THE COALITION TO PROTECT AND PROMOTE ASSOCIATION HEATLH PLANS

February 20, 2024

Submitted Electronically via:* *www.regulations.gov

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N–5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Comments on the Proposed Rescission of the AHP Final Rule: RIN 1210–AC16

To Whom It May Concern:

On behalf of The Coalition to Protect and Promote Association Health Plans, I respectfully submit the following comments in response to the Notice of Proposed Rulemaking ("NPRM"), which proposes to rescind the Department of Labor's (the "Department's") 2018 rule titled "Definition of Employer–Association Health Plans" (the "2018 AHP Rule") and to reexamine the criteria for a group or association of employers to be able to sponsor an AHP.

The Coalition to Protect and Promote Association Health Plans (the "Coalition") is an ad hoc coalition of national and state member-based organizations. Several of our member-organizations currently sponsor an "association health plan" ("AHP") formed in accordance with the Department's guidance issued prior to the release of the 2018 AHP Rule (referred to by the Department as "pre-rule guidance"). Other member-organizations established – but have since discontinued – an AHP formed in accordance with the 2018 AHP Rule. Our members also include organizations that currently provide services to existing AHPs, and also, provided services to those AHPs that have been discontinued.

COMMENTS

I. The Department Is Incorrect: AHPs Do Not Offer "Skinny Coverage"

In the preamble to the Department's proposed regulations, the Department asserts that AHPs offer "skinny coverage" because AHPs are not subject to the Affordable Care Act's ("ACA's") "essential health benefits" ("EHB") requirement.[1]

Contrary to the Department's assertion, 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.[2]

[1] 88 Fed. Reg. 87981, 87974 (Dec. 20, 2023).
[2] *See* Office of Management and Budget, EO 12866 Meeting 1210-AC16, S*ubmission 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.

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 employers – are voluntarily covering the 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 ***<u>both</u>*** cases, *<u>all</u>* ten of the EHBs are covered.

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 a group or association establishing an AHP imposes a fiduciary duty on the Board governing the AHP,[3] requiring the Board to "act in the best interest" of the AHP participants, while also keeping plan costs low.[4] 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).

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[3] The Department has 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)].

[4] 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)].

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."[5] In fact, the Congressional Budget Office ("CBO") has explained that "individual" market plans generally have narrower provider networks than employment-based plans.[6]

AHPs – which are employment-based plans that offer the same type of coverage offered by large employers – 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.[7] Although the Biden Administration has undertaken efforts to strengthen the ACA's "individual" market "network adequacy" rules,[8] the provider networks for ACA "individual" market plans pale in comparison to the breadth of employer-based health plan provider networks offered through an AHP. Same is true of "small group" market plans.

C. AHPs are NOT "Skinny Plans"

In summary, it is inaccurate for the Department – or any critics of AHPs – to claim that AHPs are "skinny plans" when there are verifiable facts that AHPs are (1) voluntarily covering the EHBs and (2) offering broader provider networks relative to ACA "individual" and "small group" market plans, and – as discussed more fully below – (3) offering lower deductibles relative to ACA "individual" and "small group" market plans for equal if not better coverage.

II. <u>The Department Is Incorrect: AHPs Do Not Underinsure Participants</u>

The Department also suggests that AHPs underinsure participants.[9]

However, when it comes to making claims that a particular type of health plan underinsures participants, the Department <u>*needs to look no further*</u> than ACA "individual" and "small group" market plans.

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[5] *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*.

[6] 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.

[7] A participant in the Nevada REALTORS®AHP that operated in 2019 – prior to the discontinuance of the plan on account of the District Court of the District of Columbia invalidating the 2018 AHP Rule – explained that on account of their participation in the AHP: "[m]y wife and I were able to go to the best hospital in Northern Nevada as well as have a network of local providers that were not covered under our previous ['individual' market] plan. As we live in a remote area at Lake Tahoe, we would normally have to drive an hour or more to go to preferred providers under the previous Obamacare plan and now we can use local providers." *See* Brief for National Association of Realtors as Amici Curiae in Support of Appellant at *20, New York v. U.S. Department of Labor, 363 F. Supp. 3d 109 (D.D.C. 2019) (No. 1:18– CV–01747–JDB).

[8] *See* Notice of Benefit and Payment Parameters for 2024 at https://www.govinfo.gov/content/pkg/FR-2023-04-27/pdf/2023-08368.pdf.

[9] 88 Fed. Reg. at 87974-75 (Dec. 20, 2023).

For example, although ACA "individual" market plans are heavily subsidized by the government (such that monthly premium payments for ACA "individual" market plans may only amount to $10 per month for particular policyholders),[10] 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 the ACA, is allowed to have the highest deductible – averaged $7,481 for single coverage and about $16,000 for family coverage for the 2023 plan year.[11] 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 $4,890 for single coverage and about $11,000 for family coverage for the 2023 plan year.[12]

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 $16,000 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 – 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. If the Department is going to label any coverage as "underinsuring" participants, the ACA's "individual" market plans fit this label to a T.

