUCI. The group health plan requirements that I described earlier, sir, about not being able to, you cannot deny someone with a pre-existing condition, you cannot deny service.

The CHAIRMAN. But the large group plans, the self-insured ERISA plans, which are about 35 percent of the total people with

insurance, they are governed by their own rules, not by the ACA rules. Right?

Mr. CONDELUCI. The ACA rules that do not apply to large group fully insured and self-insured are the Essential Health Benefits, actuary value requirements.

The CHAIRMAN. Wait a minute.

Mr. CONDELUCI. Those are the only rules, sir.

The CHAIRMAN. But, no. The ACA itself does not change the ERISA, does it?

Mr. CONDELUCI. It does not, but there are ACA rules that do apply.

The CHAIRMAN. Wait, I am not asking you that. Is it yes or no? If I am IBM, I have an ERISA plan.

Mr. CONDELUCI. Yes.

The CHAIRMAN. I do not have to worry about the ACA because I am governed by the ERISA rules.

Mr. CONDELUCI. Yes.

The CHAIRMAN. The large employer rules. Right?

Mr. CONDELUCI. I would say that you do have to worry about the ERISA rules in addition to the ACA.

The CHAIRMAN. No, I mean—

Mr. CONDELUCI. ACA rules in addition to ERISA.

The CHAIRMAN. I have to worry about ERISA, not ACA.

Mr. CONDELUCI. You have to worry about both.

The CHAIRMAN. I do have to worry about ACA?

Mr. CONDELUCI. Yes, sir.

The CHAIRMAN. What do I have to worry about?

Mr. CONDELUCI. You have to worry about—you cannot deny coverage if the person has a pre-existing condition. You cannot impose annual lifetime limits.

The CHAIRMAN. But was that not the rule under ERISA to begin with?

Mr. CONDELUCI. No, sir. Those were group health plan requirements that came in through the Affordable Care Act.

The rules that also came in through the Affordable Care Act, which include the Essential Health Benefits, actuary value, I keep mentioning it, adjusted community rating rules, they came in through the ACA as well, but they only apply to small group plans and individual market plans. They do not apply to fully insured large group and they do not apply to self-insured.

It really is those four rules, sir, that are ACA-related that do not apply in this case, but all of the other ACA group health plan requirements, in addition to ERISA, HIPAA, COBRA, et cetera, do apply to the self-insured ERISA plans, as well as fully insured large group plans.

Does that help?

The CHAIRMAN. The regulation that is proposed—

Mr. CONDELUCI. Yes, sir.

The CHAIRMAN —in essence, would apply the same protections to those covered under the regulation that apply to the ERISA, those who are covered under the ERISA plan.

Mr. CONDELUCI. Yes, sir. Other than the Essential Health Benefits, actuary value, and adjusted community rating rules, all of the

other consumer protections that apply to a small group plan as well as an individual market plan.

The CHAIRMAN. The Essential Health Benefits applies to ERISA?

Mr. CONDELUCI. They do not, sir.

The CHAIRMAN. That is what I thought.

Mr. CONDELUCI. Yes. They will apply only to the small group and only to the individual market.

The CHAIRMAN. Right.

Mr. CONDELUCI. But many of the other ACA requirements and consumer protections will apply. If I may, sir, one of the—

The CHAIRMAN. I thought the simple answer to this was that the regulation would give to the self-employed people who are insured under the regulation the same protections that employees who are insured under ERISA large group plans have.

Mr. CONDELUCI. They would, sir.

The CHAIRMAN. Is that correct?

Mr. CONDELUCI. That is correct.

The CHAIRMAN. We have about 35 percent, if my figures are right, of the total insured in America are insured under self-insured ERISA plans. This would give some of the people—who are either now uninsured, or in small group, or in the individual market—an opportunity to be insured in the same way.

Now, some of the figures that I have seen suggest that if you are insured in an employer plan, like ERISA and maybe this is one of the benefits of Wyoming, your costs go down dramatically, maybe about one-third because the tax break for each employee in an employer plan costs the taxpayer about \$5,000 an employee.

Does that sound right to any of you?

Mr. CONDELUCI. If you are speaking to the tax preference, sir, for employees?

The CHAIRMAN. Yes, a self-employed person does not get advantage of the tax break that an employer plan has.

Mr. CONDELUCI. They would be permitted a 162(L) deduction, which is an above-the-line deduction for those costs, which does have a tax preference available to the self-employed.

