

A New Pathway to Healthcare Delivery: Association Health Plans

JUNE 22, 2018

In what seemed a remote possibility just a year ago, the Department of Labor (DOL) issued final regulations earlier this week on Association Health Plans (AHPs). This guidance establishes additional criteria under ERISA for determining when employers may join together in a group or association of employers to offer health coverage that will be treated as a single multiple-employer welfare benefit plan (the final rule). By relaxing the existing rules under ERISA for meeting the criteria to be considered a bona fide association or group of employers, the DOL hopes to facilitate the adoption and administration of AHPs. Such plans, if properly structured, are treated as large group health plans for purposes of federal employee benefits and insurance laws; and thus, are exempt from more onerous requirements that apply in the small and individual group insurance markets, such as community rating and the mandate to cover essential health benefits.

Proponents of AHPs argue that they will permit small employers and individuals to leverage their combined size to level the playing field with large group health plans and afford them greater bargaining power in the insurance markets, thereby enhancing efficiencies, achieving economies of scale, and reducing costs. The final rule is not without its critics, however, who point to evidence of fraud and discrimination in past iterations of AHPs, as well as concerns about destabilization of the insurance markets that may be caused if AHPs siphon off healthier, younger workers from other coverage who may be attracted to the lower premiums AHPs can charge for less rich coverage. At least two states (Massachusetts and New York) are threatening to sue the Trump administration over this new rule. The Congressional Budget Office has estimated that up to 4 million people will be covered by such arrangements by 2024, with 3.5 million transitioning from other health arrangements, such as the public health insurance and small group markets and 400,000 newly insured individuals.

Pre-Final Rule Guidance

Historically, it has been difficult for an association or group of employers to be treated as a single sponsor of an employee welfare benefit plan due to onerous requirements in regulatory and sub-regulatory guidance issued by the DOL, the Internal Revenue Service (IRS), and state insurance commissions. Under the DOL's pre-final rule guidance, unless an AHP is sponsored by a group or association in a common geographic area and industry and meets other organizational criteria, the sponsoring group is disregarded and the regulators "look through" to the underlying size of the individual member groups to determine whether the coverage being offered to participating

members is individual, small-group, or large-group market coverage. Click [here](#) for our prior alert that discusses the DOL's pre-final rule guidance in greater detail. The DOL makes clear that pre-final rule guidance applicable to multiple employer welfare arrangements (MEWAs) and bona fide AHPs continues to apply; the new final rule is intended as an additional pathway to provide health coverage to members of an association, group of employers, or individuals.

The Final AHP Rule

The final rule does not differ in major respects from the proposed rules, which received over 900 comments from stakeholders in the insurance, business trade, and employer communities. Specifically, the final rule amends the definition of "employer" in Section 3(5) of ERISA to ease the criteria for determining when a group of unrelated employers (including working owners) may join together in a group or association of employers that will be treated as the sponsor of a single multiple-employer welfare benefit plan.

Under the new pathway to provide association health coverage, in order to qualify as a bona fide group or association of employers under Section 3(5) of ERISA, the final rule requires the following key components to be satisfied:

- **Commonality of Interest.** The members of the association must have a "commonality of interest" based on employers that (1) are in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area (even if the metropolitan area includes more than one State). This is a substantial change from pre-final rule guidance, which required the members of the AHP to both be in the same geographic location **and** industry, thereby prohibiting national health plans in the same industry or plans with membership based on common geography but no industry or business ties.
- **Purpose/Sponsorship.** The sponsoring group or association must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its members and their employees; however, the primary purpose can be to offer health coverage to members. A safe harbor under the rule deems a substantial business purpose to exist where the group or association would be a viable entity even in the absence of sponsoring an employee benefit plan. While the final rule prohibits a health insurance issuer (or other health delivery system) from itself sponsoring an AHP due to conflicts of interest with its role as a commercial insurer, such entities may provide administrative and other services to an AHP, much like in today's self-insured administration model.
- **Organizational Structure.** A group or association must have a formal organizational structure with a governing body as well as by-laws or other similar indicia of governance establishing the legal form in which the group or association operates.
- **Control.** The functions and activities of the group or association must be controlled by its members, and the group or association's members that participate in the group health plan must control the plan. Control must be present both in form and in substance and is a facts and circumstances test. Factors the regulators will assess include: (i) whether members regularly nominate and elect directors, officers, trustees, or other similar persons that constitute the governing body or authority of the employer group or association and plan; (ii) whether members have authority to remove directors, officers, trustees, or other similar persons with or without cause; and (iii) whether participating members have the authority to approve or veto decisions or activities that relate to the formation, design, amendment, and termination of the plan, such as material amendments to the plan, including changes in coverage, benefits, and premiums.
- **Eligibility.** Eligible AHP participants include employees of a current employer member of the group or association, former employees of a current employer member of the group or association who became entitled to coverage under the group's or association's group health plan when the former employee was an employee of the employer, and beneficiaries of such individuals (e.g., spouses and dependent children).
- **Nondiscrimination.** The HIPAA nondiscrimination rules (including the wellness provisions) apply to AHPs; however, distinctions based on factors other than health (such as industry, occupation, or geography) are

