CENTER FOR INSURANCE POLICY AND RESEARCH

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Journal of Insurance Regulation

Volume 43, Number 3

DOI: https://doi.org/10.52227/26889.2024

The Virtues and Vices of Association Health Plans

Roger Lee Mendoza

Journal of Insurance Regulation: A Forum for Opinion and Discussion of Major Regulatory and Public Policy Issues in Insurance

The Journal of Insurance Regulation (JIR) strives to make state insurance departments more aware of the cutting-edge, high-quality research occurring in the regulatory arena. All authors having articles that deal with insurance regulation are invited to submit manuscripts to the Journal for review. Before appearing in the Journal, each article is rigorously evaluated by the JIR Editorial Review Board to ensure that all information provides a true benefit to its readers and is of the utmost quality. The ideas expressed in the Journal are not endorsed by the NAIC, CIPR, the Journal's editorial staff, or the Journal's board.

The Virtues and Vices of Association Health Plans

Roger Lee Mendoza
College of Business and Economics
California State University-Los Angeles
Los Angeles, CA 90032
rmendoza@calstatela.edu

IMPORTANCE Association health plans (AHPs) under the U.S. Affordable Care Act (ACA) allow small firms to gain access to affordable and quality healthcare by pooling similar risk groups and taking advantage of substantial cost savings typically available only to large employers and their large group plans. A controversial U.S. Department of Labor (DOL) regulation created an alternative pathway ("Pathway 2") in 2018 that allowed small firms to form an association and sponsor an AHP based on a shared industry or shared geographic location and the self-employed to join an AHP if permitted by the association. Besides filling the void in the scholarly literature, our findings have important implications for the accessibility and affordability of employer-sponsored health insurance, especially considering that 96% of all U.S. firms are small.

OBJECTIVES This study examines why and how regulatory policy might allow small firms and the self-employed to gain or benefit from the advantages of large-group AHPs and avoid the responsibilities of small group and non-group healthcare coverage, respectively. It adapts a transaction cost approach to analyze legislative intent, market risks, and regulatory alternatives and implications.

EVIDENCE Federal and state laws and regulations governing health insurance, as well as AHP regulatory proposals between the ACA's passage in 2010 and the DOL's *Notice of Proposed Rulemaking* in 2024, were content-analyzed for the purpose of this study. Demographic data about AHPs and association employers was obtained from Association Health Plans, Inc., which conducted a one-time survey in 2023 to offer a snapshot of AHPs nationwide

FINDINGS Controversy over Pathway 2 centered on two key issues that inevitably imposed substantial transaction costs on its supporters and critics: 1) the proper interpretation and application of ACA and Employee Retirement Income Security Act (ERISA) legislative intent behind the definitions of AHP-qualified small firms and individual purchasers; and 2) whether AHP regulation should be merely concerned with how people can access affordable and quality healthcare, not necessarily whether they actually get it. Pathway 2 became equally contentious for allowing AHPs to be treated as large group plans. Critics claimed that it allowed AHPs to sidestep the ACA and gain exemption from the protections and standards afforded to small group and non-group plans. Supporters find that flexibility encourages more healthcare coverage under AHPs. In the presence of multiple and reciprocal transaction costs, judicial intervention in AHP regulatory policy may be more optimal than bargaining and other means. Besides, legislating through the political process what has been regulatorily rescinded might still offer a future option.

DOI: https://doi.org/10.52227/26889.2024

The Virtues and Vices of Association Health Plans

Roger Lee Mendoza
College of Business and Economics
California State University-Los Angeles
Los Angeles, CA 90032
rmendoza@calstatela.edu

ABSTRACT

This is a study about the non-group and small group market segments of health insurance in the United States. Association health plans (AHPs) under the Affordable Care Act (ACA) allow small firms to gain access to affordable healthcare by pooling similar risk groups and taking advantage of significant cost savings typically available only to large employers and their large group plans. Controversy arose after the U.S. Department of Labor (DOL) permitted the self-employed and made it easier for small firms to join AHPs that can be treated as large group health plans, exempt from the protections and standards of non-group and small group plans under the ACA. This study examines why and how regulatory policy might allow these beneficiaries to gain the advantages of large group AHPs and avoid the responsibilities of non-group and small group coverage. It adapts a transaction cost approach to analyze legislative intent, market risks, and regulatory alternatives and implications. Because transaction costs are considerably present, one set of jurisdictional rights could be deemed more efficient on the basis of the regulatory framework upheld by an impartial arbiter and the policy consequences — whether intended or not — that it anticipates in dispute resolution. In the presence of multiple and reciprocal transaction costs, the study suggests that litigating and adjudicating AHP regulatory policy may be optimal compared to other means that the contending parties could possibly arrive at themselves. The prospect of an adverse judgment may also incentivize at least one party to negotiate, if not withdraw from, contestation.

Keywords: association health plans (AHPs); insurance market; *bona fide* association; working owner; regulator; transaction costs

Introduction

With the onset of 21st-century healthcare reform in the United States, particularly with the enactment of the Affordable Care Act (ACA) of 2010, qualified small businesses have been permitted by law to band together and form an "association" either to purchase or self-fund healthcare coverage. Known as an association health plan (AHP), this multiple employer welfare arrangement (MEWA) plan is typically issued by an insurer to an independent trust established by professional groups, trade associations, and other organizations for the benefit of their employees. AHPs are intended to encourage these small firms to offer healthcare coverage that would otherwise be costly to them (Coleman, 2018). This is because AHPs can better pool similar risk groups (e.g., of realty firms and bakeshops, rather than only one or a few more realty firms or bakeshops) and take advantage of the cost savings typically available only to large employers and their large group plans. AHPs also tend to have lower transaction costs, including "lower administrative costs, perhaps because of [their] ongoing relationship and communication with members" (Morrisey, 2020, p. 366).

In 2018, the U.S. Department of Labor (DOL), under direction from the Trump administration, established a rule under Section 3(5) of the Employee Retirement Income Security Act (ERISA), which regulates employee benefit plans. This federal rule made it easier for small employers (i.e., employers with up to 50 employees or 100 employees in three states) to set up AHPs as large group plans. It also allowed the self-employed (e.g., sole proprietors, independent contractors, freelancers) to join these AHPs for the first time (DOL, 2018), helping them gain access to more affordable health insurance. However, in July 2024, the DOL rescinded the 2018 rule (DOL, 2023). Many employers and policymakers protested before and after the rescission, fearing it would drive small businesses to terminate employee coverage or purchase increasingly expensive health plans, while most of the self-employed will likely go uninsured (Goldowitz & Rees, 2019; Minemyer, 2019; Coleman, 2023b). It is not inconceivable that the pre-rescission "virtues-or-vices" debate might be revived in the aftermath of the 2024 U.S. presidential elections.

