

STATEMENT FOR THE RECORD

SUBMITTED TO THE

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

**Hearing on A Healthy Workforce: Expanding Access and
Affordability in Employer-Sponsored Health Care**

April 2, 2025

SUBMITTED BY THE

**The Coalition to Protect and Promote
Association Health Plans**

I. Overview

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

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

How do they do that?

AHPs are *voluntarily covering all ten of the ACA’s “essential health benefits” (EHBs)*, including pediatric major medical coverage. AHPs also cover pediatric dental and vision services either through their AHP insurance contract or through a stand-alone product. In addition, AHPs offer *broader health care provider networks* relative to many existing ACA “small group” and “individual” market plans.

AHPs are also *priced at an “actuarially fair premium”* for both young and old AHP participants. Doing so encourages more young and healthy individuals to enroll in AHP health coverage, which in turn benefits older and less healthy AHP participants by increasing the size of – and balancing out – the risk pool.

AHPs are also subject to the specific rules under the Affordable Care Act (“ACA”), the Employee Retirement Income Security Act (“ERISA”), and the Health Insurance Portability and Accountability Act (“HIPAA”) that prevent these arrangements from discriminating against individuals/employees based on a health condition. Most importantly, AHPs are *prohibited from denying people coverage if they have a pre-existing condition*.

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

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

² These States include: AL, AK, AZ, AR, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MI, MN, MS, MO, MT, NE, NV, NC, ND, OH, OK, OR, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY.

³ See Bloomberg Tax, Tax Management Compensation Planning Journal, *Association Health Plans (AHPs) and States’ Rights: An Accounting of How States Want to Regulate AHPs*, Nov. 2019 at https://www.thepowerofa.org/wp-content/uploads/2019/11/Condeluci_CPJ_Nov2019.pdf.

⁴ These States include: CA, CT, DE, ID, MD, MA, NH, NJ, NM, NY, PA, RI, VT.

⁵ For example, CA and WA refuse to grant a self-insured AHP a “license” to operate in their States.

II. AHPs Do Not Offer “Skinny Coverage”

Opponents of AHPs continually say that AHPs are “junk plans” or AHPs offer “skinny coverage.” Even the Department of Labor (“DOL”) under the Biden Administration adopted this refrain, asserting that AHPs offer “skinny coverage” because AHPs are not subject to the Affordable Care Act’s (“ACA’s”) “essential health benefits” (“EHB”) requirement.⁶

Contrary to these assertions, there is ample evidence that AHPs do **NOT** offer “skinny coverage.” Rather, AHPs offer coverage that is ***equally*** – and in some cases ***more comprehensive*** – than ACA “individual” and “small group” market plans.⁷

How do AHPs do this:

- They voluntarily cover the ACA’s EHBs.
- They offer broader provider networks relative to ACA “individual” and “small group” market plans.
- They offer lower deductibles relative to ACA “individual” and “small group” market plans for coverage that is equal to – if not better than – ACA plans.

A. AHPs Voluntarily Cover the ACA’s EHBs

With respect to EHB coverage, AHPs – just like large employer- and union-sponsored health plans – are voluntarily covering the ACA’s EHBs. Why? To meet employee demand and to attract and retain talented workers.

More specifically, regardless of whether an employer is large or small – and regardless of whether an employer is offering their own single-health plan or offering health coverage through an AHP – the employer chooses to offer health benefits to attract and retain talented workers. Why? Because both large and small employers recognize the need to offer comprehensive health coverage as an employee benefit, especially in a tight labor market.

How do AHPs voluntarily cover the EHBs?

In some cases, fully-insured and self-insured AHPs cover all ten EHBs – including coverage for pediatric dental and vision care – in the AHP insurance contract or self-insured health plan itself. In most other cases, however, a fully-insured or self-insured AHP will cover all ten EHBs, while covering pediatric dental and vision care through stand-alone products. In ***both*** cases, ***all*** ten of the EHBs are covered.

⁶ See 88 Fed. Reg. 87981, 87974 (Dec. 20, 2023).

⁷ See Office of Management and Budget, EO 12866 Meeting 1210-AC16, *Submission by the Coalition to Protect and Promote Association Health Plans*, Oct. 2, 2023 at <https://www.reginfo.gov/public/do/viewEO12866Meeting?viewRule=true&rin=1210-AC16&meetingId=223574&acronym=1210-DOL/EBSA>.

It is important to note that those AHPs that cover pediatric dental and vision care through stand-alone products choose to do so because the Board governing the AHP determined that pediatric dental and vision benefits can be provided through a stand-alone product at a lower cost, while providing the same – if not a better – level coverage than if these services were offered through the insurance contract or self-insured plan itself.

It is also important to point out that the “control test” applicable to an association establishing an AHP imposes a fiduciary duty on the Board governing the AHP,⁸ requiring the Board to “act in the best interest” of the AHP participants, while also keeping plan costs low.⁹ The requirement to adhere to these fiduciary duties drives the Board’s decision to cover pediatric dental and vision care through stand-alone products because the coverage is (1) just as – if not more – comprehensive than the type of coverage that can be offered through the insurance contract or plan itself (thus, acting in the best interest of plan participants) and (2) less costly than the type of coverage that can be offered through the insurance contract or plan itself (thereby keeping plan costs low for participants).

