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

ENTITLED

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

**WRITTEN TESTIMONY OF
MICHAEL C. MCGREW.**

**ON BEHALF OF
THE NATIONAL ASSOCIATION OF REALTORS®**

MARCH 20, 2018

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

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

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

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

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

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

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

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

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

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

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

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

- Ensuring that self-employed individuals with no employees (referred to as a “working owner”) can participate in group health plan coverage under an AHP, which are still subject to important consumer protections;
- Removing arbitrary and unnecessary eligibility criteria for being considered a working owner; and,
- Clarifying that while states may continue to regulate AHPs, states may not use existing authorities to undermine the intent of this rule which is expand access to AHPs (e.g., by simply re-characterizing large group AHPs as “small group” health plans).

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

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

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

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

If a working owner is not married³ – or their spouse's employer does not offer group health plan coverage – the only health care option available to them is coverage in the fully-insured individual market. This can dramatically limit a working owner's ability to access affordable health coverage.⁴ In today's individual market, finding a health plan that provides an adequate level of coverage at an affordable price is difficult.⁵ NAR research indicates that median monthly premium cost in the individual market for members is \$670, while those members eligible for coverage through an employer (spouse's or former employer for example) is \$500. Allowing working owners to access health coverage through an AHP – either a fully-insured large group or self-insured AHP – will dramatically improve their ability to find comprehensive health coverage that may be more affordable than their current options.

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

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

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

⁴ For example, the Congressional Budget Office ("CBO") found that premiums in the individual market were 27 percent to 30 percent higher in 2016 than they would have been in 2009. See https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf. Others have argued that many healthy individuals experienced rate increases of 100 to 200 percent. See <https://www.finance.senate.gov/imo/media/doc/12EP2017RoySTMNT.pdf>.

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

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

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

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

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

- There are existing consumer protections under the ACA that require a fully-insured large group and self-insured AHP – as a group health plan – to provide a comprehensive level of coverage. For example, according to the ACA, a fully-insured large group or self-insured AHP (1) *cannot* deny an eligible plan participant health coverage if they have a pre-existing condition,⁷ (2) *cannot* refuse to cover certain government-approved preventive services (rather, the AHP must provide free coverage for these preventive services),⁸ and (3) *cannot* impose annual and lifetime limits on the "essential health benefits" covered under the plan.⁹ Other ACA requirements including – (1) covering adult children up to age 26, (2) free access to emergency care, and (2) the prohibition against rescinding coverage absent fraud – apply.¹⁰
- Under the *Employee Retirement Income Security Act* (ERISA), there are specific notice and disclosure requirements,¹¹ and also fiduciary responsibilities that apply,¹² requiring the AHP

⁶ See ACA section 1343.

⁷ Public Health Service Act ("PHSA") section 2704.

⁸ PHSA section 2713.

⁹ PHSA section 2711.

¹⁰ PHSA sections 2714, 2719A, and 2712.

¹¹ ERISA, Title I, Subtitle B Part 1.

¹² ERISA, Title I, Subtitle B Part 4.

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

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

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

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

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

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

¹³ ERISA section 502.

¹⁴ ERISA section 503.

¹⁵ PHSA section 2719.

¹⁶ ERISA, Title I, Subtitle B Part 7.

¹⁷ ERISA section 702.

¹⁸ According to the National Conference of State Legislatures, traditionally States have enacted health mandate laws to include required categories of up to 70 distinct "benefits" as well as "health providers" (such as acupuncturists or chiropractors) and "persons covered" (such as adopted children, handicapped dependents, or adult dependents). Adding up these laws, there are more than 1,900 such statutes among all 50 states; another analysis tallies more than 2,200 individual statute provisions, adopted over more than 30 years. See "State Insurance Mandates and the ACA Essential Benefits Provisions," National Conference of State Legislators (Oct. 2017).

<http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx>, Appendix I.

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

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

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

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

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

III. State Regulation of AHPs Concerns

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

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

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

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

Conclusion

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

APPENDIX

March 6, 2018

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Mr. Alexander Acosta
Secretary of Labor
U.S. Department of Labor
200 Constitution Avenue, NW
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Re: “Definition of Employer under Section 3(5) of ERISA - Association Health Plans”; RIN 1210-AB85 or Docket ID No. 2017-28103 (submitted electronically)

Dear Secretary Acosta:

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

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

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



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

While REALTORS® understand the importance of having health insurance, affordability continues to be a primary barrier to obtaining and maintaining coverage.³ More than half of REALTORS® describe their existing insurance premiums as too expensive, costing more than \$6,000 per year.⁴ Numerous reports project rising costs for 2018, more so than in previous years. According to the Kasier Family Foundation, the average increase in the lowest-cost premium will range between 17 and 32 percent for 2018.⁵ For REALTORS®, with a nationwide median individual gross income of \$42,500, such increases could have a significant impact on whether they can afford to purchase health insurance.⁶

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

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

1. Ensuring that self-employed individuals with no employees (referred to as a "working owner") can participate in group health plan coverage under an AHP;
2. Removing arbitrary and unnecessary eligibility criteria for being considered a working owner; and,
3. Clarifying that while states may continue to regulate AHPs, states may not use existing authorities to undermine the intent of this rule, which is to expand access to AHPs (e.g., by simply re-characterizing large group AHPs as "small group" health plans).