The CHAIRMAN. Yes, and the estimates I have seen, that is about a \$5,000 per employee cost.

What is your experience, Mr. Johnson? Those who come into your plan in Wyoming, it is less expensive to be a part of your plan if they go from individual to an employer plan.

Right?

Mr. JOHNSON. Many times, that is the case. Yes, sir.

The CHAIRMAN. Yes.

Mr. JOHNSON. The difference is some of the individual plans that are coming in with very, very high deductibles looking at the catastrophic style plans in your state.

The CHAIRMAN. Right.

Mr. JOHNSON. We do not have one of those, so in essence, the premiums may not go down, but the coverage can go way up.

The CHAIRMAN. Yes.

I understand that Mr. Sturm has talked about the effect it might have on other people in the market.

But for an individual, a self-employed songwriter in Nashville, or a farmer, or a small businessperson who has seen his or her insur-

ance go from \$300 to \$1,300 a month and who pays the whole thing, if they are able to combine under this rule and have the same protections that an employee of IBM in Nashville has—which, except for four rules, are the same as in the ACA according to Mr. Condeluci—they might have a less expensive plan. First, because it is an employer plan and second, because it is part of a larger pool.

Is that correct?

Mr. CONDELUCI. Comprehensive consumer protections, as I have articulated.

Chairman ENZI. Ms. Kimmich.

The CHAIRMAN. Yes, Ms. Kimmich.

Ms. KIMMICH. Thank you, Senator. I just want to back step for a moment.

I am very concerned with Mr. Condeluci's breeze over Essential Health Benefits as though it is just one item. The Essential Health Benefit is really ten items that are critical for everyone: maternity and newborn care, mental and behavioral health, emergency services, outpatient services, hospitalization, preventative, labs, prescription drugs, pediatrics.

I just want to make sure we are really clear that is not just one benefit.

Thank you.

The CHAIRMAN. But those benefits do not apply to employers with ERISA, do they?

Mr. CONDELUCI. Sir, if I may.

I did not want to get into the details of Essential Health Benefits because I was having trouble even answering the Senator's question. It is true that Essential Health Benefits are important.

The CHAIRMAN. That means that all of the employees, the one-third of Americans, it looks to me like about 60 million Americans who get their plans through ERISA and ERISA-type plans, which would be IBM, Eastman, all these people, they have deficient plans because the Essential Health Benefits—

Mr. CONDELUCI. Do not apply.

The CHAIRMAN —do not apply. Do they?

Mr. CONDELUCI. But they offer very similar benefits, sir.

The CHAIRMAN. No, but you said they applied, but that is not correct. It is similar.

Mr. CONDELUCI. No, the Essential Health Benefits do not apply.

The CHAIRMAN. Let me go to Ms. Kimmich, she was trying to answer the question.

Ms. KIMMICH. From how I understand it, you can carve out what you want for your plan. You can have gender and age ratings when you create your plan.

The CHAIRMAN. Yes.

Ms. KIMMICH. You cannot include maternity and newborn care, and that would impact your hiring practices.

The CHAIRMAN. Right. But if it is good enough for IBM, why is it not good enough for your brewery?

Ms. KIMMICH. We have a very diverse group of employees.

The CHAIRMAN. So does IBM.

Ms. KIMMICH. We have employees that use all of our services, but I think what is really critical and what is really important

when we talk about growing our economy and making our communities stronger, it is not just our 50 employees. It is the 10,000 people in our community, the people that we rely on to come into our business and support our business.

We are not talking about different silos. We need everyone to have comprehensive health care.

The CHAIRMAN. Well, okay. But why should we let the IBM employee in your town have a better healthcare plan or a different healthcare plan than yours?

Ms. KIMMICH. In the great State of Vermont, we actually do have a unified market and it is working great for us. That is why our pricing is actually affordable, and we know what it is going to be every year.

The CHAIRMAN. But if I have a plan through IBM and I live in your town, I do not have all the protections that you have to, and I am pretty happy with my plan.

Ms. KIMMICH. I do not know if that is the case. I do not know.

The CHAIRMAN. Well, there are 60 million Americans who have plans through ERISA and we do not hear much complaint about that.

Ms. KIMMICH. I do not know if they are happy with their plans.