B. AHPs Have Broader Provider Networks Than ACA “Individual” and “Small Group” Market Plans

Another litmus test for “skinny coverage” is the health plan’s provider network.

It is well-established that ACA “individual” and “small group” market plans primarily have “narrow networks.”¹⁰ In fact, the Congressional Budget Office (“CBO”) has explained that “individual” market plans generally have narrower provider networks than employment-based plans.¹¹

AHPs – which are employment-based plans that offer the same type of coverage offered by large employers and unions – have broad provider networks which, unlike ACA “individual” and “small group” market plans, does not force participants to drive hours to and from a physician’s office or a hospital that is in-network to receive medical treatment or to even get a routine medical check-up. Although the Biden Administration has undertaken efforts to strengthen the ACA’s “individual” market “network adequacy” rules,¹² the provider networks for ACA “individual” and “small group” market plans pale in comparison to the breadth of employer-based health plan provider networks offered through an AHP.

⁸ The Department of Labor (“DOL”) developed the “control test” through decades worth of Advisory Opinions, providing that to be considered a “bona fide group or association of employers” – and thus, an “employer” under Employee Retirement Income Security Act (“ERISA”) section 3(5) – the employer members of the group participating in the AHP must control the functions and operations of the AHP through a governing Board. Such control must be present in both form and substance [see, e.g., DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 96-25A (Oct. 31, 1996)].

⁹ The Board governing an AHP is considered a fiduciary under ERISA, and as a fiduciary, the Board is required to (1) act for the exclusive purpose of providing benefits to plan participants and (2) defray the reasonable expense of administering the plan [see ERISA sections 3(21) and 404(a)(1)(A)].

¹⁰ See Avalere Health, *Plans With More Restrictive Networks Comprise 73% of Exchange Market*, Nov. 30, 2017 at <https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market>.

¹¹ Congressional Budget Office, *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*, April 2021, page 7-8 at <https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf>.

¹² See Notice of Benefit and Payment Parameters for 2024 at <https://www.govinfo.gov/content/pkg/FR-2023-04-27/pdf/2023-08368.pdf>.

C. AHPs Offer Lower Deductibles Compared ACA “Individual” and “Small Group” Market Plans

AHP opponents – and even the Biden Administration’s DOL – suggest that AHPs “underinsure” plan participants.¹³ However, when it comes to making claims that a particular type of health plan “underinsures” participants, these critics and the DOL need to look no further than ACA “individual” and “small group” market plans.

For example, although ACA “individual” market plans are heavily subsidized by the Federal government (such that monthly premium payments for ACA “individual” market plans may only amount to \$10 per month for particular policyholders),¹⁴ ACA “individual” market plans have extremely high deductibles that must be met before any policyholder can even begin enjoying their health plan’s coverage.

Let’s look at the facts: The deductible for a “bronze” level plan – which, according to the ACA, is allowed to have the highest deductible – averaged \$7,258 for single coverage and about \$15,000 for family coverage for the 2024 plan year.¹⁵ The most popular “individual” market plan (a “silver” level plan, which is the benchmark plan for determining the value of the premium subsidy) had an average deductible of \$5,241 for single coverage and about \$11,000 for family coverage for the 2024 plan year.¹⁶

This means that while it may be affordable for a family of four to *purchase* a subsidized ACA “individual” market plan (because premiums are low...around \$10 per month for certain families), this family must spend \$11,000 to \$15,000 out their own income **BEFORE** any insurance coverage begins. That is **the definition of** being underinsured.

AHPs – which, as stated, are employment-based plans that offer the same type of coverage offered by large employers and unions – offer health plans that range from a relatively low deductible plan of about \$1,000 for single and \$2,000 for family coverage to a High-Deductible Health Plan (“HDHP”) with deductibles ranging from \$2,500-\$5,000 for single coverage and \$4,000-\$8,000 for family coverage.

Based on this fact alone, AHP coverage is better coverage than ACA “individual” market plans. Add in the fact that AHPs voluntarily cover the EHBs and offer broader provider networks (as discussed above), AHPs provide comprehensive coverage that is *superior* to ACA “individual” market plans.

Similarly, the average deductible for a “small group” market plan was \$2,757 for single and \$7,000 for family coverage for the 2024 plan year, while the average deductible for a “large group” market plan – which AHPs are – was \$1,787 for single coverage and about \$5,000 for family coverage in 2024.¹⁷ This is merely additional verifiable evidence illustrating that AHPs provide comprehensive coverage that is *superior* to ACA “small group” market plans.

¹³ 88 Fed. Reg. at 87974-75 (Dec. 20, 2023).

¹⁴ See Centers for Medicare & Medicaid Services (“CMS”) Newsroom, *American Rescue Plan and the Marketplace*, March 12, 2021, explaining that “four out of five enrollees [in a subsidized ‘individual’ market plan] will be able to find a plan for \$10 or less [per] month after premium tax credits, and over 50% will be able to find a Silver plan for \$10 or less.”

¹⁵ See Kaiser Family Foundation, *Deductibles in ACA Marketplace Plans*, Dec. 22, 2023 at <https://www.kff.org/private-insurance/issue-brief/deductibles-in-aca-marketplace-plans/>.

¹⁶ *Id.*

¹⁷ See Kaiser Family Foundation, *2024 Employer Health Benefits Survey*, Oct. 9, 2024 at <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey-Summary-of-Findings.pdf>.

