

## **LOOPHOLES IN THE AFFORDABLE CARE ACT: REGULATORY GAPS AND BORDER CROSSING TECHNIQUES AND HOW TO ADDRESS THEM**

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### I. INTRODUCTION

Title I of the Patient Protection and Affordable Care Act (“ACA”) is the most comprehensive effort to date to create a uniform national program for health insurance regulation in the United States.<sup>1</sup> Prior to 1974, health insurance, like all other forms of insurance, was regulated almost exclusively by the states.<sup>2</sup> In 1974, Congress passed the Employee Retirement Income Security Act of 1974 (“ERISA”), establishing federal authority over employee benefit plans, the most common form of health insurance in the United States.<sup>3</sup> ERISA asserted exclusive federal jurisdiction over self-funded ERISA plans, but allowed states to regulate insurers that insure employee benefit plans.<sup>4</sup> States continued to have exclusive responsibility for regulating health insurance that was not subject to ERISA, including individual insurance and non-federal governmental coverage.<sup>5</sup> In 1996, Congress again extended its regulatory authority under the Health Insurance Portability

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). The two laws are collectively referred to hereinafter as “ACA.”

2. In 1944, the Supreme Court had recognized that Congress had authority under the Commerce Power to regulate insurance. *United States v. Se. Underwriters Ass’n*, 322 U.S. 533, 553 (1944). Congress immediately ceded this authority back to the states in the McCarran-Ferguson Act. See 15 U.S.C. §§ 1011-1015 (1945).

3. Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1144 (2006). In 2008, 176,000 of 202,000 privately insured Americans were insured through their employment. U.S. CENSUS BUREAU, TABLE 151. HEALTH INSURANCE COVERAGE STATUS BY SELECTED CHARACTERISTICS: 2007 & 2008, available at <http://www.census.gov/compendia/statab/2011/tables/11s0151.pdf>.

4. 29 U.S.C. § 1144(b)(2)(A).

5. See BARRY R. FURROW ET AL., *HEALTH LAW*, 653-54 (6th ed. 2008).

and Accountability Act (“HIPAA”),<sup>6</sup> but left responsibility for regulating health insurance primarily with the states.<sup>7</sup>

The ACA changes this. States still retain the authority to regulate insurance insofar as state laws do not “prevent the application” of Title I of the Act, the insurance reform provisions.<sup>8</sup> The states will continue to be primarily responsible for assuring the solvency of insurers and for rate review, and will work together with the federal government to protect health insurance consumers.<sup>9</sup> But the ACA lays out a comprehensive federal law framework for revolutionizing the underwriting practices of health insurers, stimulating competition in the health insurance industry, and protecting health insurance consumers.

The intention of Congress was to make these reforms universal. Most of the regulatory requirements of the ACA apply to “[a] group health plan and a health insurance issuer offering group or individual health insurance coverage.”<sup>10</sup> This largely captures the universe of health insurance coverage in the United States. In general, the ACA greatly diminishes the importance of the distinction that has heretofore existed between ERISA plans and non-ERISA plans, as it subjects both “group health plans” and “health insurance issuers offering group or individual health insurance coverage” to many of the same requirements.<sup>11</sup>

The ACA, however, does not subject all health benefit plans to the same rules. A number of regulatory provisions of the ACA differentiate between individual and small group plans on the one hand and large group plans on the other. Large group plans are, for example, not subject to the essential benefits package requirement,<sup>12</sup> the risk adjustment program,<sup>13</sup> the

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6. See 29 U.S.C. §§ 1181-1182; 42 U.S.C. §§ 300gg-11, -12, -41, -42, -44 (2006).

7. See Health Insurance Portability and Account Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (none of HIPAA’s modifications to ERISA have an effect on the states’ abilities to regulate insurance).

8. ACA § 1321(d) (to be codified at 42 U.S.C. § 18041).

9. ACA § 1101(g)(5) (to be codified at 42 U.S.C. § 18001); Public Health Services Act (PHSA) § 2794, amended by ACA § 1003 (to be codified at 42 U.S.C. § 300gg-94).

10. See, e.g., PHSA §§ 2711, 2712, 2713, 2714, 2715, 2715A, 2717, 2719, 2719A, 2704, 2705, 2706, 2709, added by ACA §§ 1001, 10101, 1201 (to be codified in scattered sections of 42 U.S.C.). Large group plans are defined under the ACA as plans of employers that have more than 100 employees (or, prior to 2017, at the option of a state, more than fifty employees). ACA § 1304(a)(3), (b)(1), (b)(2) (to be codified at 42 U.S.C. § 18024).

11. See, e.g., PHSA §§ 2711, 2712, 2713, 2714, 2715, 2715A, 2717, 2719, 2719A, 2704, 2705, 2706, 2709, added by ACA §§ 1001, 10101, 1201 (to be codified in scattered sections of 42 U.S.C.).

12. See PHSA § 2707(a), added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6).

13. ACA § 1343(c) (to be codified at 42 U.S.C. § 18063).

prohibition against discriminatory premiums,<sup>14</sup> and the risk pooling requirements of the ACA.<sup>15</sup>

The reform law also exempts self-insured plans from several key requirements. The reasoning behind some of these exemptions is obvious—self-insured plans, for example, are not subject to the medical loss ratio requirement, which only applies to insurers,<sup>16</sup> or to the prohibition against discrimination in favor of highly-compensated employees, which already applied to self-insured plans.<sup>17</sup> But self-insured plans are also exempted from other provisions of the statute, such as the essential benefits requirement or the risk adjustment program that could in fact have benefited their enrollees.<sup>18</sup>

Excepting large group and self-insured plans from some ACA requirements makes some sense, in particular politically, but also from a consumer-protection perspective. Historically, the large group market has functioned pretty well.<sup>19</sup> Large groups have bargaining power with insurers and present insurers with a reasonably uniform risk profile.<sup>20</sup> They have human resource departments that help out employees who encounter problems with their insurers.<sup>21</sup> The worst abuses in the large group market—pre-existing condition exclusions and health status underwriting within the group—were addressed by HIPAA.<sup>22</sup> Self-insured plans have predominantly been large group plans, and like large group plans, have been thought to not require a great deal of regulation.<sup>23</sup>

The small group and individual markets, on the other hand, have been more dysfunctional and have been the traditional targets of state regulation. They have suffered the most from health status underwriting, pre-existing condition exclusions, and arbitrary and unreasonable insurer practices, such

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14. PHS § 2701(a)(1), added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg).

15. ACA § 1312(c) (to be codified at 42 U.S.C. § 18032).

16. PHS § 2718, added by ACA § 10101(f) (to be codified at 42 U.S.C. § 300gg-18).

17. PHS § 2716, added by ACA § 10101(d) (to be codified at 42 U.S.C. § 300gg-16).

18. PHS § 2702(a), added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6); ACA § 1343 (to be codified at 42 U.S.C. § 18063).

19. Large firms are far more likely than small firms to offer health insurance to their workers and to pay more than 50% of the cost of coverage. See KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2010 ANNUAL SURVEY 3, 70 (2010).

20. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 30-35 (2001).

21. *Id.* at 30.

22. HIPAA banned health status discrimination within groups and required guaranteed issue to groups, but did not regulate premiums and only limited, rather than banned, pre-existing condition clauses. See 29 U.S.C. §§ 1181(a), 1182(a)-(b).

23. MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE 25 (1994).

as rescissions or unconscionably low annual limits.<sup>24</sup> Some problems in the individual and small group market were addressed by HIPAA, but the reforms were partial and did not address the most serious problems.<sup>25</sup> Finally, the individual and small group markets are the targets of tax credit subsidies under the ACA.<sup>26</sup> The federal government has, therefore, a particular interest in ensuring that they function properly.

While the basic structure of the insurance regulation provisions of the ACA makes some sense, the ACA leaves open significant loopholes that raise serious concerns. First, the ACA grandfathers coverage that existed prior to the date on which the legislation was signed: March 23, 2010.<sup>27</sup> Grandfathered coverage is subject to some of the reforms, but is exempt from many of the most important.<sup>28</sup> Second, some kinds of health insurance are not covered by the ACA at all.<sup>29</sup> This makes it possible for insurers to market policies to consumers that leave those consumers completely unprotected by the ACA. Third, the ACA leaves open the possibility of structuring health insurance coverage to allow small groups, and possibly individuals, to be treated as large groups or self-insured plans, thus depriving them of key protections of the statute that do not apply to large group or self-insured plans and opening significant opportunities for adverse selection, undermining the market structures established by the ACA.<sup>30</sup>

The greatest threat to the ACA is posed by loopholes that allow total exemption from ACA regulation. But the threats posed by strategies that allow insurers to move from individual or small group coverage to large group or self-insured status to avoid certain requirements of the ACA also substantially undermine the protections of the ACA. This article explores these strategies and the loopholes that make them possible. It also examines proposals as to how these loopholes might be closed or their effects mitigated.

## II. THE REGULATORY STRUCTURE OF THE ACA

The insurance reforms of Title I of the Affordable Care Act are enacted through amendments to Title XXVII of the Public Health Services Act

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24. *Id.* at 16-22.

25. HIPAA did not, for example, provide for guaranteed issue in the individual market and only limited rather than banned the use of pre-existing condition clauses in group markets. See FURROW ET AL., *supra* note 5, at 749-51.

26. ACA §§ 1401, 1421 (to be codified at I.R.C. §§ 36B, 45R).

27. ACA § 1251 (to be codified at 42 U.S.C. § 18011).

28. See *infra* Part III.

29. See *infra* Part IV.

30. See *infra* Part V.

("PHSA"), which was created by HIPAA.<sup>31</sup> The ACA extensively amends and reconfigures Title XXVII, but builds upon its foundation.

The insurance reforms of the ACA are found primarily in two sections, section 1001, which includes amendments that went into effect for the first insurance plan year following the six month anniversary of the enactment of the ACA (September 23, 2010),<sup>32</sup> and section 1201, most provisions of which will be effective beginning January 1, 2014.<sup>33</sup> Amendments found in both sections 1001 and 1201 are codified in Subparts I (General Reform) and II (Improving Coverage) of Part A (Individual and Group Market Reforms) of Title XXVII of the PHSA.<sup>34</sup> Section 1551 of the ACA provides that the definitions found in section 2791 of the PHSA shall apply to Title I of the ACA, "[u]nless specifically provided for otherwise."<sup>35</sup>

As noted above, most of the ACA reforms apply to "a group health plan and a health insurance issuer offering group or individual health insurance coverage."<sup>36</sup> Section 2791(a)(1) defines "group health plan" to mean:

an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.<sup>37</sup>

Section 2791(b)(1) defines "health insurance coverage" to mean:

benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate,

31. ACA § 1001 (to be codified in scattered sections of 42 U.S.C.) (adding PHSA §§ 2711-2719); ACA § 1201 (to be codified in scattered sections of 42 U.S.C.) (adding PHSA §§ 2701-2708); HIPAA § 102 (adding PHSA tit. XXVII).

32. ACA §§ 1001, 1004, 10101 (to be codified in scattered sections of 42 U.S.C.). Certain provisions of ACA § 1001 were amended by ACA § 10101.

33. ACA §§ 1201, 1255, 10103 (to be codified in scattered sections of 42 U.S.C.). Certain provisions of ACA § 1201 were amended by ACA § 10103, including the reclassification of the original ACA § 1253 as ACA § 1255.

34. ACA §§ 1001, 1201 (to be codified in scattered sections of 42 U.S.C.).

35. ACA § 1551 (to be codified at 42 U.S.C. § 18111); 42 U.S.C. § 300gg-91 (2006).

36. See sources cited *supra* note 10. Some of the provisions have more limited application. PHSA § 2714, for example, applies only to plans that provide dependent coverage for children, while PHSA §§ 2716 and 2718 do not apply to self-insured plans; PHSA § 2707(a) requires only individual and small group plans only to offer the essential benefits package created under section ACA § 1302, and PHSA § 2707(b) limits the deductibles of group plans only. ACA §§ 1302 (to be codified at 42 U.S.C. § 18022), PHSA §§ 2707, 2714, 2716, 2718, *added by* ACA §§ 1001, 1201 (to be codified in scattered sections of 42 U.S.C.).

37. 42 U.S.C. § 300gg-91(a)(1) (2006).

hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.<sup>38</sup>

Section 2791(b)(2) defines “health insurance issuer” to mean:

an insurance company, insurance service, or insurance organization (including a health maintenance organization) . . . which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.<sup>39</sup>

Section 2791(b)(4) defines “group health insurance coverage” to mean:

in connection with a group health plan, health insurance coverage offered in connection with such plan.<sup>40</sup>

And, finally, section 2791(b)(5) defines “individual insurance coverage” to mean:

health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.<sup>41</sup>

Section 2791(a)(1) incorporates the definition of “employee welfare benefit plan” found in section 3(1) of ERISA to define “group health plan.”<sup>42</sup>

Section 3(1) of ERISA,<sup>43</sup> defines “employee welfare benefit plan” to mean:

any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness.<sup>44</sup>

In sum, the Affordable Care Act health insurance regulatory reforms apply in general to all individual health insurance and managed care plan

38. *Id.* § 300gg-91(b)(1).

39. *Id.* § 300gg-91(b)(2).

40. *Id.* § 300gg-91(b)(4).

41. *Id.* § 300gg-91(b)(5).

42. 42 U.S.C. § 300gg-91(a)(1).

43. ERISA § 3, 29 U.S.C. § 1002(1) (2006).

44. *Id.* § 1002(1). “Participant” is further defined as:

any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

*Id.* § 1002(7). And “beneficiary” as:

a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder. *Id.* § 1002(8).

coverage (except for short-term, limited duration policies) and to all employee group coverage. There are a number of exceptions to this general rule, however, discussed in section III of this article.<sup>45</sup>

One other provision of the ACA must be understood to master its structure: the minimum essential coverage requirement, found in section 5000A of the Internal Revenue Code added by ACA section 1501(b).<sup>46</sup> The minimum coverage requirement (often called the individual mandate) provides that as of January 1, 2014, individuals that do not fall into one of a number of excepted categories (discussed below)<sup>47</sup> must purchase a high cost-sharing (bronze) health plan.<sup>48</sup> Some forms of insurance that are not subject to all of the regulatory requirements of the ACA will be acceptable coverage for meeting the minimum essential coverage requirement.<sup>49</sup> Other forms of insurance will not be, however, and thus should become less common after 2014, as individuals covered by such plans will have to pay the penalty for not complying with the minimum essential coverage requirement.<sup>50</sup> The effect of the minimum coverage requirement will be examined further below.

### III. GRANDFATHERED COVERAGE

From the beginning of his push for health care reform, President Obama's Administration promised "[i]f you like your insurance plan, your doctor, or both, you will be able to keep them."<sup>51</sup> He did not mean to say by this, however, "if you don't like the plan you have, you will be stuck with it forever," or, for that matter, "if your insurance plan changes dramatically to your disadvantage, you will not be able to escape it."<sup>52</sup>

Balancing the desire to let individuals and employers maintain relatively inexpensive pre-reform health plans on the one hand, and, on the other hand, to protect Americans from being stuck in low value health plans as the coverage offered by those plans deteriorates, posed a difficult task for Congress and continues to pose a challenge to the Administration.

Section 1251 of the ACA provides that the reform law should not be construed to require an individual to terminate coverage under an individual

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45. See *infra* Part III.

46. ACA § 1501(b) (to be codified at I.R.C. § 5000A).

47. See *infra* notes 256, 261.

48. I.R.C. § 5000A, added by ACA § 1501.

49. I.R.C. § 5000A(f)(1), added by ACA § 1501.

50. I.R.C. § 5000A(b), added by ACA § 1501.

51. See Macon Phillips, *Facts Are Stubborn Things*, THE WHITE HOUSE BLOG (Aug. 04, 2009, 6:55 AM), <http://www.whitehouse.gov/blog/Facts-Are-Stubborn-Things/>.

52. Timothy Jost, *Implementing Health Reform: Grandfathered Plans*, HEALTH AFFAIRS BLOG (June 15, 2010, 5:01 PM), <http://healthaffairs.org/blog/2010/06/15/implementing-health-reform-grandfathered-plans/>.

or group plan in which that person was enrolled at the time of enactment of the ACA (March 23, 2010), and that none of the insurance reforms of the ACA should apply to these grandfathered plans, except as specified in the ACA.<sup>53</sup>

In early versions of the ACA, grandfathering was nearly absolute.<sup>54</sup> Under the final legislation, however, enrollees in grandfathered plans were afforded a number of the protections of the PHSA,<sup>55</sup> including:

- The coverage disclosure and transparency provisions of section 2715;<sup>56</sup>
- The requirements of section 2718 that plans pay out a minimum of 80% or 85% of their premiums to cover health care claims or quality improvement activities;<sup>57</sup>
- The prohibition against waiting periods in group plans in excess of ninety days found in section 2708;<sup>58</sup>
- The provisions of section 2711 prohibiting lifetime limits;<sup>59</sup>
- The ban on rescissions except in the case of fraud found in section 2712;<sup>60</sup> and
- The requirement that plans cover adult children up to age twenty-six found in section 2714.<sup>61</sup>

In addition, the provisions of section 2711 relating to annual limits and of 2704 prohibiting exclusion of pre-existing conditions (initially only for children) apply to grandfathered group plans, although grandfathered group plans need not cover adult children if other non-grandfathered coverage is available.<sup>62</sup>

Grandfathered plans do, however, remain free from a number of the significant reforms found in the ACA. In the long-term, the most important provisions from which grandfathered plans are exempt will be the requirement that individual and small group plans cover federally-defined

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53. ACA § 1251(a)(1), (2) (to be codified at 42 U.S.C. § 18011).

