DOL Issues Final Regulations Regarding Association Health Plans

On June 19, 2018, the U.S. Department of Labor (DOL) published Frequently Asked Questions About Association Health Plans (AHPs) and issued a final rule that broadens the definition of "employer" and the provisions under which an employer group or association may be treated as an "employer" sponsor of a single multiple-employer employee welfare benefit plan and group health plan under Title I of the Employee Retirement Income Security Act (ERISA).

The final rule is intended to facilitate adoption and administration of AHPs and expand health coverage access to employees of small employers and certain self-employed individuals. Generally, it does this in four main ways:

- It relaxes the requirement that group or association members share a common interest, as long as they operate in a common geographic area.
- It confirms that groups or associations whose members operate in the same trade, industry, line of business, or profession can sponsor AHPs, regardless of geographic distribution.
- It clarifies the existing requirement that groups or associations sponsoring AHPs must have at least one substantial business purpose unrelated to providing health coverage or other employee benefits.
- It permits AHPs that meet the final rule's new requirements to enroll working owners who do not have employees.

The final rule will be effective 60 days after it is published in the Federal Register.

The final rule will apply to fully-insured AHPs on September 1, 2018, to existing self-insured AHPs on January 1, 2019, and to new self-insured AHPs formed under this final rule on April 1, 2019.

The DOL is using a staggered approach to implement this final rule so states and state insurance regulators will have time to tailor their regulations to the final rule and address a range of oversight and compliance assistance issues, especially concerns about self-insured AHPs' vulnerability to financial mismanagement and abuse.

An employer who is interested in joining an AHP should consult with its counsel to determine whether it meets the new, expanded definition of "employer" and whether the new AHP meets other requirements, such as having at least one substantial business purpose beyond providing health benefits, having formal documentation of the AHP's organizational structure, and complying with applicable state laws.

Background

Title I of ERISA covers most private sector employee benefit plans, which are voluntarily established by an employer, an employee organization, or jointly by one or more such employers. Title I applies to "employee welfare benefit plans" which requires there to be a plan (or fund or program), established or maintained by an employer, for the purpose of providing specific benefits to participants and beneficiaries. ERISA provides for a specific list of benefits, which includes medical, surgical, or hospital care or benefits.

Prior to this final rule, ERISA defined an "employer" as "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." To determine employer groups or associations that can act as an ERISA employer and sponsor a multiple employer plan, courts and the DOL analyze three sets of issues:

- Whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits;
- Whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and
- Whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program both in form and substance.

Prior to this final rule, the "commonality of interest" was determined by whether or not the group or association has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan. Prior to this final rule, even when an association health plan could form, it met obstacles. The Centers for Medicare and Medicaid Services' (CMS) 2011 guidance provided a test for determining whether association coverage was subject to individual, small group, or large group market coverage under the Public Health Service Act. CMS ignored the backing of the association and assigned a group size to each individual employer or member within the association. This led to disparate requirements within the same plan as it related to community rating, medical loss ratio (MLR) provisions, single risk pool requirements, essential health benefit requirements, risk adjustment programs, and more. This final rule seeks to alleviate that disparity within the plan.

Requirements Under the Final Rule

To be clear, the final rule does not replace the DOL's previous guidance regarding the definition of "employer." Both existing and new employer groups or associations that meet the DOL's pre-rule guidance can sponsor an AHP.

Instead, the final rule provides an additional way for employers or associations to meet the definition of an "employer" and sponsor a single ERISA-covered group health plan. The DOL explains that the expanded definition of "employer" will promote broader availability of group health coverage for small business owners and self-employed individuals, and will help alleviate the problems of limited or non-existent affordable healthcare options for these small businesses and self-employed individuals.

Under the final rule, commonality of interest will be determined based on relevant facts and circumstances and may be established by:

1. Employers being in the same trade, industry, line of business, or profession; or
2. Employers having 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).