What I do know is all the people that do not have the health insurance that they need, and the people who think they are insured, and then find out that they are not, and are short, or under and short, and it bankrupts them, it is killing our communities. That is what I do know.

Chairman ENZI. Ms. Kuenning.

Ms. KUENNING. Thank you.

We were just talking about the Essential Health Benefits. Some of the things that I talked about, that I have concerns about with regard to this proposed rule, is about the Essential Health Benefits.

You are right that the large group market does not have to have the Essential Health Benefits, but the people in the small market and in the individual markets do have the Essential Health Benefits.

To Ms. Kimmich's point, you could actually have an insurance plan, a product that does not cover mental health. Imagine if you are a family that has a 23-year-old that now has a substance use abuse disorder. You are not covered for that, so that then you lose all of those benefits because the plan does not have the Essential Health Benefits.

But the other thing that was brought up that are not covered in these Association Health Plans, you mentioned the actuarial, the community rating, and the pre-existing condition. For us, the community health center patients really are—

The CHAIRMAN. But does not the Mental Health Parity plan apply to employer plans?

Ms. KUENNING. Does the mental health parity?

The CHAIRMAN. The Federal law called the Mental Health Parity and Addiction Equity Act, does that not apply to employer plans, ERISA plans?

Mr. CONDELUCI. It does, sir.

If a plan is offering mental health services, then they do have to provide parity. If the plan is not offering mental health services, then that aspect of the law does not apply.

The CHAIRMAN. Thank you for the time. I see Senator Warren is here. I am going to have to leave.

Thank you very much for taking time to be here and letting us hear from you.

Ms. KIMMICH. Thank you, Senator.

Chairman ENZI. Thank you for being here, too, Mr. Chairman.

Senator Warren.

Senator WARREN. Thank you, Mr. Chairman.

I want to pick up on this same theme because one of the driving motivations behind the Affordable Care Act was to improve insurance coverage for small businesses and for entrepreneurs. It worked.

Nearly 5 million small business owners and entrepreneurs gained coverage under the ACA, and they were nearly three times as likely as other workers to purchase coverage through the exchange. This was a way to help small businesses get coverage.

Look, I have a list a mile long in ways that the ACA could be strengthened so that everyone can afford coverage and get a high quality plan. But I worry that we are moving in exactly the wrong direction with Association Health Plans.

These plans are deliberately designed to avoid the important protections that are there in the ACA, including requirements that they cover Essential Health Benefits, which is what you were just talking about, like maternity care or opioid treatment. They can charge people with pre-existing conditions more money than people who do not have pre-existing conditions. Now the Administration is advancing a rule aimed at increasing access to these plans.

Just so I can get this on the record because I think you have been talking about this already, Ms. Kimmich. You are a co-owner of a brewery in Vermont. You have talked in the past about the importance of providing health insurance coverage for your employees. Let me just ask it.

Is it also important that the health insurance you provide be good quality insurance?

Ms. KIMMICH. Absolutely. We need our employees to get the primary care they need, but we also need to make sure that they have the safety nets in place so that when they are most vulnerable, they are not going to go bankrupt. That they can be hospitalized and get the surgeries they need, get the chemotherapy that we need.

Our employees have gone through it all and no one has had financial distress. We have helped them with some loans to pay their deductibles, but everyone has the protections that they need in place.

Senator WARREN. Good. I really appreciate it and I appreciate the point you are trying to make here. It is not just holding a piece of paper. It is a piece of paper that is there to help you when a medical problem arises.

When a health policy is not worth the paper that it is printed on, it is not coverage. It is phony insurance and putting an end to

these scams was a big part of the reason that Congress passed the Affordable Care Act and set some real standards for coverage.

But there is another problem that I would like to probe just a little bit with Association Health Plans. They have a long track record of going belly up and leaving patients, and businesses, and health providers holding the bag.

Association Health Plans are not subject to any Federal fiscal oversight to make sure that they can stay solvent. Under the changes proposed by the Trump administration, the state's authority to regulate them is ambiguous at best.

Ms. Kuenning, you represent a group of community health centers in Vermont and New Hampshire. If a so-called insurer goes broke and cannot pay its bills, what does that mean for health centers in rural communities?

Ms. KUENNING. Thank you for the question.

I would first start with consumer protection. The community health centers exist to serve their patients. If their community health center patients, who are really the consumers, if they have a fraudulent plan where there is nobody to pay the unpaid claims, it not only then eliminates a covered benefit for the patient, it also affects the provider themselves.

