HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 897 Group Health Plans
SPONSOR(S): Health & Human Services Committee, Healthcare Regulation Subcommittee, Fernandez-Barquin
TIED BILLS: **IDEN./SIM. BILLS:** SB 940

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N, As CS	Poche	McElroy
2) Health & Human Services Committee	14 Y, 1 N, As CS	Poche	Calamas

SUMMARY ANALYSIS

An association health plan (AHP) is a group purchasing arrangement in which members of a trade group or professional association jointly obtain health insurance for employees. These arrangements differ from traditional group insurance by their unique structure, since they involve the purchase of insurance products across multiple employers.

On June 21, 2018, the Employee Benefits Security Administration within the federal Department of Labor (DOL) issued a final rule amending the parameters for association health plans (AHPs), consistent with the directives of a 2017 Presidential Executive Order. The revised regulations were intended to give an employer greater flexibility to participate in an AHP. The new federal rule, among other things, permitted establishing an AHP for the explicit purpose of providing health coverage, so long as the association has another legitimate purpose for members and allowed the self-employed and sole proprietors to participate in an AHP. Overall, the federal rule was designed to offer an expanded pathway for the establishment of an AHP.

In July 2018, eleven states and the District of Columbia sued the DOL, alleging the final rule, and particularly the rule's provisions on bona fide association and working owner provisions, conflicted with the text and purpose of Employee Retirement Income Security Act (ERISA) and Patient Portability and Affordable Care Act (PPACA), and exceeded DOL's statutory authority. On March 28, 2019, the U.S. District Court for the District of Columbia agreed with the states, finding that the DOL unreasonably expanded ERISA's definition of "employers" as an end run around the requirements of PPACA. The court struck down the portions of the DOL's AHP rule that expanded the ability of small businesses and owners to buy health insurance on the large group market that was not subject to PPACA requirements that apply to the small group market.

Current Florida law incorporates the now stricken federal rule by reference, applicable to multiple employer welfare arrangements (MEWAs).

CS/CS/HB 897 removes the reference in the MEWA statute to the federal rule regarding AHPs that was struck down by a federal district court in 2019, and incorporates the requirements from the stricken rule relating to a bona fide group for purposes of establishing a MEWA. Incorporating the requirements to be considered a bona fide group from the stricken rule maintains an expanded pathway for more groups or associations to form MEWAs.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Association Health Plans (AHPs)

An association health plan (AHP) is a group purchasing arrangement in which members of a trade group or professional association jointly obtain health insurance for employees. These arrangements differ from traditional group insurance by their unique structure, since they involve the purchase of insurance products across multiple employers.

Federal Regulation of AHPs

Employment Retirement Income Security Act (ERISA)

Congress effectively federalized the regulation of health benefits provided by large employers with the passage of the Employment Retirement Income Security Act of 1974.[1] The law sets parameters on private-sector employee health benefit plans and protects the interests of individuals who enroll in such plans. However, states retain the authority to regulate a substantial share of employer-provided health care benefit plans. ERISA does not prevent a state from regulating the activities of health *insurers*, and can be described as follows:

> *ERISA does not preempt state insurance law. The result is a dual regulatory framework. To the extent that an ERISA plan pays directly out of plan assets (a "self-funded plan"), it is exempt from state regulation. To the extent that the plan purchases insurance to cover some or all of its benefit obligations (an "insured plan"), the state's regulatory authority over the insurance contract results in indirect state regulation of aspects of the plan.*[2]

Under ERISA, AHPs are one form of a class of employee benefit plans known as "multiple-employer welfare arrangements" (MEWAs). ERISA defines MEWAs as employee health benefit plans that are established to provide benefits to the employees of two or more employers.[3] Upon meeting certain conditions, these benefit arrangements can be treated as a single employer for regulatory purposes. In order for a MEWA to constitute an "employer" under ERISA, there must be a *bona fide* group or association of employers joined together to provide benefits for their employees.[4] ERISA dictates that a *bona fide* group or association must consist of employers who share a "commonality of interests" with respect to employment relationships, meaning that the employers must be engaged in a similar trade or business activity that links their interests.[5]

Section 514(b)(6) of ERISA provides a special exception for the application of state insurance laws to MEWAs – meaning that such plans are subject to both federal and state regulation.[6]

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[1] 29 U.S.C. 1001 et seq.

[2] National Association of Insurance Commissioners, "Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation, 2004. Available at https://www.naic.org/documents/prod_serv_legal_ers_om.pdf (last viewed on March 15, 2023).

