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# Association Health Plans: Projecting the Impact of the Proposed Rule

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## Executive Summary

Association Health Plans (AHPs) are health insurance arrangements sponsored by an industry, trade, or professional association that provide health coverage to their members—typically small businesses and their employees. Health insurance coverage offered through AHPs aims to make coverage available and affordable for small groups and individual employees. Importantly, these arrangements are currently governed by state and federal requirements and are subject to state oversight, including standards related to premiums and benefit requirements.

A recent Department of Labor's (DOL) proposed regulation would seek to broaden access to AHPs by expanding eligibility and potentially allowing a larger number of these arrangements to be exempt from certain Affordable Care Act insurance protections—including coverage for essential health benefits and community rating requirements.

The proposed AHP changes are expected to have an impact on enrollment and premiums for existing individual and small group market plans. Individuals and small businesses shifting out of their respective markets into AHPs are expected to be healthier than average, fueling adverse selection. This adverse selection could increase individual and small group market premiums and could lead to decreased competition in those markets due to changes in issuer participation.

The report that follows estimates the premium and coverage impact of the DOL proposed rule over a 5-year period (2018-2022). If the rule is finalized as proposed, we estimate the following impacts on the individual and small-group markets:

- **Higher premiums in both the individual and small-group markets.** If the proposed AHP rule is finalized, Avalere projects premiums would rise in the current individual (2.7% to 4.0%) and small group (0.1% to 1.9%) markets relative to current law, largely due to healthier enrollees shifting into AHPs. This trend will lead to the individual and small group market risk scores rising.
- **Increase in the number of uninsured Americans.** The proposed rule is projected to lead to 130,000 - 140,000 additional individuals becoming uninsured by 2022, compared to current law. The increased number of uninsured is largely caused by premium increases in the individual market as healthier enrollees shift into AHPs.
- **An additional 2.4M to 4.3M people enrolled in AHPs.** This figure represents people switching out of the individual market (0.7M to 1.2M) and small group market (1.7M to 3.2M) into the expanded AHPs.
- **Lower premiums for enrollees that enroll in AHPs.** Premiums in the new AHPs are projected to be between \$1,900 to \$4,100 lower than the yearly premiums in the small group market and \$8,700 to \$10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered. While AHPs will likely offer lower premiums for many enrollees, the largest premium differences assume

AHPs offer less-generous benefits than current markets, which could expose some enrollees to high out-of-pocket costs, particularly those that have significant healthcare needs.

The AHP proposed rule continues a trend under the current administration toward increased regulatory flexibility. While this flexibility may lead to lower premiums for some (particularly younger, healthier individuals and small groups), it is likely to further adverse selection out of the individual and small group markets that could lead to increased premiums in those markets and create additional market instability.

## Overview of Association Health Plans and the Proposed Rule

### AHPs Today

AHPs provide an additional option for individuals and small businesses seeking to obtain affordable healthcare coverage.<sup>1</sup> Managing a group health plan can be administratively complex and costly for certain small businesses—especially those lacking formal or expansive human resource departments. By allowing small businesses to band together under association health plan group coverage, these arrangements aim to achieve economies-of-scale advantages to be more effective in coverage negotiations and bargaining with private payers.

Today, most AHPs limit their enrollment to specific employer groups—individual enrollees who are sole proprietors and small employers who are engaged in a specific trade or business. These limitations make many individuals and employers ineligible to participate in certain AHPs that may operate in their area and help the AHP control its enrollment and the associated risk of enrollees.

### Regulation of AHPs

Compared to the large group market, there are more extensive benefit and coverage requirements in the individual and small group market. These include requirements to offer benefits in each of the 10 essential health benefit (EHB) categories, community rating standards, network adequacy requirements, and state review of issuer rate and form filings.<sup>1</sup> Many of these requirements, including the EHBs, do not apply to or are not as strict for large group plans.