This study investigates why AHPs might be treated as a large group plan exempt from non-group (or individual) and small-group protections and standards or strictly as non-group and small-group health care coverage under pertinent laws and regulations. In doing so, it offers a transaction cost approach to uncover and analyze legislative intent, market risks, and regulatory alternatives and implications relative to AHPs.

Related Literature

The academic literature on AHPs is among the scantest in health insurance (Morrisey, 2020). This suggests the association market has not been studied in depth, particularly under the ACA.

Two of the first juried studies into AHPs covered the pre-ACA regulations. Baumgardner and Hagen (2001) developed a simulation model to estimate the impact of AHPs on: 1) price elasticities of small firms; and 2) the probability that exemption from state insurance laws (which have jurisdiction over insurance) might reduce insurance premiums. They conclude that AHPs have a relatively large price-reducing effect on the small-group market, but most of it comes at the expense of insurers. One key insight is that AHP success partly depends on the nature and structure of its provider network (e.g., doctors, hospitals, labs, and pharmacies), the prices it can negotiate, and the decision costs involved. Kofman et al. (2006) inquired into pre-ACA state approaches to AHP regulation and exemptions from state insurance laws. They find that states that applied the same or more stringent rules to AHPs in comparison to small-group and non-group health plans reported seeing fewer associations offering coverage in their markets. The challenges that many associations face in searching for and negotiating with insurers offer a primary reason why these associations seek federal exemptions from state insurance laws.

A third study covers AHP regulation under the ACA. In particular, Alzubi et al. (2022) inquired into the effects of the 2018 DOL rule on non-group plans. In structuring and operating the expanded individual AHPs based on the efficient practices of large group plans, the authors reported significant premium and expense reductions that could be generated while also preserving ACA-compliant health benefits, thus minimizing enforcement costs. They suggest non-group insurers create a statewide pseudo-association to pool all individual enrollees and offer them a large group health plan that optimizes premiums and health expenditures, with cross-subsidies from an individual guaranty fund.

Insights from these three reviewed studies suggest the significance of transaction costs (Williamson, 1979; Felder, 2001) in the AHP debate. Treated as large group plans, exempt from regulatory provisions for non-group and small group plans, AHPs impose search and information, bargaining and decision, and compliance costs on association employers, covered employees, and regulators alike.

Approach

Federal and state laws and regulations governing health insurance, as well as AHP regulatory proposals between the ACA's passage in 2010 and the DOL's Notice of Proposed Rulemaking in 2024, were content-analyzed for the purpose of this study. Analysis of the pertinent rules appears in the sections where they are covered and cited. Demographic data about AHPs and association employers was obtained from Association Health Plans, Inc., which conducted a one-time survey in 2023 to offer a snapshot of AHPs nationwide. Lastly, a three-dimensional transaction cost approach was adapted and developed to address the central question concerning the varying

treatment of AHPs from an insurance market standpoint and why regulatory rescission may not necessarily bring an end to or a final settlement of many of the issues about structuring and operating AHPs.

Rise of Large Group AHPs

In the pre-ACA period, small firms typically banded together to set up a fully insured or self-funded/self-insured AHP as a lower-cost group-purchasing alternative to healthcare coverage (Kofman et al., 2006). The self-employed were not permitted to join an AHP. The ACA's "coverage requirements" went into effect in 2010 for fully insured/funded plans sold in the individual, small-group, and large-group markets, as well as self-funded group health plans (Mendoza, 2017). Fig. 1 identifies some of the distinguishing characteristics of the three health insurance market segments under the ACA.

ACA Rules/Market Conditions	Individual/Non-Group	Small Group	Large Group
Enrollee #	1	2–50 or 2–100*	>50 or >100*
Subsidization	Partially subsidized	Employer-sponsored	Employer-sponsored
Premium rating/pricing	Modified community-rated**	Modified community-rated**	Experience-rated**
Benefits coverage	Comprehensive benefits mandate	Comprehensive benefits mandate	Few mandated benefits; exempt from most ACA rules
Pre-existing (health) conditions	Covered	Covered	Covered
Medical loss ratio (MLR)***	≥80% MLR required	≥80% MLR required	≥85% MLR required
Open enrollment period	Annual	Year-round	Year-round
Association health plan (AHP) option****	No. Sole proprietor access under 2018 U.S. Department of Labor (DOL) rule rescinded	Yes, but not as large group AHP under rescinded 2018 DOL rule	Yes. Large group AHP exempt from most ACA rules except health status ban

Fig. 1: Health insurance market segments under the Affordable Care Act (ACA)

*Three states (California, Colorado, and New York) allow employers with up to 100 employees to buy into a small group health plan.

**Community rating prohibits health insurers from charging higher premiums within a geographic area based on enrollee age, gender, health status, or medical claims history. Modified community rating introduced by the ACA allows premiums to vary based on enrollee age, geographic location, and tobacco use. Experience rating bases premiums on each group's previous medical claims experience.

***The MLR compares how much of premiums are spent by insurers on medical claims and quality improvement in contrast to how much is spent on other expenses (e.g., profit, marketing, etc.). The ACA requires insurers to spend at least 80% or 85% of premium dollars on medical care, depending on the insurance market segment.

****Based on the 2024 rescission of the DOL rule that established an alternative pathway for structuring and operating a large group AHP.

As one may also glean from Fig. 1, certain ACA healthcare reforms applied only to non-group and small-group plans. The legislative intent was to protect these plans from their inherent disadvantages in pricing and benefits coverage, as insurers would have little incentive to offer (and individuals and small firms have little clout to negotiate) comprehensive benefits, given the higher financial risks of insuring a smaller number of workers (Chaikind et al., 2010). Fig. 2 indicates significant premium growth in small-group health plans over the last two decades. Individual coverage rose by almost 119% from $3,375 in 2003 to $7,382 in 2021, representing an average annual increase of 5.9%. Family premiums for employees covered by small plans grew even more at an average of 7% during the same period, from $8,502 in 2003 to $20,406 by 2021. Premium cost increases further impose search and information costs, especially among consumers in terms of comparison-shopping and purchasing decisions (e.g., plan type, premiums, benefit offerings, covered lives, etc.), even relative to the healthcare options provided by their employer.