Based on the foregoing, it is also reasonable to ask the following question: Even in cases where a health plan covers the ACA's EHBs, if a planholder is required to pay \$11,000 or more out-of-their-own-pocket ***before any coverage of the EHBs even begins***, isn't that by definition "skinny coverage"? So it stands to reason that while ACA "individual" and "small group" market plans cover the EHBs, ACA "individual" and "small group" market plan offer "skinny coverage," unlike AHPs that are voluntarily covering the EHBs while also offering lower deductibles for such coverage.

III. AHPs Are Required to Protect People With Pre-Existing Conditions

Some critics of AHPs go so far as to say that AHPs can discriminate against people with pre-existing conditions. This assertion is ***patently FALSE***.

AHPs – as a "group health plan" under the law¹⁸ – ***CANNOT*** deny coverage for people with a pre-existing condition.

More specifically, and as discussed more fully below, the ACA's "group health plan coverage requirements" apply to AHPs.¹⁹ Chief among these "group health plan coverage requirements" is the prohibition against denying coverage for a person with a pre-existing condition.²⁰

It is also important to point out that virtually all States that allow AHPs to operate include a State law requirement that ***prohibits*** an association sponsoring an AHP from refusing to allow an employee (or their dependent) to participate in the AHP because of a health condition (i.e., a pre-existing condition).²¹

In addition, according to State law, an association sponsoring an AHP ***cannot*** condition membership in the group on any health-status related factor relating to any individual.²² This means that AHPs ***CANNOT*** prevent people with pre-existing conditions, or those who are otherwise anticipated to have higher health care costs, from joining AHPs.

IV. AHPs Are Subject to Robust Consumer Protections and Coverage Requirements

A. AHPs Are Subject to the ACA's "Group Health Plan Coverage Requirements"

As discussed above, AHPs – as a "group health plan" – ***are*** subject to the ACA's "group health plan coverage requirements,"²³ which means that a fully-insured ***and*** self-insured AHP ***must***:

¹⁸ ERISA section 733(a)(1) and Public Health Service Act ("PHSA") section 2791(a)(1) provide that a "group health plan" is any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents...directly, or through insurance, reimbursement, or otherwise.

¹⁹ ERISA section 715 incorporates by reference the ACA's coverage requirements applicable to a "group health plan" into ERISA.

²⁰ See PHSA section 2704. As stated, PHSA section 2704 is incorporated by reference into ERISA through ERISA section 715 and thus is applicable to "group health plans," including AHPs.

²¹ See, e.g., Virginia Insurance Code section 38.2-3521.1.E.1.f.

²² See, e.g., Virginia Insurance Code section 38.2-3521.1.E.1.e.

²³ As stated above, ERISA section 715 incorporates by reference the ACA's "group health plan coverage requirements" into ERISA.

- Eliminate all pre-existing condition exclusions for all plan participants.²⁴
- Stop imposing annual and lifetime limits on the “essential health benefits” covered under the plan.²⁵
- Provide coverage for certain preventive health services with no cost-sharing.²⁶
- Cover “adult children” up to age 26.²⁷
- Stop rescinding coverage absent fraud or misrepresentation.²⁸
- Include new internal and external appeals processes (and provide notice).²⁹
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.³⁰
- Provide direct access to emergency services.³¹
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.³²
- Limit the plan’s cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account (“HSA”) rules for 2014.³³
- Eliminate waiting periods that exceed 90 days.³⁴
- Cover the cost of clinical trial participation.³⁵
- Provide participants with a summary of benefits and coverage.³⁶
- Provide annual reports describing the plan’s quality-of-care provisions.³⁷

B. AHPs are Subject to the Consumer Protections Under ERISA, HIPAA, and COBRA

Under ERISA, there are specific notice and disclosure requirements that a fully-insured and self-insured AHP must comply with.³⁸ In addition, ERISA’s fiduciary responsibilities apply, requiring the Board governing the AHP and, if applicable, service providers to the AHP, to act in the best interest of the plan participants.³⁹ AHP plan participants have a private right of action to sue the AHP, the Board, and any other fiduciaries if there is wrong-doing,⁴⁰ and there are detailed procedures for filing health claims.⁴¹

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,⁴² and according to HIPAA, premiums for an AHP participant cannot be developed based on the participant’s health condition and a participant’s individually identifiable health information must be protected.⁴³

²⁴ See PHSa section 2704.

²⁵ See PHSa section 2711.

²⁶ See PHSa section 2713.

²⁷ See PHSa section 2714.

²⁸ See PHSa section 2712.

²⁹ See PHSa section 2719.

³⁰ *Id.*

³¹ See PHSa section 2719A.

³² See PHSa section 2705.

³³ See PHSa section 2707(b).

³⁴ See PHSa section 2708.

³⁵ See PHSa section 2709.

³⁶ See PHSa section 2715.

³⁷ See PHSa section 2717.

³⁸ ERISA, Title I, Subtitle B Part 1.

³⁹ ERISA, Title I, Subtitle B Part 4; *see also*, ERISA section 404(a).

⁴⁰ ERISA section 502.

⁴¹ ERISA section 503.

⁴² ERISA, Title I, Subtitle B Part 6.

⁴³ ERISA section 702.