[3] 29 U.S.C. 1002(40).

[4] U.S. Department of Labor, Employee Benefits Security Administration, "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation", August 2013 , available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf (last viewed on March 15, 2023).

[5] The "commonality of interest" test is derived from ERISA section 3(5), 29 U.S.C. 1002(5). Various advisory opinions from the U.S. Department of Labor have used this rationale to determine whether an employer group is *bona fide* under ERISA. See, for example, DOL Advisory Opinion 2017-02AC, available at https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2017-02ac (last viewed on March 15, 2023).

[6] 29 U.S.C. 1144(b)(6)(A).

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA)[7] imposed extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements.[8] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors.[9]

Many of the changes in the PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[10] For example, the PPACA requires coverage offered in the individual and small group markets to provide certain categories of services, called essential health benefits.[11]

Also, the PPACA requires that premiums for individual and small group policies may vary only by:[12]

- Age, up to a maximum ratio of 3 to 1. This means that the rates for older adults cannot be more than three times greater than the rates for younger adults.
- Tobacco, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.
- Whether coverage is for an individual or a family.

The PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or any other health-status related factor deemed appropriate by the U.S. Department of Health and Human Services.[13]

Additionally, the PPACA established minimum medical loss ratio (MLR) requirements for group and individual health insurance plans.[14] MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to increase price transparency for consumers while promoting efficiency among insurers.[15] Under the PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium payments to medical claims.[16]

AHPs are subject to a “look-through” provision that dictates how a participating employer is categorized for PPACA compliance purposes. Guidance released by the Centers for Medicare and Medicaid Services (CMS) in 2011 describes the “look-through” concept as follows:

> *CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers*

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[7] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148.

[8] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), 42 U.S.C. 300gg et seq.

[9] Under PPACA, the prohibition on preexisting condition exclusion refers to the fact that health insurance companies cannot refuse coverage or charge higher premiums to those who have a “pre-existing condition”—that is, a health problem that existed before the date that health coverage starts. Prior to passage of the PPACA, employers and insurers could exclude coverage for pre-existing conditions for a period of time if an individual had not maintained continuous insurance coverage, unless prohibited by state law.

[10] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. See PPACA s. 1251; 42 U.S.C. s. 18011.

[11] PPACA s. 1302; 42 U.S.C. 300gg-6.

[12] PPACA s. 1201; 42 U.S.C. 300gg.

[13] PPACA s. 1201; 42 U.S.C. s. 300gg-4.

[14] PPACA s. 1001; 42 U.S.C. 300gg-18.

[15] Henry J Kaiser Family Foundation, *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, February 29, 2012, available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last viewed on March 15, 2023).

[16] Supra, FN 14.

level. In these situations, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules.[17]

This means that each employer participating in an AHP is considered to have established a separate group health plan for its own employees and each employer is independently subject to PPACA's coverage requirements – unless the AHP is determined to be a *bona fide* association under ERISA. Since many PPACA coverage requirements are only applicable to the individual and small group markets, the self-employed and small employers cannot use AHPs as a vehicle to gain flexibility without meeting the ERISA definition of "employer".[18]

Revised Federal Rule on AHP Participation

On June 21, 2018, the Employee Benefits Security Administration within the federal Department of Labor (DOL) issued a final rule amending the parameters for AHPs,[19] consistent with the directives of a 2017 Presidential Executive Order.[20] The revised regulations are intended to give an employer greater flexibility to participate in an AHP. The new federal rule:

- Revises the commonality of interest requirement by allowing AHPs to be established based on either industry or geography;
- Permits an AHP to be established for the explicit purpose of providing health insurance, so long as the association has another legitimate purpose for members;
- Allows for participation in an AHP by the self-employed and sole proprietors; and,
- Eliminates the "look-through" approach previously adopted by CMS for the categorization of employer-sponsored health benefits.[21]

The federal rule was designed to offer an expanded pathway to establish an AHP. Employers who do not operate in the same trade or industry now have the option to initiate an AHP, so long as the association is limited to members within a single state or metropolitan area. Moreover, the rule opens the door to participation by self-employed individuals, who were not previously eligible to participate because they had not been considered "employers" as defined under ERISA.[22]

The rule also diverged from previous ERISA interpretation by allowing AHPs to form for the primary purpose of providing health insurance benefits to employees of participating employers. The DOL previously held that the provision of health benefits could not be the principal purpose underlying establishment of an AHP. The rule eased this standard by indicating that an AHP must only satisfy some legitimate purpose for member employers, above and beyond the provision of health benefits.[23]