AHPs may obtain the same benefit flexibility and coverage choices as the large group market if they are able to self-insure (where the AHP itself takes on the insurance risk of the individuals

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<sup>1</sup> According to the Employee Retirement Income Security Act (ERISA) of 1974, ERISA defines an employer-based AHP (also known as a Multiple Employer Welfare Arrangement (MEWA)) as any arrangement through which two or more employers and/or self-employed individuals obtain health insurance coverage." This analysis focuses on those AHPs which can be classified as MEWAs.

enrolling in the AHP) or if they can be classified as a single-employer large group plan.<sup>ii</sup> However, the small size of the risk pool in most AHPs, creating non-diversified risk, can make it financially challenging or impossible for many AHPs to self-insure. In addition, current ERISA rules make it challenging for AHPs to achieve the single employer classification.

Specifically, guidance notes that it should be “rare” that an AHP is deemed the “employer,” and is treated as sponsoring a single group health plan.<sup>vi</sup> In order to be classified as a single large group, the AHP must be constructed so that:

- All employer members are in the same profession or industry, or are members of the same employee organization;
- Access to the AHP is not the only purpose for becoming a member of the association;
- The AHP is owned and managed (directly or through elected representatives) by its member employers; and
- There must be at least 51 employees of the employers participating in the plan.

As a result of these requirements, very few AHPs are classified as single-employer large group plans and therefore do not have access to the regulatory flexibility described above.

## January 2018 AHP Proposed Rule

On January 4, DOL issued a proposed rule that seeks to expand access to and increase regulatory flexibility for AHPs.<sup>iii</sup> The proposed rule follows an executive order (EO) by President Trump on October 12, 2017, and is designed to streamline the ability of small employers, including sole proprietors, to enroll and seek coverage for their employees through AHPs.<sup>iv</sup> Indeed, the DOL’s proposed rule would broaden access to AHPs and make it easier for an AHP to be classified as a single-employer plan under ERISA. As explained above, such a classification would allow the AHP to have greater benefit and coverage flexibility, leading to potentially less generous, but also less-expensive, coverage offerings through the AHP. While the DOL did include AHP anti-discrimination provisions that are designed to prevent misuse of AHPs, there are still potential concerns that the flexibility provided to AHPs to regulate their membership could be used to discriminate against higher cost enrollees and groups.

### i. Expanding Access to AHPs

The proposed rule seeks to expand access to AHPs by clarifying DOL rules around eligibility for sole proprietors (self-employed without non-family employees). AHP rules already allow self-employed individuals to participate in AHPs.<sup>v</sup> However, the DOL sought to align regulations throughout different parts of ERISA to ensure that a working owner without employees, regardless of the legal form in which the business is operated, may choose to participate in a AHP.

### ii. Reducing Barriers to Single Employer Classification

The DOL also sought to make it easier for more AHPs, including those with participants from a diverse range of businesses or industries, to potentially be classified as a single employer group

plan. As previously noted, today, it is difficult for a AHP to be classified as a single employer group.

a. Same Industry or Business Requirement

One of the obstacles to the single-employer classification is the requirement that members of the same AHP be in the same trade or business. In the proposed rule, the DOL seeks to remove this limitation in situations where all members of the AHP are in the same state or metropolitan area. The proposed rule specifically notes that this flexibility will allow local chambers of commerce to sponsor a AHP and make it open to all members of the chamber. In addition, it could allow for the sale across state lines if the metropolitan area in which the AHP is offered occupies multiple states.

b. Sole Purpose of AHP Membership

The proposed rule also would ensure that employers can pursue AHP membership solely for access to health coverage without jeopardizing the ERISA status of the plan. The DOL proposes to do this by removing the ERISA AHP requirement that membership in the AHP must not be the sole relationship or purpose for members joining the association. In addition to expanding access, this could also make it easier for AHPs to form, as they would no longer have to offer additional benefits, such as advocacy or representation, to be able to access the coverage flexibility of a single large employer AHP.

