

# PUBLIC SUBMISSION

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Definition of Employer Under Section 3(5) of ERISA-Association Health Plans

**Comment On:** EBSA-2018-0001-0001  
Definition of Employer Under Section 3(5) of ERISA-Association Health Plans

**Document:** EBSA-2018-0001-DRAFT-0465  
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## General Comment

My comments on the proposed rule are attached as a file, along with three supporting documents referenced in the comments.

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## Attachments

AHP NPRM kp comments

Association Health Plans White Paper

IB707\_10-15-97\_AssocPlanRegulation

PDF-AHPFullReport

Office of Regulations and Interpretations, Employee Benefits Security Administration, Room N-5655, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210, Attention: **Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans** (29 CFR 2510, RIN: 1210-AB85 Document Number: 2017-28103)

To Whom It May Concern:

I am submitting comments on the Department of Labor’s proposed rule seeking to expand the use of association health plan (AHP) coverage from three perspectives:

1) as founder and CEO of the Center of Capital & Social Equity, an organization that promotes both market efficiency and inclusion of all citizens in benefiting from economic activity and growth. Thus, the Center supports health and labor policies that cover all Americans in a delivery system with a lower cost;

2) as a leading health policy analyst and researcher in the field of ERISA (the Employee Retirement Income Security Act of 1974), health coverage, and association health plan impacts; and

3) as citizen whose family members have greatly benefited from health plan coverage of mental illness and drug treatment services.

From all three of these perspectives, the Department’s proposed rule raises serious concerns.

First, the proposed rule could seriously undermine ERISA’s purpose of ensuring that promised employee benefits are delivered in a financially stable environment. Without major revisions, the proposed rule could also subvert the Affordable Care Act’s (ACA’s) fundamental goal of increasing access to health coverage for all Americans. Treating AHPs as large employer plans without specific and strong federal benefits and solvency standards will result in more uninsured employees and families, and more ERISA plans lacking coverage for people that need it the most. These people include employees and family members needing treatment for mental illness, drug treatment, maternity care, high-cost medications, and even hospital care. By considering AHPs to be large employer plans, the proposed rule would presumably exempt them from the ACA’s minimum benefit standards; therefore, AHPs could offer coverage that lacked mental health, pharmacy or other benefits – even hospital coverage as was the case with “mini-med plans” for which

hundreds of ERISA employer and union plans were granted waivers for several years during the transition to more comprehensive ACA benefit standards.

As many analyses show, AHPs could pressure and destabilize insurance markets by offering stripped-down coverage. In the proposed rule, there is no mention of how DoL would actually implement its authority to ensure the solvency of AHPs, though the Department rightly discusses how Multiple Employer Welfare Arrangements (MEWAs) have a troubled past that has required more than one revision to ERISA. AHPs, of course, are a type of MEWA.

Also missing is whether, and how, AHPs considered large employers would meet ACA minimum actuarial value standards. (See: <https://www.irs.gov/affordable-care-act/employers/minimum-value-and-affordability> “In general, under the employer shared responsibility provisions, an applicable large employer (ALE) member may either offer affordable minimum essential coverage that provides minimum value to its full-time employees (and their dependents) or potentially owe an employer shared responsibility payment to the IRS.”) A related question is how an AHP that is a large employer would be held accountable under the ACA’s pay-or-play coverage requirements, and how penalties for failing to offer coverage to member group employees would be determined and apportioned.

The proposed rule does require an AHP to have a governing body to help ensure financial integrity. The rule should further specify that AHP board members and executives are fiduciaries under ERISA, and, similar to joint union/management boards of Taft-Hartley trusts, should be held personally liable for misuse of AHP funds, or negligence.

I live in Fairfax County, Virginia and am a member of two groups advocating for improved mental health/drug treatment services locally and regionally – the National Alliance on Mental Illness and the NoVA (Northern Virginia) Mental Health Forum. Allowing the merchandizing of AHPs that could lower costs by eliminating mental health/drug treatment coverage would harm thousands of families in our region – even as national concern rises over the opioid epidemic and the need for improvements to our mental health system that has been discussed in the wake of mass shootings in schools and other places. The National Rifle Association, the National Restaurant Association, and thousands of other associations are headquartered in this region. Many already offer minimum benefit plans (e.g., short-term coverage and cancer coverage) on their web sites; adding AHPs to the mix would only hasten a race to the bottom that would destabilize the availability of affordable coverage in state-regulated markets and in the federal

exchange serving Virginia. This likely result stands in stark contrast to the Department's stated intent of broadening affordable coverage for employers and employees.

Analyses of similar AHP proposals in the past (including two I have authored or co-authored, cited below), many studies by the actuarial profession, and a new study done by Avalere all show that AHPs with stripped-down benefits operating alongside more regulated markets will result in: 1) market churning as low-risk groups move to the least regulated market; 2) higher prices in traditional state-regulated markets; 3) a probable loss of coverage for those with excluded benefits; and 4) a rise in the number of uninsured.

(See: "What Would Association Health Plans Mean for California," Kofman & Polzer, 2004, California Health Care Foundation, <https://www.chcf.org/wp-content/uploads/2017/12/PDF-AHPFullReport.pdf>;

"Preempting State Authority To Regulate Association Plans: Where Might It Take Us?," Polzer, 1997, National Health Policy Forum, GWU, [https://www.nhpf.org/library/issue-briefs/IB707\\_10-15-97\\_AssocPlanRegulation.pdf](https://www.nhpf.org/library/issue-briefs/IB707_10-15-97_AssocPlanRegulation.pdf);

"Association Health Plans Projected to Enroll 3.2M Individuals," Mendelson, Sloan, and Brooker, 2018, Avalere, [http://avalere.com/expertise/life-sciences/insights/association-health-plans-projected-to-enroll-3.2m-individuals?utm\\_source=pressRelease&utm\\_medium=Twitter&utm\\_campaign=02-28-2018](http://avalere.com/expertise/life-sciences/insights/association-health-plans-projected-to-enroll-3.2m-individuals?utm_source=pressRelease&utm_medium=Twitter&utm_campaign=02-28-2018) .)

For these reasons, I conclude that the Department should extend the period for comment and address the issues identified above before moving forward. Please note that the Center on Capital & Social Equity is a signatory on a coalition letter calling on the Department to withdraw or substantially delay this proposed rule. The coalition made this demand in conjunction with a Freedom of Information Act request, stating the DoL failed to provide critical information, data, and statistics from its own files detailing the history of financial abuses associated with AHPs and other types of MEWAs. (The letter can be found at: <https://georgetown.app.box.com/s/90t3u3b0s59cfs5yg59j3nhyw0vtcnbk>.)

Finally, please see my comments below on specific provisions of the rule.

Sincerely,

Karl Polzer

CEO, Center on Capital & Social Equity – [www.inequalityink.org](http://www.inequalityink.org)

Founder, NoVA Mental Health Forum -

[https://www.facebook.com/groups/249057865516670/?multi\\_permalinks=418574615231660&notif\\_id=1520130960270416&notif\\_t=feedback\\_reaction\\_generic&ref=notif](https://www.facebook.com/groups/249057865516670/?multi_permalinks=418574615231660&notif_id=1520130960270416&notif_t=feedback_reaction_generic&ref=notif)

### **Comments on specific provisions:**

“AHPs are an innovative option for expanding access to employer-sponsored coverage (especially for small businesses). AHPs permit employers to band together to purchase health coverage. Supporters contend that AHPs can help reduce the cost of health coverage by giving groups of employers increased bargaining power vis-à-vis hospitals, doctors, and pharmacy benefit providers, and creating new economies of scale, administrative efficiencies, and a more efficient allocation of plan responsibilities (as the AHP effectively transfers the obligation to provide and administer benefit programs from participating employers, who may have little expertise in these matters, to the AHP sponsor)” <https://www.federalregister.gov/d/2017-28103/p-15>

**Comment: AHPs probably won't achieve administrative savings compared with large employer plans. Yes, large employer plans have significantly lower administrative costs and more bargaining leverage than small employer plans (better able to self-insure, lower costs of sales and support because they're dealing with one client not many, etc.) But AHPs would not have the same advantages as large employers because they are internally unstable and not as cohesive as large employers. Despite being declared large employers by the government, AHPs still would be “clumps” of individuals and small employers. AHPs would still have to market to many entities and manage and communicate with separate employee groups. They**

**would also have to manage and price for variability internally (not all members would have equal risk – some might have high risk employees, some low). This brings up another issue: how will AHPs manage this internal variation: will they be able to risk-rate between difference member groups or individuals – seems rather labor intensive? Also, how will AHPs exert bargaining leverage with providers for benefits they don't cover – as stated above, these plans may not cover essential benefits?**

“This proposed regulation would define the term “group or association of employers” under ERISA section 3(5) more broadly, in a way that would allow more freedom for businesses to join together in organizations that could offer group health coverage regulated under the ACA as large group coverage. principal objective of the proposed rule is to expand employer and employee access to more affordable, high-quality coverage.”