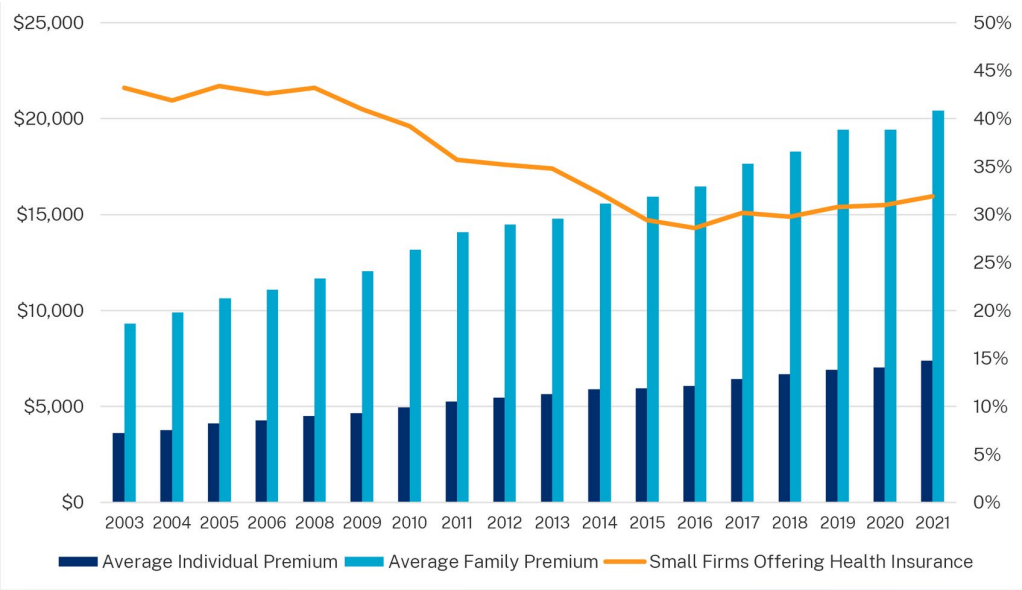

Fig. 2: Small business average health insurance premiums and % of firms offering health insurance

Source: Coleman, K. (2023). Small business health insurance equity through association health plans. Washington, D.C.: Paragon Health Institute. Retrieved from *https://paragoninstitute.org/private-health/small-business-health-insurance-equity-through-association-health-plans/*

The mandatory ACA reforms include 10 essential health benefits (EHBs) that individual and small group plans must offer; tiered actuarial values that specify policyholder and insurer cost-sharing for plan benefits; a modified community rating method that allows premiums to vary only based on age, tobacco use, geographic location, and family size; single risk-pooling so that underwriting is based solely on the pooled health risks of policyholders; and "risk adjustment," by which health plans that disproportionately enroll higher-risk people receive payments from plans that enroll younger and healthier people. These reforms proved financially burdensome to many individual and small- group market insurers (Mendoza, 2017). The ACA drafters did not impose them on fully insured and self-insured large group plans because "they felt that these plans' covered benefits… were as good if not better" than what the ACA prescribed for the non-group and small group plans (Condeluci, 2018, p. 6). Along with this came the presumption that large employers are in a better position to negotiate with insurers and, therefore, do not need as many protections (Condeluci, 2018).

The remaining ACA coverage requirements apply to all AHPs, regardless of market type. These include prohibitions against denying coverage based on pre-existing conditions, underwriting premiums based on an enrollee's or group's health status, and imposing annual and lifetime benefit limits.

While this study addresses large plan structuring and operation of AHPs from the standpoint of federal law and regulation, it should be noted that the power to regulate the insurance industry, including licensing, rates, and other practices, generally belongs to the states under the McCarran-Ferguson Act (1945). More specifically, states can override federal insurance rules if their state law is more protective of enrollees (e.g., by imposing stricter obligations on health insurance carriers and additional enrollee protections). However, ERISA also limits the application of state insurance law for those with private employer-sponsored coverage. On the other hand, some provisions of federal law, like federal tax laws, are always commanding (Pestaina et al., 2024).

The 2018 DOL Rule

In 2011, the U.S. Department of Health and Human Services (HHS) – as the ACA's major implementing agency – practically disallowed small firms from forming a fully insured large group to sponsor AHPs (HHS, 2011). The self-employed remained ineligible to join an association. The 2011 HHS "policy guidance" came amid growing concerns that many small firms had acquired the "vice" of seeking equal treatment as a large group without having to offer "just as good, if not better," coverage required of small firms under the ACA. On the other hand, once treated as a large group plan, AHPs could generate significant cost-savings to employer and employee alike, similar to large group non-AHP plans, as they would gain "negotiating leverage based on economies of scale" and be able to offer a "bigger 'risk pool'" (Condeluci, 2018, p. 9). The HHS "guidance" led to a drastic decline in fully insured AHPs after many small firms chose to discontinue their AHPs (Condeluci, 2018).

However, the HHS regulatory framework opened up an exception: If employers offering an AHP met the criteria of a *"bona fide group or association of employers"* under ERISA, a fully insured AHP can be "treated" as a large group plan and, therefore, avoid the ACA's prescriptions for individual and small group plans (HHS, 2011). Bona fide characterization meant, first and foremost, that the group or association has business or organizational purposes and functions unrelated to the provision of employee benefits (i.e., the "business purpose" standard) (Grushkin et al., 2024).

The HHS then stipulated two tests under its 2011 regulatory framework: 1) *the control test*, which requires that the association employer exercise "control," in both form and substance, over the activities and operations of the health plan it is sponsoring; and 2) the *commonality of interest test*, which requires that association employers must be "related" in terms of operating within the same industry *and* must be geographically located in the same state or tri-state area (HHS, 2011; Grushkin et al., 2024). Hence, a *"bona fide"* group of 50 small firms, each with only 10 eligible employees, could be treated as a large group plan after satisfying these tests, as it would be deemed to cover 500 workers (i.e., beyond the 50 or 100 employee-threshold to qualify as a large group), provided no self-employed people (having no employees) are allowed to join the group. Given its substantial compliance and enforcement costs, association member firms often found it difficult to satisfy this two-pronged *commonality of interest test* since they often came from different industries, were located in various states, and/or included independent contractors without any employees (Coleman, 2018). Association employers additionally faced significant search and information costs in comprehending their options and comparing their cost implications, which is admittedly complex.