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

¹ For example, with many real estate professionals falling in the baby boomer generation, maintaining protections for pre-existing conditions and ensuring guaranteed availability of coverage have been top priorities when considering health insurance options.

² See Ashley Semansee et al., *How Premiums Are Changing in 2018*, Kasier Family Foundation (Nov. 2017), <https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/>. [Hereinafter KFF 2018 Premiums.]

³ Eighty-four percent of REALTORS® plan to continue buying coverage even in light of the recent change to the individual mandate penalty. National Association of REALTORS® Research Division, 2018 Health Insurance Survey, (February 2018).

⁴ *Id.*

⁵ KFF 2018 Premiums. Figures are based on metal levels for a 40-year-old before a tax credit would apply.

⁶ National Association of REALTORS® Research Division, 2017 Member Profile, (May 2017), <https://www.nar.realtor/reports/member-profile>. [Hereinafter NAR 2017 Member Profile].

⁷ E.g., Letter from the Nat'l Ass'n of REALTORS® to Congressmen Johnson & Walberg in support of H.R. 1101, *the Small Business Health Fairness Act* (Feb. 28, 2017), <http://narfocus.com/billdatabase/clientfiles/172/2/2847.pdf>.

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

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

A. Background on the Current Treatment of AHPs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

¹³ DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 2005-24A (Dec. 30, 2005), DOL Adv. Op. 2003-17A (Dec. 12, 2003), DOL Adv. Op. 2001-04A (Mar. 22, 2001), DOL Adv. Op. 96-25A (Oct. 31, 1996).

¹⁴ *Gruber v. Hubard Bert Karle Webber, Inc.*, 159 F.3d 780 (3rd Cir. 1998) (citing *Steen v. John Hancock Mutual Life Ins.*, 106 F.3d 904 (9th Cir. 1997)); *National Ben. Administrators, Inc., National Business Ass’n By and Through v. Morgan*, 770 F. Supp. 1169 (W.D.KY 1991); *see also*, DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-24A (Dec. 30, 2005), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 2003-17A (Dec. 12, 2003).

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

¹⁶ DOL Reg. section 2510.3-3(b), (c).

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

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

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

1. REALTORS® Support the Modifications to the “Commonality of Interest” Test

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

²¹ Public Health Service Act (“PHSA”) section 2704.

²² PHSA section 2713.

²³ PHSA section 2711.

²⁴ PHSA sections 2714, 2719A, and 2712.

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

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

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

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

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

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

²⁵ ERISA, Title I, Subtitle B Part 1.

²⁶ ERISA, Title I, Subtitle B Part 4.

²⁷ ERISA section 502.

²⁸ ERISA section 503.

²⁹ PHSA section 2719.

³⁰ ERISA, Title I, Subtitle B Part 7.

³¹ ERISA section 702.

³² According to the National Conference of State Legislatures, traditionally States have enacted health mandate laws to include required categories of up to 70 distinct “benefits” as well as “health providers” (such as acupuncturists or chiropractors) and “persons covered” (such as adopted children, handicapped dependents, or adult dependents). Adding up these laws, there are more than 1,900 such statutes among all 50 states; another analysis tallies more than 2,200 individual statute provisions, adopted over more than 30 years. See “State Insurance Mandates and the ACA Essential Benefits Provisions,” National Conference of State Legislators (Oct. 2017). <http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx>, Appendix I.

³³ ERISA section 514(b)(6)(A)(ii).

4. *AHPs Will Provide Adequate Health Coverage*

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

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

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

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

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

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

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

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

³⁵ See ACA section 1343.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

³⁸ NAR 2017 Member Profile.

³⁹ See Dale H. Yamamoto, *Health Care Costs – From Birth to Death*, Society of Actuaries (June 2013), <http://tinyurl.com/q5z2zb9>.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. The Nondiscrimination Protections

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

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

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

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

⁴¹ Around 16 percent of NAR members work fewer than 30 hours per week and make less than \$10,000. NAR 2017 Member Profile.

⁴² A “health factor” is defined as: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

V. State Regulation of AHPs

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

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

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

A. **Fully-Insured Large Group AHPs**

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

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

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

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

⁴³ See ERISA section 514(b)(2)(A).

⁴⁴ See ERISA section 514(b)(2)(B).

⁴⁵ ERISA section 514(b)(6)(A)(i)(I).

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

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

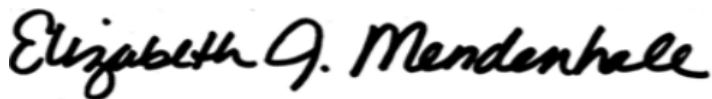
B. Self-Insured AHPs

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

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

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

Sincerely,



Elizabeth Mendenhall
2018 President, National Association of REALTORS®