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Bad Company? The Rise (Again) of Association Health Plans

Brendan Williams

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BAD COMPANY? THE RISE (AGAIN) OF ASSOCIATION HEALTH PLANS

Brendan Williams¹

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INTRODUCTION

In the first month of his presidency, Donald Trump, who had long railed against the Affordable Care Act (ACA), famously stated: “Nobody knew health care could be so complicated.”²

Proof of that complexity has come in the reaction to the Trump Administration’s supposed regulatory fix for the undeniable problems that afflict the small-group insurance market, which appears also intended to sabotage the individual market: facilitating association health plans.³

As one article describes them:

Association health plans (sometimes called AHPs) allow small businesses to band together to buy insurance. Some plans have been in place for years, and those plans can continue to operate after the new rule takes effect. But the Trump administration's regulation loosens the rules for additional plans to come onto

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² Kevin Liptak, *Trump: 'Nobody knew health care could be so complicated'*, CNN (Feb. 28, 2017), <https://www.cnn.com/2017/02/27/politics/trump-health-care-complicated/index.html>.

³ Given all the efforts by the Trump Administration to subvert the ACA, it should be noted that AHPs are in a class of health insurance coverage entirely separate from the Trump Administration’s efforts to facilitate short-term insurance plans as a means of avoiding the ACA’s protections (and attendant costs). *See, e.g.*, Robert Pear, *Trump’s Short-Term Health Insurance Policies Quickly Run Into Headwinds*, N.Y. TIMES (Aug. 6, 2018), <https://www.nytimes.com/2018/08/06/us/politics/trump-short-term-health-plans.html> (noting that a Trump Administration rule “greatly increased the maximum duration of such plans, which had been three months. The new limit is 364 days, or a total of three years with renewals and extensions, making them more like a longer-term alternative to regulated, comprehensive insurance policies.”).

the market, allowing more small businesses, including individuals who work for themselves, to join these plans.⁴

These plans have actually existed for some time, but were curbed by the ACA. As an article in *Actuary Magazine* notes:

Prior to the ACA, many states exempted AHPs from rules and standards that applied to commercial insurers, such as filing requirements, underwriting restrictions, benefit mandates and solvency standards. Additionally, AHPs would sometimes set up headquarters in one state with limited regulatory oversight and then market policies to businesses and consumers in other states with more robust regulation of rating and plan benefits.⁵

But that was then and this is now. The June 2018 rule adopted by the Department of Labor (DOL) is bullish on AHPs:

AHPs are an innovative option for expanding access to employer-sponsored coverage (especially for small businesses). Through AHPs, employers band together to purchase health coverage. By participating in AHPs, employees of small employers and working owners are able to obtain coverage that is not subject to the regulatory complexity and burden that currently characterizes the market for individual and small group health coverage and, therefore, can enjoy flexibility with respect to benefit package design comparable to that enjoyed by large employers.⁶

A DOL press release announcing the new rule stated that “[u]nder the Department's new rule, AHPs can serve employers in a city, county, state, or a multi-state metropolitan area, or a particular industry nationwide. Sole proprietors as well as their families will be permitted to

⁴ Michelle Andrews, *Read The Fine Print Before Picking An Association Plan For Your Small Business*, NPR (June 27, 2018), <https://www.npr.org/sections/health-shots/2018/06/27/623626154/read-the-fine-print-before-picking-bout-an-association-plan-for-your-small-busin>.

⁵ Sabrina Corlette, Josh Hammerquist & Pete Nakahata, *New Rules to Expand Association Health Plans*, THE ACTUARY (May 2018), <https://theactuarymagazine.org/new-rules-to-expand-association-health-plans/>.

⁶ Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912 (June 20, 2018) (to be codified at 29 C.F.R. 2510).

join such plans.”⁷ As Secretary of Labor Alex Acosta wrote in the *Wall Street Journal*:

Small-business owners and their employees often struggle to find affordable health-care options. A major reason is that ObamaCare, among other laws, makes coverage more expensive for small businesses than large companies. That’s why the Trump administration is expanding access to association health plans, or AHPs[.]⁸

On its face, this all may sound great: lower health insurance costs and more options. So what is “complicated” about this idea?

This article first examines the rule adopted by the DOL and the criticism it has drawn. It then assesses the state of the small-group insurance market for small businesses, and the flawed approach that the ACA took to assisting them. Finally it takes a look at the uncertain future for small businesses and health insurance, and it suggests new approaches.

I. THE ASSOCIATION HEALTH PLAN RULE

At the threshold, the first challenge that the DOL had in following President Trump’s directive to facilitate association health plans was that to do so flew in the face of the department’s own previous interpretations of federal law—specifically the Employee Retirement Income Security Act (ERISA) of 1974.⁹

There had long been, under section 3(5) of ERISA, “a facts-and-circumstances approach to determining whether a group or association of employers is a bona fide employer group or association capable of sponsoring an ERISA plan on behalf of its employer members.”¹⁰

Those factors were:

- (1) whether the group or association is a bona fide organization with business/organizational purposes and functions *unrelated to the provision of benefits*;
- (2) whether the employers share some commonality and genuine organizational relationship *unrelated to the provision of benefits*; and

⁷ Press Release, U.S. Dep’t of Labor, President Donald J. Trump Helps Millions of Americans Employed By Small Businesses Gain Access to Quality, Affordable Health Coverage (June 19, 2018).

⁸ Alexander Acosta, *A Health Fix For Mom and Pop Shops*, WALL ST. J. (June 18, 2018), <https://www.wsj.com/articles/a-health-fix-for-mom-and-pop-shops-1529363643>.

⁹ PL 93-406, SEPT. 2, 1974, 88 Stat 829.

¹⁰ Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912, 28914 (June 20, 2018) (to be codified at 29 C.F.R. 2510).

