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CLIENT ALERT

Association Health Plans: Meaningful Change or Much Ado About Nothing?

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The Department of Labor (DOL) recently released a notice of proposed rulemaking (NPRM) liberalizing some of the rules surrounding the formation of Association Health Plans (AHPs), as directed in October 2017 by President Trump's Executive Order 13813. The stated goal of the NPRM is to facilitate the adoption and administration of AHPs by small employers and working owners by making the rules regarding AHPs more flexible to permit such groups to band together and be treated as a single large group for purposes of the Employee Retirement Income Security Act (ERISA), insurance underwriting, and state insurance laws. While the NPRM, when final, may offer more opportunities for small employers and individual working owners to band together to form associations for the purpose of providing health benefits to its members, it remains to be seen whether insurance companies will be interested in underwriting such plans and how AHPs will be treated by state regulators.

Background

The term "association coverage" or "association health plan" is not a distinct category of health insurance under ERISA, the Affordable Care Act (ACA), or the Public Health Security Act (PHSA), nor does ERISA or the ACA specify whether such plans are to be treated as individual policies or small or large group health plans for purposes of the insurance market reforms under the ACA. In guidance issued in 2011 by the Centers for Medicare and Medicaid Services (CMS), which has jurisdiction over enforcement of certain provisions of the ACA as applied to health insurance issuers, CMS referred to "association coverage" as health insurance coverage that is offered to a collection of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements, purchasing alliances, or purchasing cooperatives and indicated it would look to the ERISA definition of "employer" to determine the treatment of health plans sponsored by associations for ACA purposes.

Generally, under both ACA and ERISA rules, it is very difficult for an association of employers to be treated as the sponsor of the health plan itself and for the plan to be treated as a single group health plan. Currently, in most cases due to stringent requirements under ERISA, regulators look through the association to the size of the underlying groups of small employers or individuals that make up the association for purposes of insurance underwriting. For individuals and small employers that obtain coverage through an insured AHP, this coverage is regulated under the same standards that apply to the individual market or the small group market. If instead, an AHP is treated as a large group health plan sponsored at the association level, it will be exempt from many of the insurance reform

requirements applicable to individuals and small groups under the ACA, such as guaranteed issue/renewability, the prohibition on setting premiums based on health status, community rating, age-banded rating, and the requirement to cover essential health benefits.

ERISA Section 3(5) defines an "employer" to mean any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; ***and includes a group or association of employers acting for an employer in such capacity***. Under current law, for a group or association of employers to qualify as a single employer under ERISA, the group of employers must be: (1) a "bona fide" association of employers tied by a common economic or representation interest, ***unrelated to provision of benefits*** ("commonality of interest test"); and (2) the employer members of the organization that sponsor the plan must exercise control, either directly or indirectly, both in form and in substance over the plan ("control test"). In addition, sole proprietors or independent contractors may not band together and be treated as an employer for ERISA purposes.

All AHPs by definition are multiple employer welfare arrangements (MEWAs) as they cover the employees of two or more unrelated employers. Whether a MEWA is also subject to ERISA turns on whether the MEWA is sponsored by an entity or entities treated as an "employer" or "group or association of employers" under ERISA. Even if the MEWA is subject to ERISA, it cannot avail itself of complete ERISA preemption and may be subject to special reserve, registration and licensing requirements under state law. MEWAs are also subject to certain federal reporting requirements, regulation and oversight. Note that AHPs subject to ERISA must comply with all of the Title I requirements applicable to group health plans, such as the requirement to have a written plan document and summary plan description, filing of Forms 5500 and M-1 (MEWA filing requirement), and compliance with ERISA's mandated benefit, fiduciary and prohibited transaction rules.

Overview of NPRM

The NPRM revises the definition of "employer" in Section 3(5) of ERISA by loosening the commonality of interest test for employers forming and maintaining an AHP. Notably, the NPRM would allow an association to exist solely for the purpose of providing group health coverage, which is not allowed under current law and guidance. In order for the AHP to be an ERISA group health plan, however, it must be sponsored by a group of "employers."

In stark contrast to decades of statutory and regulatory interpretations by the DOL, the NPRM would allow working owners of businesses and sole proprietors to join AHPs as member employers and be covered by AHPs as employees, even if the individual has no common law employees. To be eligible for coverage, the owner must have an ownership right in the business, must be earning wages or self-employment income from the business, cannot be eligible for any subsidized group health plan including group health coverage through a spouse's employer, and either (i) work for the business at least 30 hours a week or 120 hours per month or (ii) earn enough income from the business to equal the cost of coverage under the AHP. AHPs are not required by the NPRM to investigate or verify an owner's claim of eligibility. The DOL has requested comments on whether "working owners" should be allowed to join AHPs and whether these are the appropriate standards to apply.

Changes to ERISA Definition of Employer

The changes to the ERISA definition of employer in the NPRM would allow:

- A lower threshold for "commonality of interest" among the member employers of the AHP, such that employers need only be in a shared trade, industry, line of business or profession (without geographical limitation), or a shared principal place of business in the same region, same state, or same multi-state metropolitan area (without industry limitation);
- An AHP to exist solely for the purpose of providing health coverage to employees of the member employers;
- An AHP to include employer members of any size; and
- Sole proprietors and actively working business owners to be considered both employers and employees for some AHP purposes.