Similarly, the average deductible for a "small group" market plan was about $2,500 for single and $7,000 for family coverage for the 2023 plan year, while the average deductible for a "large group" market plan – which AHPs are – was about $1,478 for single and about $4,000 for family coverage in 2023.[13] This is merely additional verifiable evidence illustrating that AHPs provide comprehensive coverage that is superior to ACA "small group" market plans.

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[10] *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."

[11] *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/.

[12] *Id*.

[13] *See* Kaiser Family Foundation, *2023 Employer Health Benefits Survey*, Oct. 18, 2023 at https://www.kff.org/report-section/ehbs-2023-summary-of-findings/#:~:text=The%20average%20deductible%20amount%20in,%241%2C478).

III. The Department Is Incorrect: AHPs Cannot Discourage People With Pre-Existing Conditions from Joining AHPs

Surprisingly, the Department goes so far as to suggest that AHPs can discriminate against people with pre-existing conditions by asserting that groups sponsoring AHPs discourage people with pre-existing conditions, or those who are otherwise anticipated to have higher health care costs, from joining AHPs.[14] The Department makes this blanket statement based on comments included an Amicus Brief submitted to the Court of Appeals for the District of Columbia by the American Medical Association.[15]

Our Coalition has made it abundantly clear that AHPs ***CANNOT*** discriminate against people with pre-existing conditions, most recently in our public submission to the Office of Management and Budget on October 2, 2023,[16] and also dating back to our Coalition's own Amicus Brief we submitted to the Court of Appeals for the District of Columbia.[17]

Why did the Department opt against quoting our Coalition's Amicus Brief, but the Department chose to quote the AMA's Brief? Our statements are 100% accurate and verifiable in Federal and State statutes. The AMA's claim does not enjoy that same accuracy.

In addition, why did the Department opt against quoting our most recent public submission to OMB, which we submitted two and a half months before the release of these proposed regulations? That information similarly cites to verifiable Federal and State statutes, and goes on to enumerate – as we do below – all of the Federal and State rules and regulations that ensure that AHPs are protecting all plan participants, including participants with pre-existing conditions.

Most importantly, the Department, the media, and the public at large must know that in virtually all States that allow AHPs to operate, a State law requirement ***prohibits*** a group 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).[18] In addition, according to State law, a group sponsoring an AHP ***cannot*** condition membership in the group on any health-status related factor relating to any individual.[19] This means that AHPs ***CANNOT*** discourage people with pre-existing conditions, or those who are otherwise anticipated to have higher health care costs, from joining AHPs. The law is *crystal clear*. Our Coalition understands that the AMA may not know all of the legal requirements that apply to AHPs, but *we do expect* the Department to know this particular consumer protection.

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[14] 88 Fed. Reg. at 87974 (Dec. 20, 2023).

[15] *Id*., citing the Brief for American Medical Association and Medical Society of the State of New York as Amici Curiae in Support of Plaintiffs' Motion for Summary Judgment, at *16, New York v. U.S. Department of Labor, 363 F. Supp. 3d 109 (D.D.C. 2019) (No. 1:18– CV–01747–JDB).

[16] *See* Office of Management and Budget, EO 12866 Meeting 1210-AC16, S*ubmission 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.

[17] Brief for Coalition to Protect and Promote Association Health Plans as Amici Curiae in Support of the Appellant, at *16, New York v. U.S. Department of Labor, 363 F. Supp. 3d 109 (D.D.C. 2019) (No. 1:18– CV–01747–JDB) 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.

[18] *See, e.g.*, Virginia Insurance Code section 38.2-3521.1.E.1.f.

[19] *See, e.g.,* Virginia Insurance Code section 38.2-3521.1.E.1.e.

IV. The Department Should Know: The ACA Requires AHPs to Protect People With Pre-Existing Conditions

Although the Department did not specifically say it, the assertion that groups sponsoring AHPs can discourage people with pre-existing conditions from joining the AHP can be interpreted by the media and critics of AHPs as meaning that AHPs can somehow deny a person coverage if they have a pre-existing condition.

Once again, ***let us be clear***: AHPs – as a "group health plan" under the law[20] – ***CANNOT*** deny coverage for people with a pre-existing condition.

The Department, the media, and the public at large need to look no further than the ACA statute and ERISA (in particular Public Health Service Act ("PHSA") section 2704 and ERISA section 715), which requires "group health plans" to meet the ACA's "group health plan" coverage requirements, including the requirement to eliminate *all* pre-existing condition exclusions for *all* plan participants.