54. See, e.g., Patient Protection and Affordable Care Act, H.R. 3590, amend. 2786, 111th Cong. (2009).

55. ACA § 1251 (to be codified at 42 U.S.C. § 18011).

56. PHSA § 2715, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-15).

57. PHSA § 2718, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-18).

58. PHSA § 2708, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-7).

59. PHSA § 2711, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-11).

60. PHSA § 2712, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-12).

61. PHSA § 2714, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-14).

62. ACA § 1251(a)(4)(B) (to be codified at 42 U.S.C. § 18011). The latter provision has raised the as-yet unresolved question of whether adult children under age twenty-six can be covered under their parents' policies if an adult child has available only "mini-med" policies as to which compliance with the annual limit requirements imposed by section 2711 has been waived by HHS.

essential health benefits packages, including a list of services found in the ACA, beginning in 2014.<sup>63</sup> The essential benefit provisions also require all health plans to limit out-of-pocket expenditures to the amounts now permitted for high-deductible health plans coupled with health savings accounts and require small group health plans to limit deductibles to \$2,000 for single coverage and \$4,000 for family coverage.<sup>64</sup> Grandfathered plans are also free from mandates currently in place that require plans to:

- Cover preventive services without cost-sharing;<sup>65</sup>
- Not discriminate in favor of highly compensated individuals;<sup>66</sup>
- Report on their quality of care improvement activities;<sup>67</sup>
- Provide their enrollees with internal and external appeal procedures against claim denials (although group plans must already provide internal appeals under ERISA and most states require that plans provide both internal and external appeal procedures);<sup>68</sup> and
- Provide unimpeded access to emergency, pediatric, obstetric, and gynecological care.<sup>69</sup>

Grandfathered plans will also remain exempt from some of the other 2014 reforms, including a right to coverage of the routine costs of clinical trials and a prohibition of discrimination against providers based on their licensure status.<sup>70</sup>

Although the ACA distinguishes between grandfathered and non-grandfathered plans, it does not identify the circumstances under which a grandfathered plan might cease to be grandfathered. This was left to the regulations. On June 14, 2010, the Departments of Health and Human Services, Treasury, and Labor issued interim final regulations intended to operationalize section 1251 of the ACA.<sup>71</sup> Entitled "Preservation of right to

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63. PHS § 2707, *added by* ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6); ACA § 1302(b)(1)(A)-(J) (to be codified at 42 U.S.C. § 18022).

64. ACA § 1302(c)(2)(A)(i), (ii) (to be codified at 42 U.S.C. § 18022).

65. PHS § 2713(a)(1), *added by* ACA § 1001 (to be codified at 42 U.S.C. § 300gg-13).

66. PHS § 2716(a), *added by* ACA § 1001 (to be codified at 42 U.S.C. § 300gg-16).

67. PHS § 2717(a)(1)(A), *added by* ACA § 1001 (to be codified at 42 U.S.C. § 300gg-17).

68. PHS § 2719, *added by* ACA § 1001 (to be codified at 42 U.S.C. § 300gg-19).

69. PHS § 2719A, *added by* ACA § 10101 (to be codified at 42 U.S.C. § 300gg-19a).

70. PHS § 2706(a), *added by* ACA § 1201 (to be codified at 42 U.S.C. § 300gg-5); PHS § 2709, *added by* ACA § 10103 (to be codified at 42 U.S.C. § 300gg-8).

71. See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as Grandfathered Health Plan Under the Patient Protection and Affordable

maintain existing coverage," the regulations reaffirm the statutory principle that as long as an enrollee was enrolled in a plan that existed on March 23, 2010, the terms of that plan do not need to change to accommodate requirements of the ACA that do not apply to grandfathered plans.<sup>72</sup> Insurers or employers may add new benefits to health plans,<sup>73</sup> change the terms of a plan to comply with state or federal requirements (including ACA requirements that apply to grandfathered plans),<sup>74</sup> voluntarily adopt consumer protections,<sup>75</sup> make modest adjustments in benefits or cost sharing,<sup>76</sup> and, most importantly, raise premiums without losing grandfathered status.<sup>77</sup>

Section 1251 permits new family members and employees to be added to grandfathered plans, and specifies that renewal of plan membership does not terminate grandfathered status.<sup>78</sup> Indeed, a grandfathered group plan can add new employees as existing employees leave the plan, eventually ending up with no members who were enrollees as of March 2010, yet still remain grandfathered. The regulations, however, bar certain subterfuges that employers may be tempted to engage in to maintain grandfathered status.<sup>79</sup> A plan loses its grandfathered status if an employer engages in a merger or other business restructuring primarily to extend the coverage of a grandfathered plan.<sup>80</sup> Also, employers may not transfer employees from one grandfathered plan to another when the terms of the original plan could not have been changed into those of the transferee plan without loss of grandfathered status.<sup>81</sup>

The primary way in which a plan will lose grandfathered status, however, is if certain major changes are made in the plan to the disadvantage of enrollees. The regulation adopts bright line rules identifying the changes that will end grandfathered status so that insurers, employers, and enrollees will not have to guess when a plan ceases to be grandfathered.<sup>82</sup>

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Care Act, 75 Fed. Reg. 34,538 (June 17, 2010) (codified at 45 C.F.R. pt. 147) [hereinafter Interim Final Rules].

72. 45 C.F.R. § 147.140(a)(1)(i), (c)(1) (2010).

73. Interim Final Rules, 75 Fed. Reg. at 34,546.

74. *Id.* at 34,544.

75. *Id.* at 34,546.

76. *Id.* at 34,548-49.

77. *See id.* at 34,546.

78. ACA § 1251(b), (c) (to be codified at 42 U.S.C. § 18011); 45 C.F.R. § 147.140(b)(1) (2010).

79. 45 C.F.R. § 147.140(b)(2).

80. *Id.* § 147.140(b)(2)(i).

81. *Id.* § 147.140(b)(2)(ii).

82. *Id.* § 147.140(g)(1).

Changes that will result in the loss of grandfathered status include:

- [E]limination of all or substantially all of [any] benefits necessary to diagnose or treat a particular condition;<sup>83</sup>
- Any increase in co-insurance percentages;<sup>84</sup>
- An increase in a deductible, out-of-pocket limit, or other fixed dollar cost-sharing requirement or limit other than a co-payment by more than the increase in the medical component of the CPI since March 2010 plus a total of fifteen percentage points;<sup>85</sup>
- An increase in a co-payment in excess of the greater of: (1) medical inflation plus \$5.00 or (2) medical inflation plus a total of fifteen percentage points;<sup>86</sup>
- A decrease of the employer contribution, whether based on the cost of coverage or on a formula, by more than five percentage points below the contribution rate in place on March 23, 2010;<sup>87</sup>
- A reduction in the dollar value of existing annual limits, the imposition of an annual limit on coverage by plans that did not impose any limits before, or the adoption of annual limits less than any lifetime limits a plan imposed before if it only imposed lifetime limits before the effective date.<sup>88</sup>

The interim final rule does not determine whether other changes in a plan such as changes in plan structure, provider network, or formulary could ever result in loss of grandfathered status, and invites comments on these issues.<sup>89</sup>

Under the initial interim final rule, if an employer or employee organization entered into a new policy, certificate, or insurance contract, the new plan was not grandfathered.<sup>90</sup> Under an amendment to the interim final rule published on November 17, 2010, however, group plans are allowed to change their insurer and retain grandfathered status as long as no other changes were made in the plan that would violate the terms of the

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83. *Id.* § 147.140(g)(1)(i).

84. 45 C.F.R. § 147.140(g)(1)(ii) (2010).

85. *Id.* § 147.140(g)(1)(iii).

86. *Id.* § 147.140(g)(1)(iv).

87. *Id.* § 147.140(g)(1)(v).

88. *Id.* § 147.140(g)(1)(vi).

89. See Interim Final Rules, 75 Fed. Reg. 34,538, 34,544 (June 17, 2010) (codified at 45 C.F.R. pt. 147).

90. Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Plan under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70,114, 70,116 (Nov. 17, 2010) (amending 45 C.F.R. pt. 147.140) [hereinafter Amendment to Interim Final Rules].

regulation.<sup>91</sup> Grandfathered status is not lost, moreover, if a self-insured plan changes its plan administrator.<sup>92</sup> Collectively bargained insured plans (but not self-insured plans) are grandfathered until the expiration of the last of the collective bargaining agreements governing the grandfathered coverage.<sup>93</sup> Thereafter, the plans become subject to the general grandfathered status rules (comparing the plan as it then exists with the plan as it existed on March 23, 2010).<sup>94</sup>

Grandfathered plans must disclose to their enrollees the fact that they are grandfathered and that they are therefore not required to comply with all of the requirements of the ACA.<sup>95</sup> They must also disclose, however, that they are required to comply with some of the health reform requirements.<sup>96</sup> They must maintain documentation to verify, explain, and clarify their continuous existence as a grandfathered plan since March 23, 2010.<sup>97</sup>

Grandfathered status is important to health insurers that do not want to comply with the ACA requirements as they come into force; to individual plan enrollees who for whatever reason prefer to stay with their current plan or who do not have any option prior to 2014 except for staying with their present plan because of pre-existing conditions that would make other coverage unobtainable; and to employers who do not want to cover the cost of the enhanced consumer protections provided by the ACA.

The interim regulations will have different effects on these different groups. Large group plans, including self-insured plans, already comply with many of the reforms found in the reform legislation. HIPAA already prohibits group plans from discriminating on the basis of health status and insurers from refusing to offer or renew coverage to group plans.<sup>98</sup> It also limits the ability of group plans to apply pre-existing condition exclusions.<sup>99</sup> Further, laws in many states impose on insured group plans many of the reforms found in the ACA, such as required coverage of adult dependents or external review of claim denials.<sup>100</sup> Finally, most large group insured and self-insured plans already provide the essential benefits that will be required

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91. *Id.*

92. *Id.*

93. 45 C.F.R. § 147.140(f) (2010).

94. *Id.*

95. *Id.* § 147.140(a)(2).

96. *See id.* § 147.140(a)(2)(ii).

97. *Id.* § 147.140(a)(3).

98. 29 U.S.C. §§ 1181-1183 (2006).

99. *Id.*

100. *See Covering Young Adults through Their Parents' or Guardians' Health Policy*, NAT'L CONF. OF STATE LEGISLATURES (Sept. 23, 2010), <http://www.ncsl.org/Default.aspx?TabId=14497>; *Right to Health Insurance Appeals Process*, NAT'L CONF. OF STATE LEGISLATURES (Feb. 2011), <http://www.ncsl.org/documents/health/HRHealthInsurApp.pdf>.

under the ACA.<sup>101</sup> Indeed, section 1302 of the ACA defines the essential benefits as equal to those provided under the typical employer plan.<sup>102</sup> The Congressional Budget Office (“CBO”) in its review of the effect of the ACA on insurance premiums projected that the ACA would have little impact on premiums in the small group market, and virtually none in the large group market.<sup>103</sup>

Large employers, which currently insure 133 million enrollees,<sup>104</sup> may find complying with the ACA’s reforms less of a burden than operating within the limits that the regulations impose on grandfathered plans with respect to changes in cost-sharing, benefits, or employee premium sharing. Large groups are already exempted from the essential benefits requirement,<sup>105</sup> and the remaining requirements of Title I tend not to be high-cost items. Smaller employers, which currently insure 43 million enrollees,<sup>106</sup> may have to significantly increase coverage to comply with the essential benefit requirements in 2014, and may find grandfathered coverage more valuable. On the other hand, the absolute limits that the regulations impose on increasing cost sharing above medical inflation may be exhausted by 2014, making full compliance with the ACA, including the essential benefits, a more attractive alternative than continuing to live within the regulatory constraints of grandfathering.

The agencies estimate that between 49% and 80% of small employer plans and between 34% and 64% of large employer plans will relinquish grandfathered status by 2013.<sup>107</sup> A Mercer study estimated that 53% of firms would lose grandfather status for one or more plans in 2011 and an additional 48% by 2014,<sup>108</sup> while a Hewitt study estimated that 51% of self-insured and 46% of fully insured plans would lose grandfathered status in 2011.<sup>109</sup> A 2011 survey by the National Federation of Independent

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101. See Amy B. Monahan, *Initial Thoughts on Essential Health Benefits*, 1-1B N.Y.U. REV. EMP. BENEFITS (MB) § 1B.03 (2010).

102. ACA § 1302(b)(2)(A) (to be codified at 42 U.S.C. § 18022).

103. CONG. BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT (2009).

104. Interim Final Rules, 75 Fed. Reg. 34,538, 34,550 (June 17, 2010) (codified at 45 C.F.R. pt. 147) (97 million in private plans and 36 million in governmental plans).

105. PHS § 2707, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6).

106. Interim Final Rules, 75 Fed. Reg. at 34,550 (41 million in private plans and two million in governmental plans).

107. *Id.* at 34,552.

108. Press Release, Mercer, Even as Reform Pushes up Benefit Cost, Employers Will Take Steps to Hold 2011 Increase to 5.9% (Sept. 30, 2010), available at [www.mercer.com/press-releases/1391585](http://www.mercer.com/press-releases/1391585).

109. HEWITT ASSOC. LLC, EMPLOYER REACTION TO HEALTH CARE REFORM: GRANDFATHERED STATUS SURVEY (2010), available at [http://www.aon.com/attachments/thought-leadership/ER\\_Reaction\\_HC\\_Grandfathered.pdf](http://www.aon.com/attachments/thought-leadership/ER_Reaction_HC_Grandfathered.pdf).

Businesses, however, found that 90% of employers who intended to make significant changes in their plans had not had their plans eliminated, or received notice of an intention to eliminate their plans.<sup>110</sup> The extent to which grandfathered status will continue in the group market remains an unknown.

The ACA will likely bring about the greatest changes for the 17 million enrollees in the individual market. Here, turnover is so significant in the ordinary course of business that relatively few policies will remain grandfathered for any significant period of time. The individual market is primarily a residual market to which Americans resort when group coverage is not available. The behavior of insurers also affects duration of coverage, as insurers increase cost-sharing or reduce benefits to shed high-cost enrollees. The interim regulation preamble states that the median length of coverage in the individual market is eight months.<sup>111</sup> The agencies estimate that 40% to 67% of individual policies will turnover in any given year, and thus lose grandfathered status.<sup>112</sup> The regulations, however, are good news for individuals who prefer to stay with a particular insurer, for example, because they have pre-existing conditions that would make it difficult for them to purchase a new policy or because they prefer the network of a particular insurer. Their insurer will have only a limited ability to increase their cost sharing or decrease their benefits, and because of other provisions of the ACA like the medical loss ratio provisions, will be limited in its ability to raise premiums as well.

Eventually, if the ACA remains in effect, grandfathered plans will disappear. In the interim, the disparity between the regulatory requirements applying to grandfathered plans and fully covered plans is significant. The grandfathering provisions were important to employers, insurers, and to some individuals, and the President and Congress believed themselves to be bound by the promise. The states, however, are not. States can impose any insurance regulation that does not "prevent the application" of the ACA.<sup>113</sup> The grandfather provisions of the ACA do not prohibit the application of the ACA requirements to grandfathered plans; they merely provide that subtitles A and C of Title I of the ACA do not apply to grandfathered plans.<sup>114</sup> Many states already impose some of the ACA reforms that do not apply to

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110. WILLIAM J. DENNIS, JR., NAT'L FED'N OF INDEP. BUS., SMALL BUSINESS AND HEALTH INSURANCE: ONE YEAR AFTER ENACTMENT OF PPACA 5 (July 2011), available at <http://www.nfib.com/Portals/0/PDF/AllUsers/research/studies/ppaca/NFIB-healthcare-study-201107.pdf>.

111. Interim Final Rules, 75 Fed. Reg. 34,538, 34,549 (June 17, 2010) (codified at 45 C.F.R. pt. 147).

112. *Id.* at 34,553.