The state's authority to regulate, Vermont does regulate Association Health Plans, but in speaking to the people about the financial regulations, they know that they would have to strengthen those because, as you mentioned, there are no enforcement and authority for solvency, for any fiscal oversight to guarantee the coverage. Those consumer benefits and consumer protections are so important to the state's authority to regulate.

Then this market instability and the fragmentation where Association Health Plans, by nature, segment the population. You could have a very healthy group of people come out of the market right now, and you left with people who are sick and unhealthy, which is essentially going to just increase premiums again. That segment is really a concern.

The community health centers would see anyone regardless of their ability to pay. They would be there for that person, but the patient themselves would not have that robust coverage and the provider would not get paid.

Senator WARREN. Okay. It is powerfully important.

Mr. Condeluci.

Mr. CONDELUCI. Yes, ma'am. Thank you, Senator.

Senator WARREN. Do you want to make a comment?

Mr. CONDELUCI. I appreciate it. Two quick comments.

On the self-insured arrangements, which are governed by ERISA, which is a Federal law. ERISA explicitly gives states the authority to regulate self-insured Association Health Plans. They are called Multiple Employer Welfare Arrangements.

The reason why Congress actually changed ERISA to give states the explicit authority to regulate was due to many of the fraudulent activities and abusive behaviors and the fact that many of these MEWA's went belly up.

These MEWA laws are still on the books in about 23 states and those MEWA laws range from laws actually saying that a self-insured arrangement MEWA cannot even operate in the state. Cali-

ifornia and New York, for example, have laws on the books that say, “Self-insured arrangement MEWA’s cannot operate in our state.”

There are other states that have some coverage requirements applicable to these self-insured MEWA’s through the state MEWA statute as well as solvency requirements that arguably—I mean, I am not a student on all of the solvency requirements—but are typically as good as the solvency requirements that apply to the insurance companies operating in that state.

Senator WARREN. I understand that there are some places where there are adequate solvency requirements and some places where there are not. And obviously, where they are not, this is a real problem both for healthcare providers and for the patients who thought they had healthcare coverage.

I also am under the impression, but tell me if this is not right, that the new regulations and approaches that the Trump administration are using are putting into question the roles that the states may play here.

Are you telling me you believe there will be no change or there is no change in any of that language?

Mr. CONDELUCI. Yes, ma’am. I am telling you that.

Senator WARREN. You are confident it is going to stay exactly the same.

Mr. CONDELUCI. I am confident that the regulations, nothing to change.

Senator WARREN. We only have to deal with the problem of the places where they can go belly up right now, that these plans can go belly up and leave somebody else holding the bag.

I think you wanted to add, Mr. Sturm.

Mr. STURM. I did want to add a little bit. Thank you, Senator Warren, for pointing that out with the MEWA’s and the historical problem that we have had with solvency in the past.

I would say that it would be wise to put risk-based capital requirements on these new AHP’s so the history will not be repeated in that regard.

I will stress again that leveling the playing field amongst the various markets, and making sure that one market cannot rate for age differently than the other one, and making it consistent with the ACA, would be very wise. Because when you have different rules in different markets, creative people will find ways to go and pick off the health risks and leave the poor risk behind.

Senator WARREN. I just want to say that is a very interesting point. I wish Senator Alexander were still here because one might argue that this is a big difference with the ERISA plans.

When the people at IBM come together, they come together because of the job, and they come together because of the salary that is offered, and they come together because of the work to be done.

When people come together on health insurance plans, they are coming together for a solely different purpose. They are not coming together to brew beer or to write code. They are coming together to pick a plan that they think is going to be least expensive for the employer.

What impact that has on the customers, the patients, and what impact that has on the community health centers is a kind of devil take the hindmost; not their problem.

They have very different incentive structures and I think, as a result, very different needs for what kind of regulation we put in place.

Mr. STURM. I agree with you. I think the proposed rule, as written, tries to limit that to the extent possible and it does a pretty good job, frankly, but there are a few areas that could be buttoned up.

I think as well, if you put something in the proposed rule that requires that these AHP's be run by people with healthcare expertise, I think we can get in trouble when people come from outside industries, and think they have the solutions, and run a healthcare payer organization, there could be issues.