V. The Department Should Know: 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,[21] which means that a fully-insured and self-insured AHP ***must***:

- Eliminate all pre-existing condition exclusions for all plan participants.[22]
- Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan.[23]
- Provide coverage for certain preventive health services with no cost-sharing.[24]
- Cover "adult children" up to age 26.[25]
- Stop rescinding coverage absent fraud or misrepresentation.[26]
- Include new internal and external appeals processes (and provide notice).[27]
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.[28]
- Provide direct access to emergency services.[29]

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[20] ERISA section 733(a)(1) and 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.

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

[22] *See* PHSA section 2704.

[23] *See* PHSA section 2711.

[24] *See* PHSA section 2713.

[25] *See* PHSA section 2714.

[26] *See* PHSA section 2712.

[27] *See* PHSA section 2719.

[28] *Id*.

[29] *See* PHSA section 2719A.

- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.[30]
- 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.[31]
- Eliminate waiting periods that exceed 90 days.[32]
- Cover the cost of clinical trial participation.[33]
- Provide participants with a summary of benefits and coverage.[34]
- Provide annual reports describing the plan's quality-of-care provisions.[35]

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.[36] In addition, ERISA's fiduciary responsibilities apply,[37] requiring the Board governing the AHP and, if applicable, service providers to the AHP, to act in the best interest of the plan participants. AHP plan participants also have a private right of action to sue the AHP, the Board, and/or any other fiduciaries if there is wrong-doing,[38] and there are detailed procedures for filing health claims.[39]

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,[40] 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.[41]

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.

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[30] *See* PHSA section 2705.
[31] *See* PHSA section 2707(b).
[32] *See* PHSA section 2708.
[33] *See* PHSA section 2709.
[34] *See* PHSA section 2715.
[35] *See* PHSA section 2717.
[36] ERISA, Title I, Subtitle B Part 1.
[37] ERISA, Title I, Subtitle B Part 4.
[38] ERISA section 502.
[39] ERISA section 503.
[40] ERISA, Title I, Subtitle B Part 6.
[41] ERISA section 702.

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").[42] 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.[43] 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.

VI. The Department Must Understand: AHPs Will Not Segment the Markets

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

The Department suggests 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.[44] 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 mis-management 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.

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.

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[42] *See* ERISA section 3(40).
[43] *See* ERISA section 514(b)(6)(A)(ii).
[44] 88 Fed. Reg. at 87974 (Dec. 20, 2023).

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 "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 or 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.[45] 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.[46] 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.

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.

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[45] *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.
[46] *Id*.

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,[47] 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 Department recognized in the preamble of these proposed regulations.[48]

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 overall risk pool.[49]

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[47] *See* Section 162(l) of the Internal Revenue Code ("Code").

[48] *See* 88 Fed. Reg. at 87974 (Dec. 20, 2023).

[49] The REALTORS® are a case-in-point: The membership's average age is 53 years old. And, objective data indicates that older individuals use health care more than younger individuals [*See Health Care Costs – From Birth to Death*, Society of Actuaries, June 2013, page 44 at https://www.soa.org/493875/globalassets/assets/files/research/projects/research-health-care-birth-death-report.pdf]. In the event the REALTORS are permitted by law to establish an AHP, it is likely that the REALTORS AHP will attract older individuals which – according to objective data – are higher medical-utilizers than younger individuals, and if these individuals exit the "individual" market (assuming they were in the risk pool in the first place), this will actually have a positive impact on the existing "individual" market.

VII. <u>The Department Should Consider: The Following Legal Framework</u>

The Department requested comments on the type of criteria and legal requirements the Department should consider incorporating into a forthcoming set of proposed regulations governing the types of groups or associations that may establish an AHP, the types of participants that may enroll in an AHP, and the structure and operation of an AHP.

In response to the Department's request, we suggest the following framework, which expands access to health coverage for employees of small employers and self-employed individuals with no employees, while ***<u>not</u>*** lessening restrictions on AHP formation, which we know is a concern for the Department. For example, the Department asserted that the intent of the 2018 AHP Rule was to expand access to affordable health coverage for employees of small employers and certain self-employed individuals by *lessening restrictions* on the formation of AHPs.[50] Unlike the 2018 AHP Rule, our framework actually *<u>strengthens the restrictions</u>* on AHP formation, while also expanding access to affordable health coverage. A win for the Department, and a win for employees of small employers and self-employed individuals.

Note, our framework has been memorialized in legislative language that we are attaching for your review in Appendix A. We firmly believe that – in the absence of Congress incorporating our framework in statute – the Department can memorialize this framework in a forthcoming regulation with the proper justifications that we also articulate below.