113. ACA § 1321(d) (to be codified at 42 U.S.C. § 18041).

114. ACA § 1251(a)(2) (to be codified at 42 U.S.C. § 18011).

grandfathered plans, such as provision for external appeals or required coverage for certain preventive services.<sup>115</sup> States should consider extending consumer protections to grandfathered plans as necessary to protect their citizens.

#### IV. COVERAGE EXEMPT FROM TITLE I REGULATORY REQUIREMENTS

Although the ACA was intended as a comprehensive overhaul of America's health insurance system, a number of categories of coverage were left out. This poses at least three potential problems. First, persons who purchase these forms of coverage cannot claim the protections of the ACA. They do not, for example, have a present right to access external or internal reviews of plan decisions and their coverage can currently be made subject to annual or lifetime limits.<sup>116</sup> After 2014, their pre-existing conditions will still be excludable and they will not be guaranteed coverage for essential benefits. Second, individuals who purchase this coverage may not understand these limitations. They may believe or be led to believe that they have comprehensive coverage and that their plan is ACA compliant when in fact they do not and it is not. Third, the existence of these plans opens serious opportunities for adverse selection against the ACA compliant market, and in particular, against the exchanges. Some ACA-exempt forms of coverage will be particularly attractive to healthy individuals and groups, who may choose them over standard ACA coverage. Insurers may also intentionally market these plans to healthy individuals and groups. In either event the result will be the same: ACA compliant plans and the exchanges will end up with a less healthy, more costly, risk pool. This section examines ACA coverage exemptions and the issues they present.

##### A. *Health Care Sharing Ministries*

As noted above, the ACA requires certain Americans to purchase health insurance.<sup>117</sup> More specifically, individuals who are lawfully present in the United States and who are not covered by an employment-related group health insurance policy or by a public health insurance program, who can find a health insurance policy with a premium of 8% or less of household income (after accounting for applicable tax credits), whose household income exceeds the tax filing threshold, and who are not members of a Native American tribe or incarcerated, must purchase a high cost-sharing

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115. SUSAN S. LAUDICINA, JOAN M. GARDNER & ANGELA M. CRAWFORD, STATE LEGISLATIVE HEALTHCARE AND INSURANCE ISSUES: 2010 SURVEY OF PLANS 69, 72-76 (Blue Cross and Blue Shield Association 2010).

116. BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41069, SELF-INSURED HEALTH INSURANCE COVERAGE 6 (2010).

117. ACA § 1501 (to be codified at I.R.C. § 5000A).

(bronze level) health insurance policy or pay a penalty.<sup>118</sup> The statute further exempts individuals who are members of religious organizations that are conscientiously opposed to participating in private or public insurance programs and who themselves adhere to the teaching of the group on this issue.<sup>119</sup> Individuals who qualify for exceptions are not required to purchase health insurance.<sup>120</sup> But if they purchase insurance, they must do it through an insurer or group plan that complies with the Affordable Care Act.<sup>121</sup>

The ACA also, however, exempts from the minimum coverage requirement members of a “health care sharing ministry.”<sup>122</sup> Health care sharing ministries are arrangements that resemble insurance in that members pay a monthly charge for membership and submit claims when they incur medical bills, but ministries are not licensed as insurers and their products are not considered to be insurance under state law.<sup>123</sup> These ministries are not subject to any of the regulatory requirements of the ACA. The ACA defines the term “health care sharing ministry” to mean:

[A]n organization—

- (I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
- (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,
- (III) members of which retain membership even after they develop a medical condition,

118. *Id.* § 1501 (to be codified at I.R.C. § 5000A).

119. *Id.* § 1501 (to be codified at I.R.C. § 5000A). Religious groups whose members are exempt under this requirement are limited to those recognized under I.R.C. § 1402(g). *Id.* Members of the group must also refuse to participate in Social Security and Medicare, the group must make reasonable provision for the needs of its members, and the group must have been in continuous existence since December 31, 1950. *Id.* An email prominently circulated on the internet claims that this provision was inserted in the legislation to exempt Muslims from the ACA requirement, but in fact the only groups currently covered by the statute are Christian, predominantly Anabaptist groups such as the Amish, Mennonites, and Hutterites, who have a long tradition of mutual aid and rejection of insurance. Jess Henig, “Dhimmitude” and the Muslim Exemption, FACTCHECK.ORG (May 20, 2010, 1:51 PM), <http://www.factcheck.org/2010/05/dhimmitude-and-the-muslim-exemption/>. The exemption was upheld against an Establishment Clause challenge in *Liberty University v. Geithner*, 753 F. Supp. 2d. 611, 641 (W.D. Va. 2010).

120. ACA § 1411(a)(5) (to be codified at 42 U.S.C. § 18081).

121. See ACA § 1501(b) (to be codified at I.R.C. § 5000A).

122. ACA § 1501 (to be codified at I.R.C. § 5000A).

123. See *id.*; see also *What is a Health Care Sharing Ministry?*, ALLIANCE OF HEALTH CARE SHARING MINISTRIES, <http://www.healthcaresharing.org/hcsm/> (last visited Aug. 18, 2011) [hereinafter ALLIANCE].

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.<sup>124</sup>

In fact, three health care sharing ministries are active in the United States: Medi-Share (whose parent company is Christian Care Ministry), Christian Healthcare Ministries, and Samaritan Ministries International, and no new entrants can be recognized under the statute.<sup>125</sup> These groups currently have about 100,000 members nationally.<sup>126</sup>

Each of the health care sharing ministries operates somewhat differently. Basically, members pay a set amount monthly for membership based on family size and, for some ministries, age. Members with medical needs can go to any health care provider or, with one of the ministries, to providers who are part of the ministry's PPO. Members who incur medical expenses that are covered under the plan and that exceed the deductible, submit request assistance from the sharing ministry.<sup>127</sup> The sharing ministry publishes these requests on a monthly basis and matches the member requesting assistance with members making contributions. The ministry either transfers the funds, or the contributing member sends the funds directly to the member in need.

Membership is generally limited to Christians who abstain from tobacco, extramarital sex, illegal drugs, and alcohol abuse.<sup>128</sup> One of the ministries also engages in health underwriting,<sup>129</sup> and all exclude or limit coverage for

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124. ACA § 1501 (to be codified at I.R.C. § 5000A).

125. *Id.*; see TWILA BRASE, MEDICAL SHARING: AN INEXPENSIVE ALTERNATIVE TO HEALTH INSURANCE 1 (2010), available at [http://www.cchfreedom.org/pdf/MEDICAL\\_SHARING-FINAL\\_JAN2010.pdf](http://www.cchfreedom.org/pdf/MEDICAL_SHARING-FINAL_JAN2010.pdf); see also MEDICAL SHARING MINISTRIES (MSM) - COMPARISON CHART 1 (2010) [hereinafter MSM COMPARISON CHART], available at [http://www.cchfreedom.org/pdf/MEDICAL\\_SHARING\\_MINISTRIES-COMPARISON\\_CHART.pdf](http://www.cchfreedom.org/pdf/MEDICAL_SHARING_MINISTRIES-COMPARISON_CHART.pdf); ALLIANCE OF HEALTH CARE SHARING INDUSTRIES, <http://www.healthcaresharing.oor/hcsm/> (last visited Aug. 17, 2011); SAMARITAN MINISTRIES INTERNATIONAL, <http://www.samaritanministries.org/> (last visited Aug. 17, 2011); *Medi-Share: Medical Bill Sharing for the Christian Community*, CHRISTIAN CARE MINISTRY, <http://mychristiancare.org/medi-share/> (last visited Aug. 17, 2011); CHRISTIAN HEALTHCARE MINISTRIES, <http://www.chministries.org/default.aspx> (last visited Aug. 17, 2011).

126. ALLIANCE, *supra* note 123; BRASE, *supra* note 125, at 1.

127. MSM COMPARISON CHART, *supra* note 125, at 5. In one of the ministries, the provider sends the bill directly. *Id.*

128. MSM COMPARISON CHART, *supra* note 125, at 3. See BRASE, *supra* note 125, at 3.

129. MSM COMPARISON CHART, *supra* note 125, at 3.

pre-existing conditions.<sup>130</sup> Coverage limits range from \$100,000 per individual per incident to \$1 million per year.<sup>131</sup> Some services are not covered, including for at least two ministries, services for mental illness.<sup>132</sup>

Christian sharing ministries are not insurance. They do not maintain reserves and do not guarantee payment of claims. Twelve states have legislation exempting them from requirements that apply to insurance companies.<sup>133</sup> At least one state (Missouri) allows members to deduct their contributions from their state income taxes.<sup>134</sup> Although regulators in some states have raised concerns regarding the legality of sharing ministries, they are currently not prohibited in any state. While sharing ministries have their critics, ministry members seem on the whole to be satisfied with and committed to their ministry.<sup>135</sup>

Because no new sharing ministries can be initiated, existing sharing ministries must comply with the ACA exemption requirements, sharing ministry membership is limited to those who meet strict ministry membership requirements, and sharing ministry members qualify neither for the premium tax credits that will be available in 2014 nor for current federal tax subsidies for employment-related insurance. Sharing ministries are likely to remain limited to those who are strongly committed to their principles and who understand that they are not purchasing traditional health insurance. Some individuals may purchase coverage from sharing ministries believing they have comprehensive coverage, but sharing ministries do attempt to notify enrollees that they provide only limited coverage.<sup>136</sup> Although there is likely to be some risk selection in favor of sharing ministries, membership is unlikely to become large enough to undermine ACA risk pooling. The threat that they pose to the ACA, therefore, is relatively small. States and the federal government, however, should continue to monitor sharing ministries to ensure that enrollees are not misled as to the nature of their coverage and that the ministries comply with the ACA exemption requirements.

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130. *Id.* at 2.

131. *Id.*

132. *Id.* at 3.

133. ALLIANCE, *supra* note 123.

134. MO. REV. STAT. § 143.118.1 (2010); see also H.R. 818, 94th Gen. Assemb., Reg. Sess. (Mo. 2007).

135. See Michelle Andrews, *Some Church Groups Form Sharing Ministries to Cover Members Medical Costs*, KAISER HEALTH NEWS (Apr. 25, 2011), available at <http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/Michelle-Andrews-on-Health-Care-Religious-Cooperatives.aspx>; Moises Mendoza, *An Insurance Alternative to Believe In*, HOUS. CHRON., April 10, 2010, at A1; Sandra G. Boodman, *Seeking Divine Protection*, WASH. POST, October 25, 2005, at F1; Jennifer Garza, *Sharing in Faith*, COLUM. DAILY TRIB., June 25, 2011, at 7A.

136. See BRASE, *supra* note 125, at 3.

### B. Excepted Benefits

Section 2721 of the PHSA (which was created as part of HIPAA)<sup>137</sup> as it existed prior to the adoption of the ACA, provided that the insurance reform requirements of the PHSA (found in subparts 1 through 3 of Part A) did not apply to group plans of less than two current employees (that is, to retiree only plans) or to nonfederal governmental plans that elected to be excluded from HIPAA coverage.<sup>138</sup> HIPAA requirements also did not apply to excepted benefit plans, as defined in section 2791, that were provided under a group health plan under certain specified circumstances.<sup>139</sup>

“Excepted benefits” are benefits that provide assistance for addressing some health issues, but are not comprehensive health insurance as commonly understood. Under section 2791(c), for purposes of Title XXVII of the Public Health Services Act, “excepted benefits” means benefits:

[U]nder one or more (or any combination thereof) of the following:

- (1) Benefits not subject to requirements—
  - (A) Coverage only for accident, or disability income insurance, or any combination thereof.
  - (B) Coverage issued as a supplement to liability insurance.
  - (C) Liability insurance, including general liability insurance and automobile liability insurance.
  - (D) Workers’ compensation or similar insurance.
  - (E) Automobile medical payment insurance.
  - (F) Credit-only insurance.
  - (G) Coverage for on-site medical clinics.
  - (H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (2) Benefits not subject to requirements if offered separately—
  - (A) Limited scope dental or vision benefits.
  - (B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
  - (C) Such other similar, limited benefits as are specified in regulations.
- (3) Benefits not subject to requirements if offered as independent, no coordinated benefits—

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137. 42 U.S.C. § 300gg-21 (2006).

138. *Id.* § 300gg-21(a), (b)(2)(A).

139. *Id.* § 300gg-91.

- (A) Coverage only for a specified disease or illness.
- (B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy—Medicare supplemental health insurance . . . coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.<sup>140</sup>

Under section 2721 of the PHSA, the group insurance reforms of HIPAA found in subparts 1 through 3 of Part A of Title XXVII (such as guaranteed issue and renewal, the ban on health status discrimination, and the limitation on pre-existing condition exclusions) do not apply to any of the “benefits not subject to requirements” listed in category 1 of this list.<sup>141</sup> They also do not apply to those benefits listed in category 2 if the benefits were provided:

- (A) . . . under a separate policy, certificate, or contract of insurance; or
- (B) are otherwise not an integral part of the plan.<sup>142</sup>

The group health insurance reforms do not apply to benefits listed in category 3 if:

- (A) The benefits are provided under a separate policy, certificate, or contract of insurance.
- (B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.
- (C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.<sup>143</sup>

Finally, the group reforms do not apply to supplemental benefits listed in category 4 if the benefits are provided under a separate policy, certificate, or contract of insurance.<sup>144</sup>

140. *Id.* § 300gg-91(c). “Excepted benefits” also include similar benefits excepted by regulation. The regulations implementing this definition are found at Treas. Reg. § § 54.9801–.9802 (2011), 29 C.F.R. § 2590.732(c) (2010), and 45 C.F.R. § 146.145(c) (2010). The regulations do not create significant additional exceptions.

141. 42 U.S.C. § 300gg-21(c).

142. *Id.* § 300gg-21(d)(1).

143. *Id.* § 300gg-21(d)(2)(A)-(C).

144. PHSA § 2763, 42 U.S.C. § 300gg-63. Similarly excepted from the individual insurance reforms of HIPAA excepted benefits listed in category 1 and excepted benefits listed in categories 2, 3, and 4, if they were provided under a separate policy, certificate, or contract of insurance. *Id.*

Although there is virtually no legislative history of the excepted benefit provisions of HIPAA, these categories of benefits seem to have been excepted from HIPAA's insurance reforms because they were either not really health insurance (automobile or credit insurance, for example) or because they offered only partial, limited coverage (such as dental insurance or Medicare supplement coverage) rather than the comprehensive insurance at which the reforms of HIPAA were aimed.

The ACA amends section 2721,<sup>145</sup> although the precise result of the amendments is far from clear. First, the ACA renumbers section 2721, first as 2735 and then as 2722 and amends it twice, both times in the ACA section 1563, the "Conforming Amendments" section of Title I of the ACA.<sup>146</sup> These amendments are inconsistent. The House Office of the Legislative Counsel describes the effect of these amendments as follows:

Section 1563[2\*](a) of ACA amended subsections (b)(1), (b)(2), (c), (d)(1), and (d)(2) of this section by striking subparts '1 through 3' and inserting subparts '1 and 2.' Section 1565[sic.][3\*](c)(12)(B) of ACA subsequently struck 'subparts 1 through 3' and inserted 'subpart 1' each place it appeared in this section; this later amendment could not be executed because of the previous amendment, but the probable intent was to reflect subpart 1 as this provision is in subpart 2 and the reference to subpart 2 would be circular.<sup>147</sup>

The amendment to the pre-existing section 2721 also eliminates the exception for retiree only plans and provides that nonfederal governmental plans cannot elect to be exempt from Subparts I and II of the PHSA.<sup>148</sup> The amendment then provides the following with respect to excepted benefits (both alternative amendments are provided in bold print):

(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of **subparts 1 and 2 [alternative: subpart 1]** shall not apply to *any individual coverage or any group health plan* (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).

145. 42 U.S.C. § 300gg-21.

146. Because of a drafting error, the ACA actually has three sections 1563, the others dealing with the application of federal small business procurement law to ACA programs and a "sense of the Senate" statement on fiscal responsibility. ACA § 1563 (to be codified in scattered sections of 42 U.S.C.).

147. When obvious "scrivener's errors" appear in legislation, courts generally apply the canons of statutory construction or common sense to effectuate Congressional intent. See *Koons Buick, Pontiac, GMC, Inc. v. Nigh*, 543 U.S. 50, 65 (2004); *U.S. Nat'l Bank of Or. v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 462 (1992); NORMAN SINGER & J.D. SHAMBLE SINGER, *STATUTORY CONSTRUCTION* §§ 47.35, 47.38 (7th ed. 2007).

148. ACA § 1562(a)(1) (corrected code provision); see also T.D. 9489, 2010-29 I.R.B. 57 (specifically stating that the ACA eliminates exception for retiree only plans).

