STATEMENT FOR THE RECORD

SUBMITTED TO THE

Committee on Education & Labor, Subcommittee on Health, Employment, Labor, and Pensions

Hearing on Exploring Pathways to Affordable, Universal Health Coverage

February 17, 2022

SUBMITTED BY THE

The Coalition to Protect and Promote Association Health Plans

I. Overview

The Coalition to Protect and Promote Association Health Plans (the "AHP Coalition") respectfully submits this Statement for the Record.

The AHP Coalition is currently comprised of 25 like-minded organizations – including membership-based organizations and industry-service providers – that believe employees of small employers and self-employed individuals with no employees deserve quality and affordable health coverage with strong consumer protections. Our members include: American Composites Manufacturers Association; American Farm Bureau Federation; American Society of Association Executives; American Society of Travel Advisors; American Veterinary Medical Association; Associated Employers Benefit & Trust; Consoliplex; Food Marketing Institute; Foundation for Government Accountability; Global Cold Chain Alliance; Indiana Credit Union League; International Sign Association; Manufacturer & Business Association; Marsh McLennan; McDonald's Licensees Health & Welfare Trust; Mercer; Michigan Business and Professional Association; Michigan Dental Association; National Association of Mortgage Brokers; National Association of REALTORS®; National Restaurant Association; NFIB; Small Business Association of Michigan; Tailorwell; Vimly Benefit Solutions.

Ever since its formation in August 2018, the AHP Coalition has been working tirelessly to correct-the-record.[1] Specifically, contrary to what critics are saying, Association Health Plans ("AHPs") are *not* an "end-run around" the Affordable Care Act ("ACA"). Quite to the opposite. AHPs are currently offering better coverage than ACA-compliant "small group" and "individual" market plans. How do they do that?

AHPs are *voluntarily* covering all ten of the ACA's "essential health benefits" (EHBs), including pediatric major medical coverage. AHPs also cover pediatric dental and vision services either through their AHP insurance contract or through a stand-alone product.

In addition, AHPs offer broader "health care provider networks" relative to many existing ACA "small group" and "individual" market plans, and they are priced at an "actuarially fair premium" for both young and old AHP participants. Doing so encourages more young and healthy individuals to enroll in AHP health coverage, which in turn benefits older and less healthy AHP participants by increasing the size of, and balancing out, the risk pool.

AHPs are also subject to specific rules that prevent them from discriminating against individuals/employees based on a health condition. Most importantly, AHPs are prohibited from denying people coverage if they have a pre-existing condition.

To date, at least 30 States have signaled that they want to allow AHPs to (1) cover small employers in the *same industry*, (2) cover small employers in *different industries*, and (3) cover self-employed individuals with no employees.[2] This is compared to the 11 States and the District of

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[1] *See e.g.*, Amicus Brief submitted by The Coalition to Protect and Promote Association Health Plans to the Court of Appeals for the District of Columbia Circuit at https://www.thepowerofa.org/wp-content/uploads/2019/06/Amicus-Brief-The-Coalition-to-Protect-and-Promote-Association-Health-Plans-and-AssociationHealthPlans.com_.pdf.

[2] *See Association Health Plans (AHPs) and States' Rights: An Accounting of How States Want to Regulate AHPs,* Bloomberg Tax, Tax Management Compensation Planning Journal, Nov. 2019 at https://www.thepowerofa.org/wp-content/uploads/2019/11/Condeluci_CPJ_Nov2019.pdf.

Columbia ("DC") that have filed a lawsuit to invalidate the Department of Labor's ("DOL") final AHP regulations (issued on June 21, 2018). Importantly, these 11 States and DC *already* prohibit certain types of AHPs from operating in their State.

II. Small Employers Want to Offer the Same Comprehensive and Affordable Health Coverage that Large Employers Offer

It is important to emphasize that one of the main reasons why employers – both large and small – offer health coverage to their employees is to attract and retain talented workers and to keep their workers healthy and productive. Large employers do just that, through an offer of comprehensive health benefits that talented workers often time demand, especially in a tight labor market.

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, and will, offer comprehensive health coverage.

However, because small employers 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 play such an important and socially-beneficial role. By obtaining health coverage through an AHP – which will be treated as a health plan sponsored by a large employer – small employers can "group purchase" and effectively compete with large employers by offering comprehensive and affordable health benefits to their employees.

