STATEMENT FOR THE RECORD

SUBMITTED TO THE

House Committee on Energy & Commerce
Health Subcommittee

Hearing on "Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections"

February 13, 2019

SUBMITTED BY THE

The Coalition to Protect and Promote Association Health Plans

I. Overview

The Coalition to Protect and Promote Association Health Plans (the "Coalition") is an *ad hoc* coalition comprised of 23 national and state member-based organizations. These organizations include: the American Bankers Association; American Composites Manufacturers Association; American Farm Bureau Federation; American Society of Association Executives; American Veterinary Medical Association; Associated Employers Benefit & Trust; Association of Web-Based Health Insurance Brokers; Financial Services Institute; Food Marketing Institute; Foundation for Government Accountability; Global Cold Chain Alliance; Indiana Credit Union League; International Franchise Association; International Sign Association; Land O'Lakes, Inc.; Manufacturer & Business Association; Michigan Dental Association; National Apartment Association; National Association of REALTORS®; NFIB; National Restaurant Association; National Marine Manufacturers Association; and the Transportation Intermediaries Association.

Several of our Coalition members currently sponsor an "association health plan" (or "AHP") through which "group health plan" coverage is actively being provided to employees of their employer-members of these organizations. All of the Coalition's member-organizations are interested in offering "group health plan" coverage through an AHP in accordance with the rules and requirements set forth in the United States Department of Labor's ("DOL's") final regulations under Title I of the Employee Retirement Income Security Act ("ERISA") (the "final AHP regulations"). The final AHP regulations establish additional criteria under ERISA section 3(5) for determining when employers may join together in a "bona fide group or association of employers" that will be treated as the "employer" sponsor of a "group health plan."

The Coalition's member-organizations represent over 1 million small employers and millions more who are employees of these employer-members or who are self-employed, the majority of whom would be eligible to obtain health coverage through an AHP sponsored by Coalition member-organizations in accordance with the final AHP regulations. Thousands of employees are already covered by AHPs sponsored by a number of our Coalition members in accordance with the DOL's existing guidance that treat a "bona fide group or association of employers" as an "employer" as defined under ERISA section 3(5).

Without the rules and requirements set forth under the final AHP regulations, many Coalition members would be unable to provide quality and affordable health coverage to small employers and self-employed individuals who are currently struggling to afford health insurance offered in the existing "small group" and "individual" health insurance markets. More specifically, if all or a portion of the final AHP regulations are somehow invalidated through a court of law or through an act of Congress, thousands of employees and self-employed individuals who will be covered by an AHP established exclusively on account of the final AHP regulations – and who are currently enrolled in AHP coverage, effective January 1, 2019 – will *lose* their health coverage.

II. AHPs Are Not the Same As Short-Term Health Plans; AHPs Provide Comprehensive Coverage As Required Under the ACA, ERISA, HIPAA, COBRA, and State Law

It is important to emphasize that AHPs are *not* the same as short-term health plans. We believe it is paramount to make this distinction because ever since President Trump issued Executive Order 13813, 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*.

A. Short-Term Health Plans Are Exempt from the ACA; AHPs Are Subject to the ACA's Coverage Requirements

Under existing law, short-term health plans are *not* considered "health insurance" offered in the individual insurance market,[1] and therefore, short-term health plans are *not* subject to the Affordable Care Act's ("ACA's") insurance and coverage requirements.[2] 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"[3] – *are* subject to the ACA's coverage requirements.[4] 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*.

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.[5]
- Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan.[6]
- Provide coverage for certain preventive health services with no cost-sharing.[7]
- Cover "adult children" up to age 26.[8]
- Stop rescinding coverage absent fraud or misrepresentation.[9]
- Include new internal and external appeals processes (and provide notice).[10]

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[1] 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.
[2] 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.
[3] 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.
[4] ERISA section 715 incorporates by reference the ACA's coverage requirements applicable to a "group health plan" into ERISA.
[5] *See* PHSA section 2704.
[6] *See* PHSA section 2711.
[7] *See* PHSA section 2713.
[8] *See* PHSA section 2714.
[9] *See* PHSA section 2712.
[10] *See* PHSA section 2719.