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

Our framework (again, memorialized in legislative language attached in Appendix A) would confirm in regulations (or statute if passed by Congress) that ***<u>both</u>*** industry-based ***<u>and</u>*** non-industry-based groups that meet certain conditions can establish (1) a fully-insured "large group" AHP or (1) a self-insured AHP that would be considered a "Plan MEWA" (hereinafter referred to as a "self-insured Plan AHP"). Our framework does ***NOT*** preempt State law in any way, shape, or form.[51]

The conditions that underpin our framework include a "control test," which effectively mirrors the "control test" developed by the Department through decades of Advisory Opinions, which is a key ingredient to being considered an "employer" under ERISA section 3(5). In addition, these conditions maintain the "business purpose standard" the Department emphasizes in the preamble of these proposed regulations.[52]

Most importantly, our framework ***<u>also</u>*** includes the State law requirements discussed in Section III above, namely (1) that a group or association establishing an AHP is prohibited from conditioning membership in the group or association on any health-status related factor relating to any individual **AND** (2) the AHP must make coverage available to all employer members of the group or association regardless of any health status-related factor relating to the employer members' employees or dependents. In other words, an AHP ***<u>CANNOT</u>*** discourage people with pre-existing conditions, or those who are otherwise anticipated to have higher health care costs, from joining AHPs.

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

[51] For example, if a State does not want to follow a portion – or all – of our framework, a State is permitted to enact its own State law on the matter.

[52] *See* 88 Fed. Reg. at 87975 (Dec. 20, 2023).

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

- ***Justification for Memorializing These Requirements In Law***

Satisfying Our Legal Framework's Conditions Produces a True Employee Benefit Plan, Not a Commercial Insurance-Type Arrangement

- The conditions set forth in our framework that must be satisfied ***before*** a group or association of employers 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 groups or 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.

Our Framework's Conditions Are Consistent With State Law Consumer Protections

- The conditions set forth in our framework 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 groups or associations can establish an AHP, which ensures that those groups or associations that satisfy ALL of these conditions are *not* "masquerading as bona fide groups or associations merely to promote the commercial sale of insurance," which we know is another concern of the Department.[53] Moreover, the groups or 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. Our conditions prevent such bad actors from entering the market.

It Is Advisable to Codify the Criteria for Industry-Based AHPs

- The criteria for determining whether an industry-based group can establish a fully-insured "large group" AHP or self-insured Plan AHP has been developed through Advisory Opinions over the past 30+ years. However, hundreds of Advisory Opinions that consider differing facts and circumstances are not reliable sources for legal practitioners and groups or associations wanting to establish an AHP to rely on to determine whether the group may permissibly establish a fully-insured "large group" AHP or self-insured Plan AHP.

- As a result, it is advisable to codify in regulations the conditions that must be met to be considered an "employer" under ERISA section 3(5), thereby creating a one-stop, regulatory regime for determining whether an industry-based group may indeed permissibly establish a fully-insured "large group" AHP or self-insured Plan AHP. The framework discussed above is a common-sense approach that requires adherence to the "control test," the "business purpose standard," and State law consumer protections which together protect participants while also ensuring the provision of comprehensive health coverage.

[53] *See* 88 Fed. Reg. at 87973 (Dec. 20, 2023).

“Commonality” Should Be Based on a “Shared Business and Economic Purpose,” Not Geography

- We believe that a more efficient and reliable set of criteria for proving that a bona fide employment relationship exists is whether employers are joining a group or association for a “shared business and economic purpose,” provided the group or association was organized for purposes unrelated to the provision of benefits ***and*** the group or association satisfies ALL of the conditions set forth in our framework. This is consistent with court rulings that have examined whether a group or association of employers is an “employer” under ERISA section 3(5).[54]

- What is this shared business and economic purpose? This common bond includes a common interest in promoting a vibrant local economy. If consumers are attracted to successful places of business (e.g., restaurants, coffee shops, hardware stores, thrift shops, bike stores, appliance stores, boutique law and accounting firms, etc.) each and every business benefits from increased consumer traffic and spending. As the late President John F. Kennedy said, “a rising tide lifts all boats,” meaning if the economy improves, every participant in the economy will be in an improved financial position. You do ***not*** need to be in the same industry to share this very important economic interest.

- Another common bond includes a common interest in Local, State, and Federal regulations of business practices, taxation, and also security. It is ***arbitrary to think*** that only employers in the same industry care about the regulations they have to comply with, the taxes they have to pay, and the security of their businesses and patrons.

- Here is another shared business and economic purpose: A constructive and positive labor environment, a robust labor market, and workers who are healthy both physically and financially. Productivity is the key to economic success, and the fact that employers may not share the same industry does ***not*** mean that these employers do not share this business principle.

- It is a misnomer to conclude that non-industry-based groups are interested in offering health coverage through an AHP to “avoid[] the application of certain legal provisions governing individual and small group market [insurance requirements], such as modified community rating, single risk pool, and essential health benefits requirements,” as the Department suggests.[55] Non-industry-based groups – just like single-employers and industry-based groups – want to offer comprehensive and affordable coverage to attract and retain talented workers. Small employers that are members of non-industry-based groups also want to compete with large employers for talented and productive workers. By obtaining health coverage through an AHP – which is the same type of health plan sponsored by a large employer – small employers can “group purchase” and effectively compete with large employers by offering the same type of comprehensive and affordable health benefits to their employees.