III. Membership-Based Organizations That Include Self-Employed Individuals Want to Offer Comprehensive and Affordable Health Coverage Too

It is also important to emphasize that the type of "groups or associations" interested in sponsoring an AHP are membership-based organizations (this includes member-based organizations with self-employed individuals with no employees). These organizations *want* to offer AHP coverage – which again, is treated like a large employer plan – not only to help their individual members obtain quality and affordable coverage, 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 members).

IV. During the 2019 Plan Year, Membership-Based Organizations Offered Comprehensive and Affordable Coverage Through an AHP

Our Coalition's membership-based organizations represent over 1 million small employers, and millions more who are employees of these small employer-members or who are self-employed with no employees, the majority of whom would be eligible to obtain health coverage through an AHP if Federal law allowed AHPs to cover (1) employers in *different industries* and (2) self-employed individuals with no employees.[3] Membership-based organizations with employers in the *same*

[3] On March 28, 2019, the District Court for the District of Columbia ruled that the Department of Labor's ("DOL's") final regulations issued on June 18, 2018 that allowed AHPs to cover (1) employers in *different industries* and (2) self-employed individuals with no employees are invalid. The U.S. Department of Justice appealed the ruling to the Court of Appeals for the District of Columbia Circuit. On May 10, 2019, the Circuit Court granted an expedited review of the District Court ruling. Almost three years later, a final ruling from the Circuit Court has yet to be released.

industry already provide comprehensive and affordable health coverage to tens of thousands of employees through an AHP in accordance with existing law.[4]

A. Voluntary Coverage of the "Essential Health Benefits"

All of our AHP Coalition members that offered an AHP to (1) employers in the *same industry*, (2) employers in *different industries*, and (3) self-employed individuals with no employees during the 2019 plan year *voluntarily* covered all ten of the ACA's EHBs.[5]

It is important to emphasize that the tenth EHB requires "pediatric services, including oral and vision care." Every AHP in our Coalition provided pediatric major medical health coverage. Some AHPs covered oral (i.e., dental) and vision care through the AHP insurance contract itself, while others provided dental and vision care through stand-alone products. In both cases, *all* ten of the EHBs were covered.

Those AHPs that offered pediatric dental and vision services through a stand-alone product chose to do so because the Board governing the AHP determined that pediatric dental and vision benefits can be provided through a stand-alone product at a lower cost, while providing the same – if not a better – level coverage than if these services were offered through the AHP insurance contract itself. It is important to point out that the "control" test applicable to an AHP imposes a fiduciary duty on the Board governing the AHP, requiring the Board to "act solely in the interest" of the AHP participants and "for the exclusive purposes of providing benefits to participants and their beneficiaries…and…defraying reasonable expenses of administering the plan…"[6] The requirement to adhere to these fiduciary duties drove the Board's decision-making (to do otherwise would result in a fiduciary breach under ERISA).

B. These Same AHPs Offered Broader Provider Networks Than "Individual" and "Small Group" Market Plans

In addition to *voluntarily* covering the EHBs, these AHPs offered broader "health care provider networks" relative to many existing ACA "small group" and "individual" market plans.

It is well-established that ACA-compliant "small group" and "individual" market plans primarily have "narrow networks."[7] In fact, the Congressional Budget Office (CBO) has explained that "individual" market plans generally have narrower provider networks than employment-based

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[4] It is important to emphasize that the District Court ruling involving the DOL's final regulations issued on June 18, 2018 has *no* impact on existing law that allows membership-based organizations in the *same industry* to offer AHP coverage to their employer members with at least one common-law employee. *See* Q&A-1 of Frequently Asked Questions issued by the DOL on May 13, 2019 at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/ahp-q-and-a-court-ruling-part-2.pdf (although it appears that the DOL has de-activated this web link, requiring a formal request to review the DOL's public pronouncement).

[5] The list of ten medical services that make up the "essential health benefits" ("EHBs") include: 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)].

[6] Section 404(a)(1)(A) of the Employee Retirement Income Security Act ("ERISA").

[7] Industry studies confirm that ACA-compliant small group and individual market plans primarily have "narrow networks." *See* *Plans with More Restrictive Networks Comprise 73% of Exchange Market*, Avalere Health, Nov. 30, 2017.

plans.[8] For those AHP participants that were covered by these AHPs (i.e., an employment-based large group plan) during the 2019 plan year, their plan's broader provider network meant that they were no longer required to drive hours to and from a physician's office or a hospital that were in-network to receive medical treatment or to even get a routine medical check-up.