Then finally, you talk about the paper it is written on. You may want to consider putting some bronze and better or EHB requirements in there. As Mr. Condeluci pointed out earlier, most employers, including IBM, offer the Essential Health Benefits.

Senator WARREN. Yes.

Mr. STURM. Why not just put it in the regulation if you are concerned that people are going to go and carve out the maternity, and mental health, and that sort of thing.

Senator WARREN. Thank you, Mr. Sturm.

I think the whole point about having minimum regulations all the way through here and minimum requirements so that the Association Health Plans are not picking people off and leaving people with insurance policies that are not worth the paper they are printed on is really important here.

The way I see this is there are a lot of things we could do to improve healthcare coverage for small businesses in this country.

Massachusetts has been leading the way here launching major improvements just this year to our small business health exchange trying to make this better and more affordable.

What worries me is the Trump administration seems to be heading in the opposite direction. They are dismantling a national version of exactly the exchange that we are using so small businesses can no longer use the Small business Health Options Program Website to select their health insurance plans.

Instead of helping workers get good coverage, they want to push this phony insurance and then leave small businesses in the lurch when these fly by-night associations go broke. They want to leave community health centers in the lurch and most of all, they are going to leave patients in the lurch, and I just think that is the wrong direction for us to go.

Thank you.

Thank you, Mr. Chairman.

Chairman ENZI. Ms. Kimmich.

Ms. KIMMICH. Yes, thank you.

I would just like to add that even if the State of Vermont is able to continue regulating, it would still hurt the State of Vermont because we have a unified market. If we have lots of small businesses crossing state lines, that is going to be less people in our pool.

We are a small state. When we had a fragmented system, it hurt us. Our large pool is really helping us now. Like many states, we are a small business state. Ninety percent of the businesses in Vermont have 20 or less employees. Imagine the impact if even one-third of them left the state, crossed lines, and had an AHP.

Chairman ENZI. Ms. Kuenning.

Ms. KUENNING. Yes, thank you.

I just wanted to pick up on that, limits on the premium variation on age and gender.

My business, 25 people across two states. We have 25 employees and 90 percent of them are women. For us, we hire women 24 to over 70, and the ability of my staff to be able to have maternity care and childcare is extraordinarily important. I want to retain that talent and I do not want to lose that because of that, because of the gender, the bias there.

The other thing that we have not talked about is there is nothing in the provision for network adequacy. That is one of the reasons why we go with a particular plan for both Vermont and New Hampshire because we want to make sure that our employees have an adequate network of primary care, and specialty, and hospital care in their community, and they can see their primary care provider. Thinking about how to strengthen this rule in network adequacy would be really important.

The other thing when we lose the individual mandate, there is no penalty and then we lose it, you have this churn. Somebody—and this is what happened to many of our co-ops—where somebody would purchase an insurance in June, for something that they knew that they had to do in July or August, and then they would stop paying the premium. The plans are actually left holding, paying out these claims.

It goes into this cycle of plans not being able to have the kind of solvency requirements that they need in order to pay out all of the claims for the people that they are serving.

I just wanted to add those points. Thank you.

Chairman ENZI. Well, that is also a problem in the current system, when they come down with something, they can get insurance, not have to make any payments, and drop out of the system.

I am hearing that from Wyoming and I have a Wyoming person here who is the only one that is actually doing one of these small business health plans. I would like to ask him a couple more questions.

Can you tell me about how you have worked to inject some innovation into your insurance product and offerings that, of course, do meet the law?

Mr. JOHNSON. The plan, just to reiterate, our plan does not discriminate based on gender, does not discriminate based on any factor that is not allowed in the ACA. I mean, it is structured to comply fully. We had a desire to do that because we wanted to let people access care as needed.

When we got into the plan, I was asked, “Let us make this a health insurance plan, not just an accident or sick plan.” Again, we encourage wellness. We encourage anything that can be, the proper screenings to be covered under the wellness side of the plan.

We also encourage people to become wise consumers through a variety of sources such as Healthcare Bluebook, through a center of excellence program that says, "We have certain centers that you can go to that do it for less."

One example in Casper with multiple MRI's available, an employee that was in the plan called up and a particular MRI was going to cost just under \$5,000. By calling around in town, not leaving Casper, was able to get it for under \$1,200; the same MRI.

The ability to shop and given the incentive to shop, the incentive to find high quality care, incentives to get out and work inside of being a wise consumer of costs is how we can help people develop. Because when it gets back to the end of the day, it is the cost that drives this animal. It is the claims cost, the cost of getting that care.