The transaction costs imposed by the *commonality of interest test* subsequently led the first Trump administration to direct the DOL – tasked with administering ERISA – to expand AHP availability (Executive Order 13813, 2017). The DOL responded by considerably loosening the definition (or at least the interpretation) of an ERISA-qualified *"bona fide group or association of employers"* under the 2011 HHS framework. In 2018, the DOL released its "AHP rule" (better known as "Pathway 2"), allowing employer associations to pass the *commonality of interest test* if: 1) association employers belong to the same industry, line of business, or profession; or 2) association employers have their principal place of business in one state or metropolitan area (spanning a tri-state area), whether or not it spans more than one state (DOL, 2018).

Fig. 3 provides a flow chart to contrast Pathway 2 under the Trump administration's 2018 DOL rule with the 2011 HSS policy or "old pathway" that remained in effect.

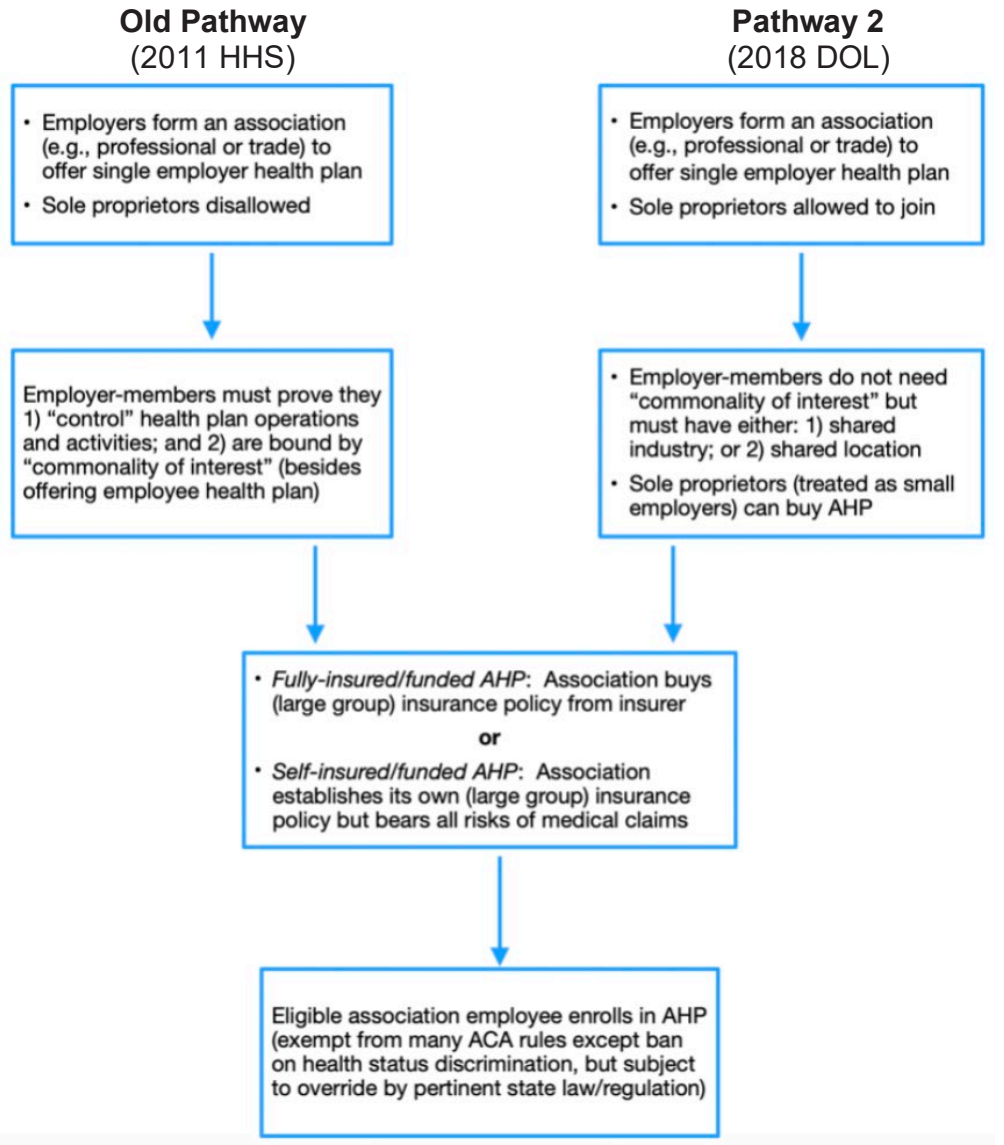

Fig. 3: Old and new pathways for structuring and operating an association health plan (AHP)

Removing the strict geographic limitation under the first *commonality of interest* sub-criterion was "critical for national trade associations, franchisees, and companies with 'cooperative' members… [and which have for decades] wanted to offer some type of health coverage to their employer members through a fully-insured or self-insured AHP *on a nationwide, or a regional basis"* (Condeluci, 2018, p. 9). The second sub-criterion allows "unrelated" employers from different industries and professions,

such as chambers of commerce, to sponsor an AHP, but only if they are principally located in the same state or metropolitan area.

The 2018 DOL rule went one step further. It permitted the self-employed (referred to as "working owners," though without any employees) to act both as an employer sponsoring a group health plan and an employee participating in an AHP (DOL, 2018). Under this scenario, the self-employed may participate in an AHP established by other "related" association member-firms (e.g., solo realtors who belong to a realty association) in the same industry/profession, even if they are located in different geographic areas.

These major changes brought about by the alternative pathway fueled the growth of AHPs, allowing 3.2 million small firms to set up large group AHPs for their almost 50 million employees and 27 million independent contractors to form AHPs for the first time. Without Pathway 2, it would have been difficult to realize the advantages or "virtues" of AHPs for the self-employed and many small firms, especially amid skyrocketing healthcare costs (Cassidy, 2024).

Rescission of Pathway 2

Over the next six years (2018–2024), the clamor to rescind Pathway 2 grew. Concerns were raised about large group-styled AHPs acting as proxies for less comprehensive or "skinny" healthcare coverage and segmenting insurance markets "by offering lower premiums to lower-cost [or lower risk] small groups and individuals, more limited benefits than would otherwise be required, or a combination of both" (Lueck, 2019). These vices, they asserted, were the logical outgrowth of AHPs that: 1) are exempt from offering EHBs; 2) can set premiums based on gender, occupation, and other underwriting factors; 3) can indirectly set higher premiums for small groups whose workers have pre-existing conditions and/or offer firms with healthier or lower risk workers a premium reduction; 4) do not have to pool together all their enrollees in the non-group and small group markets in rating premiums, encouraging association employers to set premiums reflecting enrollee health status; and 5) are exempted from participating in risk adjustment, which helps protect against risk segmentation (Lueck, 2019).