c. Joint Control

The DOL did not recommend changes to the joint control requirement that exists for an AHP to be considered a single-employer group. Joint control requires the group or association to have a formal organizational structure with a governing body where member employers control the establishment and maintenance of the group health plan—either directly or through elected representatives. The purpose of these requirements is to ensure that the organization acts as a single unit and in the interests of its members. This requirement is cited as one of the most significant barriers to a AHP being classified as a single employer group. The fact that it was not altered could impact how many AHPs can take advantage of the additional benefit flexibility.

iii. Nondiscrimination

The proposed rule specifically applies many of the nondiscrimination provisions of the Affordable Care Act (ACA) and Health Insurance Portability and Accountability Act (HIPAA) to AHPs. Specifically, AHPs must not restrict membership or impose differential premiums based on health status, medical condition (including both physical and mental illnesses), claims experience, medical history, genetic information, evidence of insurability, or disability. However, AHPs may impose different non-health-related eligibility terms and premiums based on factors such as full-time versus part-time status, different geographic locations, membership in a collective bargaining unit, date of hire, length of service, current versus former employee status, occupation, and relationship to employee member (for dependent coverage).

## Potential Implications of AHP Proposed Rule

As proposed, the rule may allow some employers to access less expensive, less generous health insurance coverage or may allow them to pursue different insurance structures, such as self-insured and fully-insured AHPs. In addition, reducing the barriers to a AHP being classified as a single large group could allow some employers to access additional benefit flexibility, which could lead lower premiums and reduced benefits for some members. Importantly, this increased flexibility creates adverse selection incentives for many sole proprietors and small businesses, particularly those who are healthier than average, to shift into AHPs. As healthier sole proprietors and small businesses shift toward AHPs, premiums are projected to rise for the remaining enrollees in the individual and small group markets. Below are some of the potential implications of the AHP proposed rule if finalized as proposed.

**Table 1: Expected Policy Impacts of the AHP Proposed Rule**

	Positive	Negative
<b>Coverage</b>	Additional coverage options and benefit flexibilities Lower administrative costs	Increased number of uninsured Potential instability if new AHPs are unprepared to effectively manage risk for their enrollees
<b>Premiums</b>	Lower premiums for enrollees compared to current markets	Higher premiums for existing individual / small group market enrollees
<b>Benefit Flexibility</b>	More benefit flexibility, which can be used to tailor benefits to meet the needs of enrollees	Higher out-of-pocket costs for enrollees with significant healthcare needs Return of potentially discriminatory insurance practices

## Projected Impact of AHP Proposed Rule

### Key Modeling Takeaways

The proposed rule on AHPs would lead to a substantive shift, within the first four years, of enrollees in both the individual and small group markets into the new AHPs. Avalere modeled three scenarios, a “High”, “Moderate”, and “Low” scenario. The scenarios vary based on the initial availability of AHPs in 2019, the average generosity of coverage offered by AHPs, and the projected level of risk selection by small businesses (i.e., healthier on average small businesses choosing to move into AHPs for lower premiums, less generous coverage). The “High” scenario assumes the highest availability of AHPs starting in 2019 of all the scenarios, a low projected level of generosity of AHP coverage (and thereby low premiums), and significant risk selection by small businesses. Conversely, the “Low” scenario assumes limited availability of AHPs in

2019, generosity of AHP coverage more akin to small group coverage today, and limited risk selection by small businesses.

Avalere projects 2.4M to 4.3M enrollees to shift into AHPs by 2022. If the proposed AHP rule is finalized, premiums would rise in both the individual (2.7% to 4.0%) and small group markets (0.1% to 1.9%) relative to current law, as healthier enrollees and small businesses in both markets self-select into AHPs. Premiums in the new AHPs are projected to be \$1,900 to \$4,100 lower than the yearly premiums in the small group market and \$8,700 to \$10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered. Additionally, 130,000 - 140,000 individuals are expected to become uninsured by 2022 due to the proposed rule.