That is what we are trying to educate, keep people involved, and help them grow. That actually has helped us maintain our costs inside the program.

Chairman ENZI. How have the premiums been and any reserves?

Mr. JOHNSON. Yes, the reserves that we hold, the way it is calculated by our underwriter is called terminal reserves is to say if the plan were to terminate, we need X number of dollars held. We currently hold 400 percent of that number, so we are well over insured as far as the premium numbers and the reserves held.

For the majority of the employers, well, probably half the employers in the plan, they were there at the beginning. They have been there for the past 12 years.

One of the things small employers can tell you, shopping for insurance—and it used to be every 17 months the average small employer changed plans in the Nation—there is a cost involved in that of change. There is turmoil to the employees with change. We have been able to take that largely away for the employers involved.

Chairman ENZI. How about the premium increases, the amount of increase?

Mr. JOHNSON. Well, the last 3 years, four calendar years, our plan years in the plan, they have not gone up at all. In fact this year, the Board of Directors voted a 3 percent rate reduction across the board to every participating employer in the plan.

Chairman ENZI. Sounds to me like a good reason to do these things.

Mr. Sturm, did you have a comment?

Mr. STURM. I was just going to follow-up one thing on the consumer protections that we talked about earlier.

If you do go ahead with the AHP proposed rule, there is something in there that is going to harm them, and that is the inability to underwrite for health status in the 51-plus market.

You cannot do that in 2 to 50 of the individual right now, so they just set up the AHP to say you cannot do it at all for all group sizes and that is because, I am guessing, when the AHP proposed rule was written, they were thinking mainly of individuals and small groups.

But there is an unintended consequence because if AHP's are not allowed to underwrite for health status in a large group market in the current marketplace under the ACA that you are allowed to do that, you are going to attract the worst risk.

Chairman ENZI. Mr. Condeluci.

Mr. CONDELUCI. I just have a concluding comment to say.

That is where it is difficult to parse this out where employer plans currently do offer benefits that are arguably as good as the Essential Health Benefits, for example, although, that requirement does not apply.

The drafters of the ACA specifically exempted fully insured, large group plans and self-insured plans from the Essential Health Benefits requirement because the drafters at the time, not saying that was the right decision, felt that those plans were doing the right thing in offering these comprehensive levels of benefits.

When you do not have that requirement, yet, there is a requirement in small group and individual, there is concern that, "Essential Health Benefits do not apply." The concern has merit.

When it comes to rating by age, and I would like Mr. Strum and Mr. Johnson to correct me if I am wrong, I know of no large employer that actually varies their premiums by age. Typically an employer's best practice is they develop a premium rate based on the health claims of the group, and they charge the premium, the same amount, to all of their employees. So a younger employee often-times is subsidizing an older employee because they are charged the same rate.

The developing premium practice is not developing specifically on age. I would like to hear if you gentlemen have a different experience than mine.

Again, not to say that the age rating should not be a concern, it arguably should, but in my experience, employers do not rate premiums based on the age of their participants.

Mr. JOHNSON. Go ahead.

Mr. STURM. I can confirm that is right. Most large employers do not do that specifically to their employees.

There is also a second age concern of rating at the group level, not at the employee level, the ACA requires three-to-one. I do not believe the AHP proposed rule requires 3-to-1. It is possible that they could come in with a different age curve and create that risk segmentation. Just to differentiate from what you are saying, but I concur with your comment.

Chairman ENZI. Mr. Johnson.

Mr. JOHNSON. Just one comment about the structure.

Correct. Most of the groups in Wyoming that are under 10 employees are all age-based, age rate structure. When you look inside the SHOP program or the fully insured individual market, it is all age-based, even up to 50 employees.

One of the impacts I can tell you about an employer in Casper, that when they went from an age-based to a composite rate, their rates actually went up 67 percent because they are an oilfield company working with mostly 20-something young males. The impact of not being able to do an age-based structure for him had a very negative impact.

The sword can swing both ways on the advantages of disadvantages of age-based rate structures.

Chairman ENZI. Ms. Kuenning.

Ms. KUENNING. Thank you.

I would like to congratulate Mr. Johnson. You were incorporated as an Association Health Plan before this new rule. Right?