(3) whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program, both in form and substance.¹¹

Thus, the DOL had to hasten to implausibly assure that the new rule “does not supplant the Department’s previously issued guidance under ERISA section 3(5), but rather provides an additional basis for meeting the definition of an ‘employer’ under ERISA section 3(5).”¹² It maintained that

[N]either the Department’s previous advisory opinions, nor relevant court cases, foreclose DOL from adopting a more flexible test in a regulation, or from departing from particular factors previously used in determining whether a group or association can be treated as acting as an “employer” or “indirectly in the interest of an employer” for purposes of the statutory definition.¹³

The DOL admitted that “[s]everal commenters stated that self-insured AHPs in particular were ripe for abuse and recommended that groups and associations that do not exist for purposes other than sponsoring an AHP should be limited to offering fully-insured AHPs.”¹⁴ The Department’s response to such concerns was:

to establish a general legal standard that requires that a group or association of employers have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees, even if the primary purpose of the group or association is to offer such coverage to its members.¹⁵

Many commentators were skeptical about the control of such AHPs, likening them to multiple employer welfare arrangements that had historically been at risk of fraud.¹⁶ The DOL acknowledged risks:

¹¹ *Id.* (emphasis added).

¹² *Id.* at 28916.

¹³ *Id.* at 28914. In other words, elections have consequences.

¹⁴ *Id.* at 28917–18.

¹⁵ *Id.* at 28918.

¹⁶ *Id.* at 28919. “A MEWA can be a single ERISA-covered plan, or an arrangement comprised of multiple ERISA-covered plans, each sponsored by unrelated employer members that participate in the arrangement. AHPs are one type of MEWA, and they are single ERISA-covered plans.” *Id.* at 28919, n.18. As the Department had previously acknowledged:

In the past, some AHPs and other MEWAs suffered from mismanagement and abuse, leading to unpaid claims and loss of coverage. Congress, the Department, and states have made progress combatting MEWA abuse and will continue their efforts as AHPs become more prevalent in response to this rule. AHPs with tighter ties to, and that are more controlled by, employer members are likely to be more insulated from mismanagement and abuse. The final rule requires certain minimum such ties and control in order to reduce operational risks. Nonetheless, risks remain.¹⁷

Some commentators “argued that allowing working owners without employees to participate in AHPs, and even permitting an AHP to consist entirely of such individuals, would harm the small group and individual markets.”¹⁸ Commentators “complained that it was an impermissible reading of ERISA for the Department to conclude that a plan with no common law employees was an employment-based plan that Congress intended to be regulated under ERISA.”¹⁹ Nonetheless, “[t]he final rule makes explicit that working owners without common law employees may qualify as both an employer and as an employee for purposes of participating in an AHP.”²⁰ The metaphysics of this are hard to fathom. People are people *and* corporations? This is a clearly transparent effort to compete with the individual market.²¹

By avoiding State insurance reserve, contribution and other requirements applicable to insurance companies, MEWAs are often able to market insurance coverage at rates substantially below those of regulated insurance companies, thus, in concept, making the MEWA an attractive alternative for those small businesses finding it difficult to obtain affordable health care coverage for their employees. In practice, however, a number of MEWAs have been unable to pay claims as a result of insufficient funding and inadequate reserves. Or in the worst situations, they were operated by individuals who drained the MEWA’s assets through excessive administrative fees and outright embezzlement.

Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act (ERISA): A Guide to State and Federal Regulation, U.S. DEP’T OF LABOR (Aug. 2013), <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>.

¹⁷ Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912, 28939 (June 20, 2018) (to be codified at 29 C.F.R. 2510)..

¹⁸ *Id.* at 28930.

¹⁹ *Id.*

²⁰ *Id.* at 28931.

²¹ Anyone doubting this is the intent could look to a Jan. 4, 2018, press release from Senator Lamar Alexander (R., Tennessee), the chair of the Senate Health and Labor Committee, claiming AHPs would “provide new, more affordable options to Americans in the *individual market* who are getting hammered by skyrocketing premiums.” Press Release, Sen. Lamar Alexander, United States Senate, Alexander: Proposed Health Insurance Rule Could Lower Costs for up to 11 Million Self-Employed or Small Business Employees (Jan. 4, 2018) (emphasis added).

Commentators were also concerned that AHPs would not be required to offer the ten essential health benefits required in the individual and small-group markets under the ACA.²² DOL declined to require this, stating:

The Department declines to adopt commenters' recommendations to make the provision of EHBs in an AHP a condition for a group or association to qualify as bona fide. Such a mandate would run contrary to the goal of leveling the playing field between small employers in AHPs, on the one hand, and large employers, on the other, who generally are not subject to the EHB requirements.²³

DOL acknowledged that “[m]any AHPs will be subject to State benefit mandates. Pennsylvania, for example, requires policies issued in the large group market to cover in-patient and out-patient services for severe mental illness, inpatient and outpatient services for substance use disorders, autism services, childhood immunizations, and mammography.”²⁴

As DOL related, “[i]n 2008 AHPs claimed approximately one-half of Washington’s small group market and more than one-third of its combined small and large group market. For small groups, the report found that AHP premiums (\$246 per member per month) were lower than community rated premiums (\$316 per member per month).”²⁵ The Department concluded that

AHPs’ historically substantial market share in Washington State stands as evidence that they delivered economic advantage to many small businesses there relative to choices available in community rated small group markets. *However, it is likely that some or much of this advantage came at the expense of other small businesses that paid higher prices in community-rated markets, or went without insurance.*²⁶

The DOL countered this damning evidence by stating that “while Washington AHPs have rated members based on health status, AHPs operating under this final rule cannot, so such AHPs’ potential to offer

²²Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912, 28933 (June 20, 2018) (to be codified at 29 C.F.R. 2510).

²³ *Id.*

²⁴ *Id.* at 28942.

²⁵ *Id.* at 28947.