**Comment: As noted above, most actuarial analyses show that promoting AHPs will do the opposite: over the years, it will result in less comprehensive coverage and more uninsured.**

“The Affordable Care Act established a multipronged approach to MEWA abuses. Improvements in reporting requirements, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration for MEWAs with the Department prior to operating in a State. The additional information facilitates joint State and Federal efforts to prevent harm and take enforcement action. The Affordable Care Act also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a financially hazardous condition.<sup>15</sup>”

**Comment: The Department needs to fully develop its new enforcement authority before promoting AHPs, which have a long**

**history of fraud and financial instability that has often required the Department to respond, often with enforcement tools that are not adequate.**

“With respect to insured coverage, whether coverage is offered in the individual, small group, or large group market affects compliance obligations under the Affordable Care Act and other State and Federal insurance laws. For example, only individual and small group market health insurance coverage is subject to the requirement to cover essential health benefits as defined under section 1302 of the Affordable Care Act.<sup>[7]</sup> Moreover, the risk adjustment program, which transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees, applies only to health insurance issuers offering coverage in the individual and small group markets, not the large group market.<sup>[8]</sup> The single risk pool requirement, which requires each health insurance issuer to consider the claims experience of all individuals enrolled in plans offered by the issuer in the individual market to be in a single risk pool, and all its individuals in the small group market to be members of a single risk pool, also applies only in the individual and small group markets, not the large group market.<sup>[9]</sup> In addition, the health insurance premium rules that prohibit issuers from varying premiums except with respect to location, age (within certain limits), family size, and tobacco-use (within certain limits) apply only in the individual and small group markets.<sup>[10]</sup> Finally, the Medical Loss Ratio (MLR) provisions, which limit the portion of premium dollars health insurance issuers may spend on administration, marketing, and profits establish different thresholds for the small group market and the large group market.<sup>[11]</sup> Self-insured group health plans are exempt from each of these obligations regardless of the size of the employer that establishes or maintains the plan. These differences in obligations result in a complex and costly compliance environment for coverages provided through associations, particularly if the coverages are simultaneously subject to individual, small group, and large group market regulation.”

**Comment: If the Department treats AHPs as large employers, it should specify what type of benefits or actuarial value test AHPs must meet. It also should specify how AHPs not meeting those standards will be penalized under the ACA's pay-or-play provisions.**

“The Department is also interested, for example, in comments on whether there is any reason for concern that associations could manipulate geographic classifications to avoid offering coverage to employers expected to incur more costly health claims.”

**Comment: AHPs would be able to manipulate geographic classifications at every geographic boundary by stripping out benefits required by neighboring jurisdictions.**

“the proposed regulation would not restrict the size of the employers that are able to participate in a bona fide group or association of employers. The Department expects minimal interest among large employers in establishing or joining an AHP as envisioned in this proposal because large employers already enjoy many of the large group market advantages that this proposal would afford small employers. However, the Department anticipates that there may be some large employers that may see cost savings and/or administrative efficiencies in using an AHP as the vehicle for providing health coverage to their employees.”

**Comment: If joining an AHP is a way for a large employer to avoid minimum actuarial standards and ACA coverage requirements, large employers will be lining up.**

“The proposal would require that the group or association have a formal organizational structure with a governing body and have by-laws or other similar indications of formality appropriate for the legal form in which the group or association operates, and that the group or association's member employers

control its functions and activities, including the establishment and maintenance of the group health plan, either directly or through the regular election of directors, officers, or other similar representatives.”

**Comment: This governing body and its individual members should have a fiduciary duty to the plan and members. Members of the body should be held accountable under ERISA’s fiduciary standards, much like board members of Taft-Hartley trusts, and should be personally liability for fiduciary breaches.**

“Thus, self-insured MEWAs, even if covered by an exemption, would remain subject to State insurance laws that provide standards requiring the maintenance of specified levels of reserves and contributions as means of ensuring the payment of promised benefits. While beyond the scope of this proposed rulemaking, the Department is interested in receiving additional input from the public about the relative merits of possible exemption approaches under ERISA section 514(b)(6)(B). The Department is interested both in the potential for such exemptions to promote healthcare consumer choice and competition across the United States, as well as in the risk such exemptions might present to appropriate regulation and oversight of AHPs, including State insurance regulation oversight functions.”

**Comment: Undercutting state authority in any way regarding self-insured plans doesn’t make sense in the context of the 1983 Erlenborn amendments, which allow increasing levels of state regulation of MEWAs depending on their level of insured funding and plan cohesion. The logic of these amendments seems to be: the more insured the funding and federal protections, the less need for state oversight: So, currently, for fully insured MEWAs, states can only apply solvency/financial type regulation and ERISA takes care of the rest; for self-insured MEWAs, states can apply the full array of insurance rules, just so long as they don’t interfere with ERISA protections (such as they are); and for MEWAs that are not ERISA plans, states can ban them, do whatever they want. Eliminating state**

**consumer protections for self-insured MEWAs in the middle of this progressive scheme doesn't make sense, and does not indicate an interest in protecting plan participants and ensuring financially stable benefits (ERISA's purpose). Rather it smacks of helping ERISA plan sub-contractors, who are a force behind this proposed rule, to make sales.**

“The Department requests comments on how it can best use the provisions of ERISA Title I to require and promote actuarial soundness, proper maintenance of reserves, adequate underwriting and other standards relating to AHP solvency.”

**Comment: If it proceeds with this proposed rule, DoL should develop AHP solvency rules and enforcement tools similar to what state insurance departments use. It should consult the NAIC before moving forward.**

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# Association Health Plans: Projecting the Impact of the Proposed Rule

Prepared for America's Health Insurance Plans | 02.28.18



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## Executive Summary

Association Health Plans (AHPs) are health insurance arrangements sponsored by an industry, trade, or professional association that provide health coverage to their members—typically small businesses and their employees. Health insurance coverage offered through AHPs aims to make coverage available and affordable for small groups and individual employees. Importantly, these arrangements are currently governed by state and federal requirements and are subject to state oversight, including standards related to premiums and benefit requirements.

A recent Department of Labor's (DOL) proposed regulation would seek to broaden access to AHPs by expanding eligibility and potentially allowing a larger number of these arrangements to be exempt from certain Affordable Care Act insurance protections—including coverage for essential health benefits and community rating requirements.

The proposed AHP changes are expected to have an impact on enrollment and premiums for existing individual and small group market plans. Individuals and small businesses shifting out of their respective markets into AHPs are expected to be healthier than average, fueling adverse selection. This adverse selection could increase individual and small group market premiums and could lead to decreased competition in those markets due to changes in issuer participation.

The report that follows estimates the premium and coverage impact of the DOL proposed rule over a 5-year period (2018-2022). If the rule is finalized as proposed, we estimate the following impacts on the individual and small-group markets:

- **Higher premiums in both the individual and small-group markets.** If the proposed AHP rule is finalized, Avalere projects premiums would rise in the current individual (2.7% to 4.0%) and small group (0.1% to 1.9%) markets relative to current law, largely due to healthier enrollees shifting into AHPs. This trend will lead to the individual and small group market risk scores rising.
- **Increase in the number of uninsured Americans.** The proposed rule is projected to lead to 130,000 - 140,000 additional individuals becoming uninsured by 2022, compared to current law. The increased number of uninsured is largely caused by premium increases in the individual market as healthier enrollees shift into AHPs.
- **An additional 2.4M to 4.3M people enrolled in AHPs.** This figure represents people switching out of the individual market (0.7M to 1.2M) and small group market (1.7M to 3.2M) into the expanded AHPs.
- **Lower premiums for enrollees that enroll in AHPs.** Premiums in the new AHPs are projected to be between \$1,900 to \$4,100 lower than the yearly premiums in the small group market and \$8,700 to \$10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered. While AHPs will likely offer lower premiums for many enrollees, the largest premium differences assume

AHPs offer less-generous benefits than current markets, which could expose some enrollees to high out-of-pocket costs, particularly those that have significant healthcare needs.

The AHP proposed rule continues a trend under the current administration toward increased regulatory flexibility. While this flexibility may lead to lower premiums for some (particularly younger, healthier individuals and small groups), it is likely to further adverse selection out of the individual and small group markets that could lead to increased premiums in those markets and create additional market instability.

## Overview of Association Health Plans and the Proposed Rule

### AHPs Today

AHPs provide an additional option for individuals and small businesses seeking to obtain affordable healthcare coverage.<sup>1</sup> Managing a group health plan can be administratively complex and costly for certain small businesses—especially those lacking formal or expansive human resource departments. By allowing small businesses to band together under association health plan group coverage, these arrangements aim to achieve economies-of-scale advantages to be more effective in coverage negotiations and bargaining with private payers.

Today, most AHPs limit their enrollment to specific employer groups—individual enrollees who are sole proprietors and small employers who are engaged in a specific trade or business. These limitations make many individuals and employers ineligible to participate in certain AHPs that may operate in their area and help the AHP control its enrollment and the associated risk of enrollees.

### Regulation of AHPs

Compared to the large group market, there are more extensive benefit and coverage requirements in the individual and small group market. These include requirements to offer benefits in each of the 10 essential health benefit (EHB) categories, community rating standards, network adequacy requirements, and state review of issuer rate and form filings.<sup>1</sup> Many of these requirements, including the EHBs, do not apply to or are not as strict for large group plans.