The new rule actually eliminates the requirement that Associations have a purpose other than offering healthcare. You are offering your members much more than just healthcare. You are business stimulation, group purchasing perhaps, all sorts of business reasons why you would want to come together. You have a vested interest in all of those members.

But in this new rule, you can be a sole proprietor and you have no ability to spread any of that risk. So there is a distinct disadvantage to the changing of the way that it is written right now, that you are just going to be able to formulate these based on a common geography or a common industry. I think, is very different than what you have provided.

One of the things that I just wanted to make mention is there has been a lot of conversation about the things that we are worried about. The public relies on Members of Congress for protections.

In this negotiated rulemaking time and this proposed rule, I think those safeguards and protections, a lot of them that have been talked about today, have to be not only in the rule but in the law, so that there is some ability for states, for instance in terms of consumer protections, to be able to go back to the law and not to a proposed rule.

Thank you.

Chairman ENZI. Mr. Kimmich.

Ms. KIMMICH. Thank you, Senator.

There has been a bit of discussion about there not being discrimination allowed with AHP's providing insurance, but I think it is important to note that the discrimination takes place in hiring practices.

If I were to open a business tomorrow, and I needed to hire 30 people, and I was looking at an AHP, I would certainly consider the age and gender of my employees because of the gender and age rating. That is really critical.

Chairman ENZI. Would that not be breaking the law?

Mr. Johnson, what kind of services do you provide besides health benefits?

Mr. JOHNSON. As far as the plan, personally, which is what I consult for?

Chairman ENZI. Yes.

Mr. JOHNSON. The Chamber, of course, provides a lot of services that sponsors or endorses the plan. The Chamber has a whole variety of services that it offers to its membership of employers including business stimulation.

Inside of what I provide to the Chamber is the consulting expertise in the Chamber Benefit Plan to help it grow, to help market it, to add new Chambers and new employers as it grows through.

I am, specifically, as a consultant to the Chamber plan.

Chairman ENZI. You would think that it could probably be done independent from all the other services?

Mr. JOHNSON. It could.

Chairman ENZI. As you are.

Mr. JOHNSON. Yes.

Mr. CONDELUCI. Sir.

Chairman ENZI. Mr. Condeluci.

Mr. CONDELUCI. Not that I agree or disagree with this change in the law which says an AHP can be created for the sole purpose of providing health insurance.

But the underlying reason why, I believe it is in the regulation, is to allow, for example, Uber drivers who might want to band together. They are not finding affordable coverage in the individual market and to set up an organization that is a legally created organization that has a Board, has bylaws.

It is that group that could then set up the Association Health Plan, which, again is governed by legal documents that set forth all of the requirements of coverage, set forth all the ERISA requirements, ACA requirements.

To an extent, I agree with the concern that this is a change in the practice of Association Health Plans. Typically, they do offer coverage in addition to other services, but the underlying reason why they are breaking with that here is to allow different types of groups to actually access health coverage through an Association Health Plan.

That is more of an explanatory reason as to why I believe that rule was put into place in the proposed regulation.

Chairman ENZI. Well, I do not know what the purpose was, but it does allow single employee businesses to be a part of it.

Mr. CONDELUCI. Yes, sir.

Chairman ENZI. There are a lot of those single employee businesses, not because they want to be single employees, but because they have not grown yet. But they would like lower cost insurance too.

Do any of you have questions for any of the others on the panel?

Is there anything that you can see that could be done, should be done that might be beneficial in this rule that is not in the proposed rule at the present time?

Just trying for a positive comment.

Ms. Kuenning.

Ms. KUENNING. Thank you.

I think it has been noted here that the ability for the Federal financing standards to make sure that there is some fiscal oversight and guarantee that the Association Health Plans can remain fiscally viable, and that the financial standards, or reserved contributions, or the solvency requirements that can be enforced by a state.

I think that is really important that the state actually can regulate the Association Health Plans, even if the Association Health Plans come together as an LLC in a different state; for instance, Texas.

I think the other thing is the fragmentation. It worries me that one of the interests of the Association Health Plans is to make sure that you have affordable healthcare coverage, but you have a good insurance plan. A plan design that is robust.

I think we have talked here about making sure that the Essential Health Benefits—and I think Mr. Sturm talked about these as well—are part of this product design. I think that would be really important as well.

Making sure that we take out the variations of gender and age, which would be really important, and talking about network ade-

quacy and churn. I think that those would be helpful to the Association Health Plan as well.

