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

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

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

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

Organization of Testimony

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

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

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

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

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

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

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

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

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

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

- Eliminate all pre-existing condition exclusions for all plan participants.[6]
- Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan.[7]
- Provide coverage for certain preventive health services with no cost-sharing.[8]
- Cover "adult children" up to age 26.[9]
- Stop rescinding coverage absent fraud or misrepresentation.[10]
- Include new internal and external appeals processes (and provide notice).[11]
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.[12]
- Provide direct access to emergency services.[13]

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

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

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

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

[6] *See* PHSA section 2704.

[7] *See* PHSA section 2711.

[8] *See* PHSA section 2713.

[9] *See* PHSA section 2714.

[10] *See* PHSA section 2712.

[11] *See* PHSA section 2719.

[12] *Id*.

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

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

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

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

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

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

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

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

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

F. State MEWA Statutes Apply to Self-Insured AHPs

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

G. What ACA Requirements Do Not Apply To AHPs?

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

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

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

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

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

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

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

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

II. Background on the Current Treatment of AHPs

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

A. Employer Groups Forming AHPs Pre-ACA

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

B. The Enactment of the ACA

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

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

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

[33] *See* ACA section 1343.

C. HHS Guidance Relating to AHPs Issued In 2011

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. <u>The DOL's Proposed AHP Regulations</u>

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

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

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

1. *"Related" Employers*

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

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

2. *"Unrelated" Employers*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[42] 541 U.S. 1 (2004).
[43] *See Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199 (2015); *see also*, *National Cable & Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967 (2005).

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

C. The Proposed Nondiscrimination Protections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. <u>State Regulation of AHPs</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. <u>Conclusion</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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