AHPs may obtain the same benefit flexibility and coverage choices as the large group market if they are able to self-insure (where the AHP itself takes on the insurance risk of the individuals

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<sup>1</sup> According to the Employee Retirement Income Security Act (ERISA) of 1974, ERISA defines an employer-based AHP (also known as a Multiple Employer Welfare Arrangement (MEWA)) as any arrangement through which two or more employers and/or self-employed individuals obtain health insurance coverage." This analysis focuses on those AHPs which can be classified as MEWAs.

enrolling in the AHP) or if they can be classified as a single-employer large group plan.<sup>ii</sup> However, the small size of the risk pool in most AHPs, creating non-diversified risk, can make it financially challenging or impossible for many AHPs to self-insure. In addition, current ERISA rules make it challenging for AHPs to achieve the single employer classification.

Specifically, guidance notes that it should be “rare” that an AHP is deemed the “employer,” and is treated as sponsoring a single group health plan.<sup>vi</sup> In order to be classified as a single large group, the AHP must be constructed so that:

- All employer members are in the same profession or industry, or are members of the same employee organization;
- Access to the AHP is not the only purpose for becoming a member of the association;
- The AHP is owned and managed (directly or through elected representatives) by its member employers; and
- There must be at least 51 employees of the employers participating in the plan.

As a result of these requirements, very few AHPs are classified as single-employer large group plans and therefore do not have access to the regulatory flexibility described above.

## January 2018 AHP Proposed Rule

On January 4, DOL issued a proposed rule that seeks to expand access to and increase regulatory flexibility for AHPs.<sup>iii</sup> The proposed rule follows an executive order (EO) by President Trump on October 12, 2017, and is designed to streamline the ability of small employers, including sole proprietors, to enroll and seek coverage for their employees through AHPs.<sup>iv</sup> Indeed, the DOL’s proposed rule would broaden access to AHPs and make it easier for an AHP to be classified as a single-employer plan under ERISA. As explained above, such a classification would allow the AHP to have greater benefit and coverage flexibility, leading to potentially less generous, but also less-expensive, coverage offerings through the AHP. While the DOL did include AHP anti-discrimination provisions that are designed to prevent misuse of AHPs, there are still potential concerns that the flexibility provided to AHPs to regulate their membership could be used to discriminate against higher cost enrollees and groups.

### i. Expanding Access to AHPs

The proposed rule seeks to expand access to AHPs by clarifying DOL rules around eligibility for sole proprietors (self-employed without non-family employees). AHP rules already allow self-employed individuals to participate in AHPs.<sup>v</sup> However, the DOL sought to align regulations throughout different parts of ERISA to ensure that a working owner without employees, regardless of the legal form in which the business is operated, may choose to participate in a AHP.

### ii. Reducing Barriers to Single Employer Classification

The DOL also sought to make it easier for more AHPs, including those with participants from a diverse range of businesses or industries, to potentially be classified as a single employer group

plan. As previously noted, today, it is difficult for a AHP to be classified as a single employer group.

a. Same Industry or Business Requirement

One of the obstacles to the single-employer classification is the requirement that members of the same AHP be in the same trade or business. In the proposed rule, the DOL seeks to remove this limitation in situations where all members of the AHP are in the same state or metropolitan area. The proposed rule specifically notes that this flexibility will allow local chambers of commerce to sponsor a AHP and make it open to all members of the chamber. In addition, it could allow for the sale across state lines if the metropolitan area in which the AHP is offered occupies multiple states.

b. Sole Purpose of AHP Membership

The proposed rule also would ensure that employers can pursue AHP membership solely for access to health coverage without jeopardizing the ERISA status of the plan. The DOL proposes to do this by removing the ERISA AHP requirement that membership in the AHP must not be the sole relationship or purpose for members joining the association. In addition to expanding access, this could also make it easier for AHPs to form, as they would no longer have to offer additional benefits, such as advocacy or representation, to be able to access the coverage flexibility of a single large employer AHP.

c. Joint Control

The DOL did not recommend changes to the joint control requirement that exists for an AHP to be considered a single-employer group. Joint control requires the group or association to have a formal organizational structure with a governing body where member employers control the establishment and maintenance of the group health plan—either directly or through elected representatives. The purpose of these requirements is to ensure that the organization acts as a single unit and in the interests of its members. This requirement is cited as one of the most significant barriers to a AHP being classified as a single employer group. The fact that it was not altered could impact how many AHPs can take advantage of the additional benefit flexibility.

iii. Nondiscrimination

The proposed rule specifically applies many of the nondiscrimination provisions of the Affordable Care Act (ACA) and Health Insurance Portability and Accountability Act (HIPAA) to AHPs. Specifically, AHPs must not restrict membership or impose differential premiums based on health status, medical condition (including both physical and mental illnesses), claims experience, medical history, genetic information, evidence of insurability, or disability. However, AHPs may impose different non-health-related eligibility terms and premiums based on factors such as full-time versus part-time status, different geographic locations, membership in a collective bargaining unit, date of hire, length of service, current versus former employee status, occupation, and relationship to employee member (for dependent coverage).

## Potential Implications of AHP Proposed Rule

As proposed, the rule may allow some employers to access less expensive, less generous health insurance coverage or may allow them to pursue different insurance structures, such as self-insured and fully-insured AHPs. In addition, reducing the barriers to a AHP being classified as a single large group could allow some employers to access additional benefit flexibility, which could lead lower premiums and reduced benefits for some members. Importantly, this increased flexibility creates adverse selection incentives for many sole proprietors and small businesses, particularly those who are healthier than average, to shift into AHPs. As healthier sole proprietors and small businesses shift toward AHPs, premiums are projected to rise for the remaining enrollees in the individual and small group markets. Below are some of the potential implications of the AHP proposed rule if finalized as proposed.

**Table 1: Expected Policy Impacts of the AHP Proposed Rule**

	Positive	Negative
<b>Coverage</b>	Additional coverage options and benefit flexibilities Lower administrative costs	Increased number of uninsured Potential instability if new AHPs are unprepared to effectively manage risk for their enrollees
<b>Premiums</b>	Lower premiums for enrollees compared to current markets	Higher premiums for existing individual / small group market enrollees
<b>Benefit Flexibility</b>	More benefit flexibility, which can be used to tailor benefits to meet the needs of enrollees	Higher out-of-pocket costs for enrollees with significant healthcare needs Return of potentially discriminatory insurance practices

## Projected Impact of AHP Proposed Rule

### Key Modeling Takeaways

The proposed rule on AHPs would lead to a substantive shift, within the first four years, of enrollees in both the individual and small group markets into the new AHPs. Avalere modeled three scenarios, a “High”, “Moderate”, and “Low” scenario. The scenarios vary based on the initial availability of AHPs in 2019, the average generosity of coverage offered by AHPs, and the projected level of risk selection by small businesses (i.e., healthier on average small businesses choosing to move into AHPs for lower premiums, less generous coverage). The “High” scenario assumes the highest availability of AHPs starting in 2019 of all the scenarios, a low projected level of generosity of AHP coverage (and thereby low premiums), and significant risk selection by small businesses. Conversely, the “Low” scenario assumes limited availability of AHPs in

2019, generosity of AHP coverage more akin to small group coverage today, and limited risk selection by small businesses.

Avalere projects 2.4M to 4.3M enrollees to shift into AHPs by 2022. If the proposed AHP rule is finalized, premiums would rise in both the individual (2.7% to 4.0%) and small group markets (0.1% to 1.9%) relative to current law, as healthier enrollees and small businesses in both markets self-select into AHPs. Premiums in the new AHPs are projected to be \$1,900 to \$4,100 lower than the yearly premiums in the small group market and \$8,700 to \$10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered. Additionally, 130,000 - 140,000 individuals are expected to become uninsured by 2022 due to the proposed rule.

The further expansion of the AHP market is constrained by the number of eligible sole proprietors and small groups, as well as the availability of AHPs offered in the area. Despite these constraints, enrollment in AHPs is expected to continue to grow in future years. In total, the proposed rule is projected to shift 0.7M to 1.2M individuals out of the individual market and 1.7M to 3.2M out of the small group market by 2022.