permitted, provided they are not directed at individual participants or beneficiaries based on a health factor of one or more of those individuals. AHPs formed pursuant to the final rule will also be permitted to charge different premiums to different member employers, as long as the difference in premiums is not based on a health factor of one or more of the employees of the member employers.

- **Working Owners.** The final rule makes clear that working owners (self-employed persons without common-law employees) may qualify as both an employer and as an employee for purposes of participating in an AHP. The final rule defines the term “working owner” as an individual (i) who has an ownership right in a trade or business, whether incorporated or unincorporated, including a partner and other self-employed individual; (ii) who is earning wages or self-employment income from the trade or business for providing personal services to the trade or business; and (iii) who either: (A) works on average at least 20 hours per week or at least 80 hours per month providing personal services to the working owner’s trade or business, or (B) has wages or self-employment income from such trade or business that at least equals the working owner’s cost of coverage for participation by the working owner and any covered beneficiaries in the group health plan. In addition, unlike the proposed rules, eligibility for coverage under another employer’s health plan, such as a spouse’s employer’s plan, will not disqualify a working owner from participating in an AHP.
- **Benefit Coverage.** AHPs are required to comply with the ACA and ERISA rules applicable to large group health plans; and to the extent they are fully insured, state mandated benefit laws will also apply. While AHPs are not required to provide essential health benefits or minimum value coverage, they are subject to other significant benefit mandates, including, for example, no pre-existing condition exclusions, coverage of adult dependent children to age 26, coverage of preventive care with no cost-sharing, and enhanced patient protections and claim and appeal rights.

In order to remain viable, AHPs will need to evaluate how their coverage offerings position them competitively in the market. To the extent an AHP covers essential health benefits, they will be subject to the ACA’s maximum out-of-pocket limits and prohibitions on annual and life time limits applicable to such benefits. Further, while there is no longer an individual penalty for failure to maintain health insurance coverage after 2018, several states have passed their own form of the individual mandate. Notably, New Jersey recently enacted an individual mandate and the legislation specifically states that coverage under an AHP will not qualify as minimum essential coverage for purposes of the law. Depending on their size, AHP members may also be subject to the ACA’s employer shared responsibility provisions and may decide not to join an AHP if the coverage provided thereunder would not provide minimum essential coverage, thereby subjecting the employer to potential penalties.

- **ERISA.** The final rule makes clear that AHPs sponsored by a bona fide group or association as set forth under the final rule are group health plans and employee welfare benefit plans as defined under ERISA. The final rule also confirms that federal laws, such as the Mental Health Parity and Addiction Equity Act and COBRA will apply to the AHP to the extent the collective membership of the AHP exceeds the employee thresholds for application of those statutes, but further guidance is needed. As ERISA plans, AHPs will be subject to the full panoply of ERISA reporting and disclosure requirements that apply to group health plans and MEWAs, including the requirement to have a plan document, distribute summary plan descriptions, summaries of material modifications and summaries of benefits and coverage to plan participants, and file with the DOL annual reports on Form 5500 and MEWA reporting on Form M-1.
- **MEWAs/Preemption of State Insurance Laws.** AHPs are by definition MEWAs because they cover the employees of two or more unrelated employers. Both the states and the DOL have joint regulatory authority over MEWAs, thus AHPs have limited ability to invoke ERISA preemption of state insurance laws. The DOL clearly states in the preamble that the final rule does not modify or otherwise limit existing State authority as established under section 514 of ERISA. For fully insured AHPs, states have full regulatory power over maintenance of specified reserves and contribution requirements and other state insurance law requirements regarding licensing, registration, certification, financial reporting, examination, and audit. Some states also regulate self-insured AHPs with respect to contribution and reserve requirements and in other areas to the extent not inconsistent with ERISA. Other states prohibit MEWAs. The DOL specifically declined to provide further guidance on ERISA preemption issues, stating in the final rule that it was beyond the scope of their rulemaking. Further federal and state law guidance in this area is needed.

