COMMENT ON DEFINITION OF 'EMPLOYER'-ASSOCIATION HEALTH PLANS PROPOSED RULE (RIN 1210-AC16)

Presented to Employee Benefits Security Administration, Department of Labor

February 15, 2024

Scott Centorino, *Visiting Fellow*

Trevor Carlsen, *Visiting Fellow*

Prepared on behalf of the Opportunity Solutions Project

Overview

The Biden administration's latest executive action on health care—a proposed rule to rescind the Trump administration's clarification of what groups of employers may band together to offer Association Health Plans (AHPs) and replace it with less formal and more restrictive rules—is illustrative of the administration's approach to health care more broadly. Like other actions, the proposed rule seeks to prop up the failed structure of ObamaCare at the expense of more creative solutions, will disrupt workers' existing and affordable private health coverage, and represents an arbitrary and capricious regulatory process that puts bureaucrats ahead of businesses.

The administration should withdraw the proposed rule and spend its energy defending the regulation it seeks to rescind and working with Congress to solidify its standing in statute.

Health Insurance Costs Are a Major Problem for Small Businesses and Federal Rules Are to Blame

Policymakers and the public alike know health care costs are on a long-term upward trajectory. Between 2013 and 2017 alone, premiums more than doubled in the United States among those shopping in the individual marketplace.[1] Other sources suggest an increase in premiums of 129 percent between 2013 and 2019.[2]

Small businesses and their employees are particularly harmed. By 2018, the average premium for a family that received coverage sponsored by a small business reached $18,739, tripling a family's average cost for coverage in 2000.[3] And the average deductible for these families quadrupled in that same timeframe.[4]

As a result, many small businesses have stopped hiring, stopped investing, or stopped offering benefits entirely.[5] Half of small businesses offered health insurance in 2000.[6] By 2018, only one-third of small businesses did so.[7] Unsurprisingly, nine million fewer Americans were covered by employer-sponsored health insurance in 2018 than in 2000.[8] Since 2018, the share has remained stagnant.[9]

With this decline in employer-sponsored coverage among small businesses, more and more Americans have been driven into the unaffordable individual insurance market, into government programs like Medicaid that should be prioritized for the truly needy, or into going without coverage altogether.[10] Premiums in the individual market increased by more than 100 percent between 2013 and 2017 in the wake of ObamaCare.[11] The individual market has only become less affordable since. From 2018 to 2023 alone, out-of-pocket maximums increased by 23.8 percent.[12]

Why is this happening? Most of these conditions are the inevitable symptoms of the deeply distorted market structure and perverse incentives created by ObamaCare and its subsequent regulatory regime. But, more specifically, federal law has put small businesses at a deep disadvantage.

Large employers who are able to self-insure gain exemptions from many of the regulations that drive costs up for small businesses and their workers.[13] For example, many adjusted community

rating regulations, essential health benefit mandates, and actuarial corridor regulations do not apply to self-insured large employers.[14] Small businesses providing health insurance, on the other hand, must comply with these regulations and do so with a smaller risk pool.[15]

The Proposed Rule Will Undermine the Progress Made by Expanded Access to Association Health Plans

The Trump administration recognized these issues.[16] To that end, the department finalized a rule in 2018 ("2018 rule") which, at least in part, sought to mitigate some of these effects by allowing more small businesses to negotiate coverage together with the leverage of a larger entity.[17] The 2018 rule established a new and more inclusive set of criteria. The 2018 rule was also a step forward because it updated rules in the post-ObamaCare context and provided a more procedurally sound and permanent structure than pre-existing sub-regulatory guidance. As the department acknowledges in ERISA Procedure 76-1, there are limitations to the applicability of "guidance" for the broader business community.[18] "Only the parties described in the request for opinion may rely on the opinion," and information letters are "informational only, and [are] not binding on the department."[19]

In short, the 2018 rule modified regulations around association health plans to allow associations that serve a business purpose but exist primarily for health insurance purposes, allow associations among businesses from different industries but the same state or region to form an association, allow businesses to provide an association health plan together even if their employees do not all live in the same state, and allow self-employed entrepreneurs or married business owners to access association health plans.[20]

At the time, it was projected that up to four million Americans could access affordable coverage as a result of the expansion of association health plans, including almost half a million Americans with no health care coverage.[21] Small business owners and workers were expected to save more than $10,000 per year in premiums compared to plans on the individual market and more than $4,000 lower than plans for small groups.[22]

After the 2018 rule went into effect, small businesses created new associations and offered health coverage with rates significantly lower than previous, small-group plans.[23] Newly created AHPs produced savings of nearly 30 percent nationwide.[24]

These new AHPs produced real savings. For example, small businesses in Vermont formed the Vermont Association of Chamber of Commerce Executives.[25] Among the businesses that saved through the new association were a solar panel installation company ($14,500 in savings in one year and less employee cost sharing), a restaurant (employees' deductibles reduced by $3,650), and an animal shelter that brought back health care coverage for its employees after dropping it due to high costs.[26]