**Table 2: Projected Impact of AHP Proposed Rule by Scenario, 2022**

	Low Scenario	Moderate Scenario	High Scenario
<b>Enrollment</b>			
<i><b>New AHP Enrollment</b></i>	2,360,000	3,180,000	4,310,000
<i><b>From Individual Market into AHPs</b></i>	(710,000)	(950,000)	(1,110,000)
<i><b>From Small Group Market</b></i>	(1,650,000)	(2,230,000)	(3,200,000)
<b>Premiums</b>			
<i><b>Change in Individual Market Premiums</b></i>	2.7%	3.5%	4.0%
<i><b>Average Individual Market Premiums<sup>2</sup></b></i>	\$14,900	\$15,000	\$15,000
<i><b>Change in Small Group Market Premiums</b></i>	0.1%	0.5%	1.9%
<i><b>Average Small Group Market Premiums</b></i>	\$8,100	\$8,200	\$8,300
<i><b>Average AHP Premiums</b></i>	\$6,200	\$5,300	\$4,200

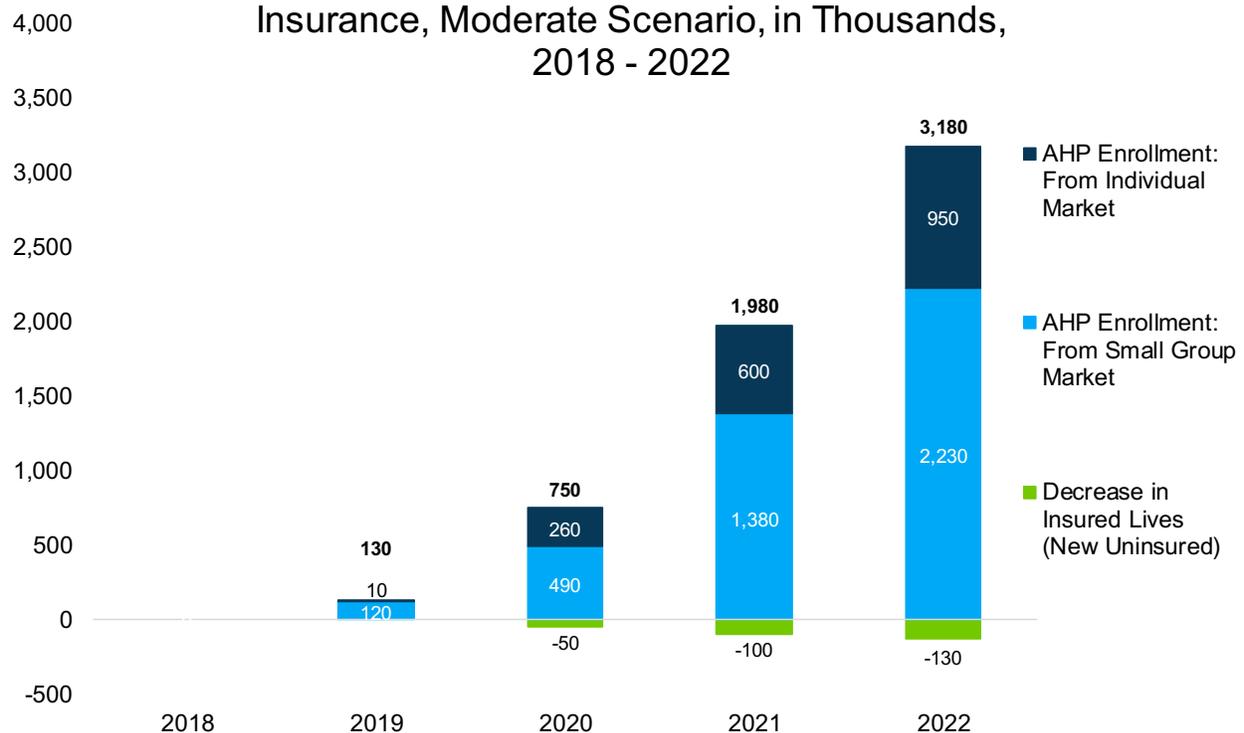
<sup>2</sup> Average individual market unsubsidized premiums.

## Model Findings

**New AHP Enrollment:** New AHP enrollment is projected to range from 2.4M to 4.3M under the high and low scenarios.

**Source of AHP Enrollment:** Enrollment in AHPs is projected to come from currently insured individuals and small businesses. Small groups would see the largest shifts into the new AHPs, comprising approximately 70% to 75% of the new AHP enrollment. The magnitude of this movement is largely due to the pool of eligible small groups substantially outweighing the eligible sole proprietors in the individual market.

**Figure 1: Projected Enrollment in AHPs and Change in Insurance, Moderate Scenario, in Thousands, 2018 - 2022**



**AHP Premiums:** Premiums in the new AHP market are expected to range \$1,900 to \$4,100 lower than the small group market average yearly premiums and \$8,700 to \$10,800 below the individual market average yearly premium by 2022. Sole proprietors in the individual market are projected to enroll at a much higher rate than small groups, particularly due to the larger differences between the premiums in the individual market and the new AHPs. The “High” scenario, which projects the largest premium differences between the new AHPs and individual and small group market premiums, assumes AHPs provide less generous coverage than currently offered in the individual and small group markets, while covering fewer benefits. This, coupled with aggressive risk selection out of the individual and small group markets into AHPs leads to substantial premium differences between the markets. The “Low” and “Moderate”

scenarios have less aggressive assumptions on the reductions in benefit generosity for AHPs and therefore have lower estimates of the premium differences between the markets.

**Risk Scores:** Risk scores are a measure of the “risk” of the insured population. The risk scores in the existing individual and small group markets will see an increase as a result of the proposed rule. Individual market average risk scores will increase 2.7% to 4.0%, while average small group risk scores are projected to increase 0.1% to 1.9%.

**Table 3: Average Risk Scores Under AHP Proposed Rule, Moderate Scenario, 2022**

Average Risk Scores	Individual Market	Small Group Market	New AHP Market
<b>Current Law</b>	1.277	1.159	-
<b>Under AHP Proposed Rule: Moderate Scenario</b>	1.321	1.165	0.905

**Uninsured:** The proposed AHP rule is projected to increase the number of uninsured in the US by 130,000 to 140,000 by 2022, largely because of the premium increases for those in the individual market who are ineligible to purchase coverage through an AHP. Over 80% of the newly uninsured come from the individual market.

## Other Results Considerations

Avalere projected the expected enrollment growth in AHPs over the next 5 years, through 2022, as the result of the proposed rule. Given the uncertainty around the number of AHPs created, the propensity of small employers and sole proprietors to shift into AHPs, and the availability of AHPs in all regions of the country, Avalere modeled 3 scenarios projecting eventual enrollment into the market.

These scenarios were informed by the universe of sole proprietors and small businesses deemed eligible and likely to enroll, expected adverse selection by small employers, and generosity of AHP benefits. According to survey data, approximately 8% of the current individual market is self-employed in industries most likely to participate in an AHP. For the small group market, approximately 42% of the current small group market is in an industry deemed most likely to participate in an AHP.

Projecting the impact of the AHP proposed rule requires projecting a variety of decisions, from enrollee uptake, to eligibility, to availability of AHPs, and the generosity of the benefits that they offer. Below are some key factors that Avalere considered when building the model:

**Initial Enrollment:** Under the scenarios, Avalere varies the number of new AHP enrollees in the first year. The 3 scenarios are based off, in part, the phase-in experience of the healthcare sharing ministries (HCSM), another alternative to ACA coverage that has been growing substantially since 2013. Avalere used the share of HCSM enrollment compared to total individual enrollment during 2013 to inform the share of the eligible enrollees who move into the

new AHPs during 2019. These numbers are varied in the scenarios to provide a range of outcomes. The risk mix of the initial enrollment is projected to be similar to that of the demographics of the eligible sole proprietors in the individual market and the small groups in industries more likely to participate in an AHP.

**Benefit Generosity:** Much of the criticism of the AHP proposed rule has focused around the potential for a “race to the bottom” in benefit generosity, which would further exacerbate the adverse selection concerns for both the individual and small group markets. To model the impacts, the scenarios model different benefit amounts, ranging from Bronze levels (60% actuarial value) for the “High” scenario to Gold levels (80% actuarial value) for the “Low” scenario. Importantly, while single-employer insured AHPs may be exempted from certain individual and small group market rules, they are still subject to many state laws and large group requirements. As such, Avalere selected a reasonable range of benefit generosity for purposes of these scenarios.

**Small Group Market Selection:** Unlike the individual market, shifts into AHPs from the small group market will happen at the group level, rather than at the individual level. This makes self-selection more difficult and less likely to be as dramatic a risk shift as the enrollees shifting from the individual market. To better account for small group behavior, Avalere varied the levels of self-selection on the part of the small group market, with the “High” scenario assuming the highest level of self-selection and the “Low” scenario assuming the lowest amount (i.e., the shifts from the small group market more closely align to the risk of the entire market).

**Eligibility Categories:** Interestingly, the overall risk of small groups most likely to shift into AHPs is projected to be higher than the average risk of the small group market, due to the demographic make-up (particularly the age mix) of their employees. While small groups still are projected to shift into AHPs, the lower risk and premiums in the new AHP market is largely driven by the low-risk sole proprietors shifting into AHPs from the individual market. Effectively, the incentives for small groups to shift into AHPs are substantially lower than those for sole proprietors exiting the individual market.

## Conclusion

The recent AHP proposed rule is expected to incentivize a larger number of healthy sole proprietors and groups to access the more affordable, potentially less generous coverage that could be available through an AHP. Conversely, those who remain in the individual and small group markets will pay more for their coverage, with an additional 130,000 to 140,000 individuals projected to become uninsured.