During public hearings held by the DOL, opposing groups and state governments voiced the direct and unintended policy consequences of these concerns:

> … implementation of the 2018 AHP Rule would have increased adverse selection against the individual and small group markets by drawing healthier, younger people into [large group] AHPs, thus increasing premiums for those remaining in those markets. AHPs can also tailor plan benefits so that individuals with preexisting conditions, or those who are otherwise anticipated to have higher health care costs are discouraged from joining AHPs, causing further adverse selection, market segmentation, and higher premiums in the individual and small group markets. The [DOL] acknowledged in the

> 2018 AHP Rule that the rule's "increased regulatory flexibility" would necessarily result in some segmentation of risk that favors AHPs over individual and small group markets and some premium increase for individuals and other small businesses remaining in the individual and small group markets.
>
> Additionally, health insurance coverage offered through AHPs in the large group markets is not subject to the requirement to offer essential health benefits, which means that individuals who join these AHPs may become underinsured if their AHP offers only "skinny" coverage (DOL, 2023: 87974).

Concerns about the limited oversight of large group AHPs and consumer protections were raised because a number of associations had defrauded their employees and left millions in unpaid claims after they became insolvent (Lueck, 2019). Monitoring and enforcement costs were deemed equally high.

Opposition to Pathway 2 culminated in *New York v. U.S. Department of Labor* (2019), filed by 11 states and the District of Columbia against the DOL to restore (the original virtues of) AHPs as exclusively non-group and small-group plans. Ruling for the opposition, the district court held that the bona fide association and working owner (re)interpretations by the DOL's 2018 AHP rule were unlawful and unreasonable expansions of legislative intent that ERISA and the ACA should apply only to those groups and associations acting directly (not indirectly) "in the interest of" their member-employers (Minemyer, 2019; DOL, 2023). Although the DOL chose to appeal the adverse decision to a Circuit Court of Appeals in 2020, it also provisionally stayed the 2018 rule while it acknowledged that it could have given "greater attention to the long-term impacts on market risk that the 2018 AHP Rule introduced, especially in the small group and individual markets" (DOL, 2023: 87974). The DOL solicited public comment on this proposed rescission until February 2024 (DOL, 2023).

Rescission supporters and critics vigorously articulated their respective positions before the mass media, the U.S. Senate, the U.S. House of Representatives (which initiated public hearings in aid of legislation), and the D.C. appellate court considering the DOL appeal (O'Neill, 2023). Critical employer groups, lawmakers, and regulators feared that rescinding the alternative pathway would drive small businesses either to discontinue employee healthcare coverage or purchase increasingly expensive, albeit federally subsidized, plans from the ACA individual and small markets and diminish employee pay as a compensating differential. Among others, they argued that it would cost small firm workers over $8,300 in average yearly premiums for family coverage or nearly 30% more than those at large firms if AHPs cannot be treated as large group plans. With about one-fourth of the self-employed currently uninsured, anti-rescission advocates believe that those who lose employer coverage will also be driven to purchase from the federally subsidized but costly non-group exchange or most likely go uninsured (Cassidy, 2024). A few middle-ground proposals sought to reconcile Pathway 2 with the 2011 HHS guidance (Klever, 2018; Association for Community Affiliated Plans [ACAP], 2024).

On April 29, 2024, the DOL issued a "final rule" to end the protracted legal debate and ensuing market challenges by fully rescinding its 2018 rule and returning to the more rigid 2011 HHS regulatory framework (see Fig. 3). In addressing the substantial search and enforcement costs of the 2018 rule as "a significant departure from the DOL's longstanding pre-rule guidance on the definition of 'employer' under ERISA," the DOL conceded that the rule "substantially weakened the … traditional criteria in a manner that would have enabled the creation of commercial AHPs functioning effectively as health insurance issuers" (Grushkin et al., 2024).

Depicting the rescission as a highly partisan move to align it with the Biden administration's health care accessibility goals and impending reelection campaign, the Republican majority in the U.S. Congress, backed by small business groups like the National Federation of Independent Business (NFIB), moved to reverse the DOL's final rule (Tong, 2024). By September 2024, a House committee had passed a resolution disapproving and criticizing the rescission for reducing AHP access and flexibility and forcing many Americans "into government-run health programs" (Tong, 2024). Considering President Trump's reelection victory along with a Republican majority in both houses of Congress by January 2025, it remains to be seen whether the rescinded alternative pathway engineered by the first Trump administration, or at least significant portions of it, will be restored, perhaps this time by means of new congressional legislation and/or regulatory (e.g., ERISA) amendment.

AHP Demographics

AHP demographic data from 37 states that allowed AHPs to fully operate under the impugned Pathway 2 offer context to their large plan characterization.

Of the AHPs that evolved under the DOL rule, as many as 71% of the 28 new AHPs were set up by regional associations. Another six AHPs were in the process of forming as of 2023. The vast majority of these 34 associations are chambers of commerce, some of which are multiple chambers sponsoring a single health plan (e.g., all 29 chambers in Vermont). Most benefitted from the DOL rule allowing AHPs for employers in different industries and professions (i.e., "unrelated" employers) but located in the same geography (e.g., same state or county). Non-chamber regional associations included business associations (e.g., the Small Business Association of Michigan, Business Resource Services), regional trade associations (e.g., Wisconsin Manufacturers & Commerce), and philanthropic organizations (e.g., the Business Fund for Texas Children Battling Cancer). On the other hand, multi-state professional AHPs, which limited membership to employers in the same line of work or trade, took longer to reach the association market because they involved more preparation and state filings. AHPs that formed under the old (HHS) pathway (e.g., Mason Contractors Association of America) were much fewer in number (Coleman, 2023a).

Over 85% (or 24) of these new AHPs were fully insured rather than self-funded as a large plan. Preference for full insurance typically owes to reliance on an insurer with greater capital resources to withstand catastrophic medical expenses (Morrisey, 2020). Name-recall could be another reason. UnitedHealthcare and its subsidiaries were the most frequent carriers, followed by Blue Cross Blue Shield Association (BCBSA). Fully

insured AHPs adopted several strategies to mitigate adverse selection and promote financial stability, including set minimums for the number of covered employees, length of time as an association employer before AHP access, and wait time prior to AHP withdrawal by an association employer (Coleman, 2023b).