In another state, businesses banded together to form the Maine Energy Marketers Association.[27] The President of the association has shared that he personally felt the rising costs of small business

coverage and simply did not go to the doctor to avoid high out-of-pocket costs.[28] With the new AHP, businesses and employees were able to access robust health care coverage rather than endure higher costs and less generous benefits.[29]

Stories just like these in associations just like this are abundant.[30]

These new AHPs offer high quality coverage which must still comply with mandates like coverage for pre-existing conditions and restrictions on limits of essential health benefits.[31] Despite concerns that new AHPs would not cover essential health benefits required for plans on the individual market, those concerns went unrealized.[32] Congress exempted AHPs from the requirement because, as a matter of practice, they already provided such benefits.[33]

The Proposed Rule Reflects an Arbitrary and Capricious Process

The 2018 rule provided additional clarity regarding which businesses banding together could be considered an "employer" for purposes of providing AHPs. The relevant statutory definition of "employer" is "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity."[34] The 2018 rule was a reasonable interpretation of that statutory definition.

The proposed rule is simple. It rescinds the previous rule finalized in 2018.[35] With this rescission, the landscape will revert to the status quo ante, driven by tighter standards promulgated via agency guidance rather than regulatory certainty. And only "bona fide associations"—as determined by the department under its previous guidance, of course—may sponsor AHPs.

Specifically, and most significantly, to establish an association health plan, associations will need to meet three criteria: (1) have a business or organizational purpose and functions "unrelated to the provision of benefits"; (2) "share some commonality of interest and genuine organizational relationship unrelated to the provision of benefits"; and (3) exercise control over the program, both in form and substance.[36]

These three standards, the business purpose standard, commonality standard, and control standard, respectively, will severely restrict the establishment of new associations seeking more coverage options.[37] And they clearly emanate from a policy preference to bolster the flawed structure of ObamaCare far more than any fidelity to the statutory text.

The proposed rule cites a court decision in which the 2018 rule was described as "clearly an end-run around" the restrictions imposed by ObamaCare.[38] As stated in this Comment, it is true that ObamaCare created more regulatory burdens on small businesses accessing health care coverage than self-insured large employers and that the 2018 rule helped mitigate that discrepancy. Nor does a difference in policy preference make a regulatory change reflecting that difference arbitrary and capricious.

Nevertheless, the court's decision rested, in large part, on the Trump administration having a distinct policy preference and replacing the previous, "longstanding sub-regulatory guidance."[39] Yet, as the court itself pointed out, the passage of ObamaCare upended the context for AHPs and demanded updated and more formal interpretations. The 2018 rule met that need.

However, for the department to reverse course so comprehensively with so little justification almost perfectly illustrates arbitrary and capricious behavior. And it is not analogous to the department's "abruptly revers[ing] course" (as the court described it) in issuing the 2018 rule because that replaced guidance with regulation.[40]

In some ways, the proposed rule is worse than simply arbitrary and capricious. A 180-degree about-face may be arbitrary, but it has a certain binary simplicity. Instead, the proposed rule reflects both an arbitrary return to the status quo ante in the context of AHPs *and* a disorganized, randomness as to the department's interpretation of the same applicable statutory text in multiple contexts.

Specifically, the department is *not* rescinding a closely related rule involving association retirement plans finalized in 2019 and what constitutes an organization eligible to establish an AHP.[41] In that rule, the Employee Benefits Security Administration explicitly sought to "mirror" the definition provided in the AHP rule of 2018 of a "bona fide group or association capable of establishing an association health plan."[42] After all, for the sake of "regulatory uniformity and simplicity," these "provisions have the same meaning and effect here as they have there. It makes sense to have consistent provisions for AHPs and [multiple employer plans or MEPs], because the department is interpreting the same definitional provisions in both contexts and because many of the same types of groups or associations of employers that sponsor AHPs for their members will also want to sponsor MEPs."[43]

This is surprising considering the department's stated intention in the new rule to "mitigate any uncertainty regarding the status of" these rules.[44] The consistency of such definitions, of course, is not simply an exercise in linguistic integrity. Federal law and the interpretation thereof are the tectonic plates on which foundational public policy decisions are built.

Enormous efforts have been made among state policymakers to adjust to the 2018 rule and promote more affordable health care coverage options within their framework.[45] If the proposed rule is finalized, those efforts will require correction, reversal, or, in the case of states with new laws written with the existing AHP rule in mind, possible conflicts of law.

With the rescission of the 2018 rule, what will replace it? A new and clear set of standards established in binding federal regulation? No. Instead, the department will provide non-binding, informal, sub-regulatory guidance to better provide "alignment with ERISA's text, purposes, and policies."[46] In all, businesses can expect less certainty and less affordability without sufficient justification.