Importantly, this proposed rule on AHPs is one in a series of expected proposed regulations from the Administration that are projected to increase benefit flexibility and coverage options for healthier enrollees in the individual and small group markets. However, changes that allow or incentivize healthier individuals to exit the individual and small group market to pursue other,



sometimes non-ACA-compliant coverage offerings, could lead to higher costs for those sicker, less healthy individuals and groups who remain behind in the ACA regulated markets. For example, the Administration recently released a proposed rule increasing the availability of short-term limited duration insurance (which is exempted from many of the ACA's requirements)—which could similarly incent healthier individuals to exit the individual market, further increasing premiums for those remaining in ACA markets. Importantly, the potential effects of the short-term plan proposed rule are not considered here.

## Methodology

The AHP proposed rule modeling results are the output of Avalere's proprietary models of individual and small group market health insurance coverage. The underlying data in the models are drawn from the American Community Survey (ACS), Current Population Survey (CPS), Centers for Medicare & Medicaid Services (CMS) exchange enrollment reports, yearly premium data from Healthcare.gov, and general exchange market demographic data released by the United States Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE). In addition, Avalere utilizes Inovalon's proprietary MORE2 claims database of individual and small group market enrollees. This allows the model to take into account underlying risk scores for purposes of modeling behavior, premiums (premiums in the model are a weighted market average by age and metal level), and risk selection by metal level, age, and gender.

Avalere determined the number of individuals in both the individual and group markets receiving coverage who would be eligible for AHPs under the proposed rule based on survey data from ACS (for the individual market) and CPS (for the small group market).

For the individual market, eligibility was determined by the number of enrollees who are sole proprietors. This data was then segmented by age and income. Income data was used to exclude those individuals who are current heavily subsidized (defined as below 250% of the federal poverty level) and who Avalere deemed will be unlikely to shift into AHPs. Similarly, Avalere analyzed the industries for sole proprietors to determine those most likely to participate in an AHP. Avalere used the 2012 IND codes for this purposes in ACS and defined those industries as likely to participate in an AHP as Construction, Transportation and Utilities, Professional (Professional, Scientific, Management, Administrative, and Waste Management Services), and Other Services (Except Public Administration). This group of individuals most likely to join AHPs was segmented by age to match up with the MORE2 risk scores and better project the expected risk shifting into the AHPs.

For the small group market, eligibility was determined by the size of the small group market and the same industry segmentation as the individual market. Employer size is available in CPS with the same industry segmentation measures as those used in ACS for the individual market. Similarly, Avalere segmented the eligible population receiving small group coverage into age groupings to match the MORE2 risk scores in the model.

Using the total eligible enrollees in AHPs as an "upper bound", Avalere assumed an enrollment phase-in based on the trend of healthcare sharing ministries enrollment growth post-2010. The trend provides the best available proxy of enrollment in an alternative form of coverage to the ACA while also providing an approximation of enrollment being constrained by availability.

With a base of enrollees in 2019, Avalere's proprietary models of individual and small group coverage model the elasticity of demand for eligible individuals and small groups to shift into

AHP coverage. These elasticity of demand assumptions are based on published literature from the Congressional Budget Office (CBO).

For the individual market, Avalere assumed that the chronically ill, defined as the top 10% of the individual market by risk score and based on Avalere analysis of the Medical Expenditure Panel Survey (MEPS), are inelastic and remain in the individual market. Essentially, the healthier individuals are more likely to shift into an alternate form of coverage with fewer covered benefits. Additionally, Avalere assumed that the heavily subsidized population does not shift into AHPs. This is defined as those individuals below 250% of the federal poverty level (FPL).

Avalere constructed three scenarios that varied based on the initial availability of AHPs in 2019, the average generosity of coverage offered by AHPs, and the projected level of risk selection by small businesses. For the initial availability of AHPs, Avalere used a high, medium, and low, based on the initial enrollment of healthcare sharing ministries in the early years of the ACA, as a percentage of the total individual market. For the average generosity of coverage, Avalere projected that AHP benefits in the “Low”, “Moderate”, and “High” scenarios had an average actuarial value approximating 60%, 70%, and 80%, respectively. Importantly, that actuarial value is based off the estimated cost of claims for the small group market.

## References

- i. 45 CFR § 147.150 requires individual and small group market health insurance issuers to offer coverage that at least covers the EHB package as defined in section 1302(a) of the Affordable Care Act (ACA). This includes the 10 categories of EHBs. However, large group plans are not required to adhere to these EHB standards.
- ii. Id.; 45 CFR § 147.130 requires a group health plan, or a health insurance issuer offering group health insurance coverage, to provide coverage, without cost-sharing for 1) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force), 2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and 3) evidence-informed preventive care and screenings for infants, children, and adolescents that are supported by the Health Resources and Services Administration. That coverage requirement is echoed in 29 CFR § 2590.715-2713 (Section 2713 of the Public Health Services Act).
- iii. U.S. Department of Labor, Employee Benefits Security Administration. “Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation,” August 2013. Available at <http://www.dol.gov/ebsa/Publications/mewas.html>.
- iv. Department of Labor (DOL). “Definition of “Employer” under Section 3(5) of ERISA -- Association Health Plans.” Jan. 4, 2018. Available at <https://www.regulations.gov/document?D=EBSA-2018-0001-0001>.
- v. White House. “President Donald J. Trump is Taking Action to Improve Access, Increase Choices, and Lower Costs for Healthcare.” Oct. 12, 2017. Available at <https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-taking-action-improve-access-increase-choices-lower-costs-healthcare/>.

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## About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. As an Inovalon company, we prize insights and strategies driven by robust data to achieve meaningful results. For more information, please contact [info@avalere.com](mailto:info@avalere.com). You can also visit us at [avalere.com](http://avalere.com).

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No. 707

# ISSUE BRIEF

NATIONAL  
HEALTH  
POLICY  
FORUM

## Preempting State Authority to Regulate Association Plans: Where Might It Take Us?

Wednesday, October 15, 1997

8:30 to 9:00 am - Continental Breakfast

9:00 to 11:00 am - Discussion

Hyatt Regency Capitol Hill  
400 New Jersey Avenue, N.W.  
Capitol A Room

A roundtable discussion featuring

**Russ Mueller**

*Actuary/Professional Staff Member –  
Majority*  
Committee on Education and the  
Workforce  
Subcommittee on Employer-Employee  
Relations  
U.S. House of Representatives

**Paul Harrington**

*Majority Health Policy Director*  
Committee on Labor and Human  
Resources  
U.S. Senate

As well as state insurance regulators, U.S. Department of Labor  
officials, and other interested parties

Registration: Please call **Dagny Wolf** at 202/872-1392 as soon as possible.

The  
George  
Washington  
University  
WASHINGTON DC

## Preempting State Authority to Regulate Association Plans

Legislation passed this spring by the House of Representatives to federalize regulation of association health plans has led to a policy standoff in which opposing factions so far see little or no room for compromise. On one side, many small businesses and associations argue that the federal government could help them lower their health benefit costs (and offer coverage to more workers) by licensing association health plans offering fully insured and self-insured options and freeing them from state benefit mandates, taxes, and rating requirements. On the other side, state insurance regulators, representatives of the actuarial profession, and many insurers argue that by preempting current state authority to regulate association plans, Congress could fragment insurance markets and do serious damage to recently enacted state and federal insurance reforms, with no overall increase in health insurance coverage. Furthermore, they argue that the financial standards in the legislation are not sufficient to prevent association plan insolvencies and that the federal government lacks the expertise and resources to regulate insurance.

This Forum meeting will explore the underpinnings of these arguments—what the direct and indirect effects of the legislation might be—as well as the overarching issue of which level or levels of government should set the rules and enforce them in this area of the market. Also on the table for discussion will be how much it might cost the federal government both in manpower and dollars to effectively regulate self-insured association plans and whether the legislation passed by the House would allocate sufficient resources to do so.

### HISTORY

The legislation in question is the latest in a series of bills originating over the years from Republicans on the House Committee on Education and the Workforce. Introduced by Rep. Harris Fawell (R-Ill.) on May 1, 1997, the bipartisan Expansion of Portability and Health Insurance Coverage Act of 1997 (H.R. 1515) was amended and ordered to be reported by the committee on June 12 by a vote of 24 to 20.<sup>1</sup> It was included in the House budget bill. A bipartisan companion bill (S. 729) was introduced in the Senate by Sen. Tim Hutchinson

(R-Ark.) on May 8, but its provisions were not included in the Senate budget package. In the conference agreement, the House yielded to the Senate and the provisions were not included in the Balanced Budget Act of 1997. Sen. Jim Jeffords (R-Vt.) is planning to hold a Senate Labor and Human Resources Committee hearing in October to consider legislative approaches to making health insurance more affordable for small employers.

During the 104th Congress, the House passed an earlier version of the Fawell bill that conflicted with a group health purchasing proposal passed by the Senate and the two legislative bodies could not resolve their differences. But the idea of preempting state authority to regulate multiple-employer health plans was not new. In 1992, for example, while gearing up his reelection campaign, President Bush proposed spending \$35 billion through tax credits and deductions to help people buy health insurance and enacting a series of other reforms, including the formation of voluntary “health insurance networks” that would have been exempted from most state laws relating to insurance regulation. At the same, Congress was considering several bills designed to strengthen the regulation of multiple-employer health plans after many such plans had gone bankrupt. A measure introduced by Rep. Thomas E. Petri (R-Wis.), for example, would have created federal certification for self-insured multiple-employer health plans that met specific funding and reporting requirements, somewhat like parts of the current Fawell legislation.