²⁶ *Id.*

targeted savings and select risk relative to small group markets are more limited.”²⁷

This blandishment ignores the fact that the DOL rule would, among other things, allow AHPs to discriminate on the basis of gender and age; practices otherwise forbidden under the ACA in the small-group market.²⁸ Some consumers would win, while others lose. As a result of the AHPs approval of gender and age rating which is forbidden under the ACA, the Blue Cross Blue Shield Association, when filing comments on the proposed rule, stated that association health plan premiums for women in their early 30s might be more than 30 percent higher than rates under regular individual and small-group rules. It is estimated that rates for young men of a similar age could be more than 40 percent lower than ACA rates.²⁹

On July 26, 2018 eleven states brought suit against the Department of Labor in U.S. District Court in the District of Columbia, seeking declaratory and injunctive relief. They alleged that the new “rule increases the risk of fraud and harm to consumers, requires States to redirect significant enforcement resources to curb those risks, and jeopardizes state efforts to protect their residents through stronger regulation. The rule is unlawful and should be vacated.”³⁰

The states maintained that the rule attempted “to shift, through manipulation of the Employment Retirement Security Act (ERISA), a large number of small employers into the large group market *because* the ACA’s core protections do not apply [there].”³¹ They contended:

To undermine core ACA protections, the U.S. Department of Labor (DOL) in the Final Rule redefines the term “employer” in Section 3(5) of ERISA—a law enacted in 1974 to protect employees by regulating employers’ pension and benefit plans—in an unprecedented way that is contrary to ERISA and the ACA, and that violates the Administrative Procedure Act

²⁷ *Id.*

²⁸ Even the health insurance industry’s trade group, not a font of pro-consumer sentimentality, shared in response to the final rule its concerns “that broadly expanding the use of AHPs may lead to higher premiums for consumers who depend on the individual or small group market for their coverage. Ultimately, the rule could result in fewer insured Americans and may put consumers at greater risk of fraudulent actors entering this market.” See Kristine Grow, *AHIP Comments on Final Rule Expanding the Use of Association Health Plans*, AHIP (June 19, 2018), <https://www.ahip.org/ahip-comments-on-final-rule-expanding-the-use-of-association-health-plans/>.

²⁹ See Andrews, *supra* note 4; see also Corlette, *supra* note 5 (“AHPs are expected to be attractive to younger and healthier individuals because under the proposed rule they are not required to offer the same comprehensive set of benefits required of ACA-compliant plans, and they are allowed to use enhanced rating factors based on age, gender, industry and other non-health-related factors.”).

³⁰ Complaint at 2, New York et al. vs. U.S. Dep’t of Labor, No. 18-1747 (D. D.C. July 26, 2018).

³¹ *Id.* at 5.

(APA). Through this unlawful redefinition, the Final Rule expands the class of “large employers” under the ACA to include a broad range of “associations.” These associations may be formed for the primary purpose of selling insurance—which, until now, has been unlawful.³²

The states also asserted, among other arguments, that “the Final Rule conflicts with the clear statutory structure that Congress adopted in the ACA to apply fundamental protections to the individual and small group markets.”³³ In that respect, they contend, “the Final Rule exceeds DOL’s authority, because DOL’s action is not designed to implement ERISA but instead to circumvent the ACA.”³⁴ We might assume, in the face of this opposition from Democratic attorneys general, that conservatives are lining up to support AHPs. Yet, as is so true with much of health care, matters are more “complicated.”

In a speech before the conservative National Federation of Independent Business, which had long pushed for association health plans, President Trump characterized setting one up as easy as “while you’re in the room together, shake hands, form an association.”³⁵ He went on to say, according to the White House transcript of his speech:

With this action, businesses in the same state or businesses in the same industry—not just the same state — anywhere in the country—remember I used to say during the debates, “Cross state lines so you can negotiate.” You now can cross state lines so you can negotiate. (Applause.) So if 20 or 30 of the

³² *Id.* at 6.

³³ *Id.*

³⁴ *Id.* at 8.

³⁵ President Donald J. Trump, Remarks by President Trump at the National Federation of Independent Businesses 75th Anniversary Celebration (June 19, 2018), WHITE HOUSE, <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-federation-independent-businesses-75th-anniversary-celebration/>

President Trump boasted “[w]e’ve created associations, millions of people are joining associations. Millions. That were formerly in Obamacare or didn’t have insurance. Or didn’t have health care. Millions of people.” Glenn Kessler, *In a 30-minute interview, President Trump made 24 false or misleading claims*, WASH. POST (Dec. 29, 2017), https://www.washingtonpost.com/news/fact-checker/wp/2017/12/29/in-a-30-minute-interview-president-trump-made-24-false-or-misleading-claims/?noredirect=on&utm_term=.af973ddca5eb. However, the rule had not yet been adopted, and such enrollment was impossible. The president engaged in a similar falsehood about AHPs in August 2018: The president on Thursday again touted his administration’s push to create plans that circumvent the Affordable Care Act. Dan Diamond, *States sue Trump administration over association health plans*, POLITICO (July 27, 2018), <https://www.politico.com/newsletters/politico-pulse/2018/07/27/states-sue-trump-administration-over-association-health-plans-298876>. “I hear it’s like record business that they’re doing,” Trump said. “We just opened about two months ago, and I’m hearing that the numbers are incredible.” Fact check: The plans aren’t available to be sold until September. *Id.*

businesses in this room get together — you get together as a group, an association—you pick the meanest, most vicious manager owner to—(laughter)—right? Right? (Laughter.) To negotiate your healthcare—and I know a few of the people in here that are going to do very well. (Laughter.) They are—they're wild. You will end up with better insurance for far less money. You will end up so great.³⁶

Yet the problem is that, upon the rule being finalized, even “the NFIB, which vigorously promoted association health plans for two decades, now says it won’t set one up, describing the new Trump rules as unworkable.”³⁷ As John Arensmeyer, the head of the liberal Small Business Majority wrote, “Business groups that have long advocated for association health plans (AHPs) just learned a valuable lesson: Beware of politicians bearing gifts.”³⁸

State insurance regulators are also protective of their prerogatives. One article noted that “[e]ven in some red states, state regulators have voiced skepticism and taken steps to limit association health plans, pointing to their history of lax regulation and fraud before Obamacare set more stringent insurance standards.”³⁹ The health insurance industry’s trade organization joined consumer groups in a letter expressing concern:

We are concerned that this could create or expand alternative, parallel markets for health coverage, which would lead to higher premiums for consumers, particularly those with pre-existing conditions. Further, these actions destabilize the health insurance markets that guarantee access to comprehensive health coverage regardless of health status.⁴⁰

II. SHORTCOMINGS OF THE ACA RELATIVE TO SMALL BUSINESSES

³⁶ *Id.*

³⁷ Adam Cancryn, *Trump promised them better, cheaper health care. It’s not happening.*, POLITICO (July 19, 2018), <https://www.politico.com/story/2018/07/19/trump-health-care-better-cheaper-693362>.