Chairman ENZI. Okay.

Mr. JOHNSON.

Mr. JOHNSON. I think one of the unintended consequences, obviously, of regulations then goes into cost.

I am reminded back in 2010 in April when the ACA had come out and the American Society of Actuaries put out a study that said the ACA by itself will raise costs 34 percent for employers across the Nation over a period of time, just the regulation itself.

Well, my neighbor in Casper is actually the former CEO of the largest hospital in Wyoming and I asked her. I said, "What does regulation actually cost?" because their costs are passed through to benefit programs in the form of premiums. Her comment was, "If there was not that oversight, and the regulation, and the challenges, our costs could go down by 20 percent."

If I went to every employer in Wyoming and said, "We can lower your cost by 20 percent," by getting into a plan that did not have that kind of regulation and that balance of competing interests between having a quality plan with quality coverage at a fair price.

It is also that interest of what do regulations actually cost us? Because it is added to the claims cost, which then translate into the premiums.

I would encourage when you look at these about how we look at the cost impact of regulatory burden because that directly impacts employer premiums.

Chairman ENZI. Mr. Sturm.

Mr. STURM. Along the lines of positive comments, if you allow an AHP to be fully insured, there is a lot of money that insurance companies set aside. This pile of cash called risk-based capital. The NAIC makes those requirements.

I would say that if you are going to allow them to be self-funded, the last thing you want are these programs running out of money. As such, I think you should have risk-based capital requirements in there so that if they are going to be self-funded, they have to have a pool of money so that when the actuary price is in the first year, and things go well or go poorly, they have enough money in that pool to offset any misestimates.

Then last, I think you should put in the proposed rule that you have professionals that sign off on their business plan, and their reserves, and their premium recalculations so you do not have a situation where 30, 40 years ago, when the MEWA was reformed, where they were not set, the rates were not set properly and/or there were no capital requirements.

Chairman ENZI. Mr. Condeluci.

Mr. CONDELUCI. I would agree with Mr. Sturm's comment about the risk-based capital being application to self-insured plans.

I do believe that many states do already have solvency requirements that are very, very similar to the risk-based capital requirement that Mr. Sturm is speaking to.

But maybe we have a rule at the Federal level and a reasonable one that is applicable. If a state has a more onerous one or a more strict one, then that should be permissible. That is something to consider.

The other comment is I do think it is critically important to allow self-employed individuals with no employees into these group health plans. They do only have one option, which is the fully insured individual market.

If they have a low income, they are typically subsidized in the exchange market and I would argue that subsidy is going to be much greater than any benefit that they might get out of going to an Association Health Plan. Those folks will likely stay in the exchange market.

But you do have folks that might be making more money such that they are not eligible for the subsidy. Thus, they are in the unsubsidized individual market. It is those folks that we all know are hurting most, and having another option available to them, I think, is critically important.

Last, when it comes to this whole age rating issue, I agree that it is a big issue. Again, employers typically do not engage in that practice. The regulations as-written seem to allow Association Health Plans to engage in that practice.

While I do not believe Association Health Plans will engage in specific age rating, that is not to say that it might be advisable to come up with a rule that tries to put some sort of guardrails around age rating for AHP's to say, "This does not happen in the regular employer plan world. This should not happen in the AHP world."

Chairman ENZI. Ms. Kuenning.

Ms. KUENNING. Yes, thank you.

I wanted to get to Mr. Johnson's remarks about the cost.

Whether you are a fan of the Affordable Care Act or not, it was really important for low and moderate income families because the pillars of that plan were to allow a Medicaid expansion for people 138 percent of poverty and below, which is around \$13,000. That kind of healthcare coverage and that security was really important. I think Ms. Kimmich talked about bankruptcy. That was really important.

Then the pillar of the marketplace where people could, to your point, get cost-sharing reductions. If you take the people out of the marketplace and into Association Health Plans, they will then not be able to get these cost-sharing reductions, which make the insurance product that they are buying much more affordable. There is a caution there as well.

Thank you.

Chairman ENZI. Thank you.

Again, thanks to all of you for being willing to provide your ideas. If any of you want to put anything additional that you thought of in writing that we will make a part of the record, you are welcome to do that. We should have that within a week.

Chairman ENZI. With that, I will conclude this roundtable.

[Whereupon, at 4:53 p.m., the hearing was adjourned.]