After defeating Bush, President Clinton developed a universal health insurance plan that would have

### ISSUE BRIEF/No. 707

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required all employers to purchase health insurance through health alliances, but the complex reform scheme foundered. Fanned by negative publicity from the insurance industry, public hostility toward the level of new government regulation in the Clinton plan helped the Republicans win control of both houses of Congress for the first time in 40 years in 1994. In recent years, a few states, most notably California, have formed purchasing cooperatives to help small employers buy health insurance, and employers have organized coalitions across the nation, some of which are helping them drive better bargains with insurers and provider groups. In its budget proposal earlier this year, the Clinton administration proposed establishing a federal grant program to help states foster the development of purchasing cooperatives offering fully insured coverage to small firms, but the \$125-million, five-year initiative was not included in the budget bill.

While many reform proposals attempt to aggregate small groups to increase their purchasing power and reduce administrative costs, self-insured multiple-employer health plans, including some association health plans, have long posed problems for both federal and state regulators.<sup>2</sup> Although many of these arrangements have helped to provide coverage to small groups that otherwise could not have afforded it, a significant number have become insolvent through either mismanagement or fraud. Efforts to regulate the solvency of these plans have been thwarted in part by the confusion created because of overlapping federal and state regulatory authority.

### **ERISA and the Erlenborn Amendments**

The McCarran-Ferguson Act, passed in 1945, affirmed the regulation of insurance as a state jurisdiction. In turn, the Employee Retirement Income Security Act of 1974 (ERISA), which was enacted primarily to protect private-sector pension plans from well-documented problems of fraud and mismanagement, preempted states from regulating employee benefit plans. Under court interpretations of ERISA, states can regulate insurers contracting with employee health plans, but states cannot regulate ERISA plans that are self-insured unless these plans are "multiple-employer welfare arrangements (MEWAs)." About 40 percent<sup>3</sup> of the roughly 125 million American workers and dependents in private-sector health plans are in self-insured arrangements.<sup>4</sup> Though large employers are more likely to self-insure health benefits than small ones, a ten-state Robert Wood Johnson Foundation (RWJF) survey found that, in 1993, 7.3 percent of health plan enrollees

in firms with 1 to 25 employees were in self-insured plans, as were 16.8 percent of employees in firms with 26 to 100 employees.<sup>5</sup> While self-insuring usually entails assuming more risk, health plan sponsors face many incentives for doing so, including avoidance of state benefit mandates, premium taxes, contributions to risk pools and guaranty funds, rating requirements, and solvency standards. In contrast to its treatment of pensions, ERISA contains fewer substantive requirements for employee health plans, although the number has been growing in recent years.

Partly because of ambiguity created by ERISA, the late 1970s and early 1980s witnessed a rash of multiple-employer health plan insolvencies, sometimes brought on by fraud and sometimes by mismanagement. Multiple-employer health plans can appear in many forms, including multiple-employer trusts organized by insurance companies or third-party administrators as marketing vehicles to attract small groups, plans offered by associations, and those offered by union plans to non-union members.

The worst of these multiple-employer plans are simply Ponzi schemes. Fraudulent operators begin selling coverage and pay a few claims at first. They then slow down payment and eventually stop. When approached by state regulators, they may claim to be running a union plan or single-employer plan, which states cannot regulate. By the time these plans can be brought to court, their operators are often nowhere to be found. Well-intentioned operators of multiple-employer plans may run into problems, as well, especially if they are self-insured. Some analysts have concluded that aggregations of small-employer groups organized for the purpose of buying health coverage are inherently unstable because of incentives for the healthier groups to opt out, leaving the sicker, costlier groups in the coverage pool.<sup>6</sup>

Less than a decade after the passage of ERISA, Former Rep. John N. Erlenborn (R-Ill.), whose state had been hit by a major multiple-employer plan bankruptcy, introduced an amendment to ERISA to clarify joint state and federal jurisdiction over multiple-employer arrangements. The Erlenborn amendments, which became effective in 1983, make a special exception to ERISA's broad preemption of state authority over employee benefit plans, so that states can regulate MEWAs. Under these provisions, the full extent of state insurance regulation can be applied to MEWAs that do not meet ERISA's definition of an employee welfare benefit plan. (An ERISA plan has to be established or maintained by an employer or an employee organization or both.) For

fully insured MEWAs that do meet ERISA's definition of employee benefit plan, states may apply insurance laws pertaining to reserve and contribution levels. For self-insured MEWAs (that is, those not fully insured) that are ERISA plans, states may apply insurance laws not inconsistent with ERISA (that is, they may apply regulations that do not weaken ERISA's requirements, including its disclosure and fiduciary requirements).<sup>7</sup>

Many states require some form of MEWA certification, although little is known about how strictly MEWAs conform with such requirements, and many states also impose solvency requirements on MEWAs. About half the states require a would-be self-insured multiple-employer organization to obtain an insurance license in order to operate. A few states have passed comprehensive laws intended to monitor and manage self-insured MEWAs. At least one of these, Michigan, seems to have maintained financial stability in this part of the market, in part by imposing solvency standards on MEWAs.<sup>8</sup> Enacted after a large insolvency in the late 1970s, Michigan's MEWA statute imposes requirements similar to those for insurance companies. By regulating self-insured MEWAs like "underfunded domestic mutuals," the law has worked tolerably well, according to a Michigan insurance regulator. The number of self-insured MEWAs there has dropped from about 20 in the late 1980s to about 10. Some leaving the market were simply too small to be viable, some were not careful about their underwriting practices, and some went broke, but all their members' claims were paid, according to the Michigan official.

Despite the powers that the Erlenborn amendments conferred upon states with regard to MEWA regulation and the fact that both the federal government and states have jurisdiction over them, many fraudulent and mismanaged MEWAs have eluded regulators and gone bankrupt, leaving hundreds of thousands of people without coverage. MEWA insolvencies tend to crest during periods of sharply rising health insurance premiums, when the lower prices offered by many MEWAs may seem most attractive, despite the riskier nature of the product as compared to fully insured policies. Although self-insured MEWAs continue to pose problems to this day, problems in this area have lessened in recent years. One reason might be that health care cost increases have slowed. Another factor is improved coordination of enforcement actions between the Labor Department and state officials, according to sources at the Labor Department and the National Association of Insurance Commissioners. One problem that states cited in the past was difficulty getting the Labor Department

to determine whether a MEWA was insured or self-insured in order that state regulators might know the extent of their jurisdiction. According to a Labor Department official, when states now make such a request, the department promptly informs them that they can at least regulate a MEWA's reserves and contributions (that is, the solvency of the plan) while a determination of its insurance status is pending.

Over the years, the Labor Department has initiated 338 civil and criminal MEWA investigations affecting more than 1.1 million participants and their beneficiaries, according to a department statement issued in July.<sup>9</sup> At that time, 98 civil and 22 criminal MEWA investigations remained open. For example, on February 27, 1997, the department filed charges in a lawsuit involving managers of two Chicago-based group health plans of the International Professional, Craft and Maintenance Employees Association Trust, a purported union, for allegedly using assets for themselves while as much as \$5 million in health benefits went unpaid for some 3,000 workers across the nation. While many of the cases under investigation involve sham union plans, some involve association plans. For example, about 1,300 participants were left with about \$1 million in unpaid claims as a result of three failed MEWAs sponsored by Independent Automobile Associations in Georgia, Ohio, North Carolina, and South Carolina and administered by Dealers Association Plan (DAP).<sup>10</sup>

## THE FAWELL BILL

Five years ago, most proposals dealing with multiple-employer plans were aimed at preventing insolvencies and providing a vehicle for insurance reforms that would help reach the goal of universal coverage. The intent of the Fawell bill is twofold, according to its authors: to stop MEWA fraud and to expand insurance coverage by reducing its cost. This would be done, in part, by helping small employers reap the fruits of ERISA preemption that self-insured large employers now enjoy by freeing them from state insurance regulations, such as benefit mandates, community rating, and taxation. According to the committee report accompanying the budget bill passed by the House,

multiple employer plans are the most efficient means to deliver affordable health coverage to employees, particularly for smaller employers and employees who work in industries with high job mobility or above-average insurance risk. However, current law has not achieved the twin goals of preserving the self-insured multiple employer plans of legitimate business and industry associations and of keeping "bogus unions"

and fraudulent insurance schemes from attempting to use the ERISA preemption clause as a shield to the promotion of their abusive health insurance practices.<sup>11</sup>

The Fawell bill would require the secretary of labor to establish regulations for certifying health plans sponsored by bona fide associations (organized for purposes other than providing medical care).<sup>12</sup> Under limited conditions, association health plans would be open to "affiliated members" as well as "members." Concern has been raised, however, about the ease with which organizations might qualify as associations under the bill and the possibility that virtually any employer might qualify as an "affiliate member" of an association.