C. State Benefit Mandates Apply to Fully-Insured “Large Group” AHPs

Another important layer of coverage requirements that is often times overlooked by critics of AHPs is this: A fully-insured “large group” AHP is subject to State benefit mandates. State benefit mandates require an insurance contract sold within a particular State to cover specified benefits and medical services. The State benefit mandates applicable to fully-insured “large group” plans in most States are as good as the ACA’s EHBs. Even in States where their benefit mandates may not cover all of the ten medical services that make up the EHB requirement, the drafters of the ACA observed that most if not all fully-insured “large group” plans cover the EHBs, which is why Congress chose to exempt fully-insured “large group plans” from the EHB requirement entirely.

D. State MEWA Statutes Apply to Self-Insured AHPs

In the case of a self-insured AHP, this arrangement is by definition a “multiple employer welfare arrangement” (“MEWA”).⁴⁴ In the case of a self-insured MEWA, Congress (back in 1983) specifically amended ERISA’s preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State.⁴⁵ Since that time, many States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. These laws often times impose specific coverage and/or premium rating requirements on self-insured MEWAs. In addition, State MEWA laws typically impose the same solvency – or reserve – requirements that apply to insurance companies operating within the State. Other States outright prohibit self-insured MEWAs. States that have yet to enact a State MEWA statute are not prohibited from doing so in the future. In addition, States with existing State MEWA statutes are free to amend those statutes to impose specific coverage, rating, and/or solvency requirements on self-insured AHPs.

V. AHPs Will Not Segment the Insurance Markets

A. AHPs Will Draw High-Medical Utilizers Out of the Existing Markets

Opponents of AHPs suggest that if AHPs are allowed to cover employees of industry-based and non-industry-based small employers and/or self-employed individuals with no employees then this will destabilize the “individual” and “small group” markets.⁴⁶ However, there is no verifiable data justifying this claim. Only theoretical assumptions that have never been corroborated.

For example, AHPs that cover employees of industry-based small employers have been operating for decades now. And never – not once – has there been a study indicating that these industry-based AHPs have adversely affected the insurance markets.

It is true that some reports have identified issues relating to insolvencies and plan mismanagement with respect to self-insured MEWAs that occurred decades ago. But, none of those reports ever claimed or illustrated that these self-insured MEWAs have ever adversely affected the insurance markets. More importantly, none of those reports ever claimed or illustrated that fully-insured AHPs ever adversely affected the insurance markets.

⁴⁴ See ERISA section 3(40).

⁴⁵ See ERISA section 514(b)(6)(A)(ii).

⁴⁶ 88 Fed. Reg. at 87974 (Dec. 20, 2023).

As described above, AHPs have – and will continue to – offer comprehensive coverage. And, in most cases, such comprehensive coverage will be offered at a lower cost relative to the “individual” and “small group” market plans. Based on these facts, we believe that in cases where AHP coverage is offered to employees of industry-based or non-industry-based employees and/or self-employed individuals with no employees such offers will actually *help stabilize* the “individual” and “small group” markets, or at a minimum, AHPs will have *no* substantive impact on the existing insurance markets.

More specifically, it is well-established that employees and individuals shop for health insurance based on price, as well as the comprehensiveness of the health coverage. The health status of a particular employee or individual also drives their behavior.

In cases where an employee or individual is healthy, they will most likely gravitate toward health coverage with a lower cost, although the comprehensiveness of coverage is important even to healthier employees and individuals. If, however, an employee or individual is less healthy (and thus a “high-medical utilizer”), they are more likely to seek out comprehensive coverage, although price remains an important factor as well.

As stated, AHPs offer comprehensive coverage at a lower cost relative to ACA “individual” and “small group” market plans. As a result, healthy employees and individuals will gravitate toward AHPs based on their cost, but also comprehensiveness. Also, less-healthy/high-medical utilizers will gravitate toward AHPs based on their comprehensiveness, and also lower cost.

The end result, *both* healthy people *and* less healthy/high-medical utilizers are going to be attracted to AHP coverage. And, this will result in less healthy/high-medical utilizers exiting the “individual” and “small group” markets to enroll in an AHP (because such plans offer comprehensive benefits at a lower cost), which means that the availability of AHP coverage will actually *benefit* the “individual” and “small group” markets from a health risk perspective – or at a minimum, AHPs will have *no* substantive impact on the existing insurance markets – by drawing less healthy/high-medical utilizers out of the current risk pool.

B. If “Lives” Are Not In the Risk Pool In the First Place, Markets Cannot Be Impacted

Predictions of market destabilization are not just theoretical, they are also incomplete because they fail to account for the number of employees and individuals who are currently *not* covered by any form of health insurance. If, for example, these uninsured employees and individuals enroll in an AHP, the current ACA insurance markets will *not* be affected because these “lives” were *never* in the risk pools in the first place.

It is important to point out that since the enactment of the ACA, health coverage offered by small employers with fewer than 50 employees has declined by roughly 20 percent.⁴⁷ Only about 50 percent of small employers with fewer than 50 employees actually offer health coverage today, as compared to 99 percent of large employers.⁴⁸ If small employers who are not currently offering health insurance coverage to their employees are attracted to AHPs (because AHPs offer comprehensive coverage at lower prices), their enrollment in AHPs will *not* – by definition – impact the existing “small group” market because the employees of these small employers are *not* a part of the ACA’s market in the first place.

⁴⁷ See Kaiser Family Foundation, *Employer Health Benefits: 2022 Annual Survey*, Oct. 27, 2022 at <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf>.