Winston Takeaways

One complicating factor to establishment of an AHP is obstacles under existing state insurance laws that prohibit or place restrictions on the formation of AHPs. In several states, group health insurance laws will need to be revised to permit individuals and small groups to participate in AHPs if they are not otherwise members of pre-existing tax-qualified bona fide associations. In addition, many states do not permit the inclusion of sole proprietors and individuals in group insurance arrangements. In certain states, AHPs will require special individual filings with state departments of insurance to ensure they meet all of the state and federal requirements applicable to these type of arrangements. There will likely be an uptick in legislative and regulatory activity at the state level with respect to the formation, licensing, reporting, and reserve requirements applicable to AHPs.

Next Steps

Associations or groups interested in establishing an AHP must carefully navigate the waters between federal requirements under ERISA and state laws (*i.e.* permissibility under state law, licensing, reserve, and mandated benefit requirements). Certain states will be more favorable than others to the formation of AHPs, which will impact the decision as to where the AHP should be situated. In addition, the AHP must meet all of the requirements applicable to an employer-sponsored health plan under ERISA, such as the reporting and disclosure requirements, fiduciary requirements, and prohibition on engaging in prohibited transactions.

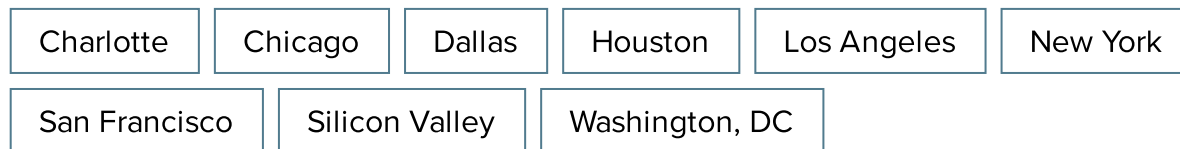
Plan documentation will be key in establishing membership criteria and governance rules for the AHP, and setting participation standards and rules for premium payment. AHP sponsors will also have to evaluate whether to fully insure the arrangement and to determine how to segregate plan assets and comply with the ERISA trust and exclusive benefit requirements. The final rule in many ways conflicts with the requirements for participation in a voluntary employees' beneficiary association (VEBA), thus a joint VEBA may be unavailable as a means for some AHPs to meet the ERISA trust requirements.

The final rule becomes effective September 1, 2018, for fully insured AHPs, January 1, 2019, for existing self-insured AHPs complying with the Department's prior rules that choose to qualify as AHPs under the final rule, and April 1, 2019, for new self-insured AHPs formed pursuant to the final rule.

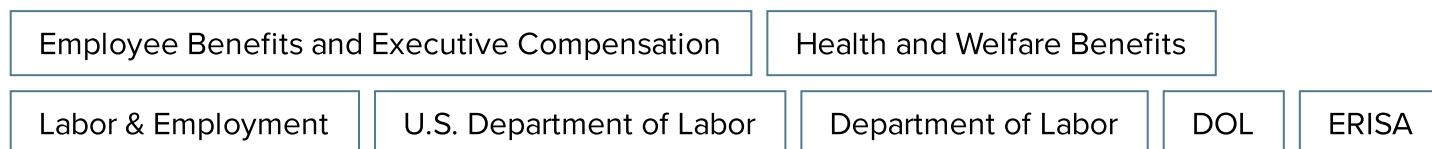
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