[54] *See, e.g.*, *Wisconsin Educ. Ass’n Ins. Trust v. Iowa State Board of Public Instruction*, 804 F.2d 1059 (8th Cir. 1986) and *MDPhysicians & Associates, Inc. v. State Bd. Of Ins.*, 957 F.2d 178 (5th Cir. 1992), both finding that an ERISA section 3(5) “employer” exists if a group of employers has a sufficient common economic or representational interest.

[55] *See* 88 Fed. Reg. at 87970 (Dec. 20, 2023).

- The "small group" market in many States is broken. The Supreme Court gives the Department latitude to interpret the statute and develop regulations to ameliorate market dysfunctions.[56] The Department would be doing just that if the Department developed a rule confirming that the "commonality of interest" test is satisfied if a group or association of employers – regardless of whether the group is industry-based or non-industry-based – has a "shared business and economic purpose," provided this shared purpose is unrelated to the provision of benefits AND the group or association satisfies ALL of the conditions set forth in our legal framework.

B. Aggregation Rule

If an industry-based ***or*** non-industry-based group satisfies ALL of the conditions discussed above, ALL the employees of ALL of the employer members of this group shall be aggregated and counted together for purposes of determining whether this aggregated group includes 51 or more employees.

- ***Justification for Memorializing This Requirement In Law***

It Is Imperative to Provide Legal Certainty So Groups Can Offer Comprehensive "Large Group" Health Plan Coverage

- This aggregation rule 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.[57] Under our framework, in cases where an industry-based ***or*** non-industry-based group (1) satisfies the above stated conditions and (2) includes at least 51 employees, this group will be considered a "large employer" that is sponsoring a "large group" plan under the PHSA and 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, our framework does ***not*** preempt State law).

- It is important to note that "large group" plans are *not* less regulated health plans, as the Department contends in the preamble to these proposed regulations.[58] As discussed in Section IV above, fully-insured "large group" plans are not only subject to the ACA's "group health plan" 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" plans 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.

- Currently, CMS's "look-through" rule is merely memorialized in sub-regulatory guidance (i.e., a CMS Insurance Standards Bulletin). Codifying this aggregation rule is imperative to ensure legal certainty for State insurance regulators, Federal regulators, and stakeholders on both sides of the AHP issue, including groups and 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.

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[56] *See Encino Motorcars, LLC v. Navarro*, 579 U.S. 211 (2016); *see also*, *Perez v. Mortgage Bankers Ass'n*, 575 U.S. 92 (2015).

[57] *See* CMS Insurance Standards Bulletin, Sept. 1, 2022 at https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

[58] *See* 88 Fed. Reg. at 87974 (Dec. 20, 2023).

C. Codifying the Practice of Varying Premiums By Employer Member

Our framework codifies the practice of varying premiums by each employer member of a group that (1) satisfies the above stated conditions and (2) offers health coverage through a fully-insured "large group" AHP or self-insured Plan AHP.

Our framework sets forth specific requirements for developing premium rates for AHPs sponsored by (1) groups that ONLY include employers with at least 1 common law employee, (2) groups made up SOLEY of self-employed individuals with no employees, and (3) "mixed groups" that include BOTH employers with at least 1 common law employee and self-employed individuals with no employees.

1. Groups 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 group 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 group, 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. Groups Made Up SOLEY of Self-Employed Individuals With No Employees

In the case of an AHP established by a group 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.[59] 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.

3. "Mixed Groups" of Employers and Self-Employed Individuals

If there is a "mixed group" 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 group," 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.

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[59] 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)].

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 group" 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 ***<u>CANNOT</u>*** 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 group" and offering health coverage through the AHP.

Note, a "mixed group" 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 group" 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 group 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 Memorializing These Requirements In Law***

<u>*Varying Premiums By Employer Member Is a Long-Standing Practice Which Is Permitted By States and the Federal Government*</u>

- 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 who are 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 – in particular the Obama Administration – has always 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)[60] or a State may choose to enact a State law prohibiting this practice. Once again, our framework does ***not*** preempt State law.

[60] *See* Virginia Insurance Code section 38.2-3521.1.E.5.

- If the Department took steps to disallow this long-standing practice for fully-insured "large group" AHPs and self-insured AHPs, this would have a severe and significant detrimental impact on all AHPs and it would effectively end health coverage for hundreds of thousands, if not millions, of employees. Put more plainly, any Departmental guidance prohibiting this practice would "create a material failure of a private market," which ***NO*** Federal Department is permitted to do through Federal guidance.[61]

- In addition, as discussed more fully below, disallowing this long-standing practice would result in the Board governing an AHP to breach their fiduciary duty of "acting in the best interest" of plan participants and undertaking efforts to keep plan costs low for participants.