³⁸ John Arensmeyer, *Buyer beware of association health plans*, THE HILL (July 25, 2018), <https://thehill.com/opinion/healthcare/398831-buyer-beware-of-association-health-plans>.

³⁹ Cancryn, *supra* note 37. Congress has made it clear that insurance regulation is generally the province of the states: “Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.” 15 U.S.C.A. § 1011 (2018).

⁴⁰ Sarah Lueck, *Trump Proposal Expanding Short-Term Health Plans Would Harm Consumers*, CTR. FOR BUDGET & POL’Y PRIORITIES (Feb. 20, 2018), <https://www.cbpp.org/blog/trump-proposal-expanding-short-term-health-plans-would-harm-consumers>.

In his September 2009 speech to Congress on health care reform, President Barack Obama touted the idea of what health insurance exchanges could do for individuals and small businesses alike: “As one big group, these customers will have greater leverage to bargain with the insurance companies for better prices and quality coverage.”⁴¹ That is simply not how it worked. As this article’s author wrote in *The Hill*:

[T]he concept of Small Business Health Option Program (SHOP) exchanges showed little understanding of insurance economics. Carriers, already making considerable money, were under no obligation to participate in SHOP exchanges even if they might gain additional small business customers interested in obtaining—through a cumbersome process, and for just two years—federal tax credits available to them only through those exchanges.⁴²

Instead, “[r]ather than assuming risk by playing in a small business exchange, an insurer could get small businesses’ employees anyway through the individual market—with employees financing their own health care and getting their own tax deductions.”⁴³

Nationally, the Obama Administration further undermined the potential for SHOP success by announcing that online enrollment for small businesses through HealthCare.gov would not be available when individual enrollment started.⁴⁴ As a *Roll Call* article noted, “[s]ometimes to save the patient, you have to chop off a limb.”⁴⁵

Much of the selling of the ACA involved a small business emphasis, as articulated in floor debate by Sen. Mary Landrieu (D., La.), the chair of the Senate Committee on Small Business and Entrepreneurship: “In Louisiana, more than 50,000 small businesses could be helped by this small business tax credit proposal!”⁴⁶ Fatefully, she boasted that the bill “requires the Government Accountability Office to

⁴¹ Obama’s Health Care Speech to Congress, N.Y. TIMES (Sept. 9, 2009), <https://www.nytimes.com/2009/09/10/us/politics/10obama.text.html>.

⁴² Brendan Williams, *Trump’s small business ‘cure’ is worse than the illness*, THE HILL (Oct. 13, 2017), <https://thehill.com/opinion/healthcare/355215-trumps-small-business-cure-is-worse-than-the-illness>.

⁴³ *Id.*

⁴⁴ Sarah Kliff, *Obamacare’s online SHOP enrollment delayed by one year*, WASH. POST (Nov. 27, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/11/27/obamacares-online-exchange-for-small-businesses-is-delayed-by-one-year/>.

⁴⁵ Steven T. Dennis, *Triage for HealthCare.gov: Administration Punts on Small Business Exchange*, ROLL CALL (Nov. 27, 2013), http://www.rollcall.com/news/triage_for_healthcaregov_administration_punts_on_small_business_exchange-229355-1.html?pos=hftxt.

⁴⁶ 155 CONG REC. S13734 (Dec. 9, 2009) (statement of Sen. Landrieu).

specifically review the impact of exchanges on access to affordable health care for small businesses to ensure that exchanges are indeed making a difference for small business owners.”⁴⁷

That did not work out so well, as it turned out. With the federal government refusing to reveal its own SHOP enrollment, a General Accounting Office report issued in November 2014 found that only 76,000 Americans were enrolled through state-based SHOP exchanges—compared to the projection that 2 million would be enrolled in 2014.⁴⁸ Further, almost half of that enrollment was located solely in Vermont (33,696).⁴⁹

More recent data was not much more encouraging. According to U.S. Centers for Medicare & Medicaid Services, where the federal government was facilitating SHOP enrollment, “as of January 2017, approximately 7,600 employers had active SHOP coverage, covering nearly 39,000 individuals.”⁵⁰ Adding state-run SHOP marketplaces, “approximately 27,000 employers have active coverage through SHOP Marketplaces, covering nearly 230,000 individuals.”⁵¹ This SHOP enrollment was less than one-sixteenth of what projections had forecast it to be just three years prior. In 2014, the Congressional Budget Office had estimated 4 million lives would be covered through SHOP exchanges by 2017.⁵²

During the ACA’s floor debate, Senator Ben Cardin (D., Md.) stated: “Small businesses in Maryland want to have the opportunity to cover their employees, and they know competition will work, and this bill provides for a lot more competition.”⁵³ Yet, according to the 2017 annual report of the Maryland Health Benefit Exchange, “[a]n average of 113 small businesses used the Small Business Health Options (SHOP) Marketplace in Maryland to cover more than 700 individuals as of Sept. 30, 2017.”⁵⁴

⁴⁷ *Id.* at 13735.

⁴⁸ *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors*, U.S. GEN. ACCT. OFF. (Nov. 2014), <https://www.gao.gov/assets/670/666873.pdf>.

⁴⁹ *Id.* And this was because “Vermont required that all small group plans in the state be offered only through the SHOP.” *Id.*

⁵⁰ *The Future of the SHOP: CMS Intends to Allow Small Businesses in SHOPS Using HealthCare.gov More Flexibility when Enrolling in Healthcare Coverage*, CMS (May 15, 2017), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/The-Future-of-the-SHOP-CMS-Intends-to-Allow-Small-Businesses-in-SHOPS-Using-HealthCaregov-More-Flexibility-when-Enrolling-in-Healthcare-Coverage.pdf>.

⁵¹ *Id.*

⁵² *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, CBO (Apr. 2014), http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

⁵³ 155 CONG. REC. S13798 (daily ed. Dec. 23, 2009) (statement of Sen. Cardin).

⁵⁴ *Annual Report 2017*, MD. HEALTH BENEFIT EXCHANGE (2017), <http://www.marylandhbe.com/wp-content/uploads/2012/10/2017-Annual-Report.pdf>.

