Statement for the Record
Senate Health, Education, Labor, and Pensions Subcommittee on Primary Health and Retirement Security

Roundtable Discussion on
"Small Business Health Plans"

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On January 4, 2018, the Department of Labor (DOL) released proposed regulations relating to "association health plans" (AHPs). Below is a brief discussion of the current treatment of AHPs, a description of the DOL's current definition of a "bona fide group or association of employers" for purposes of the Employee Retirement Income Security Act (ERISA), and an explanation of the coverage requirements and consumer protections applicable to AHPs as a "group health plan." The following also examines various legal challenges that may arise.

Current Treatment of "Association Health Plans" (AHPs)

In 2011, the Obama Administration issued guidance that essentially prohibited small employers from forming a fully-insured "large group" health plan. This meant that the ACA's "small group" market reforms applied to fully-insured AHP employer members with 50 or fewer employees.

One exception to the 2011 guidance: If the "group" of employers forming a fully-insured AHP is considered a "bona fide group or association of employers" for purposes of ERISA, the fully-insured AHP could still be treated as a "large group" plan, meaning the ACA's "small group" market reforms would *not* apply.

The 2011 guidance does not apply to self-insured AHPs. However, ERISA's definition of a "bona fide group or association of employers" is important: If a "group" of employers forming the self-insured AHP fails to meet this definition, ERISA's preemption of State benefit mandates would *not* apply.

"Bona Fide Group or Association of Employers" For Purposes of ERISA

To be considered a "bona fide group or association of employers" for purposes of ERISA, the "group" must meet (1) the "commonality of interest" test and (2) the "control" test. The control test requires the employer members to have a say over the plan design and operation. The "commonality of interest" test, on the other hand, is a facts and circumstances test which is not always easy to satisfy. According to DOL guidance, a group of employers would *not* be considered "bona fide" *unless* (1) the employer members are "related" (i.e., the employers are in the same industry) and (2) the employer members are located in the same geographical area. Also, a group of employers would *not* be considered "bona fide" if self-employed individuals with no employees are a part of the group (which means self-employed individuals with no employees are forced to find health care coverage in the fully-insured "individual" market).

The DOL's Proposed AHP Regulations

The DOL's proposed regulations endeavor to make it easier for small employers to form a fully-insured "large group" or self-insured AHP. For example, the proposed regulations would allow employers in the same industry or profession (i.e., "related" employers) to form an AHP, and offer "large group" fully-insured or self-insured AHP health coverage to the employees of these "related" employers, regardless of the employers' geographic location. The proposed regulations would also allow employers in different industries and professions (i.e., "unrelated" employers) to form an AHP, *but only if* these "unrelated" employers are located in the same State or Metropolitan area (that spans a tri-State area).

In addition, self-employed individuals with no employees (referred to as "working owners") could participate in an AHP. In this case, according to the proposed changes, working owners in the same industry/profession and located in different geographic locations could participate in an AHP

established by other "related" employer members. Working owners in the same industry/profession could also establish an AHP solely for "related" working owner members. And lastly, working owners in different industries and professions (i.e., "unrelated" working owners) could join, for example, a local Chamber of Commerce AHP, provided the working owners are located in the same State or Metropolitan area as the local Chamber's employer members.

Some of the Affordable Care Act's "Individual" and "Small Group" Market Insurance Reforms Would Not Apply to Fully-Insured and Self-Insured AHPs

Small employers and/or working owners forming a "bona fide" group and establishing a fully-insured "large group" or self-insured AHP would *not* be subject to the Affordable Care Act's (ACA) "essential health benefits" (the Federal EHBs) and "actuarial value" (AV) requirements. The AHP would also *not* be subject to the new adjusted community premium rating rules and the single-risk pool requirement.

It is important to note that the drafters of the ACA specifically decided against imposing these requirements on fully-insured "large group" and self-insured plans. Why? Because the ACA drafters felt that these plans covered benefits that were as good if not better than the Federal EHBs. The drafters also discovered that the typical group health plan was an 80% AV plan. And, the practice of "experience rating" to determine premium rates for a group of employees worked relatively well.

The Affordable Care Act's "Group Health Plan" Requirements Would Apply to Fully-Insured and Self-Insured AHPs

Several industry stakeholders were recently quoted as saying that fully-insured and self-insured AHPs (1) can deny a person coverage if they have a pre-existing condition, (2) can refuse to cover preventive services, and (3) can avoid imposing annual and lifetime limits. Unfortunately, these statements are incorrect.

As a "group health plan," a fully-insured and self-insured AHP (1) *cannot* deny a person who is eligible to participate in the plan health coverage if they have a pre-existing condition, (2) *cannot* refuse to cover preventive services (rather, the AHP must provide free coverage for certain government-approved preventive services), and (3) *cannot* impose annual and lifetime limits on the Federal EHBs covered under the plan.

All three of the above stated requirements were enacted under the ACA – fully effective in 2014. Additional ACA requirements apply – most notably – coverage for adult children up to age 26, free access to emergency care, and the prohibition against rescinding coverage absent fraud.