Varying Premiums By Employer Members Is a Fiduciary Obligation

- As discussed in Section I above, one of the most important factors for qualifying as an "employer" under ERISA section 3(5) is the "control test," which requires a group or association sponsoring an AHP to establish a governing Board to operate and manage the health coverage offered through the AHP. As also discussed in Section I, 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 group sponsoring the AHP – and by extension, the group's employer members – may no longer be able to offer health coverage.

- In addition, and as discussed more fully below, by varying premiums by employer member, an AHP has the ability to attract employer members with healthy employees who are then able to offset the health risks associated with employer members that employ less healthy/high-medical-utilizers. This means that less healthy/high-medical-utilizers can enjoy a competitive premium rate for comprehensive health coverage relative to, for example, the ACA's "small group" market.

Varying Premiums By Employer Member Helps Employer Members With High-Medical Utilizers

- In cases where an employer member employs employees who utilize a significant amount of health care (i.e., less healthy/high-medical-utilizers), this employer will typically benefit from an AHP by finding more affordable, comprehensive health coverage through the AHP. This is due the fact that this AHP can develop competitive premium rates for employer members with "healthy" employees, thus attracting these healthy groups to be a part of the AHP risk pool.

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[61] *See* Executive Order 12866 (Oct. 4, 1993).

- The fact that these healthy risks may now be a part of the AHP risk pool, these healthy risks are able to offset the exposure the less healthy/high-medical utilizers would pose to the risk pool. This also allows the AHP to offer competitive premium rates that ***both*** employers with healthy employees ***and*** employers with less healthy/high-medical-utilizers will find attractive, which not only benefits the employer member (from a financial perspective), but also its employees (especially those employees who may be less healthy/high-medical-utilizers because they now have access to comprehensive and affordable health coverage subject to the ACA's coverage requirements and ERISA's consumer protections, as discussed above).

Disallowing This Practice Will Cause a Fiduciary Breach and Effectively Take Away Health Coverage for Employees

- Putting a finer point on this fiduciary obligation, if the Department took steps to eliminate a group's ability to vary premiums by employer member, the Department would effectively force the Board to breach their fiduciary duties under ERISA.

- A more dire scenario: The Department's actions would increase premiums for ***both*** employer members with less healthy/high-medical utilizers ***and*** employers with healthy employees, which would likely cause employer members to discontinue their participation in the AHP, thereby threatening the long-term solvency of the AHP and resulting in the loss of comprehensive health coverage that employees and their dependents have come to rely on. A result that is counter to the Department's mission of promoting the provision of employee benefits.

- In addition, the above described conditions that must be satisfied set forth the appropriate safeguards to distinguish the AHP from a commercial insurance-type arrangement that lacks the requisite connection to the employment relationship and whose purpose is principally to identify and manage risk on a commercial basis. Managing risk is a fiduciary obligation that is deeply grounded in ERISA, and managing risk to satisfy the Board's fiduciary duties should in ***no way*** be conflated with managing risk on a commercial basis.

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

Our framework also confirms that self-employed individuals with no employees can participate in a fully-insured "large group" or self-insured Plan AHP. Here, 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 the Department 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 which – unlike the 2018 AHP Rule – were ***<u>NOT</u>*** invalidated by any court of law, and thus, remain in effect today).[62]

[62] *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 our framework 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 a group that satisfies the above stated conditions.

In this case, it is ***the group or 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 group or association that satisfies the above stated conditions – would be aggregated and counted together with other self-employed individual members of the group and/or other employees of employers with at least 1 common law employee that are members of the group 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 Memorializing These Requirements In Law***

There Is a Basis for Interpreting ERISA As Allowing Self-Employed Individuals With No Employee to Be an "Employer," "Employee," and a "Participant" Solely for Purposes of Participating In an AHP

- Interpreting ERISA to allow a self-employed individual with no employees to participate in an AHP is grounded in the Department's previous sub-regulatory guidance relating to "working owners" (i.e., self-employed individuals with no employees). Specifically, in 1999, the Department 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.[63] This conclusion was based on the Department'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 Department to state that "there is a clear Congressional design to include working owners within the definition of participant for purposes of Title I of ERISA."[64]

- In the case of our framework, the Department's interpretation 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 Department has taken when seeking to give individuals access to workplace benefits. In addition, such an interpretation is consistent with this Department's current efforts to re-classify certain independent contractors so they may have access to workplace benefits.[65] Importantly, the Department shares the same policy goal we do: To allow self-employed individuals with no employees to access workplace benefits. In our case, such access to workplace benefits is solely limited to accessing comprehensive and affordable health coverage offered through an AHP.

[63] DOL Adv. Op. 99-04A (Feb. 4, 1999); *see also* DOL Adv. Op. 2006-04A (April 27, 2006).
[64] *Id.*
[65] *See* 89 Fed. Reg. 1638 (Jan. 10, 2024).