⁴⁸ *Id.*

Same is true for the “individual” market. While a record number of individuals have enrolled in a subsidized “individual” market plan through an ACA Exchange for the 2024 plan year, there are still millions of individuals who have opted against enrolling in an “individual” market Exchange plan for personal and/or financial reasons. If these uninsured individuals enroll in an AHP, the existing “individual” market will not be impacted because these individuals were never a part of the risk pool.

C. Generous Premium Subsidies Drive Behavior

Related to whether AHPs will adversely affect the “individual” market, one must also take into account the financial incentives available to, for example, self-employed individuals who are eligible for a premium subsidy relative to self-employed individuals who may choose to purchase AHP coverage out-of-their-own-pocket.

More specifically, AHP coverage is not subsidized for a self-employed individual. It is true that a self-employed individual is eligible to take an above-the-line deduction for the premium costs associated with AHP coverage,⁴⁹ but in the vast majority of cases, the tax benefit flowing from the above-the-line deduction will be much less than any premium subsidy a self-employed individual may be entitled to access, especially in, for example, 2024 and 2025 when (1) the premium subsidies are available to any individual irrespective of their income and (2) the value of the premium subsidy is higher than pre-2020 law.

The reality is this: If it is not in a self-employed individual’s best financial interest to purchase coverage through an AHP – because, for example, this self-employed individual may be eligible for a generous premium subsidy that covers much of the premium cost of an “individual” market Exchange plan – this self-employed individual is not going to exit the “individual” market. This is a behavioral response that even the Biden Administration’s DOL recognized.⁵⁰

However, there may be instances where a self-employed individual does not find the premium subsidy to be meaningful (because, for example, this self-employed individual is a high-income earner). Here, this self-employed individual may indeed exit the “individual” market for AHP coverage.

There may also be non-financial reasons that account for why a self-employed individual may opt against purchasing a subsidized “individual” market Exchange plan (e.g., the individual is not comfortable with the very high deductible associated with the benchmark-“silver” plan).

In these instances, the self-employed individual should have the freedom and the flexibility to enroll in an AHP. Forcing self-employed individuals into the “individual” market is not only arbitrary, it is inequitable. **Individuals should have the right to choose.**

Most importantly, even if certain self-employed individuals (like the ones discussed above) exit the “individual” market for superior AHP coverage, this does not – in and of itself – mean that the existing market will be adversely affected. As stated, AHP coverage will be equally attractive to **both** healthy self-employed individuals **and** self-employed individuals who are high-medical utilizers. As a result, even if healthy self-employed individuals may exit the “individual market,” less healthy/high medical-utilizers will **also** exit the individual market, thus having a positive impact on the existing risk pool.

⁴⁹ See Section 162(l) of the Internal Revenue Code (“Code”).

⁵⁰ See 88 Fed. Reg. at 87974 (Dec. 20, 2023).

VI. Congress Must Pass Chairman Walberg’s Association Health Plan Act

Chairman Walberg has introduced the Association Health Plan Act which sets forth a legal framework that would allow employees of small employers and self-employed individuals with no employees to access the same type of health coverage offered by large employers and unions. The Association Health Plan Act increases access for these employees and self-employed individuals without lessening restrictions on the formation of AHPs. For example, relative to regulations relating to AHP issued by the DOL in 2018,⁵¹ the Association Health Plan Act strengthens restrictions on the formation of AHPs, while also ensuring that AHPs offer affordable and comprehensive coverage.

The following provides a detailed explanation of the various requirements set forth under the Association Health Plan Act, along with justifications as to why these requirements should be passed by Congress and signed into law by the President.

A. Industry-Based and Non-Industry-Based Associations That Meet Certain Conditions Can Establish a Fully-Insured “Large Group” AHP or Self-Insured Plan AHP

Chairman Walberg’s Association Health Plan Act (hereinafter referred to as “the Act”) would confirm in Federal statute that both industry-based and non-industry-based associations that meet certain conditions can establish (1) a fully-insured “large group” AHP or (2) a self-insured AHP that would be considered a “Plan MEWA” (hereinafter referred to as a “self-insured Plan AHP”). Importantly, the Act does NOT preempt State law in any way, shape, or form.⁵²

The conditions that must be met before an industry-based or non-industry-based association can establish (1) a fully-insured “large group” AHP or (1) a self-insured Plan AHP include a “control test,” which mirrors the “control test” developed by the DOL through decades of Advisory Opinions, which is a key ingredient to being considered an “employer” under ERISA section 3(5). In addition, the Act maintains the “business purpose standard,” requiring the association to have been organized and maintained in good faith for purposes other than that providing health coverage.

The Act also includes the State law requirements discussed in Section III above, namely (1) that an association establishing an AHP is prohibited from conditioning membership in the association on any health-status related factor relating to any individual AND (2) the AHP must make coverage available to all employer members (including self-employed individuals) of the association regardless of any health status-related factor relating to the employer members’ employees or dependents. In other words, an AHP CANNOT discourage people with pre-existing conditions, or those who are otherwise anticipated to have higher health care costs, from joining AHPs.

There are also a number of conditions that are currently set forth in State law governing the types of associations that can permissibly operate an AHP in the State so as to be consistent with State law consumer protections.

⁵¹ See Definition of Employer Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018).

⁵² For example, if a State does not want to follow a portion – or all – of the Act’s framework, a State is permitted to enact its own State law on the matter.