For a geography-based AHP, the group or association can be a participating employer by having its principal place of business within the relevant state or metropolitan area. For an industry-based AHP, the group or association itself will be treated as being in the same trade or industry as the other employer members of the group or association.

While a group or association of employers will be permitted to join together solely for the purpose of providing health benefits, it must 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. Under the final rule's safe harbor, a substantial business purpose is considered to exist in cases where the group or association would be a viable entity, even in the absence of sponsoring an employee benefit plan.

Further, the group or association must have an organizational structure with a governing body and by-laws (or similar formal documentation). The employer members of the group or association that participate in the group health plan must control the plan, including its functions or activities, such as establishment and maintenance of the group health plan. Control must be present both in form and in substance.

The DOL will use a facts and circumstances test to determine whether the requisite control exists. An AHP will meet the DOL's control test if:

- Employer members regularly nominate and elect directors, officers, trustees, or other similar people that constitute the governing body or authority of the employer group or association and plan;
- Employer members have authority to remove any such director, officer, trustees, or other similar person with or without cause; and
- Employer members that participate in the plan have the authority and opportunity to approve or veto decisions or activities which relate to the formation, design, amendment, and termination of the plan, for example, material amendments to the plan, including changes in coverage, benefits, and premiums.

These provisions are intended to prevent commercial enterprises from calling themselves associations and offering AHPs solely for profit. Further, to avoid potential conflicts of interest, the final rule prohibits health insurance issuers, in their capacity as issuers, from participating in or controlling an AHP. However, an issuer can provide administrative services to an AHP. Similarly, the final rule explains that a group, association, or plan that is controlled by a network provider, a healthcare organization, or some other business entity that is part of the U.S. healthcare delivery system would not be a bona fide group, association, or AHP.

The final rule defines the groups of people ("eligible participants") who can participate in a group health plan sponsored by the AHP:

- 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 these individuals (for example, spouses and dependent children).

Under the final rule, working owners 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 "working owner" as an individual who either works on average 20 hours per week or 80 hours per month providing services to the trade or business, or who has earned income from such trade or business that at least equals the working owner's cost of coverage for the working owner and any covered beneficiary in the group health plan. Plan fiduciaries have a duty to reasonably determine that these conditions are satisfied and to monitor continued eligibility for coverage under the AHP.

The final rules subject AHPs to the nondiscrimination provisions that apply to group health plans under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act (ACA). HIPAA prohibits group health plans and health insurers from discriminating based on health factors with regard to premiums, eligibility, or benefits. Under HIPAA, health factors are:

- Health status
- Medical condition (physical and mental)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability
- Disability

This means that AHPs cannot exclude individuals who participate in dangerous activities or have a history of high health claims, or hinge eligibility of enrollees on evidence of insurability or "passing" a physical exam. AHPs cannot charge individuals different premiums based on the existence or absence of health factors. Health factors may not affect eligibility rules, which include rules relating to enrollment, effective dates, waiting periods, late/special enrollment, benefits (covered benefits, benefit restrictions, coinsurance, co-pays, and deductibles), continued eligibility, and terminating coverage.

HIPAA allows group health plans to impose restrictions in benefit plans if they apply to all similarly situated individuals. Plans can, in conformance with other laws, provide different benefits for different groups of similarly situated employees if the differences are based on a bona fide employment-related classification that is consistent with the employer's usual business practice. Bona fide employment classifications might be part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire, lengths of service, or occupations, provided the distinction is consistent with the employer's usual business practice.

The final rule clearly states that AHPs must not treat the employees of an employer member as a distinct group of similarly-situated individuals based on the employees' health factors. The final rule provides 10 examples on this issue.

Example 1

Facts. Association A offers group health coverage to all members. According to the bylaws of Association A, membership is subject to the following criteria: all members must be restaurants located in a specified area. Restaurant B, which is located within the specified area, has several employees with large health claims. Restaurant B applies for membership in Association A and is denied membership based on the claims experience of its employees.