- Allow participants a choice of primary care physician/pediatrician/OB/GYN.[11]
- Provide direct access to emergency services.[12]
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.[13]
- 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.[14]
- Eliminate waiting periods that exceed 90 days.[15]
- Cover the cost of clinical trial participation.[16]
- Provide participants with a summary of benefits and coverage.[17]
- Provide annual reports describing the plan's quality-of-care provisions.[18]

B. 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.[19] In addition, ERISA's fiduciary responsibilities apply,[20] 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,[21] and there are detailed procedures for filing health status.[22]

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,[23] and according to HIPAA, premiums for an AHP participant *cannot* be developed based on the participant's health condition.[24]

C. 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 Democrats and Republicans in Congress have enacted into law over the past decades, *including protections for individuals with a pre-existing condition*.

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

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

Another important layer of coverage requirements that is often times overlooked by critics of AHPs is this: A fully-insured "large group" AHP will be subject to State benefit mandates. State benefit mandates require an insurance contract sold within a particular State to cover specified benefits and medical services. The State benefit mandates applicable to fully-insured "large group" plans in most States are as good as the ACA's Federal "essential health benefits" ("EHB") requirement. Even in States where their benefit mandates do not cover all of the ten (10) medical services that make up the Federal EHB standard,[25] 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.

E. 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").[26] 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.[27] 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.

III. The AHP Regulations Will Not Return the Health Care Markets to a "Pre-ACA World"

Critics of AHPs have argued that these arrangements will somehow return the country to a "pre-ACA world," particularly to a world where people with pre-existing conditions will be unprotected by Federal law. As discussed above, *every* AHP is a "group health plan" under the law, and therefore, subject to the consumer protections under ERISA, HIPAA, COBRA, and State law. More importantly, as a "group health plan," AHPs are subject to the ACA's "coverage requirements," which, among other things, requires an AHP to offer coverage to a person with a pre-existing condition (i.e., a person with a pre-existing condition *cannot* be denied coverage under an AHP).

IV. AHPs Are the Same as Large Employer Plans; Newly Created AHPs Are Offering Comprehensive Coverage

The final AHP regulations give small businesses an opportunity to stand on the same footing as large employers with respect to the provision of employee health benefits. Large employers

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[25] According to the ACA, individual and small group health plans must cover a list of ten (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)].

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

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

voluntarily offer health benefits to their employees to attract and retain talented workers, and to keep their employees healthy and productive. Large employers have historically offered comprehensive benefits because the labor market traditionally demands such quality health coverage.

Small employers – just like large employers – want to attract and retain talented workers and to keep their employees healthy and productive. As a result, small employers – just like large employers – *want* to offer comprehensive health coverage. However, because they lack the resources and bargaining power of large employers, the majority of small employers are unable to offer comprehensive coverage at an affordable price. This is where AHPs can play such an important and socially-beneficial role. By obtaining health coverage through an AHP – which effectively will be treated as a health plan sponsored by a large employer – small employers will be able to compete with large employers and offer comprehensive benefits at affordable prices.

The type of "groups or association of employers" interested in sponsoring an AHP are member-based organizations. These organizations *want* to offer AHP coverage – which again, is effectively a large employer plan – to their employer-members, not only to help their employer-members attract and retain talented workers, but as a member benefit to attract new members and retain their current members. An offer of less comprehensive, sub-standard health coverage will actually be detrimental to these organizations (i.e., their current members will leave the organization and they will be unable to attract any new employer-members).

This is not just theory, but practice. For example, Land O'Lakes, Inc. – a member of our Coalition and a member-based cooperative-owned company – has successfully enrolled 2,000 self-employed farmers and employees of employer members of a Land O'Lakes Cooperative in a self-insured AHP established in accordance with the final AHP regulations. Coverage is effective January 1, 2019. It should be noted that Land O'Lakes, Inc. is able to offer self-insured AHP coverage to their self-employed farmers *only* because of the existence of the final AHP regulations. And it should be further noted that if all or a portion of the final AHP regulations are somehow invalidated through a court of law or through an act of Congress, these self-employed farmers will *lose* their health coverage.

Importantly, the Land O'Lakes AHP offers its members eight (8) different plan designs. While the Land O'Lakes AHP is *not* required to cover the ACA's "essential health benefits" ("EHBs"), *all* of the Land O'Lakes AHP plans *voluntarily* cover the ten (10) statutory EHB categories, along with all of the services that fall into the EHB categories that are medically necessary. The health coverage Land O'Lakes offers to its farmer and employee-members is therefore "comprehensive," and also superior in price (e.g., 15% to 25% more affordable than "individual market" rates in Nebraska, and 10% more affordable than "individual market" rates in Minnesota). The National Restaurant Association – another Coalition member and a member-based organization – is likewise offering comprehensive health coverage through its 120 plan designs, which also *voluntarily* cover all of the ACA's EHB categories.