- ***Justification for Codifying These Conditions In Federal Statute***

Satisfying These Conditions Produces a True Employee Benefit Plan, Not a Commercial Insurance-Type Arrangement

- The conditions set forth in the Act that must be satisfied ***before*** an industry-based or non-industry-based association can establish an AHP is proof that the established AHP is a true employee benefit plan that is the product of a genuine employment relationship. In other words, AHPs established by associations that satisfy ALL of these conditions are ***not*** artificial structures marketed as employee benefit plans, and they are ***not*** commercial insurance-type arrangements, but instead, are true employee benefit plans.

The Act's Conditions Are Consistent With State Law Consumer Protections

- The conditions set forth in the Act are designed to be consistent with the applicable insurance regulations that State insurance regulators are familiar with and enforce every day. These conditions are narrowly tailored and place the appropriate guardrails around what types of associations can establish an AHP, which ensures that those associations that satisfy ALL of these conditions do ***not*** have some hidden objective of attempting to sidestep otherwise applicable insurance regulations or misdirect State insurance regulators. The Act's conditions prevent such bad actors from entering the market.

B. Aggregation Rule

According to the Act, if an industry-based or non-industry-based association satisfies ALL of the conditions discussed above, ALL of the employees (including self-employed individuals) of ALL of the employer members (including self-employed individuals) of this association shall be aggregated and counted together for purposes of determining whether this aggregated group includes 51 or more employees. In cases where an industry-based or non-industry-based association includes at least 51 employees, this group will be considered a “large employer” that is sponsoring a “large group” health plan under the ACA, and thus, States shall regulate this fully-insured AHP as a “large group” plan, unless a State enacts a State law providing otherwise (again, the Act does ***not*** preempt State law).

- ***Justification for Codifying the Aggregation Rule In Federal Statute***

This Will Confirm That Associations Can Offer “Large Group” Health Plan Coverage

- Codifying this aggregation rule in Federal statute is paramount on account of CMS’s “look-through rule,” which ever since 2011, has governed whether a fully-insured AHP can be considered a fully-insured “large group” plan.⁵³ Currently, CMS’s “look-through” rule is merely memorialized in sub-regulatory guidance (i.e., a CMS Insurance Standards Bulletin). Codifying this aggregation rule in Federal statute is necessary to ensure legal certainty for State insurance regulators, Federal regulators, and stakeholders on both sides of the AHP issue, including associations interested in establishing a fully-insured “large group” AHP and opponents of AHPs that continue to advance inaccurate claims on how AHPs are regulated under the law.

⁵³ See CMS Insurance Standards Bulletin, Sept. 1, 2011 at https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

- It is important to note that “large group” AHPs are not less regulated health plans, as many AHP opponents contend. As discussed in Section IV above, fully-insured “large group” AHPs are not only subject to the ACA’s “group health plan coverage requirements,” ERISA, COBRA, HIPAA, and other Federal laws such as the Women’s Health and Cancer Rights Act, and the Newborns’ and Mothers’ Health Protection Act, fully-insured “large group” AHPs are subject to State benefit mandates that in most if not all States require coverage of benefits and services that are just as good if not better than the ACA’s EHBs.

C. Codifying the Practice of Varying Premiums By Employer Member

The Act codifies the practice of varying premiums by each employer member of an association that (1) satisfies the above stated conditions and (2) offers health coverage through a fully-insured “large group” AHP or self-insured Plan AHP.

More specifically, the Act sets forth specific requirements for developing premium rates for AHPs sponsored by (1) associations that ONLY include employers with at least 1 common law employee, (2) associations made up SOLELY of self-employed individuals with no employees, and (3) “mixed associations” that include BOTH employers with at least 1 common law employee and self-employed individuals with no employees.

1. Associations That ONLY Include Employers With At Least 1 Common Law Employee

In the case of an AHP established by an industry-based or non-industry-based association that ONLY includes employers with at least 1 common law employee, this AHP shall develop a “base” premium rate based on the collective health claims experience of ALL of the employees and their dependents participating in the AHP. Then, at the election of the association, the AHP may vary this “base” premium rate up or down for each employer member based on the collective health claims experience of all of the employees employed by each respective employer member who are participating in the AHP.

2. Associations Made Up SOLELY of Self-Employed Individuals With No Employees

In the case of an AHP established by an association made up SOLELY of self-employed individuals with no employees, the AHP shall develop a “base” premium rate based on the collective health claims experience of ALL of the self-employed individuals and their dependents participating in the AHP. Then, the AHP shall charge this “base” premium rate to ALL self-employed individuals and their dependents participating in the AHP. In other words, any variation based on the health claims experience of a particular self-employed individual is prohibited.⁵⁴ The only type of variation that can occur may reflect the different “type” of health plan (e.g., a PPO vs. an HDHP) and “type” of coverage (e.g., single, employee +1, and family coverage). But again, the premium rate for the “type” of health plan and “type” of coverage shall be the SAME “base” premium rate for ALL self-employed individuals enrolled in the respective “types” of health plan and coverage.

⁵⁴ As discussed in Section IV, HIPAA prohibits a “group health plan” from charging different premium rates based on the health status of an individual participant [ERISA section 702(b)].