Conclusion. In this Example 1, Association A's exclusion of Restaurant B from Association A discriminates on the basis of claims history, which is a health factor under § 2590.702(a)(1) of this chapter. Accordingly, Association A does not satisfy the requirement in paragraph (d)(1) of this section, and, therefore would not meet the definition of a bona fide group or association of employers under paragraph (b) of this section.

Example 2

Facts. Association C offers group health coverage to all members. According to the bylaws of Association C, membership is subject to the following criteria: all members must have a principal place of business in a specified metropolitan area. Individual D is a sole proprietor whose principal place of business is within the specified area. As part of the membership application process, Individual D provides certain health information to Association C. After learning that Individual D has diabetes, based on D's diabetes, Association C denies Individual D's membership application.

Conclusion. In this Example 2, Association C's exclusion of Individual D because D has diabetes is a decision that discriminates on the basis of a medical condition, which is a health factor under § 2590.702(a)(1) of this chapter. Accordingly, Association C does not satisfy the requirement in paragraph (d)(1) of this section and would not meet the definition of a bona fide group or association of employers under paragraph (b) of this section.

Example 3

Facts. Association F offers group health coverage to all plumbers working for plumbing companies in a State, if the plumbing company employer chooses to join the association. Plumbers employed by a plumbing company on a full-time basis (which is defined under the terms of the arrangement as regularly working at least 30 hours a week) are eligible for health coverage without a waiting period. Plumbers employed by a plumbing company on a part-time basis (which is defined under the terms of the arrangement as regularly working at least 10 hours per week, but less than 30 hours per week) are eligible for health coverage after a 60-day waiting period.

Conclusion. In this Example 3, making a distinction between part-time versus full-time employment status is a permitted distinction between similarly-situated individuals under § 2590.702(d) of this chapter, provided the distinction is not directed at individuals under § 2590.702(d)(3) of this chapter. Accordingly, the requirement that plumbers working part time must satisfy a waiting period for coverage is a rule for eligibility that does not violate § 2590.702(b) and, as a consequence, satisfies paragraph (d)(2) of this section.

Example 4

Facts. Association G sponsors a group health plan, available to all employers doing business in Town H. Association G charges Business I more for premiums than it charges other members because Business I employs several individuals with chronic illnesses.

Conclusion. In this Example 4, the employees of Business I cannot be treated as a separate group of similarly-situated individuals from other members based on a health factor of one or more individuals under paragraph (d)(4) of this section. Therefore, charging Business I more for premiums based on one or more health factors of the employees of Business I does not satisfy the requirements in paragraph (d)(4) of this section.

Example 5

Facts. Association J sponsors a group health plan that is available to all members. According to the bylaws of Association J, membership is open to any entity whose principal place of business is in State K, which has only one major metropolitan area, the capital city of State K. Members whose principal place of business is in the capital city of State K are charged more for premiums than members whose principal place of business is outside of the capital city.

Conclusion. In this Example 5, making a distinction between members whose principal place of business is in the capital city of State K, as compared to some other area in State K, is a permitted distinction between similarly-situated individuals under § 2590.702(d) of this chapter, provided the distinction is not directed at individuals under § 2590.702(d)(3) of this chapter. Accordingly, Association J's rule for charging different premiums based on principal place of business satisfies paragraph (d)(3) and (d)(4) of this section.

Example 6

Facts. Association L sponsors a group health plan, available to all its members. According to the bylaws of Association L, membership is open to any entity whose principal place of business is in State M. Sole Proprietor N's principal place of business is in City O, within State M. It is the only member whose principal place of business is in City O, and it is otherwise similarly situated with respect to all other members of the association. After learning that Sole Proprietor N has been diagnosed with cancer, based on the cancer diagnosis, Association L changes its premium structure to charge higher premiums for members whose principal place of business is in City O.