HIPAA Protections Also Apply to Fully-Insured and Self-Insured AHPs

The recently quoted stakeholders also overlook the consumer protections under HIPAA. For example, premiums for an AHP plan participant *cannot* be developed based on the participant's health condition. Instead, premiums are developed based on the "health claims experience" of the entire group. As a best practice, sponsors of a fully-insured or self-insured group health plan charge every participant the same premium rate.

ERISA and Its Requirements

Under ERISA, there are specific notice and disclosure requirements, and also fiduciary responsibilities that apply, requiring the AHP and its employer members to act in the best interest of the participants. Participants also have a private right of action to sue the AHP or employers if there is wrong-doing. And, there are detailed procedures for filing health claims, and rigorous internal and external appeals processes.

State Benefit Mandates Apply to Fully-Insured AHPs

In the case of a fully-insured AHP, the plan is subject to State benefit mandates. Most State benefit mandates are as good if not better than the Federal EHB standard. As a result, a strong argument can be made that fully-insured AHPs are by definition required to provide adequate health coverage, in addition to meeting all of the rules, requirements, and consumer protections discussed above.

State MEWA Statutes Applicable to Self-Insured AHPs

A self-insured AHP must meet all of the same rules, requirements, and consumer protections discussed above. However, a self-insured AHP may not be subject to State benefit mandates on account of ERISA preemption.

Importantly, self-insured AHPs will by definition be considered "multiple employer welfare arrangements" (MEWA). ERISA explicitly gives States the authority to regulate self-insured MEWAs (i.e., a self-insured AHP). Many States have already enacted "State MEWA statutes," which impose specific requirements on self-insured AHPs that offer health coverage within the State. Some States have an outright prohibition against self-insured AHPs operating within the State (e.g., California and New York have enacted this type of prohibition). Other States impose the State's benefit mandates and/or specific premium rating requirements on self-insured AHPs.

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 requirements on self-insured AHPs.

Will the Proposed Regulations Face Legal Challenges?

A number of stakeholders have suggested that the proposed regulations are ripe for legal challenge. In my opinion, if any such legal challenges are filed, I believe they will be unsuccessful. Why?

The "commonality of interest" test – which is the test that the proposed regulations modify – is not specifically defined in the statute of ERISA itself. Rather, the "commonality of interest" test was born – and further developed – through DOL Advisory Opinions, meaning that the law in this area was solely created by Interpretive Guidance.

Currently, there is no prohibition against a Federal Department changing its interpretation of the law. More specifically, so long as a Federal Department is not re-writing the statute, the Federal Department can make changes to its own interpretation of the law.

This is also true in the case of allowing self-employed individuals with no employees to participate in an AHP. Currently, a DOL regulation prohibits self-employed individuals with no employees (and their spouses) from participating in an ERISA-covered plan. This rule, however, is not explicitly set forth in the statute, rather, this is an interpretation of the law developed by the DOL and memorialized in a regulation. Which means, the DOL can change its own interpretation of the law, and thus, change the regulation, provided the change in the regulation goes through the normal rulemaking process (e.g., proposed regulations, with a public comment period, prior to finalization).

ERISA Preemption Challenges to Certain State Laws

If a health plan is considered an ERISA-covered plan, State laws that have a direct impact on "the plan" will be preempted by ERISA (meaning, the State law would not apply). One exception to this preemption rule is if the State law is an "insurance law" that has a direct impact on the underlying "insurance contract." If a State law directly impacts the "insurance contract," then this law will be "saved" from ERISA preemption (i.e., the law would not be preempted).

The best example of a State insurance law that directly impacts the "insurance contract" is a State's benefit mandate law, which requires the insurance contract to cover a specified medical service or benefit. In this case, the State's benefit mandate law would *not* be preempted, and the fully-insured health plan providing coverage to employees must cover these mandated services or benefits (even an ERISA-covered fully-insured plan).

But, in cases where a State law attempts to "re-characterize" – or "deem" – the ERISA-covered plan as an "insurance contract" in the State's attempt to regulate "the plan," a court of law may find that this law is *not* "saved" from ERISA preemption. Why? Because ERISA provides that a State cannot back-door its way into regulating "the plan" by calling "the plan" an "insurance contract" and then arguing that the State law is an "insurance law" that is "saved" from ERISA preemption.

One example of a State law that may be found to have a direct impact on "the plan" is a law that re-characterizes a "large group" fully-insured AHP as a "small group" plan. In this case, a State will likely argue that this law is an "insurance law" that has a direct impact on the "insurance contract" (and therefore, this law is *not* preempted by ERISA). But, an argument can be made that what the State is trying to do is to "re-characterize" – or "deem" – the fully-insured AHP as an "insurance contract" and back-door its way into regulating "the plan." A court of law may find that this law is *not* "saved" from ERISA preemption, but instead, the law is indeed preempted (and therefore would be null-and-void, thus preserving "large group" status for a fully-insured AHP).

There is another legal argument that could lead a court to rule that any law that attempts to re-characterize a "large group" fully-insured AHP as a "small group" plan does *not* apply. The statute of ERISA itself states that a fully-insured MEWA – which is synonymous with 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." An argument can be made that a State law 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."

An examination of these legal arguments is important because a number of States are considering enacting a State law that re-characterizes a "large group" fully-insured AHP as a "small group" plan. Some States already have a similar law on the books.