In the ACA's Senate floor debate, Sen. Kip Bond (R., Mo.) was not incorrect in complaining of the bill's tax credit that was meant to help small businesses purchase health insurance. "The hitch is that small businesses will only receive the full tax benefits if they have less than 10 employees. If they hire that 11th employee, the tax credit is reduced. At 25 employees the tax credit is no longer available."⁵⁵

The state of Washington's SHOP exchange fatefully started out as a "pilot" offered through one insurer doing business in two counties out of thirty-nine.⁵⁶ For 2015, the Washington SHOP was to finally operate statewide, but with only a single option in thirty-seven out of thirty-nine counties.⁵⁷ By June 2015 the *Seattle Times* reported that 100 small businesses, covering only 535 lives, were using the SHOP exchange.⁵⁸

Today, with Washington's SHOP exchange defunct,⁵⁹ more individuals in the state obtain insurance through AHPs than do *all individuals* through the state's Health Benefit Exchange, the only means through which individual insurance premium subsidies could be obtained.⁶⁰ In 2015, the insurance commissioner's effort to deny the continuity of that AHP coverage was blocked by one of his own administrative law judges.⁶¹

As of a September 2018 press release, enrollment in California's SHOP exchange was only up to "more than 47,000 members."⁶² We can compare an enrollment of 47,000 covered lives to a Small Business Administration calculation of *656,542 California small businesses* of

⁵⁵ 155 CONG. REC. S13811 (daily ed. Dec. 23, 2009) (statement of Sen. Bond).

⁵⁶ Lisa Stiffler, *Small employers now eligible for health-insurance tax break*, SEATTLE TIMES (Dec 18, 2013), http://seattletimes.com/html/business/technology/2022479459_acasmallbizfoloxml.html.

⁵⁷ Lisa Stiffler & Aaron Spencer, *Small businesses can enroll in Obamacare statewide*, SEATTLE TIMES (Oct. 29, 2014), <https://www.seattletimes.com/seattle-news/health/small-businesses-can-enroll-in-obamacare-statewide/>.

⁵⁸ Lisa Stiffler, *More small employers using state's health-insurance exchange*, SEATTLE TIMES (June 4, 2015), <https://www.seattletimes.com/business/more-small-employers-using-states-health-insurance-exchange/>.

⁵⁹ See *Businesses*, WASH. HEALTH BENEFIT EXCHANGE, <https://www.wahbexchange.org/new-customers/who-can-sign-up/businesses/> ("Beginning in 2018, small business health coverage will no longer be available through Washington Healthplanfinder due to no health insurance company offering.") (last accessed Apr. 8, 2019).

⁶⁰ Ryan Blethen, *Assault on Obamacare creates 'unique challenges' in Washington state as enrollment starts*, SEATTLE TIMES (Oct. 31, 2017), <https://www.seattletimes.com/seattle-news/health/attempts-to-change-kill-obamacare-create-confusion-ahead-of-nov-1-enrollment/>.

⁶¹ Lisa Stiffler, *Small businesses hail ruling that protects association health plans*, SEATTLE TIMES (July 12, 2015), <http://www.seattletimes.com/seattle-news/small-businesses-hail-ruling-that-protects-association-health-plans/>.

⁶² Press Release, Covered California, Covered California for Small Business Announces Rates and Plans for 2019 With an Average Premium Increase of 4.6 Percent (Sept. 13, 2018).

fewer than twenty employees—all eligible for the ACA’s small business tax credit.⁶³

And unlike, say, Walmart or other large-group insurance purchasers or self-insureds, under the ACA the health insurance small businesses made available to their employees had to rise to the Bronze actuarial level, or “a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.”⁶⁴ And, as was true with individual market plans (but not for large groups), small-group offerings also had to include the ten essential health benefits mandated by the ACA.⁶⁵ As one article reported, such plans “have to cover the same set of minimum benefits that individual health plans will have to provide, including pediatric care and mental health and substance abuse services.”⁶⁶

III. THE UNCERTAIN FUTURE FOR SMALL BUSINESS HEALTH INSURANCE

The first step in public policy should be to “do no harm,” and it is not clear that this mandate is met by enabling AHPs, given past experience. According to a 2004 General Accounting Office report:

DOL and the states identified 144 unique entities not authorized to sell health benefits coverage from 2000 through 2002. The number of entities newly identified increased each year, almost doubling from 31 in 2000 to 60 in 2002. Many of these entities targeted employers and policyholders in multiple states, and, of the seven states with 25 or more entities, five were located in the South.

DOL and the states reported that the 144 unique entities

- sold coverage to at least 15,000 employers, including many small employers;
- covered more than 200,000 policyholders; and

⁶³ *Small Business Profile: California*, U.S. SMALL BUS. ADMIN. (2018),

<https://www.sba.gov/sites/default/files/advocacy/2018-Small-Business-Profiles-CA.pdf>.

⁶⁴ 42 U.S.C. 18022 (2012). As there is no rational basis for this disparity, one can cynically conclude it was driven by campaign finance concerns. Not incorrectly, Sen. Lamar Alexander (R., Tenn.) argued that the exclusion, from AHPs, of the “essential health benefits” the ACA required “is the exact same exemption Democrats made in 2010 for large employer plans, which cover roughly 160 million people, or half of all Americans.” Lamar Alexander, *Health care is about to get way easier for small businesses and self-employed Americans*, WASH. POST (June 19, 2018), https://www.washingtonpost.com/opinions/health-care-is-about-to-get-way-easier-for-small-businesses-and-self-employed-americans/2018/06/19/685817ba-731f-11e8-9780-b1dd6a09b549_story.html?utm_term=.7ffe7fbf2d5c.

⁶⁵ 42 U.S.C. § 300gg–6 (2018).

⁶⁶ David Nather, *Next ACA crisis: Small biz costs?*, POLITICO (Dec. 17, 2013), <https://www.politico.com/story/2013/12/next-obamacare-crisis-small-business-costs-101212>.