Lastly, the 2018 federal guidance affirms the ability of states to regulate AHPs, so long as existing ERISA law does not preclude them from doing so.[24]

Federal Court Strikes Down Revised Federal Rule on AHP Participation

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[17] Centers for Medicare and Medicaid Services, *"Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations*," Insurance Standards Bulletin Series—INFORMATION*,* September 1, 2011, available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf (last viewed on March 15, 2023).
[18] Alden J. Bianchi, *"Association Health Plan Perspectives (Part 2): The Look-Through Rule and the Limits of State Regulatory Power"*, The National Law Review, October 3, 2018, available at https://www.natlawreview.com/article/association-health-plan-perspectives-part-2-look-through-rule-and-limits-state (last viewed on March 15, 2023).
[19] Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 FR 28912. June 21, 2018.
[20] Promoting Healthcare Choice and Competition Across the United States, 82 FR 48385. October 21, 2017.
[21] Milliman, Inc.*, "Association health plans after the final rule"*, August 22, 2018, available at http://www.milliman.com/insight/2018/Association-health-plans-after-the-final-rule/ (last viewed on March 15, 2023).
[22] Supra, FN 19.
[23] Avalere Health, *"Association Health Plans: Projecting the Impact of the Proposed Rule"*, prepared for America's Health Insurance Plans (AHIP), February 28, 2018, available at http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf (last viewed on March 15, 2023).
[24] Supra, FN 18.

In July 2018, eleven states[25] and the District of Columbia sued the DOL, alleging the final rule, and particularly the rule's provisions on bona fide association and working owner provisions, conflicted with the text and purpose of ERISA and PPACA, and exceeded DOL's statutory authority. On March 28, 2019, the U.S. District Court for the District of Columbia agreed with the states, finding that the DOL unreasonably expanded ERISA's definition of "employer" as an end run around the requirements of PPACA.[26]

The court struck down the portions of the DOL's AHP rule that expanded the ability of small businesses and owners to buy health insurance in the large group market that was not subject to PPACA requirements that apply to the small group market, such as the requirements related to EHB coverage and limitations on premium rates. The court reasoned that the DOL rule went beyond ERISA's focus on employer benefit plans to instead cover commercial insurance transactions between unrelated parties. Indeed, the court stated that DOL had so greatly expanded the "purpose" criteria in the final rule that "virtually no association could fail to meet it."

Further, the court concluded that the DOL rule provided no meaningful limit on what associations needed to demonstrate to qualify as "employers" under ERISA, failed to show why geographic proximity was connected to common employer interest essential for coverage under ERISA, did not require members of associations to be sufficiently aligned in purpose, and allowed owners without any employees to "absurdly" count themselves as both employer and employee to suggest an employment relationship and justifying coverage under ERISA.

State Regulation of AHPs

The regulatory oversight of health insurance is generally reserved to the states, except when explicitly preempted by federal law. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuing certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code (the Code).[27]

All health insurance policies issued in Florida, with the exception of certain self-insured policies,[28] must meet certain requirements that are detailed throughout the Code. Chapter 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for health plans issued by HMOs. At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[29]

Florida Nonprofit Multiple-Employer Welfare Arrangement Act

The Florida Nonprofit Multiple-Employer Welfare Arrangement Act (MEWA Act) was enacted in 1983 to regulate self-funded MEWAs operating in the state.[30] Under this law, a MEWA is an employee welfare benefit plan maintained for the purpose of offering health insurance benefits to employees of two or more employers, or to their beneficiaries.[31] This definition is consistent with the federal standard included in ERISA. Among other requirements, a MEWA must have a certificate of authority issued by OIR, must be operated in accordance with sound actuarial principles, must maintain appropriate loss reserves, and must maintain a fund balance equal to 10 percent of its total liabilities.[32] Current law

[25] California, Delaware, Kentucky, Maryland, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Virginia, and Washington .
[26] State of New York, et al. v. U.S. Department of Labor, et al., No. 1:18-cv-01747 (D.D.C. Mar. 28, 2019).
[27] S. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[28] 29 U.S.C. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.
[29] S. 627.413(1)(d), F.S.
[30] Ss. 624.436–624.446, F.S.
[31] S. 624.437(1), F.S.
[32] Ss. 624.426–624.446, F.S.

provides an exception to the regulatory laws for a MEWA which is fully insured by an authorized insurer or an arrangement exempt under the provisions of ERISA.[33]

There are currently three self-funded MEWAs operating in the state, accounting for more than 21,000 covered lives.[34] The participation parameters currently in the MEWA Act limit the ability of unrelated employers to form MEWAs. MEWAs may only be established among employers who share a common trade or profession,[35] in keeping with federal ERISA standards. At present, statutes prevent employers from exercising the additional flexibility under the revised federal rule on AHPs. If the statutes are amended to mimic the federal rule, additional employers may seek to form MEWAs in an effort to obtain more affordable employee health benefits.