The further expansion of the AHP market is constrained by the number of eligible sole proprietors and small groups, as well as the availability of AHPs offered in the area. Despite these constraints, enrollment in AHPs is expected to continue to grow in future years. In total, the proposed rule is projected to shift 0.7M to 1.2M individuals out of the individual market and 1.7M to 3.2M out of the small group market by 2022.

**Table 2: Projected Impact of AHP Proposed Rule by Scenario, 2022**

	Low Scenario	Moderate Scenario	High Scenario
<b>Enrollment</b>			
<i><b>New AHP Enrollment</b></i>	2,360,000	3,180,000	4,310,000
<i><b>From Individual Market into AHPs</b></i>	(710,000)	(950,000)	(1,110,000)
<i><b>From Small Group Market</b></i>	(1,650,000)	(2,230,000)	(3,200,000)
<b>Premiums</b>			
<i><b>Change in Individual Market Premiums</b></i>	2.7%	3.5%	4.0%
<i><b>Average Individual Market Premiums<sup>2</sup></b></i>	\$14,900	\$15,000	\$15,000
<i><b>Change in Small Group Market Premiums</b></i>	0.1%	0.5%	1.9%
<i><b>Average Small Group Market Premiums</b></i>	\$8,100	\$8,200	\$8,300
<i><b>Average AHP Premiums</b></i>	\$6,200	\$5,300	\$4,200

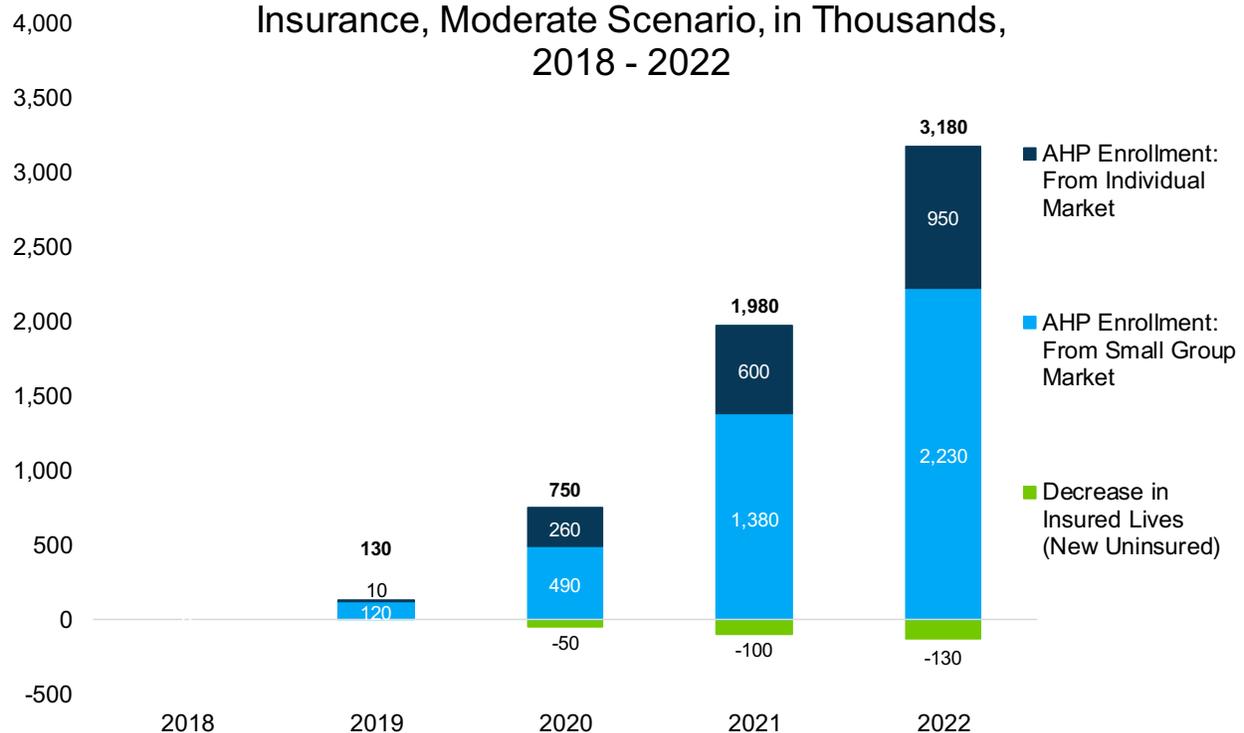
<sup>2</sup> Average individual market unsubsidized premiums.