The Department Has the Authority to Deem Self-Employed Individuals With No Employees to Be an "Employer," "Employee," and a "Participant" Solely for Purposes of Participating In an AHP

- DOL regulation section 2510.3-3 does *not* reflect an interpretation that ERISA prohibits a self-employed individual with no employees from participating in an ERISA-covered plan. The regulation simply makes clear that self-employed individuals with no employees are not required to undertake the burdens of complying with, for example, ERISA's reporting and fiduciary requirements.

- The regulation, however, makes clear that in cases where a self-employed individual with no employees participates in an employee benefit plan *alongside other* employees, the self-employed individual will be deemed an "employee," and the plan *will* be governed by Title I of ERISA. This point was underscored by the Department's long, and ultimately successful struggle to convince the courts that ERISA was never intended to exclude self-employed individuals from ERISA-covered plans based on their status as a working owner. This led the Supreme Court to find that "a working owner can be an employee entitled to participate in a plan and, at the same time, the employer who established the plan."[66]

- As discussed above, there will be many cases in which a self-employed individual with no employees is a member of a "mixed group" of (1) employers with at least 1 common law employee and (2) self-employed individual with no employees. Here, the self-employed individual *will be* participating in the AHP *alongside other* employees, which is consistent with the Supreme Court's ruling and also the Department's sub-regulatory guidance.

- Although there may be instances where a group is made up SOLELY of self-employed individuals with no employees (as discussed above), these instances should not transform a reasonable interpretation of ERISA to an unreasonable one.

Changing Market Dynamics Justifies Deeming Self-Employed Individuals With No Employees to Be an "Employer," "Employee," and a "Participant" Solely for Purposes of Participating In an AHP

- In our view, the Department has broad authority to interpret the provisions of ERISA in light of changing times and circumstances. The Supreme Court agrees, explaining that a Federal agency can supersede a prior interpretation of the law to address marketplace developments and new policy and regulatory issues.[67] The preamble of these proposed regulations also recognized this precedent, explaining that "an agency has the discretion to change a policy position provided that the agency acknowledges changing its position, the new policy is permissible under the governing statute, there are good reasons for the new position, the agency believes that the new policy is better, as evidenced by the agency's conscious action to change its policy, and the agency takes into account any serious reliance interests in the prior policy."[68]

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[66] *See Yates v. Hendon*, 540 U.S. 1, 16 (2004).

[67] *See Encino Motorcars, LLC v. Navarro*, 579 U.S. 211 (2016); *see also*, *Perez v. Mortgage Bankers Ass'n*, 575 U.S. 92 (2015).

[68] *See* 88 Fed. Reg. at 87974 (Dec. 20, 2023), citing *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 220-23 (2016).

- 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.[69] With the continued growth of the "gig economy," and more and more millennials working as self-employed individuals – by choice or by circumstance[70] – the Department can no longer ignore the needs of these types of workers. In our view, it is incumbent upon the Department 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.

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, as noted above. 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.

As noted, please see Appendix A which includes legislative language that memorializes the framework detailed above.

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[69] *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.

[70] *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.

Thank you in advance for considering these comments. Please do not hesitate to contact me with any questions or if you would like to schedule a meeting to discuss these very important issues.

Sincerely,

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APPENDIX A

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A BILL

To amend the Employee Retirement Income Security Act of 1974 to clarify the treatment of certain association health plans as employers, and for other purposes.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Multiple Employer Welfare Arrangement Act" or the "MEWA Act".

SEC. 2. TREATMENT OF GROUP OR ASSOCIATION OF EMPLOYERS.

(a) In General.—Section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)) is amended—

(1) by striking "The term" and inserting "(A) The term"; and

(2) by adding at the end the following:

"(B) For purposes of subparagraph (A), a group or association of employers shall be treated as an 'employer', regardless of whether the employers composing such group or association are in the same industry, trade, or profession, if such group or association—

"(i)(I) has established and maintains an employee welfare benefit plan that is a group health plan (as defined in section 733(a)(1));

"(II) provides coverage under such plan to at least 51 employees after all of the employees employed by all of the employer members of such group or association have been aggregated and counted together as described in subparagraph (D);

"(III) has been actively in existence for at least 2 years;

"(IV) has been formed and maintained in good faith for purposes other than providing medical care (as defined in section 733(a)(2)) through the purchase of insurance or otherwise;

"(V) does not condition membership in the group or association on any health status-related factor (as described in section 702(a)(1)) relating to any individual;

"(VI) makes coverage under such plan available to all employer members of such group or association regardless of any health status-related factor (as described in section 702(a)(1)) relating to such employer members;

"(VII) does not provide coverage under such plan to any individual other than an employee of an employer member of such group or association;

"(VIII) has established a governing board with by-laws or other similar indications of formality to manage and operate such plan in both form and substance, of which at least 75 percent of the board members shall be made up of employer members of such group or association participating in the plan that are duly elected by each participating employer member casting 1 vote during a scheduled election;

"(IX) is not a health insurance issuer (as defined in section 733(b)(2)), and is not owned or controlled by such a health insurance issuer or by a subsidiary or affiliate of such a health insurance issuer, other than to the extent such a health insurance issuer may participate in the group or association as a member;

“(ii) is structured in good faith with any set of criteria to qualify for such treatment in any advisory opinion issued prior to the date of enactment of the Multiple Employer Welfare Arrangement Act; or

“(iii) meets any other set of criteria to qualify for such treatment that the Secretary by regulation may provide.