In 2019, the legislature adopted the federal rule by reference into Florida law, which allowed for expanded availability of association and short-term health insurance policies, as permitted under the revised federal regulations.[36] Specifically, the law allows employers of different trades or industries to establish an AHP. Under previous law, only employers who shared a common trade or business interest were eligible to set up such a plan. The law also allows an association to be established for the primary purpose of providing health care coverage and benefits to employees of employer members of the association.

Effect of Proposed Changes

CS/CS/HB 897 removes the reference in the MEWA statute to the federal rule regarding AHPs that was struck down by a federal district court in 2019, and incorporates the requirements from the stricken rule to be considered a bona fide group for purposes of establishing a MEWA under state insurance regulations. Incorporating the requirements to be considered a bona fide group from the stricken rule maintains an expanded pathway for more groups or associations to form MEWAs.

The bill specifies the following criteria for a bona fide group or association of employers for purposes of establishing a MEWA:

- The entity must have at least one substantial business purpose among its employer members that is unrelated to health plan coverage or other employee benefits.
    - A substantial business purpose exists if the entity would be a viable business without sponsoring an employee benefit plan. The business purpose can include promoting common business interests or common economic interests, and need not be a for-profit activity.
- Each employer member is a person acting directly as an employer of at least one employee who participates under the plan.
- The entity has a formal organizational structure with a governing body.
- The entity's functions and activities are controlled by its employer members, which also control the health plan in form and substance.
- The employer members have a principal place of business in the same region, not exceeding the boundaries of a single state or a metropolitan area, even if the metropolitan area includes more than one state.
- The entity makes coverage under the health plan available only to a:
    - Participating employer.
    - Current participating employer's employee.
    - Former employee of a current participating employer who became eligible for coverage under the plan while still employed.
    - A beneficiary, such as a spouse or dependent child.
- The entity and the health plan coverage offered comply with nondiscrimination provisions of s. 627.6699.

[33] S. 624.437(3), F.S.
[34] They are Florida Bankers Health Consortium, Inc., Greater Health Trust, and Independent Colleges and Universities Benefits Association, Inc.; Office of Insurance Regulation, *Company Search*, available at https://companysearch.myfloridacfo.gov (last viewed on March 15, 2023); e-mail correspondence from Kevin Jacobs, Director of Government Affairs for OIR, March 15, 2023.
[35] S. 624.438(1), F.S.
[36] S. 624.438(1)(b), F.S.

- The entity is not a health insurance issuer as defined in s. 733(b)(2) of ERISA, or owned or controlled by a health insurance issuer or by a subsidiary or affiliate of a health insurance issuer, other than to the extent such issuers are employer members.

The bill provides an effective date of upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Amends s. 624.438, F.S., relating to general eligibility.
Section 2: Amends s. 627.654, F.S., relating to labor union, association, and small employer health alliance groups.
Section 3: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

OIR has sufficient rulemaking authority to implement the bill provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 22, 2023, the Healthcare Regulation Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment reflected technical input from OIR and other stakeholders. Specifically, the amendment:

- Removed the term “employee welfare benefit plan” from the criteria necessary to be considered a bona fide group that may establish MEWA.
- Reworded “member employers” to “employer members” to more accurately reflect the entities joined in a MEWA.
- Expanded the definition of beneficiary to participate in a MEWA, suggesting a spouse or dependent child as examples of a beneficiary.
- Defined “health insurance issuer” consistent with s. 733(b)(2) of the Employee Retirement Income Security Act of 1974 for purposes of criteria necessary to be considered a bona fide group that may establish a MEWA.
- Changed the effective date from July 1, 2023, to upon becoming a law.

On April 10, 2023, the Health and Human Services Committee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- Added a cross-reference correction in s. 627.6564, F.S.
- Made non-substantive wording changes to align with Senate companion.

The bill was reported favorably as amended. The analysis is drafted to the amended bill as passed by the Health and Human Services Committee.