## (c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—The requirements of . . . **subparts 1 and 2 [alternative: subpart 1]** shall not apply to any *individual coverage* or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements

Of . . . **subparts 1 and 2 [alternative: subpart 1]** shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.<sup>149</sup>

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any individual coverage or any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.<sup>150</sup>

Whether the first or second amendment is effective, the change remains problematic because the ACA removes the prior subparts 1 and 2, creating

149. OFFICE OF LEGISLATIVE COUNSEL, COMPILATION OF TITLE XXVII OF THE PUBLIC HEALTH SERVICE ACT (AND RELATED PROVISIONS) 51-2 (2010), available at <http://democrats.energycommerce.house.gov/documents/20100917/PHSA027.pdf>. The House Legislative Counsel notes as to these changes: “[Insertion above reflects probable intent; placement of inserted language not specified in section 1563[2\*](a)(4)(B)(ii) of ACA.]” *Id.*

150. *Id.*

new subparts I and II.<sup>151</sup> The House Office of Legislative Counsel attempts to clarify this situation by adding a note stating, “[References in this section to subparts ‘1’ and ‘2’ appear in law and may be intended to refer to subparts ‘I’ and ‘II’.]”<sup>152</sup> This is a plausible approach to this problem.

It is likely, therefore, that excepted benefits are not covered by the insurance reforms of the ACA, although it is possible that the insurance reforms found in subpart I of the amended PHSA (dealing with portability, access and renewability) do not apply but those found in subpart II (other insurance reforms) do, or that all of the insurance reforms apply.<sup>153</sup>

In fact, the exclusion of most categories of excepted benefits coverage from the protections of the ACA is not a major threat to the effectiveness of the ACA. Medicare supplement policies are regulated elsewhere in federal law and automobile insurance and workers’ compensation, for example, are regulated under state law. Two categories of excepted benefits do, however, raise concerns: specified disease or illness coverage and hospital indemnity or other fixed indemnity insurance.

Specified disease policies, often called dread disease policies provide coverage only for specifically listed diseases.<sup>154</sup> These policies only provide coverage when an enrollee is diagnosed with a particular disease, or in some cases, if there is a hospitalization for the disease. This insurance often pays a flat dollar amount intended to help cover cost-sharing or uncovered consequential costs of a disease (loss of income, travel for accompanying family, etc.). It is not a substitute for comprehensive insurance, but rather a supplement. An uninformed consumer, however, particularly a consumer anxious about particular diseases such as cancers, may purchase a specified disease policy in lieu of comprehensive insurance.

Fixed dollar indemnity insurance is even more problematic. Fixed indemnity policies include a long list of specific medical procedures and assign a dollar amount to each.<sup>155</sup> Sometimes the insurer additionally

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151. ACA §§ 1201, 1562(c)(2), (c)(7), (c)(11) (to be codified in scattered sections of 42 U.S.C.).

152. See OFFICE OF LEGISLATIVE COUNSEL, *supra* note 149, at 50.

153. PHSA section 2763 excluding excepted benefits from the requirements that apply to individual plans was not amended by ACA. This section will be superfluous as of 2014, however, as amended section 2762 subjects individual plans to the requirements of Part A, which includes all of the ACA insurance reforms. ACA §§ 1255, 1562(c)(15) (to be codified at 42 U.S.C. §§ 18013, 300gg-23).

154. N.Y. DEP’T OF INS., PRODUCT OUTLINE INDIVIDUAL SPECIFIED DISEASE COVERAGE 4-5 (2003), available at [http://www.ins.state.ny.us/acrobat/sdout\\_re.pdf](http://www.ins.state.ny.us/acrobat/sdout_re.pdf); see also *Specified Diseases and Supplemental Insurance*, TEX. DEP’T OF INS., <http://www.texashealthoptexas.com/cp2/specifieddispeci/html> (last visited Aug. 17, 2011).

155. *How Assurant Health Access Plans Work*, ASSURANT HEALTH, <http://www.assuranthealth.com/corp/ah/HealthPlans/HowAHAPPlansWork.htm> (last visited Aug. 17, 2011).

negotiates provider discounts. Fixed indemnity policies can cover a wide range of procedures and look a great deal like comprehensive insurance. Benefits are limited to the dollar amounts specified, however, which can be far less than the actual amount charged. Also, procedures that are not listed are not covered.

Assuming fixed dollar indemnity policies are exempted from the ACA reforms, they are not subject to the annual and lifetime limit provisions of the ACA.<sup>156</sup> Indeed, fixed dollar policies are being touted as replacements for limited indemnity or “mini-med” policies, which are currently available only under specific waivers of the annual limit requirements and will cease to be available after 2014.<sup>157</sup>

In the short-term, there is a substantial likelihood of fraud, or at least of misunderstanding, in the sale of excepted benefit policies. The marketing of some insurers will in all likelihood suggest that they offer comprehensive coverage and fail to notify enrollees that they are not ACA compliant.<sup>158</sup> There is also some possibility of risk selection if these policies are sold to healthier purchasers.

Fortunately, whatever else the ACA does with excepted benefit policies, including specific disease and fixed dollar indemnity policies, it does explicitly provide that such policies do not count as minimum essential coverage for purposes of the ACA.<sup>159</sup> After the minimum essential coverage requirement goes into effect in 2014, therefore, an individual whose only coverage was through a specific disease or fixed-dollar indemnity policy would still need to pay the penalty for not maintaining minimum essential coverage.<sup>160</sup> Although it is conceivable that some individuals will choose to purchase excepted benefit coverage and pay the penalty, or even that insurers will offer to pay the penalty for people who purchase excepted benefits coverage, this form of coverage will become much less attractive once the minimum essential benefit requirement goes into effect. Excepted

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156. PHS § 2711, added by ACA § 10101(a) (to be codified at 42 U.S.C. § 300gg-11).

157. See *Assurant Health CEO: MLR Rules Shook Up Sales Landscape for Major Medical*, Insurancenet.com (Aug. 2, 2011), <http://www.insurancenet.com/article.aspx?id=271263> (last visited Aug. 17, 2011); Tim Adkisson, *Don't Give Up on Limited Benefit Medical Panel*, VoluntaryBenefitsMagazine.com (Jul. 10, 2010), <http://www.voluntarybenefitsmagazine.com/article-detail.php?issue=issue-13&article=don-t-give>; Press Release, Symetra Financial, Symetra Introduces ‘Shared Maximum’ Option to Limited Benefit Medical Policy (May 20, 2010), available at [http://media.symetra.com/article\\_display.cfm?article\\_id=1217](http://media.symetra.com/article_display.cfm?article_id=1217).

158. See U.S. Dep’t of Health & Human Servs., CCIIO Supplemental Guidance (CCIIO 2011- 1D): Concluding the Annual Limit Waiver Application Process (2011), available at [http://cciio.cms.gov/resources/files/O6162011\\_annual\\_limit\\_guidance\\_2011-2012\\_final.pdf](http://cciio.cms.gov/resources/files/O6162011_annual_limit_guidance_2011-2012_final.pdf).

159. ACA § 1501(b) (to be codified at I.R.C. § 5000A).

160. See *id.* This would be true whether the coverage were an employee benefit or purchased as individual coverage.

benefits policies are thus unlikely to play a major role in undermining the risk pool of the exchanges.

In the interim, excepted benefit policies should be monitored closely by the states, which do have authority to regulate them. Both specified disease policies and fixed dollar indemnity policies are regulated under the laws of most states; in many states under NAIC Model Laws 170 and Model Regulation 171.<sup>161</sup> In particular, Model Regulation 171 requires indemnity policies to disclose in large bold or contrasting color type that the policy is intended to provide supplemental coverage and not intended to cover all medical expenses.<sup>162</sup> Purchasers must understand that they are purchasing limited coverage that may fall far short of their actual needs and is not covered by the protections of the ACA.

### C. *Retiree Coverage*

As noted earlier, the ACA incorporates the definition of group health plan from section 2791 of the PHSa,<sup>163</sup> which in turn defines group health plan by reference to the definition of employee welfare benefit plan in ERISA.<sup>164</sup> ERISA excludes from its coverage a number of types of group plans, including governmental plans, church plans, workers' compensation plans, and plans "maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens."<sup>165</sup> Nothing in the ACA, the PHSa, or ERISA, however, suggests that these plans are not covered by Title XXVII of the PHSa or by the ACA.

The ACA amends ERISA by adding the following language:

#### SEC. 715. ADDITIONAL MARKET REFORMS.

(a) GENERAL RULE.—Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health

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161. NAIC MODEL LAW 170, ACCIDENT AND SICKNESS INSURANCE MODEL ACT (1999); NAIC MODEL REGULATION 171, NAIC MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MODEL ACT (1999).

162. NAIC MODEL REGULATION 171, § 8(A)(17) (1999).

163. ACA §§ 1301(b)(3), 1551.

164. 42 U.S.C. § 300gg-91 (2006) (referencing 29 U.S.C. § 1002(1) (2006)).

165. 29 U.S.C. § 1003.

insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.<sup>166</sup>

This amendment is found in Part 7 of Subtitle B of ERISA,<sup>167</sup> the part that implemented HIPAA, and is intended to align this section with the amendments made to Part A of Title XXVII of the PHS Act (the group and individual market reforms) by the ACA.<sup>168</sup> The ACA amends the Internal Revenue Code by adding identical language in a new section 9815.<sup>169</sup> Both amendments are not strictly necessary, as the provisions of the ACA on their own terms apply to group health plans, which are defined to include ERISA plans. But these provisions emphasize the fact that the protections of the ACA apply to ERISA plans as well as to state-regulated insurance.

In their introduction to the regulations adopted to implement the grandfather provisions of ACA section 1251, however, HHS, DOL, and the IRS state:

The Affordable Care Act also adds section 715(a)(2) of ERISA, which provides that, to the extent that any provision of part 7 of ERISA conflicts with part A of title XXVII of the PHS Act with respect to group health plans or group health insurance coverage, the PHS Act provisions apply. Similarly, the Affordable Care Act adds section 9815(a)(2) of the Code, which provides that, to the extent that any provision of subchapter B of chapter 100 of the Code conflicts with part A of title XXVII of the PHS Act with respect to group health plans or group health insurance coverage, the PHS Act provisions apply. Therefore, although ERISA section 715 (a)(1) and Code section 9815(a)(1) incorporate by reference new provisions, they do not affect pre-existing sections of ERISA or the Code unless they cannot be read consistently with an incorporated provision of the PHS Act. For example, ERISA section 732(a) generally provides that part 7 of ERISA—and Code section 9831(a) generally provides that chapter 100 of the Code—does not apply to plans with less than two participants who are current employees (including retiree-only plans that cover less than two participants who are current employees). Prior to enactment of the Affordable Care Act, the PHS Act had a parallel provision at section 2721(a). After the Affordable Care Act amended, reorganized, and renumbered most of title XXVII of the PHS Act, that exception no longer exists . . . .

. . . . The absence of an express provision in part A of title XXVII of the PHS Act does not create a conflict with the relevant requirements of ERISA and

166. ACA § 1562(e) (to be codified at 29 U.S.C. § 1185(d)) (amending ERISA, 29 U.S.C. § 1181). This section contains an exception for sections 2716 (nondiscrimination in insured plans in favor of highly-compensated employees) and 2718 (minimum medical loss ratios).

167. ERISA § 715, *added by* ACA § 1562(e) (to be codified 29 U.S.C. § 1185d).

168. PHS Act §§ 2711–2719, *added by* ACA § 1001(5) (to be codified 42 U.S.C. §§ 300gg-11–19).

169. ACA § 1562(f) (to be codified at I.R.C. § 9815).

the Code. Accordingly, the exceptions of ERISA section 732 and Code section 9831 for very small plans and certain retiree-only health plans, and for excepted benefits, remain in effect and, thus, ERISA section 715 and Code section 9815, as added by the Affordable Care Act, do not apply to such plans or excepted benefits.<sup>170</sup>

The preface thus states that ERISA's exceptions for groups that include fewer than two current employees and for excepted benefits continue to apply to group plans.<sup>171</sup> The preface further provides that nothing in the ACA indicates that nonfederal governmental retiree-only plans and nonfederal governmental excepted benefit plans should be treated differently than private retiree-only plans or excepted benefit plans.<sup>172</sup> These plans are not subject to ERISA or the IRC, and thus are not subject to supervision by the Departments of Labor or Treasury. Because, apparently, it is the policy of HHS under a memorandum of understanding and under section 104 of HIPAA to enforce the law uniformly with respect to ERISA plans and non-ERISA plans, the preface further states that "HHS does not intend to enforce ACA against retiree-only plans or excepted benefit plans,"<sup>173</sup> and then:

HHS is encouraging States not to apply the provisions of title XXVII of the PHS Act to issuers of retiree-only plans or of excepted benefits. HHS advises States that if they do not apply these provisions to the issuers of retiree-only plans or excepted benefits, HHS will not cite a State for failing to substantially enforce the provisions of part A of title XXVII of the PHS Act in these situations.<sup>174</sup>

As noted above, the ACA expressly eliminates from Title XXVII of the PHSA the exception for retiree only plans.<sup>175</sup> The ACA does not amend section 732(a) of ERISA, but, as acknowledged in the preamble text quoted above, it adds section 715 to ERISA and 9815 to the IRC providing that if there is a conflict between Part 7 of Subtitle B of ERISA and Part A of Title XXVII of the PHSA, the PHSA governs. Since Part A covers retiree only plans, ERISA does as well. This was clearly the intention of Congress, as this is what the language of the ACA says. The strained and implausible reading of sections 715 and 9815 by the Departments of HHS, Labor, and Treasury

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170. Interim Final Rules, 75 Fed. Reg. 34,538, 34,539 (June 17, 2010).

171. *Id.*

172. *Id.*

173. *Id.* at 34,540.

174. *Id.*; see also U.S. DEP'T OF LABOR, FAQs ABOUT THE AFFORDABLE CARE ACT IMPLEMENTATION PART III (Oct. 12, 2010), available at <http://www.dol.gov/ebsa/faqs/faq-aca3.html> (reaffirming this interpretation and extending its coverage, at least temporarily, to long-term disability coverage).

175. ACA § 1562(a)(1); see *supra* text accompanying note 166.

disregards the express language of sections 715(a) and 9815(a) which provide that conflicts between ERISA and the PHSA must be resolved in favor of the PHSA; sections 1001 and 1201, which apply to all group plans with no exclusion for retiree only plans; section 1551, which incorporates PHSA definitions for purposes of the ACA; and section 1563 which eliminates the retiree only plan exception from the PHSA. There is absolutely nothing in the ACA that suggests that it is not intended to cover retiree-only plans. The fact that ERISA itself does not regulate certain types of employee welfare benefit plans has no relevance to the scope of the ACA. The position of the Departments to the contrary should not be accorded *Chevron* deference in this interpretation of the statute because the intent of Congress is clearly and unambiguously expressed to the contrary.<sup>176</sup> Moreover, because the position of the Departments has only been expressed in guidance and not in an agency rule, it should be afforded even less deference.<sup>177</sup>

The most significant problem posed by early retiree policies is that individuals covered with them lack the protection of the ACA. It would seem that fraud and risk selection will be less of an issue. But at least some individuals with this form of coverage will have passed up the opportunity to purchase comparably priced ACA compliant coverage, or perhaps to continue employment and retain ACA compliant employee coverage. DOL and the IRS should abandon their untenable interpretation of the statute so that early retirees can enjoy full ACA protection. If they do not, individuals should be warned of the limited nature of this coverage before they purchase it or before they move from regular employee to retiree coverage. Alternatively, the states can regulate insured (although not self-insured) retiree plans to assure enrollees protections similar to those found in the ACA.<sup>178</sup>

#### D. *Short-term Limited Duration Health Plans and Student Health Plans*

The ACA incorporates the PHSA definition of individual insurance coverage.<sup>179</sup> That definition excludes “short-term limited duration

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176. Under the leading case of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the courts should defer to a “permissible construction” of a statute if Congress has not addressed the issue in question, but should not defer to the agency where Congress has directly spoken to the issue. 467 U.S. at 842-43.

177. See *United States v. Mead Corp.*, 533 U.S. 218, 232 (2001); see also *La. Envtl. Action Network v. EPA*, 382 F.3d 575, 583 (5th Cir. 2004) (refusing *Chevron* deference to a preamble).

178. 29 U.S.C. § 1191 (2006). Self-insured plans would be protected from state regulations by ERISA preemption. See 29 U.S.C. § 1144(b)(2)(B).