Under the proposal, an association health plan is defined as a group health plan that offers at least one coverage option offered by a state-licensed insurer or health maintenance organization (HMO). An association could also offer self-insured health options. Existing self-insured associations would not be required to offer a fully insured option. The bill would allow certain other entities to seek certification as association health plans; these entities include franchise networks, certain collectively bargained arrangements, and certain arrangements not meeting the statutory definition of single employer plans. The measure would allow a combination of employees from different employers to be certified as an association health plan, if the majority of the participants were employees of a single employer and the employers were related "by a common ownership interest or a substantial commonality of business operations based on common suppliers or customers."<sup>13</sup> The bill also would allow church plans, which currently fall outside ERISA's jurisdiction and which states now can regulate, unilaterally to move out from under state control and into federal control.

Federally certified association plans would not be subject to state regulation allowed under current law. Interestingly, ERISA would be amended to allow states even more latitude in regulating self-insured MEWAs (those that do not meet the requirement for federal certification as an association health plan). As stated above, states are currently limited in regulating self-insured MEWAs in that they must apply laws "consistent" with ERISA; this restriction would be lifted by the Fawell bill. This change, along with new criminal penalties and expanded enforcement authority for both the Labor Department and the states with regard to nonfederally certified multiple-employer entities, is intended to put a stop to fraudulent MEWAs, according to the bill's authors.

Under the bill, state benefit mandates generally would not apply to federally certified association plans, except that the plan or issuer of coverage to the plan could not avoid state prohibitions on exclusions of specific diseases from coverage. New federal mandates establishing minimum hospital stays for mothers and newborns and limited mental health coverage parity would apply to association plans. Under the bill, a health insurer offering coverage to members of a federally certified association plan could offer the same policy type to any employer in the state "eligible" for coverage under the association health plan, whether or not the employer participated in the association health plan. Thus, insurers conceivably could sell products to almost any employer in the state (any employer that paid dues to a broad-based association, for example) without conforming with many state benefit mandates.

State rating and contribution requirements would not apply to self-insured association plans. Contribution rates could be based on experience of an association plan as a whole. Within the plan, rates for participating employers could not vary significantly on the basis of claims experience or type of industry in which the employer was engaged.

Under the Fawell bill, association plans would automatically qualify for federal certification if all their coverage options were fully insured. Association plan options that were not fully insured would have to meet federal solvency standards, including the maintenance of claims reserves, stop-loss coverage, and minimum surplus amounts (at least equal to the greater of 25 percent of expected incurred claims and expenses for the year or \$400,000 over the reserve for benefit liabilities incurred but not paid and for which risk of loss had not been transferred). The secretary of labor could make various adjustments to these standards.

### **Arguments for and against**

Proponents of the Fawell bill—principally associations and small business groups—argue that it will help them reduce administrative costs, spread risk, and put them on the same footing as large businesses as far as ERISA preemption of state authority. Representatives of the U.S. Chamber of Commerce and the National Federation of Independent Business, for example, testified during a May 8 hearing held by the House Committee on Education and the Workforce Subcommittee on Employer-Employee Relations that the legislation would save small businesses about 30 percent in overhead and regulatory costs. The bill

would provide improved access to health coverage in the workplace for more than 20 million uninsured Americans, according to the Chamber of Commerce. Jack Faris, president of the National Federation of Independent Business, testified that the measure was crucial to allowing small businesses to afford to insure their workers and that its most important feature was giving small employers the chance to purchase health coverage on the same terms as big business. Donald Dressler, president of insurance services for the Western Growers Association, which is based in California, testified that the legislation would help growers provide health benefits to agricultural workers, partly because it is difficult to provide intermittent coverage (as workers move from one farm to the next) under the existing insurance regulatory structure of the states.

In 1996, the U.S. General Accounting Office (GAO) discussed some of the trade-offs presented by state insurance regulation for employer plans and their participants. While insurance regulation may benefit consumers, it imposes burdens on insured health plans that self-insured plans do not face, according to the GAO.<sup>14</sup> Premium taxes increase costs to commercial health insurers by about 2 percent in most states. Furthermore, state mandates to cover certain benefits and providers potentially can raise costs if employers would not have chosen to include such items otherwise. Earlier studies estimated that mandated benefits represented 22 percent of claims in Maryland and 5 percent in Iowa. Little information is available on the actual scope of benefits under self-insured employee health plans nationwide. Based on a 1991 national survey by the Health Insurance Association of America and a 1993 Robert Wood Johnson Foundation survey in 10 states, analysts have recently concluded that coverage in self-insured plans is quite similar to that in indemnity or PPO arrangements, though somewhat less generous than that offered by HMOs.<sup>15</sup> So, while exempting plans from state benefit mandates would give them more flexibility, it is an open question how much money might be saved.

Opposing the Fawell bill are several groups representing states, the Clinton administration, and a group of insurance companies led by the Blue Cross and Blue Shield Association (BC/BS). The American Academy of Actuaries also has expressed concerns about the bill to members of Congress. Critics' arguments basically run as follows: If enacted, the legislation would allow federally certified association plans to draw healthier risks out of the state-regulated small-group insurance markets. This would cause prices to rise in the insured

market, thereby undermining state insurance reforms, create an even more fragmented and confusing regulatory system, and place many consumers at greater risk than today. While self-insured association plans might gain market share, the number of people covered by insurers would shrink, with no population-wide gain in health coverage.

During the budget bill conference committee negotiations between staff of the Senate Labor and Human Resources Committee and staff of the House Education and the Workforce Committee, staff representing Jeffords advanced four principles to guide further discussions in this policy area:

- Association health plans should be subject to appropriate consumer protections, benefits standards, and solvency requirements.
- Association health plans should not undermine states' efforts in achieving small-group and individual market health insurance reform.
- The members of association health plans should continue to fund states' uncompensated care mechanisms.
- The oversight structure for these plans should have the necessary resources and expertise to provide an effective level of regulation.

Depending on the beholder, the Fawell bill's solvency standards can be viewed as a glass half-empty or half-full. They are more stringent than ERISA's solvency standards for health plans—ERISA currently has none even for small firms that self-insure without purchasing stop-loss coverage. The 1993 RWJF employer insurance survey mentioned above found that more than half of self-insured establishments with 1 to 25 employees had no stop-loss coverage, a situation that would appear to place many of those workers at financial risk. In fact, arguments by the Fawell bill's proponents about the merits of establishing solvency standards for self-insured association plans seem to underscore the question of why ERISA has no such standards for other types of self-insured plans, particularly those involving small groups for which claims costs may fluctuate widely from year to year. Although they are greater than what ERISA imposes now, the solvency standards in the Fawell bill are significantly less stringent than those applied by most states to HMOs and insurers. According to the academy of actuaries, a more appropriate minimum capital level would be \$2 million, reducible to \$500,000 if appropriate specific stop-loss were in place.<sup>16</sup>

No one, of course, can predict exactly how many associations might attempt to gain federal certification to sell health coverage, how many groups and individuals they might attract, how healthy those people might be, and how this activity might be distributed across states with widely varying market and regulatory environments. In an analysis of the predecessor of the Fawell bill prepared for BC/BS, William Custer of the Georgia State University Research Center for Risk Management and Insurance estimated that between 700 and 2,200 associations would sponsor MEWAs, potentially covering between 1.2 million and 60 million people; he noted that the data did not permit a more precise estimation procedure.<sup>17</sup> In a companion paper, Gordon Trapnell and other analysts from the Actuarial Research Corporation (ARC) concluded that "expanded access to experience rated MEWAs would have premium impacts due to the loss of good risks from the regulated side of the market."<sup>18</sup> Using a simulation model, ARC concluded that, if federally certified MEWAs occupied 25 to 35 percent of the small-group health insurance market, premiums would increase 11 to 16 percent in community-rated small-group markets and 9 to 13 percent in markets with community rating adjusted for age and gender. As of the end of 1996, about 15 states had enacted community rating laws such as these and another 4 allowed group health insurers only very limited use of experience, health status, or duration in setting premiums for small groups.<sup>19</sup>

Federally certified MEWA market penetrations of 25 to 35 percent in individual health insurance markets would cause 18 to 30 percent premium increases in the markets with pure community rating and 14 to 24 percent increases in markets with community rating adjusted for age and gender, according to the ARC simulation. Movements of individuals and groups out of regulated markets could also reduce states' ability to generate assessments used to guarantee claim payment in the event of insurer insolvencies.

ARC's assumption that federally certified association plans would draw healthier people out of state-regulated insurance markets was challenged in an analysis commissioned by the Association Healthcare Coalition, proponents of the Fawell bill. According to Gerard Connelly, of W. F. Morneau & Associates, "associations have no ability to control the risk of their membership." Instead, these organizations succeed in offering competitive health plans by using clout to negotiate lower administrative expenses, developing plan designs tailored to member needs, and providing more responsive service than traditional insurers.<sup>20</sup>

State insurance regulators, however, remain concerned that, while self-insured association plans might give some people increased access to low-priced coverage, they are unlikely to cater to the sickest individuals and groups, which would be left in the state-regulated insurance markets. This, in turn, might lead to a spiral of higher premiums in the state-regulated markets and loss of coverage for many who could no longer afford the price. On the other hand, many of the associations supporting the Fawell bill represent firms in higher-risk industries that traditionally have had difficulty obtaining affordable coverage due to rating practices in the insured market, according to the bill's authors.