- left at least \$252 million in unpaid medical claims, only about 21 percent of which had been recovered at the time of GAO’s 2003 survey.⁶⁷

A *New York Times* article quoted an attorney who investigated insurance fraud for the Department of Labor for more than two decades and fears the worst: “‘Fraudulent association health plans have left hundreds of thousands of people with unpaid claims,’ he said. ‘They operate in a regulatory never-never land between the Department of Labor and state insurance regulators.’”⁶⁸ AHP insolvency would be damaging enough for consumers, but the health of individual insurance markets would also be damaged by such arrangements cherry-picking healthy risk for plans that avoid the ACA’s high standards, especially as no individual mandate to purchase insurance exists.

Medical provider advocates have universally expressed serious concerns about the risk, both financially and as to what services might be omitted from coverage, inherent in such arrangements.⁶⁹

In Iowa’s 2018 legislative session, the Iowa Farm Bureau pushed legislation into law giving it preferential treatment under the state’s insurance laws and actually exempting “health benefit plans” it sells, in partnership with the state’s leading insurer, from the very *definition* of insurance.⁷⁰ According to one article: “The Iowa Farm Bureau is partnering with Blue Cross affiliate Wellmark on the new health benefit

⁶⁷ *Employees and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, U.S. GEN. ACCT. OFF. (Feb. 2004), <https://www.gao.gov/new.items/d04312.pdf>.

⁶⁸ Robert Pear, *Cheaper Health Plans Promoted by Trump Have a History of Fraud*, N.Y. TIMES (Oct. 21, 2017) (The article shares many examples of AHP failures, including one where “a federal appeals court found that a health plan for small businesses in New Jersey was ‘aggressively marketed but inadequately funded.’ The plan collapsed with more than \$7 million in unpaid claims.”).

⁶⁹ See Virgil Dickson, *Association health plan rule poses financial threat for providers*, MOD. HEALTHCARE (Mar. 7, 2018), <http://www.modernhealthcare.com/article/20180307/NEWS/180309924>. According to the *Los Angeles Times*, “[m]ore than 95% of healthcare groups that have commented on President Trump’s effort to weaken Obama-era health insurance rules criticized or outright opposed the proposals, according to a Times review of thousands of official comment letters filed with federal agencies.” Noam N. Levey, *Trump’s new insurance rules are panned by nearly every healthcare group that submitted formal comments*, L.A. TIMES (May 30, 2018), <http://www.latimes.com/politics/la-na-pol-trump-insurance-opposition-20180530-story.html>.

⁷⁰ Amy Goldstein, *Iowa tries another end run around the Affordable Care Act*, WASH. POST (Apr. 2, 2018), https://www.washingtonpost.com/national/health-science/iowa-tries-another-end-run-around-the-affordable-care-act/2018/04/01/cd25baec-3429-11e8-94fa-32d48460b955_story.html?utm_term=.16eddd09ebd8.

plans.”⁷¹ It was reported that “[a]bout half of the Iowa Farm Bureau’s 150,000 member families may sign up for the plans, and as many as 60,000 other Iowans may join the group to sign up, too.”⁷²

Because the AHPs are not “insurance” under Iowa law, they will unabashedly discriminate based upon preexisting conditions: The paperwork that potential customers fill out will ask them whether they have been diagnosed or treated within the last five years for 16 pre-existing conditions, including autoimmune diseases, mental health difficulties, drug or alcohol addiction, heart disease, and diabetes. Applicants will also need to share their medical records and the types of prescriptions they have taken.⁷³

Idaho, in partnership with Blue Cross, had tried to similarly exempt health plans from ACA requirements and allow discrimination based upon preexisting conditions.⁷⁴

Perhaps it should have simply declared, as Iowa effectively did, that *insurance is not insurance* – even the Trump Administration found Idaho had gone too far.⁷⁵ In Michigan, an early entrant into the AHP space,

⁷¹ Steve Jordon, *Iowa Farm Bureau will sell health plans outside 'Obamacare' exchange*, OMAHA WORLD-HERALD (Apr. 3, 2018), https://www.omaha.com/livewellnebraska/consumer/iowa-farm-bureau-will-sell-health-plans-outside-obamacare-exchange/article_0ca98a68-9b97-54e6-a39d-81c282570442.html.

⁷² *Id.* The Nebraska Farm Bureau has also established an AHP. See Press Release, Nebraska Farm Bureau, Nebraska Farm Bureau Works to Lower Health Costs for Farmers and Ranchers; Unveils New Large Group Association Health Plan (Sept. 19, 2018).

⁷³ KIMBERLY LEONARD, *IOWA TO OFFER PLANS WITHOUT OBAMACARE'S PROTECTIONS FOR SICK PEOPLE*, WASH. EXAMINER (OCT. 4, 2018), <https://www.washingtonexaminer.com/policy/healthcare/iowa-to-offer-plans-without-obamacares-protections-for-sick-people>.

This was true in Tennessee *before* the DOL rule was proposed: “State insurance regulations have actually created a loophole where a major association health plan called Farm Bureau is *not* subject to Obamacare regulations. It *can* offer skimpy plans and it *can* charge sick people higher premiums.” Sarah Kliff, *Tennessee has insurance rules like the ones Trump proposed. It's not going well.*, VOX (Oct. 12, 2017), <https://www.vox.com/policy-and-politics/2017/10/9/16449558/lowdown-tennessee-insurance-markets>. This plan has been “open to any Tennessee resident; you don’t have to be a farmer to enroll.” *Id.* Perhaps, as a consequence, “[t]he Society of Actuaries **estimated** in 2016 that Tennessee’s marketplace has the sickest enrollees in the entire country. The state also has some of the highest Obamacare premiums in the entire country, too. In 2017, a mid-level plan cost, on average, **\$472** per month.” *Id.* Conversely, “Farm Bureau plan premiums can be as much as two-thirds lower than for ACA-compliant plans because the underwritten policies can and do deny coverage to people with pre-existing conditions.” Karen Pollitz & Gary Claxton, *Proposals for Insurance Options That Don’t Comply with ACA Rules: Trade-offs In Cost and Regulation*, Kaiser Fam. Found. (Apr. 18, 2018), <https://www.kff.org/health-reform/issue-brief/proposals-for-insurance-options-that-dont-comply-with-aca-rules-trade-offs-in-cost-and-regulation/>.