179. ACA § 1551 (incorporating 42 U.S.C. § 300gg-91(b)(5) (2006)).

insurance.”<sup>180</sup> Short-term limited duration insurance is defined in the federal regulations as:

health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer’s consent) that is less than 12 months after the original effective date of the contract.<sup>181</sup>

Short-term limited duration policies are often purchased as “bridge policies” by individuals who are between jobs or who have just graduated from college or university or lost coverage under their parents’ policy and are waiting for employment coverage to commence.<sup>182</sup> Because individual short-term limited duration policies are defined by the PHSA to not be individual coverage, they were exempt from HIPAA requirements and are exempt from the provisions of the ACA.<sup>183</sup> On the other hand, short-term policies are not considered to be minimum essential coverage for purposes of the ACA minimum coverage requirement.<sup>184</sup> It is likely, therefore, that they will continue to occupy the market niche they have always filled and not become a major means of evading the requirements of the ACA.

The short-term individual insurance policy exception has become an issue in the implementation of the ACA primarily because of student health plans. Many American colleges and universities offer health plans to their students.<sup>185</sup> Indeed, many colleges and universities require their students who are not otherwise insured to purchase student health coverage through

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180. 42 U.S.C. § 300gg-91(b)(5).

181. 26 C.F.R. § 54.9801-.9802 (2007); 29 C.F.R. §§ 2590.701-.703 (2008); 45 C.F.R. § 144.103 (2010).

182. MICH. DEP’T OF CONSUMER & INDUS. SERVS., MICH. DIV. OF INS., REPORT ON SHORT TERM OR 1-TIME LIMITED DURATION HEALTH INSURANCE POLICIES: YEAR ENDED 2000, at 1-2, available at [http://www.michigan.gov/documents/cis\\_ofis\\_st\\_rept00\\_25593\\_7.pdf](http://www.michigan.gov/documents/cis_ofis_st_rept00_25593_7.pdf) (last visited Aug. 21, 2011).

183. 42 U.S.C. § 300gg-91(b)(5). The PHSA definition of group health insurance does not exclude short-term limited duration policies, which are presumably subject to HIPAA and ACA requirements. *Id.* at § 300gg-91(b)(4).

184. ACA § 1501(b) (to be codified at I.R.C. § 5000A). The minimum coverage requirement, however, only applies after a person has been uninsured for at least three months, so it is likely that short-term policies of less than three months will continue to be relied upon for bridge policies. *See id.*

185. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-08-389, HEALTH INSURANCE: MOST COLLEGE STUDENTS ARE COVERED THROUGH EMPLOYER-SPONSORED PLANS, AND SOME COLLEGES AND STATES ARE TAKING STEPS TO INCREASE COVERAGE 5 (2008).

the university.<sup>186</sup> It is estimated that between 1.1 and 1.5 million college and university students are covered through student health plans.<sup>187</sup>

These plans are usually quite inexpensive, reflecting the fact that university students are generally healthy and rarely incur high medical costs. The policies also, however, often offer coverage of little value, with low medical loss ratios, high administrative expenses, many exceptions and exclusions, and low annual dollar limits.<sup>188</sup> Student health plans have proven quite lucrative both for insurers and for the colleges and universities that require them.<sup>189</sup> With the extension of parental coverage to adult children up to age twenty-six, however, they are likely to become less common.<sup>190</sup>

Student health plans as such do not exist under the ACA. The ACA only recognizes individual and employment-related group policies. Since student health plans are obviously not employment-related, they must be individual policies. But individual plans under the ACA are already subject to annual limit requirements that far exceed the limits found in most student health plans and will be subject beginning in 2014 to regulatory requirements such as guaranteed issue and renewal that do not fit well with plans designed to offer coverage only within the university setting. Also, section 1560(c) of the ACA provides enigmatically:

Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.<sup>191</sup>

One way of avoiding the regulatory requirements of the ACA would be to classify student health plans as short-term policies.<sup>192</sup> Indeed, some

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186. *Id.*

187. Student Health Ins. Coverage, 76 Fed. Reg. 7767, 7777 (Feb. 11, 2011) (to be codified at 45 C.F.R. pt. 147.145).

188. Danny Hakim, *Insurers Shortchange College Students on Health Plans, Cuomo Says*, N.Y. TIMES, Apr. 9, 2010, at A21; Letter from Andrew Cuomo, Att'y Gen. of N.Y., to Presidents of Schools (Apr. 6, 2010) (on file with author), available at <http://www.nystudenthealth.com/pdfs/Letter%20to%20Schools%2004-06-10.pdf>; see also MASS. DIV. OF HEALTH CARE FIN. & POLICY, STUDENT HEALTH PROGRAM: ACADEMIC YEARS 2005-2006 THROUGH 2007-2008 BASELINE REPORT 15, 19, 20, 22 (Nov. 2009).

189. Cuomo, *supra* note 188.

190. PHSA § 2714, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-14).

191. ACA § 1560(c) (to be codified at 42 U.S.C. § 18118).

192. See Letter from Molly Corbett Broad, President of the Am. Council of Educ. to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. & Nancy-Ann DeParle, Dir., White House Office of Health Reform (Aug. 12, 2010), available at <http://www.aau.edu/WorkArea/DownloadAsset.aspx?id=11126> (taking this position).

student health plans were written so as to cover a day or even minutes less than a full year in order to squeeze within the short-term exception.<sup>193</sup> Student coverage, however, was generally renewable for as long as a student remained enrolled in the school, however, and thus did not actually meet the definition of short-term coverage.<sup>194</sup>

On February 11, 2011, HHS published a proposed rule to exempt student health plans from certain ACA requirements, asserting that these exemptions were necessary to continue to allow student health plans to exist, as provided in the ACA.<sup>195</sup> Specifically, the proposed regulation would free student health plans from the guaranteed availability and renewal provisions of the ACA that go into effect in 2014, permit them to have annual limits as low as \$100,000 through policy years beginning by September 23, 2012, and allow them to charge administrative fees for student health services without running afoul of the prohibition on cost-sharing for preventive services.<sup>196</sup> Student health plan policies must, however, include a notice that the policy does not fully comply with the ACA.<sup>197</sup> HHS also requested comments as to whether student health plans should be exempted from the free choice of provider provisions of the ACA and given special treatment with respect to its medical loss ratio provisions.<sup>198</sup>

The proposed rule does not apply to self-funded student plans, which HHS believes to be neither individual nor group plans, and, which are thus not subject to the PHSA or the ACA.<sup>199</sup> HHS believes that these plans are not widespread, covering only about 200,000 students.<sup>200</sup> These plans would not qualify as minimum essential coverage under the ACA's coverage requirement, and thus are likely to cease to exist after 2014. For the moment, however, they remain subject to state regulation but not the requirements of the ACA.

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193. See Student Health Ins. Coverage, 76 Fed. Reg. 7767 (Feb. 11, 2011) (to be codified at 45 C.F.R. pt. 147.145).

194. See Letter from the Young Invincibles to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. & Nancy-Ann DeParle, Dir., White House Office of Health Reform (Sept. 10, 2010), available at [http://www.younginvincibles.org/News/Releases/20100910\\_Letter\\_Re\\_Student\\_Plans.pdf](http://www.younginvincibles.org/News/Releases/20100910_Letter_Re_Student_Plans.pdf)

195. See Student Health Ins. Coverage, 76 Fed. Reg. 7767.

196. *Id.* at 7781 (to be codified at 45 C.F.R. pt. 147.145(b)(1), (b)(2), (c)). The proposed regulation frees student health plans from the guaranteed issue and renewability provisions by treating them as bona fide associations, an exception that will end as of 2014. See *infra* notes 241–247.

197. Student Health Ins. Coverage, 76 Fed. Reg. at 7781-82.

198. See *id.* at 7772-73.

199. *Id.* at 7769.

200. *Id.*

Finally, true short-term limited duration policies continue to exist free of ACA regulation, and policies lasting under three months are likely to continue even after 2014.

True short-term policies and student health plans are unlikely to pose a major risk selection threat to the exchanges, as their markets will be quite limited. There is, however, a real danger that individuals will purchase these forms of coverage not understanding that they are not subject to the ACA protections. It is important, therefore, that states require insurers who market this form of coverage to disclose prominently that the ACA does not cover short-term policies, and for the federal government to continue to require disclosure for student health plans.

#### V. BORDER CROSSING STRATEGIES

The ACA applies to individual and employer coverage.<sup>201</sup> There are four categories of employers under the ACA: small employers, large employers, grandfathered employers, and self-insured employers.<sup>202</sup> There are potentially five employer insurance markets: the exchange market, the small group market outside the exchange, the large group market outside the exchange, the grandfathered market, and the self-insured market. The small employer market inside and outside of the exchange is subject to many of the same regulatory requirements. Whether in or out of the exchange, small group plans must offer the essential benefits package,<sup>203</sup> include their members in a single risk pool,<sup>204</sup> participate in the risk adjustment program,<sup>205</sup> offer non-discriminatory premiums,<sup>206</sup> and offer the precious metal tiers.<sup>207</sup> Large group plans are not subject to these requirements. Neither are self-insured plans. There is thus a potential incentive for plans covering individuals or small groups to achieve large group or self-insured status to avoid some ACA requirements. This section discusses some of the strategies that might be attempted to achieve this, as well as possible regulatory responses.

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201. HINDA CHAIKIND ET AL., CONG. RESEARCH SERV., R40942, PRIVATE HEALTH INSURANCE PROVISIONS IN PPACA (P.L. 111-148) (2010).

202. *Id.* at 5, 10, 11.

203. PHS § 2707, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6).

204. ACA § 1312 (to be codified at 42 U.S.C. § 18032).

205. ACA § 1343(c) (to be codified at 42 U.S.C. § 18063).

206. PHS § 2701(a)(1), added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg).

207. PHS § 2707(a), added by ACA §§ 1201, 1302(a)(3) (to be codified at 42 U.S.C. §§ 300gg-6, 18022).

### A. Association Health Plans

Association health plans are arrangements in which an insurance policy is held by an association to cover its members, or through which an association self-insures for the benefit of its members.<sup>208</sup> The association in turn issues certificates of coverage to its members, who are thus insured through the association. An association may be a legitimate professional or trade association, which incidentally offers health insurance to its members as a benefit.<sup>209</sup> It may also be a captive of an insurance company, established specifically to market the insurer's products.<sup>210</sup> Alternatively, an association may be established by an independent entity, like a professional employer organization, that exists to market a range of products including health insurance.<sup>211</sup> There is a long history of fraud and misrepresentation in the sale of insurance by entities claiming to be associations.<sup>212</sup>

Association health plans have long been championed by free-market advocates and by some business groups as a way of providing affordable health insurance to small businesses.<sup>213</sup> Association health plans, it is argued, offer the advantages of large group coverage—economies of scale, larger pools, greater bargaining power—to small groups.<sup>214</sup> Proponents of association health plans have repeatedly introduced legislation in the U.S. Congress to facilitate their sale, largely by limiting or preempting state regulation.<sup>215</sup>

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208. See Mila Kofman et al., *Association Health Insurance: Is it Time to Regulate This Product?*, J. INS. REG., Fall 2005, at 31, 33 (2005) [hereinafter Kofman, *Time to Regulate*]; Mila Kofman et al., *Association Health Plans: What's all the Fuss About?*, 25 HEALTH AFF. 1591, 1592 (2006) [hereinafter Kofman, *What's all the Fuss About?*].

209. Kofman, *Time to Regulate*, *supra* note 208, at 34; Kofman, *What's all the Fuss About?*, *supra* note 208, at 1592.

210. Kofman, *Time to Regulate*, *supra* note 208, at 33-34.

211. *Professional Employer Organizations . . . What is a PEO?*, PA INS. SERVS., <http://www.insurancepa.com/small-businesses-offer-big-benef.htm> (last visited Aug. 19, 2011).

212. See generally Kofman, *What's all the Fuss About?*, *supra* note 208, at 1598 (providing an overview of the history of fraud and abuse).

213. See GREG SCANDLEN, NAT'L CTR. FOR POL'Y ANALYSIS, BRIEF ANALYSIS NO. 419, ASSOCIATION HEALTH PLANS—PART ONE: LOWERING SMALL GROUP COSTS 1-2 (2002).

214. JOSEPH P. ANNIS, COUNCIL ON MEDICAL SERVICE, CMS REPORT 5 - I-05: ASSOCIATION HEALTH PLANS (2005).

215. See JEAN HEARNE, CONG. RESEARCH SERV., RL 31963, ASSOCIATION SPONSORED HEALTH PLANS: LEGISLATION IN THE 109TH CONGRESS 5 (2006), available at <http://www.allhealth.org/briefingmaterials/CRSAHPLegislationin108thCongress-94.pdf>; JEAN HEARNE, CONG. RESEARCH SERV., RL 31963, ASSOCIATION HEALTH PLANS, HEALTH MARTS, AND THE SMALL GROUP MARKET FOR HEALTH INSURANCE 6 (2003), available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL31963.pdf/>.

On the other hand, deregulation of association health plans has been strongly opposed by consumer advocates and some regulators. A primary concern has been the possibility of risk selection if associations can find ways to market their products to low risk individuals and groups, leaving higher risks to traditional markets.<sup>216</sup> Association health plans destroyed attempted small group insurance market reforms in Kentucky in the 1990s by siphoning off healthy groups from the market.<sup>217</sup> Insurance commissioners from Montana and Washington expressed concerns about the regulation of association health plans in their comments to HHS on proposed rate review reforms based on their experience with associations undermining small group reforms in their states.<sup>218</sup> If associations that market to individuals and small groups were regulated as large groups and thus free from the essential benefits, guaranteed issue, guaranteed renewal, and rating bans that will go into effect under the ACA in 2014 in the individual and small group market, they could have destabilized those markets. Association plans and multiple employer welfare plans have also often been repeatedly involved in fraud, marketing non-existent or unlicensed coverage to unsuspecting individuals or small businesses.<sup>219</sup>

Association health plans take many different forms, including group trusts, multiple employer welfare arrangements, multiple employer trusts, employer purchasing alliances and coalitions, and professional employer organizations.<sup>220</sup> Although there are significant functional and

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216. See Mark A. Hall, *The Geography of Health Insurance Regulation*, HEALTH AFF., Mar./Apr. 2000, at 173, 181-82 (2000).

217. GEORGE NICHOLS III, KY. DEP'T OF INS., MARKET REPORT ON HEALTH INSURANCE ii-iii (1997).

218. Letter from Mike Kreidler, Ins. Comm'r, Wash. State, to the Office of Consumer Info. & Ins. Oversight (Feb. 1, 2011), available at <http://www.insurance.wa.gov/consumers/reform/documents/fedregcomment45cfrpart154.pdf>; letter from Monica J. Lindeen, Mont. Comm'r of Sec. & Ins., to Kathleen Sebelius, Sec'y, U.S. Dep't. Health & Human Servs. (Feb. 22, 2011), available at <http://www.regulations.gov/#!documentDetail;D=HHS-OS-2010-0029-0048>.

219. See Kofman, *What's all the Fuss About?*, supra note 208, at 1598; Larry Kirsch & Sonya Schwartz, FAMILIES USA, THE ILLUSION OF GROUP HEALTH INSURANCE: DISCRETIONARY ASSOCIATIONS 6-8 (2004), available at [http://www.familiesusa.org/assets/pdfs/Disc\\_brief\\_summary350f.pdf](http://www.familiesusa.org/assets/pdfs/Disc_brief_summary350f.pdf); FAMILIES USA, BUYER BEWARE: UNLICENSED INSURANCE PLANS PREY ON HEALTH CARE CONSUMERS 9 (2010), available at <http://www.familiesusa.org/resources/resources-for-consumers/Scam-Insurance-Plans.pdf>. MEWA fraud continues to be an important concern. The Affordable Care Act includes a number of provisions addressing MEWA regulation. ACA § 6601 (to be codified in scattered sections of 29 U.S.C. and 42 U.S.C.). Section 6601 creates a new section 519 of ERISA, which makes it a crime to make certain false statements in the marketing of a MEWA association plan, including a false statement regarding the regulatory status of the plan. *Id.* § 6601 (to be codified at 29 U.S.C. § 1149).

220. See Kofman, *Time to Regulate*, supra note 208, at 33; Kofman, *What's all the Fuss About?*, supra note 208, at 1592.

organizational differences among these various models, for purposes of the ACA, they break down into two categories—association health plans that market insurance to individuals and those that market insurance to groups. The former will be referred to here as association health plans and the latter as multiple employer welfare associations, or MEWAs.

A regulation released by HHS on September 1, 2011, seems to have largely resolved the problem of association health plans. The regulation was issued specifically to resolve the question of whether association health plans would be regulated as large groups or as individual and small group coverage for purposes of review of unreasonable premium increases under ACA section 2794.<sup>221</sup> The rule provides that, regardless of state law, association plans that market plans to individuals must be regulated as individual plans and associations plans that market to small groups as small group plans for purposes of rate review.<sup>222</sup> The preamble to the rule, however, clarifies that this rule will apply for all of the regulatory provisions of the ACA, closing decisively one of the most significant loopholes in the ACA.<sup>223</sup> This section discusses the rationale for this position.