AHP premiums were 30% lower than premiums for ACA-regulated non-group and small group coverage (Congressional Budget Office [CBO], 2019). Plan options within fully insured and self-funded AHPs averaged 11. In terms of benefits, most of the new AHPs offered comprehensive coverage that fairly resembles mandatory EHBs for non-group and small group plans. These include primary care physician and specialist visits, hospitalization, emergency care, prescription drug coverage, maternity coverage, preventive care, and mental health care. Where large group AHPs differed from ACA standards appears to be in (their lack of) pediatric dental care and pediatric vision care coverage, which can be offered through stand-alone dental and vision plans. Half of the new AHPs in 2023 additionally offered pretax savings account options, especially a health savings account, that the insured could use for out-of-pocket costs, including copays, deductibles, and coinsurance (Coleman, 2023a).

Half of the new AHPs in 2023 were further restricted to small firms with two to 50 employees. Less than half (43%) were available to the self-employed (Coleman, 2023a). A total of four million workers were estimated to have enrolled in AHPs as a result of Pathway 2 (DOL, 2018).

Discussion: The Transaction Costs of Association

Transaction costs are incurred in "doing business" in the market. In contrast to production and delivery costs, these refer to search and information, bargaining and decision-making, and monitoring and compliance costs to the transacting parties (in this case, AHP member-employers/working owners and regulators). Because transaction costs are rarely absent or minimal, and property rights and contracts are considered problematic, the transaction cost approach is generally better suited to explaining why inefficiencies exist, as opposed to a way to resolve disputes and which institutional arrangements might better minimize them (Williamson, 1979).

In the presence of transaction costs, the initial allocation of rights between parties matters (Felder, 2001). We refer to the jurisdictional rights of the two federal regulators (HHS and the DOL) over legislation (the ACA and ERISA) governing AHPs and the opportunities they open up or constrain for other players, namely the self-employed and their dependents and small firm sponsors and their eligible employees. The HHS and DOL regulatory purviews collided on two grounds: 1) the proper interpretation and application of ACA and ERISA legislative intent behind the definitions of AHP-qualified employer and individual purchaser; and 2) whether policy outcomes and consequences should be considered in resolving the conflicting claims, meaning, whether regulation should be merely concerned with how people can access affordable and quality healthcare, and not necessarily whether they actually get it. Space constraints do not permit a discussion of all the transaction costs that inevitably arose, but a sampling is offered here.

Consider *search and information costs* imposed on the transacting parties. Some evolved not from implementing the HHS or DOL pathways but from the legislative ambiguities and policy assumptions of healthcare reform policy. The ERISA clause, *"any person acting… indirectly in the interest of an employer,"* is illustrative. Supporters of the DOL's Pathway 2 invoked it as a reasonable basis for an expanded "employer" definition or interpretation encompassing "unrelated employers" "with some additional, non-benefit-related business purpose" relative to a bona fide association (DOL, 2019). Legislative intent was liberally interpreted by the 2018 DOL rule to overcome ACA and HHS policy restrictions that the DOL believed tended to discourage the less likely to purchase health insurance in the marketplace. Critics claimed that the rule constituted an unreasonable interpretation of legislative intent, and the district court sided with them in ruling in 2019 that Pathway 2 was a "magic trick" to bypass ACA compliance (Minemyer, 2019). The court also upheld the opposition's contention that Pathway 2 encourages employer associations bound by nothing more than an interest in insurance or geographic proximity – a trend supported by demographic data – and contrary to the intended commonality of economic or representational interest (State of New York, 2019). If text, legislative history, and judicial precedence only offered clear guidance to substantive intent and procedural content of the ERISA clause, the transaction costs of search and information, as well as compliance, would have been insignificant. The DOL and HHS, working with AHP representatives, could have collaborated on or at least negotiated a more definitive interpretation aligned with ACA healthcare reform. Instead, the regulatory complexities built into the old and alternative pathways for setting up AHPs (refer to Fig. 3) imposed more search and information costs on small businesses trying to figure out their options.

Consider, too, the self-employed (working owner) access granted by Pathway 2. The American Medical Association (AMA) and seven other physician associations contended that the creative interpretations "legislated" by the DOL distort or skew enrollee information. Redefining *commonality of interest* based on either shared industry or shared location and qualifying working owners as "employers" even without any employees can serve to lure individual purchasers and small firms in search of lower premiums until a medical emergency strikes. It is only then that they discover essential care is not covered, which is particularly devastating to economically vulnerable and unhealthy populations and their dependent children (Golder, 2019). Former DOL officials, on the other hand, find that (self-certified) information required of working owners fails to verify the self-employed status and that minimum work hours for individual AHP membership are met on a continuing basis rather than only at plan enrollment. These also invite "unscrupulous promoters to commit insurance fraud" (Handorf, 2019, p. 11).

Lacking in pool size, negotiating clout, and actuarial experience, individual purchasers and small firms face heavy *bargaining and decision costs*. Insurers have every incentive to raise premiums and cost-sharing, narrow provider networks, and offer minimum benefits for non-group and small-group plans sold in the ACA exchanges (Condeluci, 2018). Hence, Pathway 2 "sees associations as a vehicle for bootstrapping them into the large-group market" (Golder, 2019, p. 25).

Critics countered that market segmentation will produce even higher bargaining and decision costs. Because large group AHPs do not have to play by the same rules, Families USA and other citizen groups contended that they would be incentivized to offer cheaper coverage by offering less comprehensive and less protective care that attracts the young and healthy. Conversely, "higher prices…, less comprehensive coverage [and exclusion for certain conditions,] and discriminatory impacts on individuals who are elderly, female, or live with disabilities, whether they obtain insurance through their employer or on their own" will arise "in ways that Congress did not intend" (Joshi & Sieve, 2019, p. 2).

Monitoring and enforcement/compliance costs equally abound. The DOL itself conceded that "increased flexibility afforded AHPs under this rule will introduce increased opportunities for mismanagement or abuse, in turn increasing oversight demands" on federal and state regulators (Golder, 2019, p. 59). However, the DOL also suggested that non-fraud/abuse monitoring costs (e.g., unpaid claims and tax revenue losses from no-premium self-insured AHPs) are either "speculative" or "self-inflicted" (DOL, 2019, p. 17).

Opponents of the DOL rule pointed out that the ACA and ERISA are not the only controlling regulations. Among others, they cited the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules that apply to AHPs, which, like any group health plan, cannot discriminate in eligibility, benefits, and premiums against an individual within a group of similarly situated individuals based on health factors. Proponents clarified that AHPs, like other group health plans, may generally make distinctions between groups of individuals from *bona fide* employment-based classifications consistent with the employer's usual business practice, provided such distinction is not directed at individual participants based on those factors (Coleman, 2018; Lueck, 2019).