## Model Findings

**New AHP Enrollment:** New AHP enrollment is projected to range from 2.4M to 4.3M under the high and low scenarios.

**Source of AHP Enrollment:** Enrollment in AHPs is projected to come from currently insured individuals and small businesses. Small groups would see the largest shifts into the new AHPs, comprising approximately 70% to 75% of the new AHP enrollment. The magnitude of this movement is largely due to the pool of eligible small groups substantially outweighing the eligible sole proprietors in the individual market.

**Figure 1: Projected Enrollment in AHPs and Change in Insurance, Moderate Scenario, in Thousands, 2018 - 2022**



**AHP Premiums:** Premiums in the new AHP market are expected to range \$1,900 to \$4,100 lower than the small group market average yearly premiums and \$8,700 to \$10,800 below the individual market average yearly premium by 2022. Sole proprietors in the individual market are projected to enroll at a much higher rate than small groups, particularly due to the larger differences between the premiums in the individual market and the new AHPs. The “High” scenario, which projects the largest premium differences between the new AHPs and individual and small group market premiums, assumes AHPs provide less generous coverage than currently offered in the individual and small group markets, while covering fewer benefits. This, coupled with aggressive risk selection out of the individual and small group markets into AHPs leads to substantial premium differences between the markets. The “Low” and “Moderate”

scenarios have less aggressive assumptions on the reductions in benefit generosity for AHPs and therefore have lower estimates of the premium differences between the markets.

**Risk Scores:** Risk scores are a measure of the “risk” of the insured population. The risk scores in the existing individual and small group markets will see an increase as a result of the proposed rule. Individual market average risk scores will increase 2.7% to 4.0%, while average small group risk scores are projected to increase 0.1% to 1.9%.

**Table 3: Average Risk Scores Under AHP Proposed Rule, Moderate Scenario, 2022**

Average Risk Scores	Individual Market	Small Group Market	New AHP Market
<i>Current Law</i>	1.277	1.159	-
<i>Under AHP Proposed Rule: Moderate Scenario</i>	1.321	1.165	0.905

**Uninsured:** The proposed AHP rule is projected to increase the number of uninsured in the US by 130,000 to 140,000 by 2022, largely because of the premium increases for those in the individual market who are ineligible to purchase coverage through an AHP. Over 80% of the newly uninsured come from the individual market.

## Other Results Considerations

Avalere projected the expected enrollment growth in AHPs over the next 5 years, through 2022, as the result of the proposed rule. Given the uncertainty around the number of AHPs created, the propensity of small employers and sole proprietors to shift into AHPs, and the availability of AHPs in all regions of the country, Avalere modeled 3 scenarios projecting eventual enrollment into the market.

These scenarios were informed by the universe of sole proprietors and small businesses deemed eligible and likely to enroll, expected adverse selection by small employers, and generosity of AHP benefits. According to survey data, approximately 8% of the current individual market is self-employed in industries most likely to participate in an AHP. For the small group market, approximately 42% of the current small group market is in an industry deemed most likely to participate in an AHP.