3. “Mixed Associations” of Employers and Self-Employed Individuals

If there is a “mixed association” that includes BOTH employers with at least 1 common law employee AND self-employed individuals with no employees, this AHP shall develop a “base” premium rate based on the collective health claims experience of ALL of the employees and their dependents AND the self-employed individuals and their dependents participating in the AHP. Then, at the election of this “mixed association,” the AHP may vary this “base” premium rate up or down for each employer member with at least 1 common law employee based on the collective health claims experience of all of the employees employed by each respective employer member who are participating in the AHP.

For purposes of varying the “base” premium rate for self-employed individuals with no employees, ALL of the self-employed individuals who are members of the “mixed association” shall be aggregated together into one, single group of self-employed individuals. This aggregated group of self-employed individuals would effectively stand alongside all of the employer members that employ at least 1 common law employee. In other words, the aggregated group of self-employed individuals would themselves operate as their own group within the larger group, just like the employer member groups.

It is important to emphasize that the AHP **CANNOT** vary premiums for EACH self-employed individual participating in the AHP. As stated, HIPAA currently prohibits a “group health plan” from varying premiums for an individual participant based on health status. The approach here would allow the AHP to vary the “base” premium rate for the *entire* aggregated group of self-employed individuals up or down based on the collective health claims experience of ALL of the self-employed individuals who are a part of this aggregated group and who are participating in the AHP.

In other words, the AHP shall be permitted to vary the “base” premium rate for the aggregated group of self-employed individuals as if this aggregated group were their own group standing side-by-side with those employers with at least 1 common law employee that are members of this “mixed association” and offering health coverage through the AHP.

Note, a “mixed association” MUST have at least 20 self-employed individual members that can be aggregated into a single group of self-employed individuals with no employees. If this “mixed association” does ***not*** include at least 20 self-employed individuals that can be aggregated together, this group may ***NOT*** establish an AHP that covers self-employed individuals. However, this association could still establish an AHP for its employer members with at least 1 common law employee just like groups that ONLY include employers with at least 1 common law employee can, as described above.

- ***Justification for Codifying These Requirements In Federal Statute***

Varying Premiums By Employer Member Is a Long-Standing Practice Which Is Permitted By States and the Federal Government

- Fully-insured “large group” AHPs and self-insured AHPs have a ***long history*** of (1) developing a “base” premium rate for ALL of the plan participants based on the collective health claims experience of ALL of these participants – and then – (2) varying this “base” premium rate up or down for each employer member based on the collective health claims experience of all of those employees employed by a particular employer member participating in the AHP.

- In the 37 States that allow fully-insured AHPs to operate as a “large group” plan, every Department of Insurance allows the fully-insured AHP to vary premiums in the above described manner. Same is true in those States that allow self-insured AHPs to operate (both Plan and Non-Plan MEWAs). The Federal government – including the Obama Administration, Trump Administration, and Biden Administration – have allowed this practice to exist as well, deferring to States and how States want to regulate their own insurance markets. States may choose to enact a State law codifying this practice (as Virginia did in 2023)⁵⁵ or a State may choose to enact a State law prohibiting this practice. Once again, the Act does ***not*** preempt State law.

Varying Premiums By Employer Members Is a Fiduciary Obligation

- As discussed above, one of the most important factors for qualifying as an “employer” under ERISA section 3(5) is the “control test,” which requires an association sponsoring an AHP to establish a governing Board to operate and manage the health coverage offered through the AHP. As also discussed above, the Board – as an ERISA fiduciary – must “act in the best interest” of the AHP plan participants and undertake efforts to keep health plan costs low. Importantly, electing to vary the premium rates for each employer member based on the collective health claims experience of all of the employees employed by the respective employer members who are participating in the AHP is driven by the duty to “act in the best interest” of AHP plan participants. If the AHP ***did not*** develop different premium rates for particular employer members, the solvency of the AHP ***could be*** called into question, which ***could*** adversely affect the health coverage offered to plan participants, which ***would be counter*** to the participants’ “best interest.”
- As a result, to ensure that comprehensive and affordable health coverage is consistently made available to employees of the sponsoring employer members, the Board ***has a fiduciary obligation*** to elect to vary premiums by employer member to maintain the AHP’s long-term solvency. In other words, engaging in practices that would ensure the long-term solvency and viability of the AHP (like varying premiums by employer member) is by definition “acting in the best interest” of plan participants because without engaging in this practice, the association sponsoring the AHP – and by extension, the association’s employer members – may no longer be able to offer health coverage.

D. Self-Employed Individuals With No Employees Would Be Considered an “Employer,” “Employee,” and “Participant” for the Sole Purpose of Participating In an AHP

The Act confirms in Federal statute that if a self-employed individual with no employees satisfies a specified definition, this self-employed individual would be considered (1) an “employer,” (2) an “employee,” and (3) a “participant” under ERISA for the **SOLE** purpose of participating in an AHP.

In other words, even if a self-employed individual with no employee satisfies the specified definition, this self-employed individual **WOULD NOT** be considered (1) an “employer,” (2) an “employee,” and (3) a “participant” for ***any other purposes*** under ERISA (although Congress and/or the DOL may consider allowing this self-employed individual to be considered (1) an “employer,” (2) an “employee,” and (3) a “participant” for purposes of participating in an Association Retirement Plan, consistent with regulations that were finalized in 2019).⁵⁶

⁵⁵ See Virginia Insurance Code section 38.2-3521.1.E.5.