Conclusion

The Biden administration should withdraw the proposed rule in question. Instead, the department should defend the 2018 rule and encourage Congress to codify it into statute.

References

[1] Office of the Assistant Secretary for Planning and Evaluation, "Individual market premium changes: 2013- 2017," U.S. Department of Health and Human Services (2017), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/174771/IndividualMarketPremiumChanges.pdf.
[2] Edmund Haislmaier and Abigail Slagle, "Obamacare Has Doubled the Cost of Individual Health Insurance," Heritage Foundation (2021), https://www.heritage.org/health-care-reform/report/obamacare-has-doubled-the-cost-individual-health-insurance.
[3] Nick Stehle and Jonathan Ingram, "Association health plans: Expanding opportunities for small business owners and entrepreneurs," Foundation for Government Accountability (2018), https://thefga.org/research/association-health-plans-small-business/.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Agency for Healthcare Research and Quality "Medical Expenditure Panel Survey," U.S. Department of Health and Human Services (2024), https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2022/ic22_iia_f.pdf.
[10] Nick Stehle and Jonathan Ingram, "Association health plans: Expanding opportunities for small business owners and entrepreneurs," Foundation for Government Accountability (2018), https://thefga.org/research/association-health-plans-small-business/.
[11] Ibid.
[12] Healthinsurance.org, "What is an out-of-pocket maximum?," Healthinsurance.org (2023), https://www.healthinsurance.org/glossary/out-of-pocket-maximum/.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Executive Order 13813 (2017), https://www.govinfo.gov/content/pkg/FR-2017-10-17/pdf/2017-22677.pdf.
[17] Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 Fed. Reg. 28912 (2018), https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans.
[18] ERISA Advisory Opinion Procedures 76-1 (FR Doc. 76-25168), https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/advisory-opinions/filing-requests-for-erisa-aos.
[19] Ibid.
[20] Nick Stehle and Jonathan Ingram, "Association health plans: Expanding opportunities for small business owners and entrepreneurs," Foundation for Government Accountability (2018), https://thefga.org/research/association-health-plans-small-business/.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Greg George and Hayden Dublois, "Association health plans: Affordable health insurance options for small businesses following COVID-19," Foundation for Government Accountability (2020), https://thefga.org/research/association-health-plans-insurance/.
[25] Hayden Dublois, "Association health plans work: How the Trump administration expanded access to affordable & quality health care," Foundation for Government Accountability (2020), https://thefga.org/research/association-health-plans-trump-administration/.
[26] Ibid.
[27] "Association health plans: Lower costs, better coverage, quality care," Foundation for Government Accountability (2019), https://thefga.org/success-story/association-health-plans-lower-costs-better-coverage-quality-care/.
[28] Ibid.

[29] Ibid.
[30] Ibid.
[31] Hayden Dublois, "Association health plans work: How the Trump administration expanded access to affordable & quality health care," Foundation for Government Accountability (2020), https://thefga.org/research/association-health-plans-trump-administration/.
[32] "Association health plans myths v. reality," Foundation for Government Accountability (2020), https://thefga.org/one-pagers/association-health-plans-myths-vs-reality/.
[33] Ibid.
[34] 29 USCS § 1002
[35] Definition of "Employer" under section 3(5) of ERISA-Association health plans, 88 FR 87968 (2023), https://www.federalregister.gov/documents/2023/12/20/2023-27510/definition-of-employer-association-health-plans.
[36] Ibid.
[37] Hayden Dublois, "Association health plans work: How the Trump administration expanded access to affordable & quality health care," Foundation for Government Accountability (2020), https://thefga.org/research/association-health-plans-trump-administration/.
[38] New York v. United States Dep't of Labor, 363 F. Supp. 3d 109, 2019 U.S. Dist. LEXIS 52725, 2019 WL 1410370.
[39] Ibid.
[40] Ibid.
[41] Definition of "Employer" under section 3(5) of ERISA-Association Retirement Plans and other multiple-employer plans, 84 Fed. Reg. 37508 (2019), https://www.federalregister.gov/documents/2019/07/31/2019-16074/definition-of-employer-under-section-35-of-erisa-association-retirement-plans-and-other.
[42] Ibid.
[43] Ibid.
[44] Definition of "Employer" under section 3(5) of ERISA-Association health plans, 88 FR 87968 (2023), https://www.federalregister.gov/documents/2023/12/20/2023-27510/definition-of-employer-association-health-plans
[45] David McFarlane, Meredith Parnell, and Michelle Chipetine, "Taking the pulse of new association health plans," Crowell & Moring's C&M Health Law Blog (2019), https://www.cmhealthlaw.com/2019/01/taking-the-pulse-of-new-association-health-plans-2/.
[46] Definition of "Employer" under section 3(5) of ERISA-Association health plans, 88 FR 87968 (2023), https://www.federalregister.gov/documents/2023/12/20/2023-27510/definition-of-employer-association-health-plans.