⁷⁴ Nate Poppino & Audrey Dutton, *Otter defends Idaho health insurance move, Little’s role as questions swirl in Congress*, IDAHO STATESMAN (Feb. 15, 2018), <https://www.idahostatesman.com/news/politics-government/state-politics/article200455194.html>.

⁷⁵ Rebecca Boone & Audrey Dutton, *Idaho argues it can save its controversial health plans after federal criticism*, IDAHO STATESMAN, (Mar. 9, 2018) <https://www.idahostatesman.com/news/politics-government/state-politics/article204224444.html> (“Idaho authorities disagreed with that interpretation Friday, saying they believe a letter from Centers for Medicare and Medicaid Services Administrator Seema Verma was encouragement to pursue some form of the plans.”).

following the DOL rule, was formed by two small business groups working with Blue Cross Blue Shield of Michigan and Blue Care Network.⁷⁶ According to an article, “[t]he partners have created a 501c6 nonprofit organization, at TranscendMichigan.org, that will allow other associations and chambers of commerce to join.”⁷⁷

Vermont is among the states that reacted quickly to the DOL rule by adopting AHP protections: “The Commissioner shall adopt rules . . . regulating association health plans in order to protect Vermont consumers and promote the stability of Vermont’s health insurance markets, to the extent permitted under federal law, including rules regarding licensure, solvency and reserve requirements, and rating requirements.”⁷⁸ Among other things, Vermont’s rule requires that “[a]n insurer offering a health benefit plan to an association or MEWA shall obtain rate approval from the Green Mountain Care Board.”⁷⁹ It requires such plans provide all the ACA’s essential health benefits.⁸⁰ The rule also prohibits AHPs from using any of the following risk factors in rating premiums:

1. demographic rating, including age and gender rating;
2. geographic area rating;
3. health status rating;
4. industry rating;
5. medical underwriting and screening;
6. experience rating;
7. tier rating (except for tiers related to family structure); or
8. durational rating.⁸¹

⁷⁶ Jay Greene, *Small business groups in Michigan form association health plan under federal rules*, CRAIN’S DETROIT BUS. (Oct. 1, 2018), <https://www.crainsdetroit.com/health-care/small-business-groups-michigan-form-association-health-plan-under-federal-rules>.

⁷⁷ *Id.*

⁷⁸ VT. STAT. ANN. tit. 8, § 4079a(b) (West 2018).

⁷⁹ *Emergency Rule I-2018-01-E*, VT. DEP’T OF FIN. REG., <http://www.dfr.vermont.gov/reg-bul-ord/fully-insured-multiple-employer-welfare-arrangements-and-association-health-plans> (last modified Aug. 1, 2018).

⁸⁰ *Id.*

⁸¹ *Id.* In contrast, in neighboring New Hampshire some are worried those with preexisting conditions will suffer:

Susan Stearns, deputy director of the state chapter of NAMI, the National Alliance on Mental Illness, worried that AHPs might skimp on mental health or other essential services, leaving behind a sicker population in both the individual and small group markets, “inadvertently creating a high-risk pool.” At the very least, said Stearns, the state should insist on clear transparency of what consumers would do without it.

In California, the *Los Angeles Times* had reported:

Just a few decades ago, small businesses in California often banded together to buy health insurance on the premise that a bigger pool of enrollees would get them a better deal. California's dairy farmers did it; so did car dealers and accountants. But after a string of these "association health plans" went belly up, sometimes in the wake of fraud, state lawmakers passed sweeping changes in the 1990s that consigned them to near extinction.⁸²

The past "association plan failures hit a number of small businesses, affecting employees across industries. Thousands of farmworkers suffered when a plan created by Sherman Oaks-based Sunkist Growers collapsed. When Irvine-based Rubell-Helm Insurance Services went out of business, it reportedly left \$10 million in medical claims unpaid."⁸³

Following the adoption of the DOL rule, California quickly amended its health insurance statute to clarify that the term "eligible employee" does not include either sole proprietors or their spouses.⁸⁴ Thus, effective January 1, 2019, "one employee, sole proprietors and their spouses, and partners of a partnership and their spouses, are not employees."⁸⁵

In New York, the insurance regulator issued a reminder to "that the recent U.S. Department of Labor final rule, also known as the Association Health Plan (AHP) Rule, expressly does not preempt New York Insurance law, which strictly limits the associations or groups of employers that may sponsor a health insurance plan."⁸⁶ Among other things:

New York Insurance Law requires that an association be in active existence for at least two years and be formed principally for purposes other than obtaining insurance coverage for its

Bob Sanders, *Health savings by association? Why association health plans 'could be a game-changer'*, N.H. BUS. REV. (Sept. 27, 2018), <https://www.nhbr.com/September-28-2018/Health-savings-by-association/>.

⁸² Pauline Bartolone, *Possible return of a troubled healthcare model has California officials worried*, L.A. TIMES (Nov. 22, 2017), <https://www.latimes.com/business/la-fi-trump-health-plan-associations-20171122-story.html>

⁸³ *Id.*

⁸⁴ CAL. HEALTH & SAFETY CODE § 1357.500(c)(1)(2018).

⁸⁵ *Id.* at (j)(2).

⁸⁶ Richard Loconte, Press Release: N.Y. Dep't of Fin. Services, *DFS Superintendent Vullo Reminds Insurers that Federal Association Health Plan Rule Does Not Preempt State Law*, July 27, 2018.

members. An association formed for the purpose of obtaining health insurance coverage is not a recognized group in New York and therefore is not permitted to purchase health insurance coverage in New York.⁸⁷

The reminder noted that “New York’s rules regarding essential health benefits and approval of rates apply to such members without any impact by the new federal rule.”⁸⁸

Oregon’s insurance regulator issued a bulletin clarifying the state’s position on AHPs.⁸⁹ It warned that the state “will continue to enforce all Oregon laws applicable to health benefit plans issued by or to a group or association of employers as they existed prior to the issuance of the AHP rule without modification.”⁹⁰ It went on to note:

The Oregon Insurance Code generally requires that health benefit plan coverage issued to an individual or a small employer through an association must comply with the requirements that would otherwise apply in the individual or small employer market. These requirements include state rating and benefit requirements such as single risk pool, community rating, and provision of essential health benefits.⁹¹

Other states should enact similar protections to avoid a repeat of the “Wild West” MEWA collapses of the past because it is clear that AHPs are going to continue to be pushed.