### 1. Individual Coverage through Association Plans

Association health plans have become very common in the individual market in some states. Some are bona fide associations that exist for other purposes but incidentally market health insurance to their members. But some are “air breather” associations that exist only for the purpose of marketing insurance and will sell insurance to anyone who meets underwriting requirements (who breathes air) without requiring that members belong to an association for any other purpose.<sup>224</sup>

Many states regulate association health plans differently than they regulate other plans that market to individuals.<sup>225</sup> Some states also regulate domestic association plans differently than they do association plans marketed by national associations, which they regulate less closely or do not regulate at all.<sup>226</sup> Association health plans that market to individuals are treated like group plans under the laws of some states and are thereby able to escape state regulations imposed on the individual market.<sup>227</sup> To the extent that state laws require community rating or in some other way limit

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221. Rate Increase Disclosure and Review: Definitions of “Individual Market” and “Small Group Market,” 76 Fed. Reg. 54,969 (Sept. 6, 2011) (to be codified at 45 C.F.R. pt. 154).

222. *Id.*

223. *See id.* at 54,971.

224. Hall, *supra* note 216, at 182.

225. Kofman, *What’s all the Fuss About?*, *supra* note 208, at 1592-3.

226. *Id.* at 1593.

227. Hall, *supra* note 216, at 175-6.

health status underwriting in the individual market, but not in the group market, association health plans can facilitate risk selection by insurers and adverse selection by healthy enrollees.

The status of association health plans that market to individuals is clear under the ACA—they do not enjoy any special status but are simply regulated as individual insurance. Section 1304 of the ACA, which provides the definitions used under the ACA for classifying markets, defines the group market only in terms of employer groups and defines the individual market to include all health insurance coverage marketed to individuals other than through employer groups.<sup>228</sup> Section 1301(b)(3) defines “group health plan” by reference to PHSa 2791(a).<sup>229</sup> Section 2791(a) defines group health plan to mean an employer plan.<sup>230</sup> There is nothing in the ACA that suggests that a plan that markets coverage to individuals outside of an employee groups is anything other than an individual plan.

As noted earlier, the ACA simply builds on the framework of HIPAA.<sup>231</sup> The HIPAA regulations provide:

(c) Coverage that is provided to associations, but is not related to employment, is not considered group coverage under 45 C.F.R. parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under State law.<sup>232</sup>

HIPAA Insurance Standards Bulletin 02-02 states even more explicitly:

If the health insurance offered to an association member is offered other than in connection with a group health plan, or is offered to an association’s employer-member that is maintaining a group health plan that has fewer than two participants who are current employees on the first day of the plan year, the coverage is generally considered individual health insurance coverage for purposes of title XXVII.<sup>233</sup>

228. ACA § 1304 (to be codified at 42 U.S.C. § 18024).

229. ACA § 1304(b)(3) (to be codified at 42 U.S.C. § 18024). Section 1551 further incorporates the definitions found in the PHSa into Title I of the ACA “unless specifically provided otherwise.” ACA § 1551 (to be codified at 42 U.S.C. § 18111).

230. PHSa § 2791(a) (codified at 42 U.S.C. § 300gg-91 (2006)).

231. See *supra* notes 1-9.

232. 45 C.F.R. § 144.102 (1999).

233. Memorandum from the U.S. Dep’t of Health & Human Servs. on Application of Group and Individual Market Requirements Under Title XXVII of the Public Health Service (PHS) Act When Insurance Coverage is Sold To, or Through, Associations 2 (Aug. 2002) [hereinafter Insurance Bulletin 02-02], available at <http://www.cms.gov/HealthInsReformforConsume/downloads/HIPAA-02-02.pdf>.

The ACA does nothing to change this, as has been recognized in an HHS regulation governing review of unreasonable premium increases.<sup>234</sup> Association coverage sold to individuals other than through an employer group is individual coverage and is subject to all of the regulatory requirements that attend to individual health plans.<sup>235</sup>

## 2. Association Plans in the Group Market: MEWAs

Regulation of association plans in the group market under the ACA is somewhat more complex, although in the end they too do not receive special treatment but are regulated just like other group plans.<sup>236</sup> As noted above, the ACA regulates all insurance coverage (except for excepted benefits) as either group health plans or as health insurance issuers offering individual or group coverage.<sup>237</sup> Thus group association plans must either be group health plans or issuers offering group coverage for purposes of the ACA. There is no separate category for association plans as such.

It does matter under the ACA, however, whether group association health plans are considered to be self-insured group plans or insured group plans and also whether they are classified as small or large group plans. As noted above, some of the protections of the ACA, such as limitations on annual and lifetime limits or guaranteed access to internal and external appeals, apply to self-insured plans.<sup>238</sup> But other protections do not. One important question, therefore, is whether association health plans are always considered to be insured plans or whether they might be considered self-insured under some circumstances. Another important distinction is that between small group and large group plans. As noted at the outset, some of the protections extended to enrollees in small group plans do not apply to large group plans.<sup>239</sup> It is important, therefore, whether coverage sold to small groups by association health plans is small or large group coverage.

Association plans are nowhere mentioned in the ACA. Bona fide associations were recognized under HIPAA.<sup>240</sup> Section 2791(d)(3) of the PHSA defines “bona fide associations” as entities in existence for more than five years, formed in good faith for purposes other than providing insurance,

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234. See generally *Rate Increase Disclosure and Review: Definitions of “Individual Market” and “Small Group Market,”* 76 Fed. Reg. 54,969 (Sept. 6, 2011) (to be codified at 45 C.F.R. pt. 154).

235. This is recognized in the HHS medical loss ratio regulation, which treats individual association health plans as individual plans for reporting purposes. *Medical Loss Ratio*, 75 Fed. Reg. 74,864, 74,871 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158.120(d)(1)).

236. 45 C.F.R. § 154.

237. *Supra* p. 51.

238. FERNANDEZ, *supra* note 116, at 21.

239. See *supra* text accompanying notes 12-15.

240. HIPAA § 102, 42 U.S.C. § 300gg-91 (2006).

that make health insurance coverage available to all members regardless of any health status related factor, that do not make health insurance coverage available other than to members, and that meet state law requirements.<sup>241</sup> This is obviously a much smaller category of association health plans than those recognized by state laws, which in many cases would not meet this definition.<sup>242</sup>

Prior to the adoption of the ACA, bona fide associations were not required to offer guaranteed issue or renewal to non-member small groups under PHSA sections 2711 and 2712.<sup>243</sup> The ACA renumbers sections 2711 and 2712 as sections 2731 and 2732.<sup>244</sup> ACA section 1563(c)(8) next drops the exception for bona fide associations from the guaranteed issue requirements of section 2731, which now apply to all groups and individuals.<sup>245</sup> The ACA then renumbers section 2731 a second time to section 2702.<sup>246</sup> The ACA does not drop the references to bona fide associations as to nonrenewal in former section 2712, now section 2703, but since guaranteed issue now applies to all issuers, the non-extension of nonrenewal would not seem to provide any special protection for association health plans.<sup>247</sup> In any event, none of these provisions of HIPAA give bona fide association plans, any special status under the ACA, as is recognized in the preamble to the HHS regulation on association health plans in premium review.<sup>248</sup>

This analysis of the PHSA does not, however, fully answer the question of how group coverage sold through associations is treated under the ACA. An evaluation of their status under ERISA, and of ERISA's intersection with the ACA, is also required. Under ERISA, most association plans that cover employment-related groups are classified as MEWAs.<sup>249</sup> A MEWA is defined as:

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241. PHSA § 2791(d)(3), amended by HIPAA § 102, 42 U.S.C. § 300gg-91 (2006).

242. NAIC MODEL LAW 110 (1999).

243. See PHSA §§ 2711, 2712, 42 U.S.C §§ 300gg-11, -12 (2006). Similarly, the individual guaranteed issue and renewal provisions of section 2741 and 2742 did not protect non-association members with respect to associations. See PHSA §§ 2741, 2742, 42 U.S.C. §§ 300gg-41, -42 (2006).

244. ACA § 1001.

245. ACA § 1562(c)(8) (to be codified at 42 U.S.C. § 300gg-1) (amending PHSA § 2731).

246. ACA § 1562(c)(8)(F) (to be codified at 42 U.S.C. §300gg-1)(designating PHSA § 2731 as § 2702).

247. See PHSA § 2703, amended by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-2). Sections 2741 and 2742 are not amended, but because the small group provisions are extended to individuals, sections 2741 and 2742 also become irrelevant after 2013.

248. See generally Rate Increase Disclosure and Review: Definitions of "Individual Market" and "Small Group Market," 45 C.F.R. § 154.

249. See U.S. DEP'T OF LABOR, ADVISORY OP. 2005-25A, at 3 (2005) [hereinafter DOL 2005-25A], available at <http://www.dol.gov/ebsa/regs/aos/ao2005-25a.html>; U.S. DEP'T OF

an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing [health and welfare benefits] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

- (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,
- (ii) by a rural electric cooperative, or
- (iii) by a rural telephone cooperative association.<sup>250</sup>

Any association that includes two or more employee groups is, therefore, a MEWA unless it fits into one of three excepted categories.

Under ERISA, a MEWA can itself be an “employee welfare benefit plan,” but many MEWAs are not. ERISA defines an employee welfare benefit plan as a plan established by an employer or employee organization to provide welfare benefits to participants and beneficiaries.<sup>251</sup> The term “employer” is defined to mean:

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.<sup>252</sup>

The category of associations that can actually qualify as employers, however, is quite limited. Only a bona fide employer group or association can serve as an employer for purposes of establishing an employee welfare benefit plan.<sup>253</sup> The term “bona fide employer group or association” as used in this context, is not the same as a bona fide association used in HIPAA. Factors that are to be considered in determining whether there is a “bona fide employer group or association” include:

how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was

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LABOR, ADVISORY OP. 2005-20A, at 3 (2005) [hereinafter DOL 2005-20A], available at <http://www.dol.gov/ebsa/regs/aos/ao2005-20a.html>; U.S. DEP’T OF LABOR, ADVISORY OP. 2003-13A, at 3-4 (2003) [hereinafter DOL 2003-13A], available at <http://www.dol.gov/ebsa/regs/aos/ao2003-13a.html>.

250. 29 U.S.C. § 1002(40)(A) (2006).

251. *Id.* § 1002(1). Employee organizations are defined as labor unions or employees’ beneficiary associations. See *infra* note 306.

252. 29 U.S.C. § 1002(5).

253. U.S. DEP’T OF LABOR, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA): A GUIDE TO FEDERAL AND STATE REGULATION 8 (2004) [hereinafter DOL GUIDE], available at <http://www.dol.gov/ebsa/Publications.mewas.html>; *MDPhysicians & Assocs., Inc. v. Tex. State Bd. of Ins.*, 957 F.2d 178, 186 (5th Cir. 1992), *cert. denied*, 506 U.S. 861 (1992).

formed; the purposes for which it was formed and what, if any, were the pre-existing relationships of its members; the powers, rights and privileges of employer-members; and who actually controls and directs the activities and operations of the benefit program. In addition, employer-members of the group or association that participate in the benefit program must, either directly or indirectly, exercise control over that program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the benefit program.<sup>254</sup>

Bona fide employer groups and associations include only those associations that have a genuine organizational relationship among the members and of whom all members are employee groups.<sup>255</sup> An association that includes individuals as well as employers does not qualify.<sup>256</sup> Neither would an association that exists simply to market insurance.<sup>257</sup> None of these associations, therefore, can qualify as employee welfare benefit organizations, that is, as ERISA plans. The preamble to the HHS association health plan rule recognizes that some association plans may in fact be single employer ERISA plans, which would be categorized as large or small employer plans based on the number of their enrollees, but that this category will be governed by a fact and circumstances test that will strictly limit the associations that qualify for this exception.<sup>258</sup>

Of particular importance, the Department of Labor has determined that professional employer organizations (“PEOs”) do not qualify as ERISA plans under this fact and circumstances test.<sup>259</sup> PEOs are associations that take over the human resource functions of employers by claiming to “co-employ” the employees of an employer and to administer employee benefit plans for these employees.<sup>260</sup> Were PEOs treated as large groups for purposes of the ACA, this could again undermine ACA protections. The Department of Labor analyzes these arrangements by considering whether the PEO actually employs the employees of the member groups, applying the common law control test.<sup>261</sup> PEOs cannot meet this test because they do not actually

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254. DOL GUIDE, *supra* note 253, at 8-9.

255. See U.S. DEP’T OF LABOR, ADVISORY OP. 2008-07A, at 3-4 (2008) [hereinafter DOL 2008-07A], available at <http://www.dol.gov/ebsa/regs/aos/ao2008-07a.html>.

256. U.S. DEP’T OF LABOR, ADVISORY OP. 2011-02A, at 3, 6 (2011) [hereinafter DOL 2011-02A], available at <http://www.dol.gov/ebsa/regs/aos/ao2011-02a.html>.

257. *MDPhysicians & Assocs., Inc.*, 957 F.2d at 195.

258. Rate Increase Disclosure and Review: Definitions of “Individual Market” and “Small Group Market,” 45 C.F.R. § 154.

259. See DOL 2011-02A, at 6-7.

260. *Professional Employer Organizations . . . What is a PEO?*, *supra* note 211.

261. See DOL 2011-02A, at 4 (citing *Nationwide Mutual Ins. Co. v. Darden*, 503 U.S. 318 (1992)).

control the work of the employers they serve, thus they are not considered to be employee welfare benefit plans.

MEWAs that are in fact employee welfare benefit plans are fully subject to regulation under ERISA.<sup>262</sup> They were not, however, subject to state regulation under ERISA as originally adopted in 1974 because of ERISA preemption. As noted above, ERISA establishes exclusive federal regulatory authority over employee benefit plans and expressly preempts all state law relating to them.<sup>263</sup> ERISA saves from preemption state laws regulating insurance, but does not allow states to apply such laws directly to ERISA plans themselves, thus saving from state regulation, for example, self-insured plans.<sup>264</sup> The federal government has traditionally been quite passive in regulating ERISA plans, and this created a regulatory vacuum (augmented by a great deal of uncertainty) that contributed to serious fraud problems.<sup>265</sup> In 1983, therefore, Congress amended ERISA to broaden the authority of the states to regulate MEWAs.<sup>266</sup>

Under the post-1983 law, MEWAs that are self-insured are fully subject to state regulation.<sup>267</sup> MEWAs that are fully insured (that is, whose benefits are fully covered by an insurance contract) are only subject to state regulation as to solvency.<sup>268</sup> Of course, the insurers that insure fully insured MEWAs are subject to state regulation, and MEWAs that are not employee benefit plans are also subject to state regulation, thus state regulation of MEWAs is potentially more or less comprehensive.<sup>269</sup>

MEWAs only include multiple employer plans and not single employer plans. A plan maintained by a single employer or by a group of employers under common control, therefore, is not a MEWA.<sup>270</sup> An employer plan maintained by an association, however—including a bona fide association—is not a single employer plan, but is a MEWA.

Unlike association plans, MEWAs are specifically mentioned in the ACA. Section 1301(b)(1)(B) provides:

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—

Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple employer welfare

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262. 29 U.S.C. § 1003(a)(2) (2006).

263. See *id.* § 1144(a) (2006); *supra* p. 1.

264. 29 U.S.C. § 1144(b)(2)(A)–(B).

265. See Koffman, *What’s all the Fuss About?*, *supra* note 208.

266. DOL GUIDE, *supra* note 253, at 3.

267. 29 U.S.C. § 1144(b)(6)(A)(ii).

268. *Id.* § 1144(b)(6)(A)(i).

269. See U.S. DEP’T OF LABOR, ADVISORY OP. 2011-01A, at 4 (2011) [hereinafter DOL 2011-01A], available at <http://www.dol.gov/ebsa/pdf/ao2011-01a.pdf>.

270. DOL GUIDE, *supra* note 253, at 5.

arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of [ERISA].<sup>271</sup>

This exception applies to self-insured, single-employer, ERISA plans, which are clearly exempt from state regulation. It may apply to fully-insured MEWAs, which are partially exempt.<sup>272</sup> It would not apply to MEWAs that are self-insured or to MEWAs that are not employee benefit plans, as they are subject to state regulation.

The term "health plan" is used throughout the ACA as part of the phrase "group health plan."<sup>273</sup> Group health plans are, however, by definition self-insured plans under the ACA, since the term "group health plan" always appears in tandem with "and issuer offering coverage in the group and individual markets."<sup>274</sup> Moreover, section 1563(e) and (f), adding section 715 to ERISA and section 9815 to the IRC, specifically apply the ACA amendments of the PHSa to ERISA plans, including self-insured plans.<sup>275</sup> Thus section 1301(b)(1)(B) must be read to mean that where the term "group health plan" is used, "health plan" specifically includes all group health plans, including those not subject to state regulation under section 514, but where "health plan" appears without the qualifier "group" self-insured single-employer ERISA plans and possibly fully-insured MEWAs are excepted.