The costs of compliance and enforcement extend to revocation. Oklahoma and eight other states that took the side of the DOL argued that they would need to commit much time and other resources to consider new legislation if Pathway 2 were eventually invalidated. These do not even take into account the number of small firms and individuals who have made changes to their benefit plans based on the alternative pathway to AHP access (Oklahoma Insurance Department, 2019).

The transaction costs imposed upon each other by the contending parties drove large group (re)characterization of AHPs, the impetus to reverse it, and the submission of the ongoing virtues and vices dispute to litigation and adjudication (judicial decision-making).

In the presence of substantial transaction costs, one other key insight from this study is that some distribution of limited jurisdictional rights may be adjudged superior to any that the transacting parties could have arrived at themselves through bargaining (Felder, 2001). Because policy interpretation and outcomes impose reciprocal costs and benefits, dispute resolution might end up with a (neutral) third party. In this case, it is the judicial system. While trial and appellate courts may decide on this matter (differently), their presumed superiority over the contending parties arises from their impartiality, legal competence and reputation, and binding authority. However, there is no gainsaying that courts could adjudicate by assigning greater weight to the original intent of legislation based on the text, structure, and history of the ACA and

ERISA, assuming they can be reconciled with each other. Otherwise, courts can equally read into legislation a broader and more progressive interpretation that considers its outcomes and consequences – whether imagined or real, intended or not – to adapt it to changing times and exigencies.

Equally important, albeit counterintuitively, is a transacting party's fear of an adverse judgment that raises their compliance and enforcement costs. This could nudge them toward compromise, if not withdrawal from contestation, to reduce negotiation and compliance costs as litigation or adjudication unfolds. It is not uncommon for parties to start negotiating only after litigation has begun. The DOL's eventual rescission of Pathway 2, effective July 2024, as well as the public comment period it opened before that – partly in search of a middle-ground between the contending claims – illustrate this point. At the same time, it is not entirely unlikely that the outcomes of the 2024 U.S. elections and the Republican trifecta could pave the way for the revival of the first Trump-era DOL rule in one form or the other, perhaps by means of new legislation and/or regulatory amendment. From several indications, the virtues-or-vices debate over AHP structuring and operation as a large group plan is not yet fully settled; rather, it is currently in a state of suspended animation.

Conclusion

Pathway 2 aimed to increase healthcare access and affordability among small firms and the self-employed by reinterpreting employee benefit legislation under ERISA to overcome the protections and standards of healthcare reform under the ACA. It did so by expanding the permissible circumstances under which AHPs could be considered a single employer, providing a flexible commonality of interest test, and treating sole proprietors both as employers and employees. Critics held that the cardinal vice of AHPs under the alternative pathway is that they allow small businesses to sidestep the ACA to legitimately offer less comprehensive benefits. Proponents find that flexibility in AHPs is Pathway 2's cardinal virtue as it encourages more healthcare coverage. The debate continues amid an impending change of presidential administration from the rescinding power to the enacting authority of the alternative pathway.

We can consider the resulting transaction costs in three ways. First, absent transaction costs, the initial allocation of jurisdictional rights would not matter or matter less as parties can bargain or negotiate to reach an optimal outcome. However (and secondly), in the presence of multiple transaction costs, the initial allocation of jurisdictional rights matters. One may be deemed more efficient than the other based on the regulatory approach or framework upheld by an impartial arbiter and the resulting policy and practical consequences it may consider in resolving the dispute. Finally, litigating and/or adjudicating regulatory policy over AHPs may be more optimal than other means that the contending parties could possibly arrive at themselves. At the very least, we find that the prospect of an adverse court judgment can motivate one or both parties to seek a negotiated settlement if not withdrawal from contestation. Legislating what has been rescinded might still offer a future option. After all, it is well to remember that what cannot be achieved directly from adjudication can often be done indirectly through the political process, which constitutes both a challenge and opportunity to AHPs and healthcare reform in the U.S.

References

Alzubi, J., Fung, D., Yang, C., & Yeh, J. (2022). Improving health insurance markets: Cost efficiency, implementation, and financing of expanding association health plans. *Review of Quantitative Finance and Accounting, 59*(2): 671–694.

Association for Community Affiliated Plans (ACAP) (2024, February 20). RIN 1210–AC16, Definition of "Employer" — Association Health Plans. Letter to Lisa Gomez, Assistant Secretary, Employee Benefits Security Administration. Retrieved from https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00029.pdf

Baumgardner, J. R., & Hagen, S. A. (2001). Predicting response to regulatory change in the small group health insurance market: The case of association health plans and HealthMarts. *Inquiry, 38*(4): 351–364.

Cassidy, B. (2024, February 29). *Letter to Julie Su, Acting Secretary, U.S. Department of Labor*. Retrieved from https://www.help.senate.gov/ranking/newsroom/press/ranking-member-cassidy-rebukes-proposed-dol-rule-restricting-health-coverage-for-millions-of-american-workers?fbclid=IwAR2OQeVMzUtL7XLuPVmXeJJkn 3SzaXc9oTxf-3c4qm2cksqoa4E5v5stbU7g

Chaikind, H., Fernandez, B., Peterson, C. L., Newsom, M., & Mulvey, J. (2010). *Private health insurance provisions in Senate-Passed H.R. 3590, The Patient Protection and Affordable Care Act*. Washington D.C.: Congressional Research Service.

Coleman, K. (2023a). *First phase of new association health plans reveal promising trends*. AssociationHealthPlans.com Retrieved from https://www.associationhealthplans.com/reports/new-ahp-study/#_edn6

Coleman, K. (2023b). *Study: Chamber of commerce association health plans building political bridges while refuting opposition*. AssociationHealthPlans.com Retrieved from https://www.associationhealthplans.com/reports/chamber-of-commerce-ahp/

Coleman, K. (2018). *Association health plans & the future of American health insurance*. San Francisco, CA: Publisher Services Publication (self-publication).

Condeluci, C. E. (2018). *Testimony before the Committee on Education and the Workforce, Subcommittee on Health, Employment, Labor, and Pensions*. Washington D.C.: U.S. House of Representatives. Retrieved from https://edworkforce. house.gov/uploadedfiles/testimony_condeluci_revised_3.20.18.pdf

Congressional Budget Office (CBO) (2019). *How CBO and JCT analyzed coverage effects of new rules for association health plans and short-term plans*. Washington D.C.: CBO. Retrieved from https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf

Executive Order 13813 (2017). *Promoting healthcare choice and competition across the United States. Office of the President of the United States*. Retrieved from: https://www.federalregister.gov/documents/2017/10/17/2017-22677/promoting-healthcare-choice-and-competition-across-the-united-states

Felder, J. (2001). Coase theorems 1-2-3. *The American Economist, 45*(1): 54–61.