V. A Regulatory Framework Has Been Put In Place Over Time to Combat Fraud and Abuse; Our Coalition Pledges to Work With the NAIC and Congress to Fight Against Fraud and Abuse

It is important to point out that an AHP can take the form of either a fully-insured or a self-insured arrangement. This is a crucial distinction when it comes to the issue of fraud and abuse. For example, fully-insured AHPs are under-written by insurance companies, which are themselves subject

to significant State regulation. In addition, States impose specific requirements on agents and brokers who sell insurance, imposing significant penalties on agents/brokers that engage in the fraudulent sale of insurance products. As result, there have been very few cases of fraud and abuse in fully-insured AHPs. And based on the current regulatory environment, it is unlikely that any fraud will occur in the context of fully-insured AHPs in the future.

While self-insured AHPs have in the past been more vulnerable to fraud and abuse, this history prompted Congress to act. Before 1983, self-insured AHPs resisted efforts at State regulation by arguing that such State regulation was pre-empted by ERISA. However – as stated above – Congress amended ERISA to give States the exclusive authority to regulate self-insured AHPs in any manner the State may choose.

Therefore, since 1983, the States have been free to regulate self-insured AHPs as they see fit, and they have exercised that authority through the enactment of State multiple employer welfare arrangement ("MEWA") laws. Currently, a number of States – including California, Illinois, and Wisconsin – flatly prohibit the establishment of any new self-insured AHPs. Other States – such as Indiana, Michigan, Nebraska, and Ohio – have enacted MEWA laws that set forth comprehensive certification and approval processes that an organization seeking to operate a self-insured AHP in the respective State must satisfy. Any such certification/approval must come directly from the State's Insurance Commissioner, and any such certification/approval will only be provided by the Commissioner if all of the State's MEWA law requirements are satisfied.

More extensive oversight has also come at the Federal level through the enactment of the ACA. Specifically, Congress expanded and strengthened the DOL's authority over MEWAs – and thus over AHPs – through a multi-pronged approach to eliminate MEWA/AHP abuses. These new requirements include improvements in reporting, together with stronger enforcement tools, and expanded required registration with the DOL prior to operating in a State. This additional information enhances the State and Federal governments' joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor the authority to issue a cease and desist order when a MEWA/AHP engages in fraudulent or other abusive conduct, and to issue a summary seizure order when a MEWA/AHP is in a financially hazardous condition.

This detailed State and Federal regulatory framework – which was not in place at all prior to 1983, and which has been built up over the years – provides safeguards that will largely prevent fraud and abuse, and, where such misconduct does occur, will significantly mitigate its effects. The Coalition has also pledged to the National Association of Insurance Commissioners ("NAIC") that we are ready, willing, and able to work with the State Insurance Commissioners to build on the current regulatory framework. In addition, the Coalition seeks to work with members of Congress to provide additional funding for the DOL's enforcement activities – as established under the ACA – as well as to fund State enforcement efforts.

VI. AHPs Will Not Segment the Markets

Critics of AHPs argue that these arrangements will somehow destabilize the "individual" and "small group" markets. Our Coalition believes that these claims are over-stated. For example, critics have overlooked the fact that AHPs are offering comprehensive coverage at a lower cost relative to the "individual" and "small group" market plans (as described above). In our experience, employees and individuals shop for health insurance based on price, as well as the comprehensiveness of the health

coverage. The health status of a particular employee or individual also drives their behavior. In cases where an employee or individual is healthy, they will most likely gravitate toward health coverage with a lower cost. If, however, an employee or individual is less healthy (and thus a "high-medical utilizer"), they are more likely to seek out comprehensive coverage, although price remains an important factor as well.

Critics, therefore, are wrong when they predict that AHPs will draw *only* healthy people out of the ACA markets. Because AHP coverage is proving to be as comprehensive as – if not more comprehensive than – existing "small group" or "individual" market coverage, while still being offered at a more affordable price, both healthy people *and* less healthy/high-medical utilizers are going to be attracted to AHP coverage. Thus, due to the fact that less healthy/high-medical utilizers will exit the "small group" or "individual" markets to enroll in an AHP (because such plans will offer comprehensive benefits at a lower cost), the expanded availability of AHP coverage will actually *benefit* the "small group" and "individual" markets from a health risk perspective, drawing less healthy/high-medical utilizers out of the current risk pool. At the very least, this beneficial effect should offset any "destabilizing" effect that will result when healthy employees and "working owners" also leave the "small group" and "individual" markets for superior AHP coverage.