Control Test

The NPRM requires that the member employers exert authority and control over the AHP, either directly or indirectly, such as through the adoption of bylaws and participating employer membership on a governing board. AHPs may not act simply as brokers or exchanges, since the member employers must retain ultimate control and oversight through the regular nomination of directors, officers or other similar representatives that control the group or association and the establishment and maintenance of the plan.

AHPs that meet the requirements of the NPRM would still be treated as MEWAs for purposes of ERISA (and applicable state insurance laws). The NPRM makes a distinction between commercial insurance programs marketed to individuals and small employers that remain fully subject to state insurance regulation and AHPs that are sponsored by employers for the benefit of their members which are subject to ERISA and more limited state regulation.

Winston Takeaway

It is important to note that the NPRM does not apply ERISA preemption to AHPs and the DOL did not create any individual or class exemption for AHPs from existing state regulation. Therefore, many state law requirements could still apply to AHPs, including state-level insurance coverage requirements that are comparable to ACA essential health benefits rules. This state-level regulation mirrors the longstanding treatment applied to MEWAs, which Congress explicitly excluded from ERISA federal preemption in 1983. Therefore, in reality, the cost savings and coverage levels of AHPs may not significantly diverge from the coverage otherwise available to small employers.

The NPRM is also conspicuously silent on the treatment of professional employer organizations (PEOs) under the revised rules and does not call into question such arrangements. It remains to be seen how the PEO industry will be affected by the new rules as they present a new opportunity for small employers to provide health insurance benefits to their employees without entering into arrangements with PEOs.

Discrimination Rules Applicable to AHPs

While broadening the ability of employers to form an AHP, the NPRM makes clear that the AHP may not discriminate against a member employer due to health factors of its employees or former employees. The AHP may not charge more to employees of a member employer based on the health status of its employee population. Prospective member employers cannot be excluded from participation in the AHP on the basis of health factors of their employees or former employees. Member employers and prospective member employers who meet the membership requirements of the AHP, or of the underlying association, may not be barred from the AHP on the basis of their employees' health. This means that AHPs cannot directly discriminate in favor of the healthiest and least costly employee populations and against the sickest and costliest employee populations.

Exclusion from the AHP is allowed where the prospective member employer does not meet the industry or geographic membership limitations of the AHP. Distinction among covered employees is also permitted between classifications of employees, if it is a bona fide employment-based classification, such as part-time versus full-time status. Distinction is also allowed on a geographic basis, such as a member employer having a principal place of business in a costlier segment of the membership region, provided that the distinction is not directed at the cost of covering specific individuals. The NPRM contains examples setting forth permitted distinctions that do not rise to the level of discrimination, including charging a different premium to association members based on the member's principal place of business.

Winston Takeaway

Discrimination rules may make it difficult for AHPs to project costs and set premiums, given that an AHP may not exclude costlier employers. The discrimination rules could in some cases result in significant cross-subsidies between member employers. Thus, the size of an AHP may be an important factor in its ability to project costs and even out variations in the health costs of the different member employers. Certain associations may also, by census, have healthier populations than others making the membership criteria of the association an important risk factor in deciding whether to insure a particular group of employers.

Additional Considerations for AHPs

The expanded ability to form AHPs under the NPRM provides several advantages for employers who were not previously able to offer AHPs but potentially could under the NPRM's expanded definition of employer.

Less Onerous Coverage Requirements

As noted above, AHPs that are large group market plans are exempt from many of the ACA insurance market reforms, including the essential health benefits requirements. The large group market, depending on the state, is limited to employers with at least 50 to 100 employees. Small employers typically participate in the small group insurance market, where insurers are required by the ACA to cover essential health benefits. Joining an AHP would allow employers with fewer than 50 employees to band together and join the large group market. The less extensive coverage requirements of the large group market may in many cases allow employers to provide less costly coverage.

Membership Advantages

AHPs may provide some advantages to employers by economies of scale, improved administration, or insurance rates. The AHP may be able to create more tailored insurance than the member employers could otherwise obtain. AHP membership may also provide decreased risk for some employers with self-insured group health plans and stop-loss coverage.

Winston Takeaway

Employers who previously were unable to participate in an AHP but would be eligible under the NPRM, including sole proprietors, should evaluate whether an AHP is an attractive option for providing health coverage to employees. It should be noted that participation in an AHP would likely constitute an offer of coverage from an employer which could disqualify the individual from receiving premium subsidies on the federal and state public marketplace exchanges. It is likely that states will continue to assert their regulatory authority over AHPs, particularly with regard to solvency and reserve requirements, as AHPs have been used in the past as fraudulent schemes for operators who collected premiums from members but left many unpaid claims in their wake when they became insolvent. It also remains to be seen how the insurance markets will react to the new AHP rules and whether insurers will be keen to underwrite associations on a large group basis. Consumer groups have also warned that AHPs may be used as a vehicle to cherry pick healthier risk while undermining the small and individual group markets which will be left with fewer, sicker individuals to insure.

Next Steps

The DOL is seeking comments on the NPRM and has specifically asked for comments on how ERISA can be used to promote AHP solvency and whether the final rule should include information to assist existing employer associations, including MEWAs that would now be considered AHPs, in making changes to health coverage, governing documents, or business structures to qualify as AHPs under the final rule. The NPRM was published January 5, 2018 and comments are due no later than March 6, 2018. Please contact a member of the Winston & Strawn Employee Benefits and Executive Compensation Practice for more information or if you wish to submit written comments on the NPRM.

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