GUIDE TO THE ISSUES

HOUSE REPUBLICAN POLICY COMMITTEE
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LOWER PREMIUMS BY CODIFYING ASSOCIATION HEALTH PLANS

On the heels of judicial action striking down a federal rule expanding access to association health plans (AHPs), Congress should codify AHPs as an effective mechanism to provide quality health insurance at a lower cost to consumers.

Quick Take

On June 18, 2018, DOL expanded access to AHPs by improving the ability of small businesses and self-employed workers to associate by geography or industry and be treated as a single large employer.

With the rule invalidated by a federal judge, Congress should enact legislation codifying AHPs.

BACKGROUND

AHPs have been around for decades[1] and generally refer to "a wide spectrum of arrangements that provide health coverage through different types of organizations, including but not limited to trade associations, professional societies, and chambers of commerce."[2] Presently, there is no singular definition of AHPs used by all federal regulatory agencies.[3] AHPs permit individuals or employers to shop for coverage as a larger group in an effort to obtain more favorable coverage and pricing from insurers.

The Department of Labor (DOL) regulates AHPs as multiple employer welfare agreements (MEWA) that amount to two or more employers providing benefits to their employees. The majority of AHPs have historically provided individual or small group coverage.[4] In most cases, DOL has concluded that the association is not an employer for regulatory purposes.[5]

On June 18, 2018,[6] DOL increased access to AHPs by expanding the ability of small businesses and self-employed workers to associate by geography or industry and be treated as a single large employer.[7] Under the rule, "AHPs may not charge higher premiums or deny coverage as a result of pre-existing conditions, or cancel coverage because an employee becomes ill."[8] AHPs, "like any other group health plan, cannot discriminate in eligibility, benefits, or premiums against an individual within a group of similarly situated individuals based on a health factor."[9]

Following the rule, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated that nearly 5 million people would enroll in AHPs in 2022.[10] Additionally, the CBO report estimated that roughly 400,000 people, who would otherwise be uninsured, would receive AHP coverage over the 2019 to 2028 period.[11] Most importantly, "CBO and JCT estimate[d] that premiums for AHPs sold under the new rules will be, on average, roughly 30 percent lower than premiums for fully regulated small-group coverage."[12]

In March 2019, a federal judge in the District of Columbia struck down the final rule after determining that the DOL's interpretation of "employer" was unreasonable and exceeded the statutory authority delegated by Congress through the Employee Retirement Income Security Act (ERISA).[13] Following the Department of Justice's appeal in April 2019, the DOL announced that it would not pursue enforcement actions against employers who relied in good faith on the AHP rule's validity.[14]

CONSTITUTIONAL AUTHORITY AND REPUBLICAN PRINCIPLES

The Constitution grants Congress the power to regulate interstate commerce.[15] Consumer choice—not government mandates—should determine the variety of products available in any marketplace.

POLICY SOLUTIONS

Congress should amend ERISA[16] to provide smaller employers and self-employed individuals access to large-group coverage by permitting AHPs to function as "employers." Legislation should include nondiscrimination provisions which prohibit an AHP from basing membership, eligibility for health benefits, and premiums on health factors.

Congress should also exempt AHPs from certain state insurance requirements when association members reside in different states. Enacting H.R. 2294, the Association Health Plans Act of 2019, would accomplish many of these objectives.

Please contact Cameron Smith or Kelsey Wall with the Republican Policy Committee at (202) 225-4921 with any questions.

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[1] U.S. Gov't Accountability Off., HEHS-96-59R, *Employer Association Health Plans* (1995), https://www.gao.gov/assets/90/85191.pdf.
[2] Bernadette Fernandez, Cong. Research Serv., R45216, *Background Information on Health Coverage Options Addressed in Executive Order 13813* (Jun. 2018), https://fas.org/sgp/crs/misc/R45216.pdf.
[3] *Id.*
[4] *See* Centers for Medicare & Medicaid Services, *Application of Individual and Group Market Requirements Under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or Through, Associations* 3 (September 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/ association_coverage_9_1_2011.pdf.
[5] Fernandez, *supra,* note 2.
[6] 29 C.F.R. § 2510.3-5 (2018).
[7] U.S. Dep't of Labor, *About Association Health Plans,* https://www.dol.gov/general/topic/association-health-plans, (last visited Jun. 17, 2019).
[8] *Id.*
[9] 29 C.F.R. § 2510.3-5 (2018).
[10] Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* (January 2019), https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf
[11] *Id.*
[12] *Id.* at 5.
[13] California v. U.S. Dep't of Labor, 2018 D.C. Cir. 18-1747.
[14] *Id.*
[15] U.S. Const. art. I, § 8, cl. 3.
[16] Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, (1974).