⁸⁷ *Id.*

⁸⁸ *Id.* The regulator has called AHPs “junk insurance.” Nick Niedzwiedek & Amanda Eisenberg, *Vullo comments on 2019 rates, Trump administration*, POLITICO, July 12, 2018.

⁸⁹ Or. Division of Fin. Reg. Bull. No. DFR 2018-07 (Sept. 10, 2018).

⁹⁰ *Id.* at 2.

⁹¹ *Id.* at 3. A “single risk pool” is important lest an insurer try to segregate risk. As one analysis notes:

AHPs have in the past flourished by segmenting state health insurance markets — a trend the proposed regulation could further promote by creating an uneven playing field between AHPs and the individual and small-group markets. For example, under the proposed regulation, AHPs could design cheaper, skimpier plans, siphoning off healthy patients and leading to adverse selection and ultimately higher premiums for individuals and employers buying plans in the traditional insured markets.

Kevin Lucia & Sabrina Corlette, *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*, THE COMMONWEALTH FUND (Jan. 24, 2018), https://www.commonwealthfund.org/blog/2018/association-health-plans-maintaining-state-authority-critical-avoid-fraud-insolvency-and?redirect_source=/publications/blog/2018/jan/association-health-plans-state-authority.

The U.S. House version of a farm bill considered by Congress in 2018 had \$65 million allocated for loans and grants for the Department of Agriculture to assist in setting up such association health plans.⁹² One healthcare expert expressed doubt: “I don't know that anyone at the Department of Agriculture, with all due respect, knows a darn thing about starting and maintaining a successful insurance company,” said Sabrina Corlette, a professor and project director at the Georgetown University Health Policy Institute.⁹³

In March 2019 a federal judge in the District of Columbia ruled in favor of the states seeking to invalidate the DOL rule.⁹⁴ Judge John Bates stated that the “[t]he Final Rule is clearly an end-run around the ACA. Indeed, as the President directed, and the Secretary of Labor confirmed, the Final Rule was designed to expand access to AHPs in order to avoid the most stringent requirements of the ACA.”⁹⁵ He concluded that “[t]he Final Rule’s bona fide association standard fails to establish meaningful limits on the types of associations that may qualify to sponsor an ERISA plan, thereby violating Congress’s intent that only an employer association acting ‘in the interest of’ its members falls within ERISA’s scope.”⁹⁶

Even assuming that the DOL rule survives legal challenge, it is not enough for states to establish consumer protections to mitigate the potential harms of AHPs. The failure of the ACA to address health

⁹² Julie Appleby, *Farm Bill Could Undo Part Of The Affordable Care Act*, NPR (May 8, 2018), <https://www.npr.org/sections/health-shots/2018/05/08/608566531/farm-bill-could-undo-part-of-the-affordable-care-act>.

⁹³ *Id.* As one article noted:

At least in structure, these agriculture plans seem eerily similar to two dozen cooperative plans created under the ACA that almost all collapsed over the past few years under heavy financial losses. The dramatic and undeniable failure of the co-op plans — which had been added to the ACA to spur competition in the marketplaces — were, for a while at least, a top GOP critique of the health-care law.

Paige Winfield Cunningham, *The Health 202: Guess what's in the farm bill? Funding for health plans pushed by Trump*, WASH. POST (May 7, 2018), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/05/07/the-health-202-guess-what-s-in-the-farm-bill-funding-for-health-plans-pushed-by-trump/5aeb0e5530fb042db57972be/?utm_term=.30c6969f303b.

⁹⁴ *N.Y. v. U.S. Dep’t of Lab.*, 2019 WL 1410370 (D.D.C. Mar. 28, 2019).

⁹⁵ *Id.* at *2.

⁹⁶ *Id.* at *10. In these politically-polarized times, it’s perhaps worth noting that Judge Bates was a Republican appointee. Timothy Bella, ‘Clearly an end-run’: Federal judge rejects Trump’s health-care plan to go around Obamacare, WASH. POST (MAR. 29, 2019), https://www.washingtonpost.com/nation/2019/03/29/clearly-an-end-run-federal-judge-strikes-down-trump-administrations-health-plan-go-around-obamacare/?utm_term=.840b3d480903 (Bates was “an appointee of President George W. Bush[.]”).

insurance affordability in the small-group market must be acknowledged,⁹⁷ and new approaches tried out. As one columnist wrote:

Let's be clear: With the ACA, small businesses and the self-employed have high costs and limited choices of doctors. Without the ACA, we'll have higher costs, worse coverage, or no coverage at all.

Here's the dirty little secret of health insurance: Insurance companies don't like covering small businesses, and they hate insuring the self-employed. Why? Individuals and small groups are just too big a risk. Insurance is designed to spread risk among large groups, especially those with plenty of young, healthy people paying premiums for services they don't use.⁹⁸

Partisan bickering will not address these truths.

⁹⁷ Data in a 2016 report showed that small businesses of the size eligible for ACA subsidies actually *decreased* coverage following its enactment:

Offer rates among smaller employers have been falling since 2009: (a) for employers with fewer than 10 employees, from 35.6 percent in 2008 to 22.7 percent in 2015 (a 36 percent decrease), (b) for employers with 10–24 employees, from 66.1 percent in 2008 to 48.9 percent in 2015 (a 26 percent decline)[.]

Paul Fronstin, *Fewer Small Employers Offering Health Coverage; Large Employers Holding Steady*, EMP. BENEFIT RES. INST. (July 2016), https://www.ebri.org/pdf/notespdf/EBRI_Notes_07-No8-July16.Small-ERs.pdf. No certain conclusions could be drawn about “what factors have driven smaller employers away from providing health coverage and whether the current trends are likely to continue.” *Id.*

⁹⁸ Rhonda Abrams, *Big problems for small business on health care*, USA TODAY (July 19, 2017), <https://www.usatoday.com/story/money/columnist/abrams/2017/07/19/big-problems-small-business-health-care/457952001/>.