It is ironic that recent federal health insurance reforms might exacerbate the effects of allowing association plans to operate outside state jurisdiction. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires insurers to offer products ("guaranteed issue") to small groups up to 50 employees and to certain eligible individuals and to renew all contracts, thereby depriving insurers of mechanisms to avoid sicker populations.

Insurance regulators and legislative analysts interviewed in Kentucky have expressed concern that the state's recently enacted modified community rating laws most likely will be undermined because the state's general assembly also has exempted association plans from the requirements, thereby creating an uneven playing field. In 1994, the state adopted a package of reforms affecting the small-group and individual health insurance markets. After a great deal of controversy about subsequent rate changes (and with very little hard data upon which to make decisions), the general assembly in 1996 revised the modified community rating formula and now allows association plans to use experience rating. According to an analysis by the Kentucky Legislative Research Commission's chief economist: "Over time, premiums in the community-rated section of the market will increase in such a fashion that the entire market will revert back to a pure experience-rated market."<sup>21</sup>

### Enforcement Issues

An important set of issues pertains to (a) how effectively the Fawell bill might provide consumer protection, (b) which level of government would perform enforcement functions, and (c) how much that might cost. Assuming that the federal government would be required to perform most of the regulatory functions for association plans that states now perform for insurers (including oversight of solvency, market

conduct, and nondiscrimination requirements), Custer estimated that it would cost about \$85,000 a year to regulate each plan (or \$141 million a year to oversee his mid-range estimate of 1,658 certified association plans). Under Michigan's MEWA statute, the organizations are assessed one-quarter of 1 percent of their revenues to cover the costs of regulating them, but actual regulatory costs are difficult to determine because the same personnel oversee MEWAs as well as insurers, according to the state official. The academy of actuaries points out that the Fawell bill would create a significant new regulatory function for the Labor Department, duplicating part of what states do to regulate health insurance.

Concern has been raised that the one-time filing fee of \$5,000 that associations would be required to pay under the Fawell bill would fall far short of the cost of regulating self-insured association plans. However, the bill's authors contend that, by reducing health insurance fraud, the legislation would allow the Labor Department and state insurance regulators to redirect funds currently used to prosecute illegitimate operations toward administering the new system.<sup>22</sup> Both federal and state regulators have expressed concern that the Fawell bill would not alleviate problems with fraudulent MEWAs, which would be unlikely to seek federal certification. The Labor Department could crack down on illicit MEWAs more effectively by using three additional tools, according to officials there. One such tool is already available: HIPAA gives the Labor Department expanded authority to require MEWAs to register—a provision that the department has yet to implement. The other tools are the ability to impose tougher sanctions and to exercise "cease and desist" authority over operations under investigation. These tools are included in the Fawell bill and under the legislation could be used in dealing with association plans, but they would not be available to regulators in other contexts, such as traditional MEWAs, according to Labor Department officials.

While the Custer paper points out that the expected regulatory burden on the federal government is "potentially large," BC/BS has argued that the Fawell bill would exempt self-insured association plans from many state consumer protection laws, including marketing and sales standards, utilization review standards, quality standards, fiduciary requirements, disclosure of information, solvency standards, and other requirements. There is a great deal of variation in the level of consumer protection between federal regulation of self-insured plans and state regulation of insurers and HMOs, as well as between the states.<sup>23</sup> For example, while state insurance departments typically investigate

and often attempt to resolve consumer complaints relating to fully insured plans, in the self-insured sector the Labor Department has neither the mandate nor the resources to respond to individual complaints to the same degree. Instead, the department usually confines its enforcement activity to address patterns of abuse rather than individual violations.

The Fawell bill would allow a state to enter into an agreement with the secretary of labor to enforce its provisions. Concerns about the level of funding for enforcement already have been noted. Concern also has been raised that the bill would limit enforcement authority for each association plan to one domicile state, which would face barriers in attempting to correct problems in other states.

### **FEDERAL RULES, STATE ENFORCEMENT?**

A pattern appears to be forming as several pieces of recent legislation attempt to limit state latitude to regulate insurance while giving states the option to enforce newly acquired federal jurisdiction. As long as states view the substance of such laws favorably, many or most will probably opt to enforce federal rules; but when they oppose the policy goals of increased federal preemption, they may be less enthusiastic about helping with enforcement.

States generally viewed HIPAA favorably; even though it imposed minimum federal standards, such as guaranteed issue and guaranteed renewability, on insurance markets, most states had already enacted similar laws and were pleased that many provisions in HIPAA applied to both insured and self-insured health plans. So far, most state legislatures have enacted laws allowing states to enforce insurance standards set forth under HIPAA. Because Missouri and Rhode Island have not passed such laws, however, the Department of Health and Human Services (DHHS) will have to enforce HIPAA insurance regulations in those states concerning requirements in both the group and individual insurance markets. Also, as of this writing, DHHS had learned it will have to enforce the HIPAA provisions guaranteeing certain individuals access to products in the individual insurance market in California, although state officials there will enforce the group insurance provisions. (The Labor Department is responsible for enforcing HIPAA rules pertaining to ERISA plans.)

States have opposed more recent congressional proposals to restrict their authority to regulate insurance, such as shifting primary responsibility for assuring the

solvency of Medicare provider-sponsored organizations (PSOs) to the federal government<sup>24</sup> and preempting state authority to regulate association plans (as in the Fawell bill). If fewer states decided to enforce federal rules in these areas, the federal government might find itself running the beginning of a national insurance regulatory system. Whether Congress intends to do this is an open question.

## THE FORUM SESSION

The meeting will begin with comments from **Russ Mueller**, actuary/professional staff member—majority, House Committee on Education and the Workforce Subcommittee on Employer-Employee Relations, and **Paul Harrington**, majority health policy director, Senate Committee on Labor and Human Resources. Discussion will then open up to include state insurance regulators, Department of Labor officials, and other interested parties.

### Issue Questions

- In practical terms, what would be the impact of preempting state authority over association health plans as proposed in the Fawell bill? What would be its impact in terms of risk segmentation, consumer protection, and financing subsidized risk pools? What would be its impact on state-regulated insurance markets?
  - To what degree would the Fawell bill assist small businesses in purchasing affordable health insurance? How many new employer groups and individuals, if any, might be covered as a result?
  - What type of regulatory capacity would the Labor Department have to develop in order to regulate association health plans? To what degree might the states assume responsibility for enforcement? Would it make sense to increase the Labor Department capacity to regulate insurance functions while DHHS is expanding its capacity to regulate insurance functions relating to HIPAA and Medicare PSOs?
  - Are associations, especially those whose principal mission is to influence legislation, appropriate places to house multiple-employer health plans? Would such organizations have an unfair competitive advantage over other types of health plans?
  - To what degree, if any, would federal certification of association health plans lessen enforcement
- problems still facing federal and state regulators with regard to fraudulent MEWAs? What new problems might arise?
- What potential for compromise exists between proponents and opponents of the Fawell bill's approach?
  - What is the best way to help small employers band together to purchase health insurance?
  - What new tools does the Labor Department need to crack down on fraudulent MEWAs?
  - Are the two major intents of the Fawell bill—fighting MEWA fraud and expanding coverage—separable issues? Do they need to be dealt with in the same legislation? If so, why?

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## ENDNOTES

1. Beth C. Fuchs, "Subtitle D of Title V of H.R. 2015, Expansion of Portability and Health Insurance Coverage," memorandum prepared by the Congressional Research Service, Library of Congress, July 15, 1997.
2. For more detail, see Karl Polzer, "Multiple Employer Purchasing Groups (METs, MEWAs, HINs, HIPCs): The Challenge of Meshing ERISA Standards with Health Insurance Reform," National Health Policy Forum, Issue Brief No. 604, September 24, 1992.
3. Gregory Acs, Stephen H. Long, M. Susan Marquis, and Pamela Farley Short, "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums," *Health Affairs*, 15(1996), no. 2.
4. ERISA covers private-sector health benefit plans sponsored by employers or employee organizations. It does not cover plans sponsored by government agencies and by churches.
5. RAND tabulations of 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey of 10 states.
6. Arleen Leibowitz, Cheryl Damberg, and Kathleen Eyre, "Study 5: Multiple Employer Arrangements," in *Health Benefits and the Workforce* (Washington, DC: U.S. Department of Labor, Pension and Welfare Benefits Administration, 1992) 75.
7. ERISA, however, forbids states from regulating "multiemployer" plans, which are established under collective bargaining agreements, as well as multiple-employer plans offered by rural electric cooperatives or rural telephone cooperative associations.
8. Leibowitz, Damberg, and Eyre, "Multiple Employer Arrangements," 70, 75.
9. U.S. Department of Labor Fact Sheet on MEWA Enforcement, July 3, 1997.
10. According to the Labor Department, "DAP, specifically one M. L. Vaughan, was a fiduciary and service provider to the MEWAs and contributed to the failure of the health plans by collecting insufficient premiums to pay both claims and anticipated