Golder, C. (2019). *Brief of amici curiae American Medical Association, Medical Society of the State of New York, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American College of Emergency Physicians, American College of Obstetricians & Gynecologists, and American Psychiatric Association in support of appellees*. Retrieved from https://litigationtracker.law.georgetown.edu/wpcontent/uploads/2023/04/NY_20190722_AMICUS-BRIEF-filed-by-American-Academy-of-Family-Physicians-et-al.pdf

Goldowitz, I., & Rees, S. E. (2019). *Amicus curiae brief of the Coalition to Protect and Promote Association Health Plans joined with AssociationHealthPlans.com, in support of United States Department of Labor with the consent of all parties*. Retrieved from https://litigationtracker.law.georgetown.edu/wpcontent/uploads/2023/04/NY_20190808_AMICUS-FINAL-BRIEF-filed-by-Coalition-to-Protect-and-Promote-Association-Health-Plans-et-al.pdf

Grushkin, J., Ferreyra, B. L., & Nevins, E. (2024, May 15). U.S. *Department of Labor rescinds Trump-era rule on association health plans (AHPs).* Shepphard Mullin Healthcare Law Blog. Retrieved from https://www.sheppardhealthlaw.com/2024/05/articles/association-health-plans/u-s-department-of-labor-rescinds-trump-era-rule-on-association-health-plans-ahps/

Handorf, K. L. (2019). *Brief of former United States Department of Labor officials Phyllis C. Borzi, M. Patricia Smith, Alan D. Lebowitz, Marc I. Machiz and Daniel C. Maguire as amici curiae on support of appellees and affirmance*. Retrieved from https://litigationtracker.law.georgetown.edu/wpcontent/uploads/2023/04/NY_20190722_AMICUS-BRIEF-filed-by-Borzi-C.-Phyllis-et-al.pdf

Joshi, N. M., & Zieve, A.M. (2019). *Brief for amici curiae Families USA, National Partnership for Women and Families, National Women's Law Center, National Employment Law Project, National Health Law Program, United Hospital Fund, and Public Citizen supporting appellees and affirmance*. Retrieved from https://litigationtracker.law.georgetown.edu/wpcontent/uploads/2023/04/NY_20190722_AMICUS-BRIEF-filed-by-Families-USA-et-al.pdf

Keith, K. (2018, June 21). Final rule rapidly eases restrictions on non-ACA-compliant association health plans. *Health Affairs* Blog. https://doi.org/10.1377/forefront.20180621.671483

Klever, B. (2018, February 9). *Considerations related to modeling the potential impact of association health plans*. Letter to the Office of Regulations and Interpretations, Employee Benefits Security Administration. Retrieved from https://www.actuary.org/sites/default/files/files/publications/AHP_modeling_considerations_02092018.pdf

Kofman, M., Lucia, K., Bangit, E., & Pollitz, K. (2006). Association health plans: What's all the fuss about? *Health Affairs, 25*(6): 1591–1602.

Lucia, K., Giovannelli, J., Corlette, S., & Goe, C. (2018, November 27). In the wake of new association health plan standards, states are exercising authority to protect consumers, providers, and markets. *To the Point (blog), Commonwealth Fund*. Retrieved from https://www.commonwealthfund.org/blog/2018/initial-state-approaches-association-health-plans

Lueck, S. (2019). *Association health plan expansion likely to hurt consumers, state insurance markets*. Center on Budget and Policy Priorities, Washington, D.C., Retrieved from https://www.cbpp.org/sites/default/files/atoms/files/3-7-19health.pdf

McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1945).

Mendoza, R. L. (2017). Information asymmetries and risk management in healthcare markets: The US Affordable Care Act in retrospect. *Journal of Economic Issues, 51(2): 520–540*.

Minemyer, P. (2019, March 28). Judge strikes down association health plans, calls them 'magic trick' to avoid ACA. *Fierce Healthcare Blog*. Retrieved from https://www.fiercehealthcare.com/payer/another-legal-blow-to-trump-administration-judge-strikes-down-association-health-plan-rule

Morrisey, M. A. (2020). Health insurance (3rd ed.). Chicago, IL: Health Administration Press.

Oklahoma Insurance Department. (2019). *Amici curiae brief of the Oklahoma Insurance Department joined with the Montana state auditor, commissioner of securities and insurance, and the Mississippi Insurance Department in support of appellant United States Department of Labor*. Retrieved from https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/04/NY_20190808_AMICUS-FINAL-BRIEF-filed-by-the-Oklahoma-Insurance-Department-et-al.pdf

Pestaina, K., Wallace, R., & Long, M. (2024). The regulation of private health insurance. In *Health Policy 101*, Altman D, (Ed.). San Francisco, CA: KFF.

State of New York et al. v. United States Department of Labor et al., Civil Action No. 18-1747 (2019). 1:2018cv01747 - Document 79, D.D.C. Retrieved from https://cases.justia.com/federal/district-courts/district-of-columbia/dcdce/1:2018cv01747/198818/79/0.pdf?ts=1553851204

Tong, N. (2024, September 12). House Republicans stand firm on association health plans. *Fierce Healthcare Blog*. Retrieved from https://www.fiercehealthcare.com/ai-and-machine-learning/house-republicans-stand-firm-association-health-plans

U.S. Department of Health and Human Services (HHS). (2011). *Insurance Standards Bulletin Series—INFORMATION: 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*. Baltimore, MD: HHS. Retrieved from https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf

U.S. Department of Labor (DOL). (2018). Definition of Employer—*Association Health Plans (2018 AHP Rule),* 29 CFR 2510.3–5 (83 FR 28912). Retrieved from https://www.govinfo.gov/content/pkg/FR-2018-06-21/pdf/2018-12992.pdf

U.S. DOL. (2019). Final brief for appellants. Retrieved from https://litigationtracker.law.georgetown.edu/wpcontent/uploads/2023/04/NY_20190808_APPELLANT-FINAL-BRIEF.pdf

U.S. DOL. (2023). Notice of proposed rulemaking, Definition of "Employer" – Associaion Health Plans, 29 CFR Part 2510 (88 FR 87968-87981). Retrieved from https://www.govinfo.gov/content/pkg/FR-2023-12-20/pdf/2023-27510.pdf

Williamson, O.E. (1979). Transaction-cost economics: The governance of contractual relations. *The Journal of Law & Economics, 22*(2): 233–261.