

STATEMENT FOR THE RECORD

SUBMITTED TO THE

**Committee on Education & the Workforce,
Subcommittee on
Health, Employment, Labor, and Pensions**

**Hearing on Reducing Health Care Costs for
Working Americans and Their Families**

April 26, 2023

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”)¹ respectfully submits this Statement for the Record.

Ever since its formation in August 2018, the AHP Coalition has been working tirelessly to correct-the-record.² 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 37 States allow small employers in the *same industry* to establish an AHP that is regulated like a “large employer health plan.”³ In addition, at least 30 States have signaled that they want to allow AHPs to (1) cover small employers in *different industries* and (2) cover *self-employed individuals with no employees*.⁴ Note, 13 States currently do not allow employers in the *same industry* to establish an AHP that is regulated like a large employer plan,⁵ while other States prohibit self-insured AHPs from operating in their State.⁶

¹ The AHP Coalition is currently comprised of 18 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 Farm Bureau Federation; American Society of Association Executives; Associated Employers Benefit & Trust; Consoliplex; Foundation for Government Accountability; Indiana Credit Union League; Manufacturer & Business Association; Marsh McLennan; McDonald’s Licensees Health & Welfare Trust; Mercer; Michigan Business and Professional Association; Michigan Dental Association; National Association of REALTORS®; National Restaurant Association; NFIB; Small Business Association of Michigan; Tailorwell; Vimly Benefit Solutions.

² See 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.

³ These States include: AL, AK, AZ, AR, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MI, MN, MS, MO, MT, NE, NV, NC, ND, OH, OK, OR, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY.

⁴ See Bloomberg Tax, Tax Management Compensation Planning Journal, *Association Health Plans (AHPs) and States’ Rights: An Accounting of How States Want to Regulate AHPs*, Nov. 2019 at https://www.thepowerofa.org/wp-content/uploads/2019/11/Condeluci_CPJ_Nov2019.pdf.

⁵ These States include: CA, CT, DE, ID, MD, MA, NH, NJ, NM, NY, PA, RI, VT.

⁶ For example, CA and WA refuse to grant a self-insured AHP a “license” to operate in their States.

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 typically demand, especially in a tight labor market. Small employers are no different. That is, small employers – needing to compete with large employers in today’s market – *want* to offer comprehensive health benefits to meet employees’ demands.

However, large employers with thousands of employees are in a better position to negotiate comprehensive, yet affordable coverage with insurers. Why? Because large employers offer insurers a bigger risk pool over which health claims may be spread and moderated. In some cases, these large employers can also negotiate lower rates with healthcare providers. How? Because large employers offer providers a large volume of patients to utilize their services.

Small employers, on the other hand, lack the resources and bargaining power of large employers, and therefore, 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 is the same type of 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 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 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. *Self-Employed Individuals With No Employees Should Be Treated as an “Employer” and an “Employee” For Purposes of Participating In an AHP*

A self-employed individual with no employees provides services to the individual’s own trade or business by providing services to a third-party entity, which itself is traditionally a trade or business or a third-party consumer. This self-employed individual generates revenue for its own trade or business through the provision of these services for these third-parties, and the Internal Revenue Code treats this

revenue generated as “income,” which is taxed for both income and employment tax purposes, similar to “wages” that are paid to an employee by an employer.

Over the past three decades, our nation’s economic environment has evolved into a competitive, global economic environment. Our nation’s workforce has similarly evolved from a traditional employment-based setting where “employees are employed by an employer,” to a non-traditional employment-based setting where a growing number of workers are self-employed individuals with no employees, who in reality operate as *both* (1) an “employer” and (2) an “employee.”⁷

Stated differently, while self-employed individuals with no employees do not act in the capacity of “employees who are employed by an employer” in the traditional employment sense, these self-employed individuals continue to provide services just like an employee (generating income that is taxed just like wages). These same self-employed individuals also operate as an employer of a trade or business. A failure to recognize that these revenue generating, taxpaying self-employed individuals operate in an employment setting is a failure to recognize that we now live in a competitive, global economy that no longer relies on a workforce made up of the traditional “employee employed by an employer.”

Recognizing these changing economic dynamics, it is imperative that Congress update our nation’s laws by developing a flexible framework that permits self-employed individuals with no employees to access affordable and comprehensive health coverage through an AHP.

V. *Our Coalition Members Offer of 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*. Our Coalition’s membership-based organizations with employers in the *same industry* **ALREADY** provide comprehensive and affordable health coverage to tens of thousands of employees through an AHP in accordance with existing law.

A. Voluntary Coverage of the “Essential Health Benefits”

All of our AHP Coalition members that offered an AHP to (1) employers in *different industries* and (2) *self-employed individuals with no employees* during the 2019 plan year – along with all of our AHP Coalition members that **CURRENTLY** offer an AHP to employers in the *same industry* – *voluntarily* covered all ten of the ACA’s EHBs.

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

⁷ See Small Business Trends, *Key Trends at Sole Proprietorships Over the Past 30 Years*, Dec. 4, 2015 at <https://smallbiztrends.com/2014/09/key-trends-sole-proprietorships-past-30-years.html> (reporting that the Internal Revenue Service found that sole proprietorships nearly doubled from 1980, when there were 39.2 for every thousand Americans to 76.7 sole proprietors for every thousand Americans in 2007).