⁵⁶ See 29 C.F.R. 2510.3-55; *see also*, Definition of “Employer” Under Section 3(5) of ERISA—Association Retirement Plans and Other Multiple-Employer Plans, 84 Fed. Reg. 37508 (July 31, 2019).

It is important to note that the Act is not endeavoring to treat a self-employed individual with no employees as an “employer” and “employee” under the PHSA or the ACA. Instead, a self-employed individual with no employees would be treated as an “employer” and “employee” for purposes of ERISA only. And only for the sole purpose of being considered an “employer member” and an “employee” of an association that satisfies the above stated conditions.

In this case, it is the association that stands as the “employer” under the PHSA and ACA, not the self-employed individual with no employees. In addition, the self-employed individual – as an “employee” of the association that satisfies the above stated conditions – would be aggregated and counted together with other self-employed individual members of the association (in the case of an association made up SOLELY of self-employed individuals) and/or other employees of employers with at least 1 common law employee that are members of the association (in the case of a “mixed association”) for purposes of determining whether this group includes at least 51 employees, and thus, can be treated as a “large employer” sponsoring a “large group” AHP.

- ***Justification for Codifying These Requirements In Federal Statute***

This Will Confirm That Self-Employed Individuals With No Employee Can Be an “Employer,” “Employee,” and a “Participant” Solely for Purposes of Participating In an AHP

- Confirming in Federal statute that ERISA allows a self-employed individual with no employees to participate in an AHP is grounded in the DOL’s sub-regulatory guidance relating to “working owners” (i.e., self-employed individuals with no employees). Specifically, in 1999, the DOL issued Advisory Opinion 99-04, concluding that a self-employed individual with no employees (i.e., a working owner) may have dual status as an “employer” and an “employee,” and thus, permissibly be considered a “participant” in an ERISA-covered plan.⁵⁷ This conclusion was based on the DOL’s opinion that multiple sections of ERISA (e.g., ERISA section 402(a)(2), ERISA section 403(b)(3)(A), ERISA section 408, ERISA section 4001(b)(1), ERISA section 4021(b)(9), and ERISA section 4022(b)(5)(A)) all served as an indication that self-employed individuals may be considered “participants” for purposes of ERISA coverage. This opinion led the DOL to explain that “there is a clear Congressional design to include [self-employed individuals with no employees] within the definition of participant for purposes of Title I of ERISA.”⁵⁸
- Confirming in Federal statute that a self-employed individual with no employees has dual status as “employer” and “employee” for purposes of participating in an AHP is consistent with the flexible approach the DOL has taken when seeking to give individuals access to workplace benefits. In addition, codifying this requirement is consistent with this DOL’s current efforts to re-classify certain independent contractors so they may have access to workplace benefits.⁵⁹

⁵⁷ DOL Adv. Op. 99-04A (Feb. 1999); *see also* DOL Adv. Op. 2006-04A (April 27, 2006).

⁵⁸ *Id.*

⁵⁹ *See* 89 Fed. Reg. 1638 (Jan. 10, 2024).

An Employment Relationship Exists Even for Self-Employed Individuals With No Employees

- A self-employed individual with no employees provides services to the self-employed individual's own trade or business by providing services to a third-party entity, which itself is traditionally a trade or business or a third-party consumer. This self-employed individual generates revenue for its own trade or business through the provision of these services for these third-parties, and the Internal Revenue Code treats this revenue generated as "income," which is taxed for both income and employment tax purposes, just like "wages."
- While these self-employed individuals with no employees do not act in the capacity of employees of an employer in the traditional employment sense, these self-employed individuals continue to provide services just like an employee, and these self-employed individuals generate income that is taxed just like wages. A failure to recognize that these revenue generating, taxpaying self-employed individuals operate in an employment setting is a failure to recognize that we now live in a competitive, global economy that no longer relies on a workforce made up of the traditional employee employed by a traditional employer. In other words, accepting the notion that "one does not have an employment relationship with oneself" fails to recognize changing market dynamics and is rooted in economic theory of the 1970s when ERISA was first enacted into law.
- It is important to emphasize that over the past three decades, our nation's economic environment has evolved into a competitive, global economic environment. Our nation's workforce has similarly evolved from a traditional employment-based setting where "employees are employed by an employer," to a non-traditional employment-based setting where a growing number of workers are self-employed individuals with no employees.⁶⁰ With the continued growth of the "gig economy," and more and more millennials working as self-employed individuals – by choice or by circumstance⁶¹ – Congress can no longer ignore the needs of these types of workers. In our view, it is incumbent upon Congress to develop new policies that not only reflect current market dynamics, but that provide access to meaningful workplace benefits that self-employed individuals with no employees so glaringly lack solely because they choose – or are forced – to work without a traditional employer.

⁶⁰ See Small Business Trends, *Key Trends at Sole Proprietorships Over the Past 30 Years*, Dec. 4, 2015 at <https://smallbiztrends.com/2014/09/key-trends-sole-proprietorships-past-30-years.html>, reporting that the Internal Revenue Service found that sole proprietorships nearly doubled from 1980, when there were 39.2 for every thousand Americans to 76.7 sole proprietors for every thousand Americans in 2007.

⁶¹ See McKinsey Global Institute, *Independent work: Choice, Necessity, and the Gig Economy*, October 2016, page 4 at <https://www.mckinsey.com/featured-insights/employment-and-growth/independent-work-choice-necessity-and-the-gig-economy>.