The term "health plan" is used in Title I of the ACA without the qualifier "group" in four contexts. First, and most important, it is used in the phrase "qualified health plan." Qualified health plans are plans certified by the exchanges to meet certain ACA requirements.<sup>276</sup> Since section 1301 is entitled "qualified health plan defined," it makes sense to read 1301(b)(1)(B) to mean that self-insured plans and fully-insured MEWAs cannot be qualified health plans, offered through the exchanges.<sup>277</sup> This interpretation is also reasonable considering the purpose and functioning of the exchanges. The exchanges facilitate enrollment in individual and small group insured health plans and would not be marketing self-insured plans.

The term "health plan" is also used without the modifier "group" in provisions dealing with standard health plans under the basic health plan

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271. ACA § 1301(b)(1)(B) (to be codified at 42 U.S.C. § 18021).

272. In the preface to the Exchange NPRM, HHS indicates that it is not clear on this point and requests comments. See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,869 (Jul. 15, 2011).

273. See, e.g., ACA § 1001 (to be codified in scattered sections of 42 U.S.C.).

274. See, e.g., *id.*

275. ACA § 1563(e), (f) (to be codified at 29 U.S.C. § 1185d & I.R.C. § 9815).

276. See ACA §§ 1301-1303, 1311 (to be codified at 42 U.S.C. §§ 18021-18023, 18031).

277. ACA § 1301 (to be codified at 42 U.S.C. § 81021).

program,<sup>278</sup> the risk adjustment program,<sup>279</sup> and a prohibition against health plan discrimination for refusal to assist in suicide.<sup>280</sup> In each of these contexts, excluding self-insured plans and MEWAs is not unreasonable (although the last section may simply involve a drafting oversight).

Except for these specific provisions, however, there is nothing in the ACA that would indicate that MEWAs are regulated any differently from other health plans under the ACA. MEWAs are generally group health plans and thus subject to ACA regulatory provisions, as has been recognized by the HHS regulation.<sup>281</sup> We must return, therefore, to the questions raised at the beginning of this section. First, can at least some MEWAs be considered self-insured plans within the meaning of Title I and thus exempt from requirements that do not apply to self-insured plans? Second, should MEWAs that market to small groups be regulated under the small group provisions of Title I of the ACA, or can they be considered to be large groups?

Although Title I of the ACA contains a number of exceptions for self-insured plans, the term is nowhere defined in Title I.<sup>282</sup> Title IV of the ACA defines “self-insured” for purposes of a tax imposed on insured and self-insured plans to support the Patient-Centered Outcomes Research Trust Fund, and defines the term very broadly, including for example, self-insured MEWAs.<sup>283</sup> This definition, however, is expressly “for the purposes of this section” and does not apply to Title I.<sup>284</sup> In Title I, “self-insured” is generally used in the phrase “self-insured group health plan,”<sup>285</sup> thus the definition of “group health plan” becomes relevant.

Section 1301(b)(3) defines “group health plan” by cross-referencing section 2971(a) of the PHSA.<sup>286</sup> Section 2791(a) defines “group health plan” as an “employer welfare benefit plan” as defined in ERISA section 3(1)

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278. ACA § 1331 (to be codified at 42 U.S.C. § 81051).

279. ACA § 1343 (to be codified at 42 U.S.C. § 81063).

280. ACA § 1553 (to be codified at 42 U.S.C. § 18113). The term is also used in the administrative simplification provisions of the statute, but there the term is expressly defined to include group health plans with more than fifty members and MEWAs. 42 U.S.C. § 1320d(5) (2006).

281. See Rate Increase Disclosure and Review: Definitions of “Individual Market” and “Small Group Market,” 45 C.F.R. § 154.

282. The status of self-insured plans is further considered below. *Infra* notes 284-288.

283. ACA § 6301 (to be codified at I.R.C. § 4376(c)).

284. *Id.*

285. See, e.g., ACA §§ 1253, 1343, 1562 (to be codified at 42 U.S.C. §§ 300gg, 18063).

286. ACA § 1301(b)(3) (to be codified at 42 U.S.C. § 18021) (incorporating PHSA § 2971(a)). ACA section 1551 also incorporates definitions from PHSA section 2791. ACA § 1551 (to be codified at 42 U.S.C. § 18111).

that provides medical care to employees or their dependents.<sup>287</sup> When Title I of the ACA uses the term “self-insured group health plan” therefore, it is referring to a self-insured ERISA plan, which could include a self-insured MEWA, but only if the MEWA is in fact self-insured (i.e. is not covered by an insurance policy) and only if the MEWA meets the definition of an employer, i.e. is a bona fide employer group or association. This, again, is a limited subset of MEWAs or association health plans. Some self-insured MEWAs may qualify as self-insured employer welfare benefit plans; some may not.

The other question is whether a MEWA or association plan that markets to small groups could be considered a large group plan. The key to understanding the classification of markets under Title I of the ACA is section 1304. Section 1304 provides:

(a) DEFINITIONS RELATING TO MARKETS.—In this title:

(1) GROUP MARKET.—The term ‘group market’ means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) INDIVIDUAL MARKET.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) LARGE AND SMALL GROUP MARKETS.—The terms ‘large group market’ and ‘small group market’ mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) EMPLOYERS.—In this title:

(1) LARGE EMPLOYER.—The term ‘large employer’ means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) SMALL EMPLOYER.—The term ‘small employer’ means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

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287. 29 U.S.C. § 1002(1) (2006).

## (3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—

In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting ‘51 employees’ for ‘101 employees’ in paragraph (1) and by substituting ‘50 employees’ for ‘100 employees’ in paragraph (2).

## (4) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this subsection—

## (A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—

All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.<sup>288</sup>

The statute also contains special provisions pertaining to new employers, successor employers, and growing employers.<sup>289</sup>

Because these definitions are contained within Title I of the ACA, they take precedence over definitions found elsewhere in the PHSA, ERISA, or even elsewhere in the ACA.<sup>290</sup> Section 1304 articulates several principles relevant to the question of association health plans and the small group market.

First, the large and small group markets are unambiguously defined in terms of large and small employers.<sup>291</sup> Second, whether an employer is a large or small employer is defined in terms of the number of employees employed by the employer.<sup>292</sup> Third, a small employer is defined as an employer with 1–100 employees and a large employer as an employer with 101 or more employees.<sup>293</sup> Fourth, states may choose prior to January 1, 2016, to treat employers with fifty-one or more employees as large, but are not authorized to change the statutory definition of large and small employer in any other way.<sup>294</sup> A state statute that defined an association that marketed insurance to small employer groups to be a large group insurer would be preempted by the ACA for purposes of the regulatory requirements of the ACA.<sup>295</sup> Fifth, section 1304 only allows aggregation of employers under limited circumstances identified in section 414 of the

288. ACA § 1304 (to be codified at 42 U.S.C. § 18024).

289. ACA § 1304(b)(4)(B)-(D) (to be codified at 42 U.S.C. § 18024).

290. ACA § 1551 (to be codified at 42 U.S.C. § 18111). This section incorporates into the ACA definitions found in section 2791 of the PHSA, but only “except as specifically provided otherwise.” *Id.* ERISA definitions are incorporated into the ACA only through PHSA § 2791. See 42 U.S.C. § 300gg-91 (2006).

291. ACA § 1304(b) (to be codified at 42 U.S.C. § 18024).

292. *Id.*

293. *Id.*

294. ACA § 1304(b)(3) (to be codified at 42 U.S.C. § 18024).

295. ACA § 1321(d) (to be codified at 42 U.S.C. § 18041). Under ACA section 1321(d), state laws are preempted if they would “prevent the application” of the ACA. *Id.*

Internal Revenue Code (but requires the aggregation of employers under these circumstances).<sup>296</sup> These include only situations when employees are employed by corporations or partnerships under common control or are in affiliated organizations.<sup>297</sup> Specifically not mentioned are associations, PEOs, or MEWAs.

Finally, employer size is defined in terms of the number of employees. Under well-established DOL and judicial interpretations of the law, employees must be common law employees rather than nominal employees.<sup>298</sup> Thus organizations like PEOs that claim to co-employ employees but do not actually do so under the common law test, or associations that do not even claim to employ employees, cannot claim to be employers for purposes of determining group size.<sup>299</sup>

In conclusion, under the ACA, small group regulations apply to employee groups of 100 or fewer (or at the option of a state, fifty or fewer prior to 2016) regardless of the way in which insurance is marketed to these groups. An association that includes small groups is governed to that extent by the small group provisions of the ACA (including the essential benefits package, risk pooling and adjustment requirements, and the rating limitations) with respect to any small groups it includes. This applies to self-insured as well as fully-insured MEWAs, and regardless of anything in state law to the contrary, which would be preempted under ACA section 1321(d) as preventing the application of section 1304. The only exceptions to this principle would be for associations or MEWAs that cover a group of employer groups that can be treated as a large group under the aggregation principles recognized by ACA section 1304 and for associations that are single ERISA plans.<sup>300</sup> This is consistent with the DOLs interpretation of HIPAA.<sup>301</sup> It is also consistent with the position taken by the NAIC.<sup>302</sup> It is, finally, and most importantly, the conclusion reached by HHS in its premium review rule, which states: “[C]overage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small

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296. ACA § 1304(b)(4)(A) (to be codified at 42 U.S.C. § 18024); I.R.C. § 414(b), (c), (m), (o) (2006).

297. I.R.C. § 414(b), (c), (m), (o) (2006).

298. DOL 2011-02A, *supra* note 256, at 4 (citing *Nationwide Mutual Ins. Co. v. Darden*, 503 U.S. 318, 323 (1992)).

299. *See id.*

300. *See* ACA § 1304 (to be codified at 42 U.S.C. § 1824).

301. *See* Insurance Bulletin 02-02, *supra* note 233.

302. Letter from Nat'l Ass'n of Ins. Comm'rs to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (July 20, 2011) (on file with Nat'l Ass'n of Ins. Comm'rs).

group market coverage.”<sup>303</sup> It is the way in which the ACA must be interpreted. A loophole that would allow association health plans to cross the border from small to large group regulation must not be recognized.

*B. Employee Organization and Collectively Bargained Plans*

As already noted, the ACA adopts the PHSa definition of “group health plan,” which in turn incorporates the ERISA definition of “employee welfare benefit plan.”<sup>304</sup> ERISA defines “employee welfare benefit plan” to include plans “established or maintained” by “an employer, by an employee organization, or by both.”<sup>305</sup> An “employee organization” is defined as:

[A]ny labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees’ beneficiary association organized for the purpose in whole or in part, of establishing such a plan.<sup>306</sup>

The first part of the definition refers to plans administered by labor unions or other organizations that deal with employers in matters incidental to employment relationships. These are primarily, though not exclusively, Taft-Hartley plans. Approximately 10 million Americans are insured through about 1500 Taft-Hartley plans, which are administered by joint union and management trusts through collective bargaining arrangements.<sup>307</sup> These plans are called “multiemployer plans” under ERISA,<sup>308</sup> and must not be confused with MEWAs, indeed they are specifically defined under ERISA not to be MEWAs.<sup>309</sup> Taft-Hartley plans share several characteristics:

- a) one or more employers contribute to the plan;
- b) the plan is collectively bargained with each participating employer;
- c) the plan and its assets are managed by a joint board of trustees equally representative of labor and management;
- d) assets are placed in a trust fund; and,

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303. Rate Increase Disclosure and Review: Definitions of “Individual Market” and “Small Group Market,” 45 C.F.R. § 154.

304. ACA § 1551.

305. 29 U.S.C. § 1002(a)(1) (2006).

306. *Id.* § 1002(a)(4).

307. *Introduction to Multiemployer Plans*, PENSION BENEFIT GUARANTY CORP., <http://www.pbgc.gov/prac/multiemployer/introduction-to-multiemployer-plans.html>.

308. 29 U.S.C. § 1002(37).

309. *Id.* § 1002(40); see also *ERISA Glossary*, HEALTH PLAN LAW, [http://www.healthplanlaw.com/?page\\_id=6](http://www.healthplanlaw.com/?page_id=6).

e) mobile employees can change employers without losing health or pension coverage provided the new job is with an employer who participates in the same Taft-Hartley trust fund.<sup>310</sup>

Many of these arrangements are found in the construction trades and involve many small employers. Others are found in the entertainment, trucking, maritime, retail food, mining, and garment manufacturing industries.<sup>311</sup>

Employee organization plans, including Taft-Hartley plans, are regulated by the Department of Labor under ERISA.<sup>312</sup> Over 90% of Taft-Hartley plans are self-insured.<sup>313</sup> As self-insured plans, they are not subject to state regulation. Insurers that insure employee organization plans are subject to state regulation, however, under the savings clause of ERISA section 514.<sup>314</sup> There are special grandfathering rules for collectively-bargained plans under the ACA,<sup>315</sup> but otherwise they enjoy no special status under the ACA, nor did they enjoy special status under HIPAA. They should be regulated just like any other group health plan, and should be subject to the small group provisions of the ACA if they include small groups; the large group provisions if they cover large groups.<sup>316</sup>

Potentially more troublesome are “employees’ beneficiary organizations,” which are explicitly not union plans.<sup>317</sup> In a number of instances, entrepreneurs have attempted to market health insurance to employees claiming protection from state regulation as employees’ beneficiary organization ERISA plans. The term employees’ beneficiary organization is not defined in ERISA. It is clear, however, that Congress was aware of the potential for abuse of this category. In the words of a Congressional Report:

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310. *Health Information: health plans: Hearings on A.B. 952 Before the Assembly Comm. on Health, 2009-2010 Sess. 9 (Cal. 2009) [hereinafter Hearings on A.B. 952], available at [http://leginfo.public.ca.gov/pub/09-10/bill/asm/ab\\_0951-1000/ab\\_952\\_cfa\\_20090504\\_132014\\_asm\\_comm.html](http://leginfo.public.ca.gov/pub/09-10/bill/asm/ab_0951-1000/ab_952_cfa_20090504_132014_asm_comm.html); see also *Taft Hartley Funds Basics*, CTR. FOR ADVANCED INSTRUCTIONAL TECH. AT THE NAT’L LABOR COLL., [http://www.nlc.edu/cait/olc/Taft\\_Hartley/html/t-chpater%201.html](http://www.nlc.edu/cait/olc/Taft_Hartley/html/t-chpater%201.html) (last visited Sep. 8, 2011).*

311. *Introduction to Multiemployer Plans*, *supra* note 307.

312. 29 U.S.C. § 1003(a)(2).

313. *Hearings on A.B. 952*, *supra* note 310, at 9.

314. 29 U.S.C. § 1144(b)(2)(A).

315. ACA § 1251(d) (to be codified at 42 U.S.C. § 18011).

316. It should be noted that ACA § 1304(b)(4)(A), which permits aggregation of employers for determining employer size under certain circumstances does not permit aggregation for multiemployer plans, which are recognized by I.R.C. § 414(f).

317. Employees’ beneficiary organizations are not the same as “voluntary employees’ beneficiary association,” a form of tax-exempt trust used for providing employee benefits. See 26 C.F.R. 1.501(c)(9)-7 (2006).

certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation. We are concerned with this type of development, but on the basis of the facts provided us, we are of the opinion that these programs are not "employee benefit plans" as defined in Section 3(3). As described to us, these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction, nor is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisites of the Act. They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan . . . .

. . . . We are mindful of the potentially harmful effects of an overly broad interpretation of the term "employee benefit plan" when coupled with the policy of section 514. As we have already noted, we do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the definition. Where a "plan" is, in effect, an entrepreneurial venture, it is outside the policy of section 514 for reasons we have already stated. In short, to be properly characterized as an ERISA employee benefit plan, a plan must satisfy the definitional requirement of section 3(3) in both form and substance.<sup>318</sup>

The Department of Labor has determined that an employees' beneficiary organization must have the following characteristics:

- (1) membership in the association must be conditioned on employment status—for example, membership is limited to employees of a certain employer or union;
- (2) the association has a formal organization, with officers, bylaws or other indications of formality;
- (3) the association generally does not deal with employers; and
- (4) the association is organized for the purpose of establishing a welfare or pension plan.<sup>319</sup>

A number of cases have construed the first requirement. They have generally interpreted it quite conservatively to mean that members must be employees of a common employer or employees who share a commonality of economic interest or representational interest other than the provision of

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318. H.R. REP. NO. 94-1785, at 48 (1977), *reprinted in* Union Calendar No. 905.