C. <u>These AHPs Offered Lower Deductible Plans for the Same Level of Coverage Offered Through "Individual" and "Small Group" Market Plans</u>

The average deductible for a single plan in the "individual" and "small group" markets is over $4,000[9] and $3,000,[10] respectively. However, individuals and employees who were covered by an AHP during the 2019 plan year enjoyed *lower* deductibles for the same level of coverage as they would receive under an ACA-compliant "small group" or "individual" market plan.[11]

D. <u>These AHPs Developed "Actuarial Fair Premiums"</u>

These AHPs also were priced at an "actuarially fair premium" for both young and old AHP participants. This was achieved through developing rate-bands based on age that did *not* exceed a 5 to 1 ratio. Alternatively, composite rates were developed by the average age of the employer member (not to exceed a 5 to 1 ratio among employer members), and then every employee of a particular employer member participating in the AHP was charged the same premium regardless of age.

Importantly, a health plan sponsored by a labor union (which is similar to an AHP because the union aggregates small employers together and offers a "large group" plan to these small employer members) ***<u>ALSO</u>*** develops premium rates based on a 5 to 1 age band or based on the average age of the employer member (not to exceed a 5 to 1 ratio among employer members). Why? Because the union is advised to do so by their actuaries, and the law currently allows unions to engage in this practice.

The Federal Employees Health Benefit Program ("FEHBP") also develops premiums based on a 5 to 1 ratio. Why? Because based on a study cited by the Congressional Budget Office, actuaries conclude that older individuals utilize health care 4.8 times more than younger individuals, and a 3 to 1 age ratio – as opposed to a 5 to 1 age ratio – "encourages older people to enroll and discourages younger people, and because the costs of the former are greater, average premiums rise."[12]

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[8] *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*, Congressional Budget Office, April 2021, page 7-8 at https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf.
[9] *How Much Does Individual Health Insurance Cost?*, eHealth, January 21, 2022 at https://www.ehealthinsurance.com/resources/individual-and-family/how-much-does-individual-health-insurance-cost.
[10] *What Is the Average Cost of Small Business Health Insurance?*, eHealth, January 11, 2021 at https://www.ehealthinsurance.com/resources/small-business/average-cost-small-group-health-insurance.
[11] As stated, an AHP is a "large group" employer plan. Kaiser Family Foundation indicates that the average deductible for a single employer-sponsored plan was $1,945 in 2020, which is consistent with our Coalition member's AHPs offered during the 2019 plan year. *See Average Annual Deductible per Enrolled Employee in Employer-Based Health Insurance for Single and Family Coverage* at https://www.kff.org/other/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[12] *Private Health Insurance Premiums and Federal Policy,* Congressional Budget Office, February 2016, page 22 at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.

E. Data Shows that AHPs Can Offer Lower Costing Plans While Providing Coverage That Is More Comprehensive Than ACA-Compliant "Individual" and "Small Group" Plans

Data from AHPs providing coverage to (1) employers in *different industries* and (2) self-employed individuals with no employees (which began their operations on or after January 1, 2019) show that there is savings that can be achieved while also covering the ACA's EHBs and offering broader provider networks and lower-deductible plans.

For example, coverage that was offered to self-employed individuals through an AHP that was established by five different State and Local REALTORS® – the Baldwin County Association of REALTORS® in Alabama, the Greater Las Vegas Association of REALTORS®, the Kansas City Regional Association of REALTORS®, the Nevada REALTORS®, and the Tennessee REALTORS® – produced savings relative to ACA "individual" market plans.

Specifically, participants in the Kansas City Regional Association of REALTORS® AHP averaged savings between 5 percent and 50 percent, while participants in the Tennessee REALTORS® AHP experienced 25 to 50 percent savings. The Nevada REALTORS® AHP participants saw savings from 2 percent up to 32.5 percent, while participants in the Baldwin REALTORS® AHP realized savings ranging from $150 to $15,000 per year. Unfortunately, these AHPs have been discontinued due to the legal uncertainty surrounding the DOL's 2018 final regulations.