Projecting the impact of the AHP proposed rule requires projecting a variety of decisions, from enrollee uptake, to eligibility, to availability of AHPs, and the generosity of the benefits that they offer. Below are some key factors that Avalere considered when building the model:

**Initial Enrollment:** Under the scenarios, Avalere varies the number of new AHP enrollees in the first year. The 3 scenarios are based off, in part, the phase-in experience of the healthcare sharing ministries (HCSM), another alternative to ACA coverage that has been growing substantially since 2013. Avalere used the share of HCSM enrollment compared to total individual enrollment during 2013 to inform the share of the eligible enrollees who move into the

new AHPs during 2019. These numbers are varied in the scenarios to provide a range of outcomes. The risk mix of the initial enrollment is projected to be similar to that of the demographics of the eligible sole proprietors in the individual market and the small groups in industries more likely to participate in an AHP.

**Benefit Generosity:** Much of the criticism of the AHP proposed rule has focused around the potential for a “race to the bottom” in benefit generosity, which would further exacerbate the adverse selection concerns for both the individual and small group markets. To model the impacts, the scenarios model different benefit amounts, ranging from Bronze levels (60% actuarial value) for the “High” scenario to Gold levels (80% actuarial value) for the “Low” scenario. Importantly, while single-employer insured AHPs may be exempted from certain individual and small group market rules, they are still subject to many state laws and large group requirements. As such, Avalere selected a reasonable range of benefit generosity for purposes of these scenarios.

**Small Group Market Selection:** Unlike the individual market, shifts into AHPs from the small group market will happen at the group level, rather than at the individual level. This makes self-selection more difficult and less likely to be as dramatic a risk shift as the enrollees shifting from the individual market. To better account for small group behavior, Avalere varied the levels of self-selection on the part of the small group market, with the “High” scenario assuming the highest level of self-selection and the “Low” scenario assuming the lowest amount (i.e., the shifts from the small group market more closely align to the risk of the entire market).

**Eligibility Categories:** Interestingly, the overall risk of small groups most likely to shift into AHPs is projected to be higher than the average risk of the small group market, due to the demographic make-up (particularly the age mix) of their employees. While small groups still are projected to shift into AHPs, the lower risk and premiums in the new AHP market is largely driven by the low-risk sole proprietors shifting into AHPs from the individual market. Effectively, the incentives for small groups to shift into AHPs are substantially lower than those for sole proprietors exiting the individual market.

## Conclusion

The recent AHP proposed rule is expected to incentivize a larger number of healthy sole proprietors and groups to access the more affordable, potentially less generous coverage that could be available through an AHP. Conversely, those who remain in the individual and small group markets will pay more for their coverage, with an additional 130,000 to 140,000 individuals projected to become uninsured.

Importantly, this proposed rule on AHPs is one in a series of expected proposed regulations from the Administration that are projected to increase benefit flexibility and coverage options for healthier enrollees in the individual and small group markets. However, changes that allow or incentivize healthier individuals to exit the individual and small group market to pursue other,



sometimes non-ACA-compliant coverage offerings, could lead to higher costs for those sicker, less healthy individuals and groups who remain behind in the ACA regulated markets. For example, the Administration recently released a proposed rule increasing the availability of short-term limited duration insurance (which is exempted from many of the ACA's requirements)—which could similarly incent healthier individuals to exit the individual market, further increasing premiums for those remaining in ACA markets. Importantly, the potential effects of the short-term plan proposed rule are not considered here.

## Methodology

The AHP proposed rule modeling results are the output of Avalere's proprietary models of individual and small group market health insurance coverage. The underlying data in the models are drawn from the American Community Survey (ACS), Current Population Survey (CPS), Centers for Medicare & Medicaid Services (CMS) exchange enrollment reports, yearly premium data from Healthcare.gov, and general exchange market demographic data released by the United States Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE). In addition, Avalere utilizes Inovalon's proprietary MORE2 claims database of individual and small group market enrollees. This allows the model to take into account underlying risk scores for purposes of modeling behavior, premiums (premiums in the model are a weighted market average by age and metal level), and risk selection by metal level, age, and gender.