319. See *Mandala v. Cal. Law Enforcement Ass'n*, 561 F. Supp. 2d 1130, 1133-34 (C.D. Cal. 2008) (citing ERISA Op. Letter 79-19A, at 2 (1979)).

benefits.<sup>320</sup> Organizations that include employers or self-employed persons cannot qualify.<sup>321</sup> Associations that are based on a common fraternal, civic, religion, or common social purpose do not qualify.<sup>322</sup> Most importantly, organizations that are established by third-parties and marketed to employees for commercial purposes do not qualify.<sup>323</sup>

There is no reason to believe that “employee organization” ERISA plans should be treated any differently from any other ERISA plan under the ACA. They are fully subject to all ACA provisions that apply to group plans and that are explicitly extended to ERISA plans. As noted above, most Taft-Hartley plans are self-insured, and are thus only subject to ACA provisions that apply to self-insured plans.<sup>324</sup> Most union plans that are not Taft-Hartley plans are in all likelihood large employer plans. Just as with employer plans, however, under section 1304, employee organization plans that cover small groups are to that extent small group plans and must be regulated as such under the ACA.

### C. Self-Insured Plans

Another way in which insurers covering small groups may try to escape some of the requirements of the ACA is through selling “self-insured” plans. This is a particular threat to the health insurance exchanges created by the ACA, but is also a threat to the implementation of the ACA generally. ACA section 1321 requires that the states (or the federal government in non-electing states) establish SHOP exchanges through which “qualified employers” can offer health insurance to their employees.<sup>325</sup> As noted above, under section 1304, qualified employers are small employers with up to 100 employees, although a state may limit exchange participation to employers with fifty or fewer employees prior to 2016.<sup>326</sup> Most states currently define small employers as employers with fifty or fewer employees.<sup>327</sup> Beginning in 2017, states may open the exchanges to employment-related groups of 100 or more.<sup>328</sup>

320. *Wis. Educ. Ass’n Ins. Trust v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1063 (8th Cir. 1986); *Mandala*, 561 F. Supp. 2d at 1135 (C.D. Cal. 2008).

321. *Mandala*, 561 F. Supp. 2d at 1134; *Baucom v. Pilot Life Ins. Co.*, 674 F. Supp. 1175, 1180 (M.D.N.C. 1987).

322. *Bell v. Emp. Sec. Benefit Ass’n*, 437 F. Supp. 382, 395 (D. Kan. 1977).

323. *Empire Blue Cross & Blue Shield v. Consol. Welfare Fund*, 830 F. Supp. 170, 172-75 (E.D.N.Y. 1993); *Angoff v. Kenemore*, 887 S.W.2d 782, 787-88 (Mo. Ct. App. 1994).

324. *Hearings on A.B. 952*, *supra* note 310.

325. ACA §§ 1311(b)(1)(B), 1321(a)(1)(A) (to be codified at 42 U.S.C. §§ 18031, 18041).

326. ACA § 1304 (to be codified at 42 U.S.C. § 18024).

327. This is because HIPAA defined small employer to mean employers with fifty or fewer employees. 42 U.S.C. § 300gg-91(e)(4) (2006).

328. ACA § 1312(f)(2) (to be codified at 42 U.S.C. § 18032).

It is generally believed that exchanges should enroll as many participants as is possible.<sup>329</sup> Indeed, small enrollments have proved a primary barrier to success for earlier exchange efforts.<sup>330</sup> An obvious strategy for enlarging the pool of exchange participants is to accept the ACA default definition of small employer at 100 employees rather than reduce it to fifty and to open the exchange as soon as possible to large employers. Unfortunately, this strategy makes the exchange more vulnerable to adverse selection.

Self-insured group plans pose a serious threat to the regulatory structure of the ACA and in particular to the exchanges. Self-insured plans are not subject to the risk adjustment requirements of section 1343, the risk pooling requirements, or the essential benefits requirements.<sup>331</sup> They are also exempt from the minimum loss ratio requirements and the requirement that insurers justify unreasonable premium increases, although self-insured do not technically have loss ratios or premiums since they are not insured.<sup>332</sup> Self-insured plans also do not have to pay a fee imposed on insurers under the ACA.<sup>333</sup> Although most self-insured plans are large group plans, there is presently no prohibition under federal law against small group plans self-insuring; thus self-insured plans threaten both the large and small group exchange market. Indeed, it is estimated that 7.9% of employers with three to forty-nine employees and 20.3% of employers with 50–199 employees offer at least one self-insured plan.<sup>334</sup> Of the 474 self-insured groups

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329. Timothy Stoltzfus Jost, *Health Insurance Exchange and the Affordable Care Act: Eight Difficult Issues*, THE COMMONWEALTH FUND, 1, 16-17 (2010), [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444\\_Jost\\_hlt\\_ins\\_exchanges\\_ACA\\_eight\\_difficult\\_issues\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf).

330. *Id.* at 8.

331. This is because these provisions only apply to insured plans. See PHSA § 2707, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-6); ACA § 1301 (to be codified at 42 U.S.C. § 18021).

332. PHSA § 2718, added by ACA § 1001 (to be codified at 42 U.S.C. § 18052); ERISA § 715(b), added by ACA § 1563(e) (to be codified at 29 U.S.C. § 1185d); ACA § 1563(f) (to be codified at I.R.C. § 9815(b)).

333. ACA § 9010 (to be codified at 42 U.S.C. § 4001).

334. See Christine Eibner et al., U.S. Dep't of Labor & U.S. Dep't of Health & Human Servs., *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)* 1, 17-18 (2011), available at <http://aspe.hhs.gov/health/reports/2011/LGHPstudy/EmployerSIDACA.pdf>. Health plans with fewer than 100 members need not file Form 5500, the annual ERISA plan reporting form, which identifies whether plans are fully-insured or self-insured. See Michael J. Brien & Constantijn W.A. Panis, Deloitte, *Self-Insured Benefit Plans* 1, 11 (2011), available at <http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport032811.pdf>.

approved by HHS for “mini-med” waivers by July 15, 2011, 109 had fewer than fifty enrollees and forty-seven had fewer than twenty-five enrollees.<sup>335</sup>

Self-insured plans are particularly problematic because they are not subject to state regulation. Section 514(a) of ERISA supersedes state laws that “relate to” employee benefit plans.<sup>336</sup> Section 514(b)(2)(A) saves from preemption state laws that regulate insurance, but section 514(b)(2)(B) provides that employee benefit plans shall not be deemed to be insurance companies.<sup>337</sup> The Supreme Court has interpreted this clause to exempt self-insured plan entirely from state regulation.<sup>338</sup> This means that states cannot regulate self-insured plans outside the exchange, even if they would otherwise qualify as small group plans.

Beyond the adverse selection problems they raise, self-insured plans provide an easy means of escape for small employers who do not wish to comply with the essential benefits requirements of the ACA. An employer that wishes to insure its employees but does not want to cover the essential benefits required by section 1301 can simply arrange its plan as a “self-insured” plan by purchasing stop-loss coverage rather than health insurance, and it is free from the requirement.

Although the ACA uses the term self-insured in a number of provisions, nowhere does it define it. The term is also not defined in the PHSA or in ERISA. The term “self-insured medical reimbursement plan” is defined in the Internal Revenue Code (which prohibits self-insured plans from discriminating in favor of highly compensated employees) to mean “a plan of an employer to reimburse employees for [medical] expenses . . . for which reimbursement is not provided under a policy of accident and health insurance.”<sup>339</sup> Federal regulations implementing this provision clarify that a plan is not self-insured simply because it is experience-rated, but that an employer does not lose self-insured status simply because it is administered by an insurer if risk is not transferred to the insurer.<sup>340</sup>

Federal court cases interpreting ERISA have held that self-insured plans do not lose their self-insured status simply because the plans have stop-loss coverage.<sup>341</sup> Moreover, a federal court in Maryland and a state court in

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335. See *Self-Insured Employers: Approved Applications for Waiver of the Annual Limit Requirements*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, 1 (June 15, 2011), [http://cciiio.cms.gov/resources/files/employer\\_07152011.pdf](http://cciiio.cms.gov/resources/files/employer_07152011.pdf).

336. 29 U.S.C. § 1144(a) (2006).

337. *Id.* § 1144(b)(2)(B).

338. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

339. I.R.C. § 105(h)(6) (2006).

340. 26 C.F.R. § 1.105-11(b) (2003).

341. *Bill Gray Enters. v. Gourley*, 248 F.3d 206, 209 (3d Cir. 2001); *Thompson v. Talquin Bldg. Prods.*, 928 F.2d 649, 653 (4th Cir. 1991); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986).

Missouri have held that states may not regulate self-insured plans through regulating the stop-loss plans that insure them, although a Kansas court upheld that state's stop-loss rule, and the NAIC Model Stop-Loss Act was amended in 1999 to clarify that it does not regulate self-funded plans.<sup>342</sup> Both the Department of Labor and the courts, however, have recognized that stop-loss coverage with very low attachment points can make self-insured status a sham, although the limits are far from clear.<sup>343</sup> Insurers are selling "self-insured plans" to employee groups with as few as ten members, and the prevalence of these plans may greatly increase as 2014 approaches—the effective date of the essential benefits coverage requirement—and small group plans seek to evade this requirement.

The threat to exchanges is obvious. If small businesses with healthy employees can remain "self-insured" until the health of their pool deteriorates and then join the exchange, premiums within the exchange will increase and the exchange will become less viable. If a state opens its exchange to groups above 100, the threat is even greater, as legitimate self-insured plans will seek to insure their employees through the exchange when their experience deteriorates.

The most extensive attempt to date to model the effect of self-insurance on the ACA reforms was done by the RAND Corporation in the Spring of 2011.<sup>344</sup> This study concluded that if stop-loss coverage is available with attachment points as low as \$20,000, 33% of employers with fewer than 100 employees would self-insure.<sup>345</sup> RAND estimated that banning self-insurance in the small group market would lower premiums for the platinum plan in the exchange (which RAND believes will be the most commonly offered ESI policy) by 3.3%.<sup>346</sup> The study's authors acknowledge, however, that it is very difficult to accurately project employer responses to the ACA and the effect that these will have on the exchanges until more is known about the 2014 regulatory and insurance environment.<sup>347</sup>

The problem of self-insurance exists primarily because of the availability of generous stop-loss coverage. If employers had to actually bear significant risk in becoming self-insured, few small employers would pursue

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342. *Am. Med. Sec. Inc. v. Bartlett*, 111 F.3d 358, 364 (4th Cir. 1997); PATRICIA BUTLER, *ERISA PREEMPTION MANUAL FOR STATE HEALTH POLICY MAKERS 64-65* (2000), available at [http://www.nashp.org/sites/default/files/ERISA\\_Manual.pdf](http://www.nashp.org/sites/default/files/ERISA_Manual.pdf).

343. See *McDaniel v. N. Am. Indem.*, No. 1:02-cv-0422-LJM-JMS, 2008 WL 1336832 at \*2, \*13 (S.D. Ind. 2008) (citing U.S. DEP'T OF LABOR, ADVISORY OP. 2003-03A; U.S. DEP'T OF LABOR, ADVISORY OP. 92-21A).

344. See Eibner et al., *supra* note 334, at xii, 4.

345. See *id.* at 84.

346. See *id.* at 90.

347. See *id.* at 74, 78-80, 83-84, 87, 95-97.

it.<sup>348</sup> But stop-loss coverage with low “attachment points,” i.e. amounts beyond which the employer is not at risk for the costs of any employee, can dramatically lower the risk of “self-insurance” for employers. As the RAND study acknowledges, this can draw a considerable number of small employers away from the exchange, in all likelihood those who present the lowest risks.<sup>349</sup>

The problem of self-insurance undermining the exchanges is most appropriately addressed by the federal government. The Department of Labor should issue a regulation defining how much risk an employee health benefits plan must itself carry to be a legitimate self-insured plan for purposes of the ACA. The agency could do so under its inherent authority to administer ERISA, but also because the ACA makes it even more imperative that a legitimate distinction be drawn between legitimate and illegitimate self-insured plans. The DOL regulations define “employee welfare benefit plan,” and could also define “self-insured” plan.<sup>350</sup> The agency concluded in advisory opinion 2003-03A that an insurance company that purported to offer 100% reinsurance coverage to “self-insured” ERISA plans was in fact an insurance company insuring an insured plan, and was subject to state regulation.<sup>351</sup> The Departments of Labor and Treasury should go further and define self-insured plan so as to permit employers to self-insure only if they can legitimately bear a substantial share of the risk of an employee health benefits plan. This could limit self-insurance to plans with 250 or more members.<sup>352</sup> Alternatively, a revised rule could raise stop-loss attachment limits to the level of the NAIC Model Stop-Loss Act, adjusted for inflation in health care costs since the NAIC model act was adopted in 1995 to assure that stop-loss insurance was not simply direct insurance.<sup>353</sup>

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348. *Id.* at 13-14.

349. Eibner et al., *supra* note 334, at 84.

350. 29 § C.F.R. 2510.3-1 (1996).

351. U.S. DEP'T OF LABOR, ADVISORY OP. 2003-03A (2003) [hereinafter DOL 2003-03A], available at <http://www.dol.gov/ebsa/regs/aos/ao2003-03a.html>.

352. Joanne Sammer, *Is Self-Insurance for You?*, HR MAG., May 2011, at 35, 37.

353. Section 3 of the NAIC Model Stop-Loss Act, provides:

- A.(1) An insurer shall not issue a stop-loss insurance policy that:
- (a) Has an annual attachment point for claims incurred per individual which is lower than \$20,000;
  - (b) Has an annual aggregate attachment point, for groups of fifty (50) or fewer, that is lower than the greater of:
    - (i) \$4,000 times the number of group members;
    - (ii) 120 percent of expected claims; or
    - (iii) \$20,000;
  - (c) Has an annual aggregate attachment point for groups of fifty-one (51) or more that is lower than 110 percent of expected claims; or

Another approach would be for the Department of the Treasury to amend its regulations implementing the provision barring discrimination in favor of highly-compensated employees to limit the definition of self-insured plans to plans that are truly self-insured.<sup>354</sup> Section 2716 of the PHSA added by section 1001 of the ACA extends the non-discrimination provision to insured group plans as well, so Treasury will have to draft new regulations in this area.<sup>355</sup> It could use this opportunity to revisit its earlier self-insured plan regulations.

In the absence of a regulatory response from the Departments of Labor or Treasury, the states could themselves take action, or at least attempt to do so. Stop-loss insurance is insurance, and the states can regulate it under the ERISA savings clause so long as they do not attempt to regulate the terms of self-insured plans through stop-loss plan regulation.<sup>356</sup> The most straightforward approach would be to simply ban the sale of stop-loss insurance to small groups. Delaware,<sup>357</sup> New York,<sup>358</sup> and Oregon<sup>359</sup> currently ban the sale of stop-loss insurance to small groups, so there is ample precedent. Alternatively, the current NAIC Model Stop-Loss Act could be strengthened to ensure that stop-loss insurance attachment points are high enough to ensure that it is true stop-loss insurance and not a sham.

The NAIC should amend its model stop-loss coverage law to prohibit stop-loss coverage for small groups, or at least to update the model law for inflation since it was last amended in 1999. States should then adopt the amended model law to ban stop-loss insurance for small groups or to require stop-loss insurance to in fact be legitimate stop-loss insurance, not comprehensive insurance masquerading as stop-loss insurance.

## VI. CONCLUSION

The ACA was enacted to change comprehensively the way health insurance is regulated in the United States. It may yet do that. But the ACA is a leaky vessel, and if its many perforations are not attended to, they may sink it. Some of these are intentional and likely to cause little damage, like

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(d) Provides direct coverage of health care expenses of an individual.

354. I.R.C. § 105(h)(6) (2006).

355. PHSA § 2716, added by ACA § 1001 (to be codified at 42 U.S.C. § 300gg-16).

356. *Edstrom Indus. v. Companion Life Ins.*, 516 F.3d 546, 551 (7th Cir. 2008); *General Motors v. Cal. State Bd. of Equalization*, 815 F.2d 1305, 1311 (9th Cir. 1987).

357. DEL. CODE. ANN. tit. 18, § 7218(e) (2010) (groups with no more than fifteen members).

358. N.Y. INS. LAW §§ 3231(h), 4317(e) (2010). New York also prohibits insurers as serving as third party administrators for self-insured plans, as does North Carolina. N.C. GEN. STAT. § 58-50-130(a)(5) (2010). North Carolina also bans stop-loss insurance for small groups that do not comply with its small group reforms. *Id.*

359. OR. REV. STAT. § 742.065(3) (2010).

the religious sharing ministry exception to the minimum coverage requirement or the short-term limited duration policy exception. Others, like the excepted benefits exception are potentially more problematic, but will, it is hoped, be less problematic once the minimum coverage requirement goes into effect. But some potential loopholes, like association health plans and faux self-insured plans are serious and have the potential to sink the ACA. Federal and state regulators must be fully aware of the loopholes in the ACA, and must take action where necessary to protect its integrity. This article has exposed those loopholes and suggested how they might be plugged.