Similarly, an AHP offered by the Nebraska Farm Bureau to self-employed farmers produced savings of up to 25 percent relative to "individual" market rates in Nebraska. This AHP has also been discontinued.

Another AHP jointly sponsored by the Small Business Association of Michigan and the Michigan Business and Professional Association – called Transcend AHP – covered both small employers and self-employed individuals. Although this AHP has been discontinued as of December 31, 2019, below are some statistics showing savings during the 2019 plan year:

- 22 employee investment manager – 35% savings - $100,000/year and composite rates.
- 15 employee architecture firm – $3,700 savings and composite rates.
- 27 employee managed service provider – 27% savings - $53,000/year.
- 3 employee law firm – 5% savings from comparable BCBSM "small group" plan.
- Sole proprietor, health insurance agent – 17% in savings - $2,400/year in savings vs. an ACA Exchange plan.
- 16 employee light manufacturer – 11.3% savings - $16,000 a year and lower deductible.
- 7 employee refrigeration company – $2,400/year savings and composite rates.
- 15 employee manufacturer – 27% savings - $59,500/year savings.
- Sole proprietor, investment manager – 10% savings and a more robust plan design vs. an ACA Exchange plan.
- 16 employee small municipality – 10% savings - $18,400/year.
- 24 employee construction company – 8.66% saving and cut deductible in half to $1,000.
- 9 employee credit union – 18.5% savings - $15,600/year in savings and a lower deductible.

V. 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 the media and critics of these health care arrangements 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, While 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,[13] and therefore, short-term health plans are *not* subject to the Affordable Care Act's ("ACA's") insurance and coverage requirements.[14] 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"[15] – *are* subject to the ACA's coverage requirements.[16] Again, this distinction is important to understand because – under current law – AHPs (1) *cannot* deny a person coverage if they have a pre-existing condition, (2) *cannot* develop premiums based on a participant's health condition, and (3) *cannot* impose annual and lifetime limits on the EHBs covered under the plan.

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.[17]
- Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan.[18]
- Provide coverage for certain preventive health services with no cost-sharing.[19]

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[13] 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.

[14] 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.

[15] ERISA section 733(a)(1) 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.

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

[17] *See* PHSA section 2704.

[18] *See* PHSA section 2711.

[19] *See* PHSA section 2713.

- Cover "adult children" up to age 26.[20]
- Stop rescinding coverage absent fraud or misrepresentation.[21]
- Include new internal and external appeals processes (and provide notice).[22]
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.[23]
- Provide direct access to emergency services.[24]
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.[25]
- 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.[26]
- Eliminate waiting periods that exceed 90 days.[27]
- Cover the cost of clinical trial participation.[28]
- Provide participants with a summary of benefits and coverage.[29]
- Provide annual reports describing the plan's quality-of-care provisions.[30]

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.[31] In addition, ERISA's fiduciary responsibilities apply,[32] 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,[33] and there are detailed procedures for filing health status.[34]

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,[35] and according to HIPAA, premiums for an AHP participant *cannot* be developed based on the participant's health condition.[36]

C. 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

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[20] *See* PHSA section 2714.
[21] *See* PHSA section 2712.
[22] *See* PHSA section 2719.
[23] *Id*.
[24] *See* PHSA section 2719A.
[25] *See* PHSA section 2705.
[26] *See* PHSA section 2707(b).
[27] *See* PHSA section 2708.
[28] *See* PHSA section 2709.
[29] *See* PHSA section 2715.
[30] *See* PHSA section 2717.
[31] ERISA, Title I, Subtitle B Part 1.
[32] ERISA, Title I, Subtitle B Part 4.
[33] ERISA section 502.
[34] ERISA section 503.
[35] ERISA, Title I, Subtitle B Part 7.
[36] ERISA section 702.

most States are as good as the ACA's EHBs. Even in States where their benefit mandates do not cover all of the ten medical services that make up the EHBs, the drafters of the ACA observed that most if not all fully-insured "large group" plans were already covering the EHBs, which led Congress to exempt fully-insured "large group plans" from the EHB requirement entirely.

D. 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").[37] 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.[38] 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.

E. 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 MEWA laws. Currently, a number of States – including California, Illinois, and Washington – flatly prohibit the establishment of any new self-insured AHPs. However, most other States 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.

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[37] *See* ERISA section 3(40).
[38] ERISA section 514(b)(6)(A)(ii).

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.