“(C)(i) For purposes of subparagraph (B), a self-employed individual shall be treated as—

“(I) an employer who may become a member of a group or association of employers;

“(II) an employee who may participate in an employee welfare benefit plan established and maintained by such group or association; and

“(III) a participant of such plan subject to the eligibility determination and monitoring requirements set forth in clause (iii).

“(ii) For purposes of this subparagraph, the term ‘self-employed individual’ means an individual who—

“(I) does not have any common law employees;

“(II) has a bona fide ownership right in a trade or business, regardless of whether such trade or business is incorporated or unincorporated;

“(III) earns wages (as defined in section 3121(a) of the Internal Revenue Code of 1986) or self-employment income (as defined in section 1402(b) of such Code) from such trade or business; and

“(IV) works at least 10 hours a week or 40 hours per month providing personal services to such trade or business.

“(iii) The board of a group or association of employers shall—

“(I) initially determine whether an individual meets the requirements under clause (ii) to be considered to a self-employed individual for the purposes of being treated as an—

“(aa) employer member of such group or association (in accordance with clause (i)(I)); and

“(bb) employee who may participate in the employee welfare benefit plan established and maintained by such group or association (in accordance with clause (i)(II));

“(II) through reasonable monitoring procedures, periodically determine whether the individual continues to meet such requirements; and

“(III) if the board determines that an individual no longer meets such requirements, not make such plan coverage available to such individual (or dependents thereof) for any plan year following the plan year during which the board makes such determination. If, subsequent to a determination that an individual no longer meets such requirements, such individual furnishes evidence of satisfying such requirements, such individual (and dependents thereof) shall be eligible to receive plan coverage.

“(D) For purposes of subparagraph (B), all of the employees (including self-employed individuals) employed by all of the employer members (including self-employed individuals) of a group or association of employers shall be—

“(i) treated as participants in a single plan multiple employer welfare arrangement; and

“(ii) aggregated and counted together for purposes of any regulation of an employee welfare benefit plan established and maintained by such group or association.”.

(b) Determination of Employer or Joint Employer Status.—The provision of employee welfare benefit plan coverage by a group or association of employers shall not be construed as evidence for establishing an employer or joint employer relationship under any Federal or State law.

SEC. 3. RULES APPLICABLE TO EMPLOYEE WELFARE BENEFIT PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181, et seq.) is amended by adding at the end the following:

"SEC. 736. RULES APPLICABLE TO EMPLOYEE WELFARE BENEFIT PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

"(a) Premium Rates for a Group or Association of Employers.—

"(1)(A) In the case of an employee welfare benefit plan established and maintained by a group or association of employers described in section 3(5)(B), such plan may, to the extent not prohibited under State law—

"(i) establish base premium rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all plan participant claims; and

"(ii) utilize the specific risk profile of each employer member of such group or association to determine contribution rates for each such employer member's share of a premium by actuarially adjusting above or below the established base premium rates.

"(B) For purposes of paragraph (1), the term 'employer member' means—

"(i) an employer who is a member of such group or association of employers and employs at least 1 common law employee; or

"(ii) a group made up solely of self-employed individuals, within which all of the self-employed individual members of such group or association are aggregated together as a single employer member group, provided the group includes at least 20 self-employed individual members.

"(2) In the event a group or association is made up solely of self-employed individuals (and no employers with at least 1 common law employee are members of such group or association), the employee welfare benefit plan established by such group or association shall—

"(A) treat all self-employed individuals who are members of such group or association as a single risk pool;

"(B) pool all plan participant claims; and

"(C) charge each plan participant the same premium rate.

"(b) Discrimination and Pre-Existing Condition Protections.—An employee welfare benefit plan established and maintained by a group or association of employers described in section 3(5)(B) shall be prohibited from—

"(1) establishing any rule for eligibility (including continued eligibility) of any individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual) to enroll for benefits under the terms of the plan that discriminates based on any health status-related factor that relates to such individual (consistent with the rules under section 702(a)(1));

“(2) requiring an individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual), as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor that relates to such individual (consistent with the rules under section 702(b)(1)); and

“(3) denying coverage under such plan on the basis of a pre-existing condition (consistent with the rules under section 2704 of the Public Health Service Act).”.

SEC. 4. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to exempt a group health plan which is an employee welfare benefit plan offered through a group or association of employers from the requirements of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et. seq.), including the provisions of part A of title XXVII of the Public Health Service Act as incorporated by reference into this Act through section 715.