Those AHPs that offered “pediatric dental and vision care” 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...”⁸ 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. Broader Provider Networks Than “Individual” and “Small Group” Market Plans

In addition to *voluntarily* covering the EHBs, our Coalition member’s AHPs offer/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.”⁹ In fact, the Congressional Budget Office (CBO) has explained that “individual” market plans generally have narrower provider networks than employment-based plans.¹⁰

For those employees currently covered by an AHP (which as stated, is an employment-based large group plan) – and for those employees and self-employed individuals covered by an AHP during the 2019 plan year – their plan’s broader provider network means/meant that AHP participants are/were no longer required to drive hours to and from a physician’s office or a hospital that are/were in-network to receive medical treatment or to even get a routine medical check-up.

C. AHPs Offer Lower Deductible Plans for the Same Level of Coverage Offered Through “Individual” and “Small Group” Market Plans

For the 2022 plan year, the average deductible for a single “silver metal” plan in the “individual” market was \$4,890, while the average deductible for a single “small group” market plan was \$2,543.¹¹ However, employees and self-employed individuals 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. Same for employees **CURRENTLY** covered by an industry-based AHP.¹²

⁸ Section 404(a)(1)(A) of the Employee Retirement Income Security Act (“ERISA”).

⁹ 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.

¹⁰ Congressional Budget Office, *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*, April 2021, page 7-8 at <https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf>.

¹¹ See Healthinsurance.org, *What is a health insurance deductible* at <https://www.healthinsurance.org/glossary/health-insurance-deductible/#:~:text=KFF%20reported%20the%20average%202023,and%20%2445%20for%20Platinum%20plans.>

¹² As stated, an AHP is a “large group” employer plan. Kaiser Family Foundation indicates that the average deductible for a single “large” employer-sponsored plan was \$1,493 in 2022, which is consistent with our Coalition member’s AHPs. See Kaiser Family Foundation, *Employer Health Benefits 2022 Annual Survey* at <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf>.

D. These AHPs Developed “Actuarial Fair Premiums”

Importantly, existing AHPs – and those AHPs that provided coverage to employees and self-employed individuals during the 2019 plan year – are/were priced at an “actuarially fair premium” for both young and old AHP participants. This is/was achieved through developing rate-bands based on age that did *not* exceed a 5 to 1 ratio. Alternatively, composite rates are/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 is/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) ***ALSO*** 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.”¹³

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* during the 2019 plan year 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 with no employees* 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 AHPs.¹⁴

¹³ Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy*, February 2016, page 22 at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.

¹⁴ 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. Four years later, a final ruling from the Circuit Court has yet to be released.

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.

VI. *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 short-term health plans 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,¹⁵ and therefore, short-term health plans are *not* subject to the Affordable Care Act’s (“ACA’s”) insurance and coverage requirements.¹⁶ 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*

¹⁵ 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.

¹⁶ 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.

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”¹⁷ – *are* subject to the ACA’s coverage requirements.¹⁸ 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.¹⁹
- Stop imposing annual and lifetime limits on the “essential health benefits” covered under the plan.²⁰
- Provide coverage for certain preventive health services with no cost-sharing.²¹
- Cover “adult children” up to age 26.²²
- Stop rescinding coverage absent fraud or misrepresentation.²³
- Include new internal and external appeals processes (and provide notice).²⁴
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.²⁵
- Provide direct access to emergency services.²⁶
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.²⁷
- 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 2014.²⁸
- Eliminate waiting periods that exceed 90 days.²⁹
- Cover the cost of clinical trial participation.³⁰
- Provide participants with a summary of benefits and coverage.³¹
- Provide annual reports describing the plan’s quality-of-care provisions.³²

¹⁷ 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.

¹⁸ ERISA section 715 incorporates by reference the ACA’s coverage requirements applicable to a “group health plan” into ERISA.

¹⁹ See PHSa section 2704.

²⁰ See PHSa section 2711.

²¹ See PHSa section 2713.

²² See PHSa section 2714.

²³ See PHSa section 2712.

²⁴ See PHSa section 2719.

²⁵ *Id.*

²⁶ See PHSa section 2719A.

²⁷ See PHSa section 2705.

²⁸ See PHSa section 2707(b).

²⁹ See PHSa section 2708.

³⁰ See PHSa section 2709.

³¹ See PHSa section 2715.

³² See PHSa section 2717.

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.³³ In addition, ERISA’s fiduciary responsibilities apply,³⁴ 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,³⁵ and there are detailed procedures for filing health status.³⁶

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,³⁷ and according to HIPAA, premiums for an AHP participant *cannot* be developed based on the participant’s health condition.³⁸

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 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).³⁹ 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.⁴⁰ 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.

³³ ERISA, Title I, Subtitle B Part 1.

³⁴ ERISA, Title I, Subtitle B Part 4.

³⁵ ERISA section 502.

³⁶ ERISA section 503.

³⁷ ERISA, Title I, Subtitle B Part 7.

³⁸ ERISA section 702.

³⁹ *See* ERISA section 3(40).

⁴⁰ ERISA section 514(b)(6)(A)(ii).

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. For example, most 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.

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. Our 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, our 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.