In addition, predictions of market destabilization are not just speculative, but also incomplete because they fail to account for the numbers of small employers – as well as "working owners" in the "unsubsidized" individual market – who are currently *not* covered by any form or health insurance. If the employees of these small employers – along with these "working owners" – choose to enroll in an AHP, the current ACA's "small group" or "individual" markets will *not* be affected because these insured "lives" were never in those markets (and in their risk pools) in the first place.

This is not a theoretical consideration. Since the enactment of the ACA in 2010, health coverage offered by small employers with fewer than 50 employees has declined by over 20%.[28] Only about 50% of small employers with fewer than 50 employees actually offer health coverage, as compared to 97% of large employers with 50 to 199 employees.[29] Importantly, 47% of small employers with fewer than 50 employees identify the high cost of health insurance as the primary reason for not offering coverage.[30]

A similar phenomenon exists in the "unsubsidized" individual market. Since 2015, about 3 million individuals have exited the ACA's "individual" market.[31] This amounts to a loss of about 17% of the "individual" market from its peak.[32] It is reasonable to infer that many, if not most, of these individuals exited the "individual" market due to significant premium increases following the enactment of the ACA. It is also reasonable to infer that many of these individuals will be attracted to an AHP that offers comprehensive coverage, additional flexibility, and lower prices. As a result, it is reasonable to conclude that these "lives" are currently *not* a part of the ACA's "individual" market, which therefore cannot be affected by their migration from uninsured status to an AHP.[33]

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[28] *See* Employer Health Benefits: 2018 Annual Survey (Kaiser Family Foundation 2018).
[29] *Id*.
[30] *Id*.
[31] *See* Semanskee, Cox, and Levitt, *Data Note: Changes in Enrollment in the Individual Health Insurance Market* (Kaiser Family Foundation, July 2018) at p.1.
[32] *Id*.
[33] In 2013, the Obama Administration announced what is referred to as its "transitional policy," which authorized States to allow insurance companies to continue to sell non-ACA-compliant health plans to small employers and individuals. This "transitional policy" has been extended multiple times, most recently through December 31, 2019. Although this market has

VII. Conclusion

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, small 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.

Most of the AHPs that have started offering coverage as of January 1, 2019 voluntarily cover all of the EHBs. In some cases, all of the plan designs offered by the AHP cover all ten (10) EHBs. In other cases, an AHP will offer multiple plan designs, some of which do not cover all ten (10) EHBs, while other plan designs cover all ten (10) EHBs. This approach provides flexibility for plan participants, while ensuring that *all* plan participants have access to EHB-plans.

There has been very little fraud in the case of fully-insured AHPs in the past. Why? Because States heavily regulate insurance carriers under-writing AHP health coverage. In addition, States impose specific requirements on agents and brokers who sell insurance, imposing significant penalties on agents/brokers that engage in the fraudulent sale of insurance products. Based on the current regulatory environment, it is unlikely that any fraud will occur in the context of fully-insured AHPs. In the case of self-insured AHPs, States and the DOL have the necessary tools to combat fraud, and existing law now acts as a deterrent against fraudulent behavior in the self-insured AHP context.

Economics 101 tells us that less healthy groups and less healthy individuals will be attracted to AHPs to the same extent healthy groups and individuals will be attracted to AHPs. Why? Because AHPs will offer comprehensive coverage at a lower cost. AHPs can offer the same level of coverage as a "small group" or "individual" market plan at a lower cost because of (1) lower administrative costs in the "large group" and self-insured markets, (2) no "risk adjustment," which results in defensive pricing, and (3) the flexibility to provide benefit offerings like tele-health or value-based insurance designs. If less healthy groups and individuals exit the "small group" and "individual" markets, this will benefit the existing markets. At a minimum, less healthy groups and individuals exiting the markets will offset the effects of healthy people exiting the markets, thus negating the adverse effects that critics claim.

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been shrinking, a good number of small employers – as well as individuals – are still enrolled in these non-ACA-compliant plans. Because these non-ACA-compliant plans are subject to different rules than ACA-compliant "small group" and "individual" market plans, these "lives" are in a separate risk pool and not a part of the existing "small group" and "individual" market risk pools. If the small employers and individuals that currently get coverage under these non-ACA-compliant "transitional" plans are attracted to an AHP, their enrollment in the AHP will likewise have zero impact on the ACA's reformed "small group" and "individual" markets.