Avalere determined the number of individuals in both the individual and group markets receiving coverage who would be eligible for AHPs under the proposed rule based on survey data from ACS (for the individual market) and CPS (for the small group market).

For the individual market, eligibility was determined by the number of enrollees who are sole proprietors. This data was then segmented by age and income. Income data was used to exclude those individuals who are current heavily subsidized (defined as below 250% of the federal poverty level) and who Avalere deemed will be unlikely to shift into AHPs. Similarly, Avalere analyzed the industries for sole proprietors to determine those most likely to participate in an AHP. Avalere used the 2012 IND codes for this purposes in ACS and defined those industries as likely to participate in an AHP as Construction, Transportation and Utilities, Professional (Professional, Scientific, Management, Administrative, and Waste Management Services), and Other Services (Except Public Administration). This group of individuals most likely to join AHPs was segmented by age to match up with the MORE2 risk scores and better project the expected risk shifting into the AHPs.

For the small group market, eligibility was determined by the size of the small group market and the same industry segmentation as the individual market. Employer size is available in CPS with the same industry segmentation measures as those used in ACS for the individual market. Similarly, Avalere segmented the eligible population receiving small group coverage into age groupings to match the MORE2 risk scores in the model.

Using the total eligible enrollees in AHPs as an "upper bound", Avalere assumed an enrollment phase-in based on the trend of healthcare sharing ministries enrollment growth post-2010. The trend provides the best available proxy of enrollment in an alternative form of coverage to the ACA while also providing an approximation of enrollment being constrained by availability.

With a base of enrollees in 2019, Avalere's proprietary models of individual and small group coverage model the elasticity of demand for eligible individuals and small groups to shift into

AHP coverage. These elasticity of demand assumptions are based on published literature from the Congressional Budget Office (CBO).

For the individual market, Avalere assumed that the chronically ill, defined as the top 10% of the individual market by risk score and based on Avalere analysis of the Medical Expenditure Panel Survey (MEPS), are inelastic and remain in the individual market. Essentially, the healthier individuals are more likely to shift into an alternate form of coverage with fewer covered benefits. Additionally, Avalere assumed that the heavily subsidized population does not shift into AHPs. This is defined as those individuals below 250% of the federal poverty level (FPL).

Avalere constructed three scenarios that varied based on the initial availability of AHPs in 2019, the average generosity of coverage offered by AHPs, and the projected level of risk selection by small businesses. For the initial availability of AHPs, Avalere used a high, medium, and low, based on the initial enrollment of healthcare sharing ministries in the early years of the ACA, as a percentage of the total individual market. For the average generosity of coverage, Avalere projected that AHP benefits in the “Low”, “Moderate”, and “High” scenarios had an average actuarial value approximating 60%, 70%, and 80%, respectively. Importantly, that actuarial value is based off the estimated cost of claims for the small group market.

## References

- i. 45 CFR § 147.150 requires individual and small group market health insurance issuers to offer coverage that at least covers the EHB package as defined in section 1302(a) of the Affordable Care Act (ACA). This includes the 10 categories of EHBs. However, large group plans are not required to adhere to these EHB standards.
- ii. Id.; 45 CFR § 147.130 requires a group health plan, or a health insurance issuer offering group health insurance coverage, to provide coverage, without cost-sharing for 1) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force), 2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and 3) evidence-informed preventive care and screenings for infants, children, and adolescents that are supported by the Health Resources and Services Administration. That coverage requirement is echoed in 29 CFR § 2590.715-2713 (Section 2713 of the Public Health Services Act).
- iii. U.S. Department of Labor, Employee Benefits Security Administration. “Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation,” August 2013. Available at <http://www.dol.gov/ebsa/Publications/mewas.html>.
- iv. Department of Labor (DOL). “Definition of “Employer” under Section 3(5) of ERISA -- Association Health Plans.” Jan. 4, 2018. Available at <https://www.regulations.gov/document?D=EBSA-2018-0001-0001>.
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