Conclusion. In this Example 6, cancer is a health factor under § 2590.702(a) of this chapter. Making a distinction between groups of otherwise similarly situated individuals that on its face is based on geography (which is not a health factor), but that is directed at one or more individuals based on a health factor (cancer), is in this case a distinction directed at an individual under § 2590.702(d)(3) of this chapter and is not a permitted distinction. Accordingly, by charging higher premiums to members whose principal place of business is City O, Association L violates § 2590.702(c) of this chapter and, consequently, the conditions of paragraphs (d)(3) and (d)(4) of this section are not satisfied.

Example 7

Facts. Association P is an agriculture industry association. It sponsors a group health plan that charges employers different premiums based on their primary agriculture subsector, defined under the terms of

the plan as: crop farming, livestock, fishing and aquaculture, and forestry. The distinction is not directed at individual participants or beneficiaries based on a health factor.

Conclusion. In this Example 7, the premium distinction between members is permitted under paragraphs (d)(3) and (d)(4) because it is not based on a health factor and is not directed at individual participants and beneficiaries based on a health factor.

Example 8

Facts. Association Q is a retail industry association. It sponsors a group health plan that charges employees of employers different premiums based on their occupation: cashier, stockers, and sales associates. The distinction is not directed at individual participants or beneficiaries based on a health factor.

Conclusion. In this Example 8, the premium distinction is permitted under paragraph (d)(3) and (d)(4) of this section because it is not based on a health factor and is not directed at individual participants and beneficiaries based on a health factor.

Example 9

Facts. Association R sponsors a group health plan that is available to all employers with a principal place of business in State S. Employers are charged different premiums based on their industry subsector, defined under the terms of the plan as: construction, education, health, financial services, information services, leisure and hospitality, manufacturing, transportation, natural resources, and other. In addition, within any employer, employees are charged different premiums based on part-time versus full-time status (part time status is defined, under the terms of the plan, as regularly working at least 40 hours, but less than 120 hours, per month). These distinctions are not directed at individual participants or beneficiaries based on a health factor.

Conclusion. In this Example 9, the premium distinctions between employer members of a State AHP based on industry, and between employees of employer members who are working part-time versus full-time, are permitted under paragraphs (d)(3) and (d)(4) of this section because these distinctions are not based on a health factor or directed at individual participants and beneficiaries based on a health factor.

Example 10

Facts. Association T sponsors a group health plan that offers a premium discount to participants who participate in a wellness program that complies with section 2590.702(f) of this chapter.

Conclusion. In this Example 10, providing a reward (such as a premium discount or rebate, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive, as well as avoiding a penalty such as the absence of a premium surcharge or other financial or nonfinancial disincentive) in return for adherence to a wellness program that satisfies conditions of § 2590.702(f) of this chapter is permissible under this paragraph (d).

Application of Other Federal Laws

The final rule addresses public comments on whether and how certain federal laws may apply to AHPs.

- For those AHPs that choose to offer coverage to applicable large employers subject to the ACA's employer shared responsibility provisions, the large employers face the possibility of having to

make an employer shared responsibility penalty payment if the AHP does not provide affordable, minimum value coverage.

- An AHP sponsored by a bona fide group or association is subject to all ERISA provisions applicable to group health plans and employee welfare benefit plans, including Title I of ERISA.
- AHPs must provide coverage for certain recommended preventive services without imposing cost-sharing.
- AHPs are subject to Title VII of the Civil Rights Act, as amended by the Pregnancy Discrimination Act, and must generally reimburse pregnancy-related expenses for employees and their spouses in the same manner as expenses incurred for other medical conditions.
- To determine whether an AHP is subject to the mental health and substance use disorder parity requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the AHP would calculate its size based on the number of employees employed in the aggregate by the employer members of the bona fide group or association. Generally, if an AHP members' employees total over 50 in the aggregate during the preceding calendar year, then the MHPAEA applies.
- If an AHP covers a benefit that would be considered an essential health benefit (EHB), all such benefits must be covered without any annual or lifetime dollar limit. Further, the AHP must count an individual's out-of-pocket spending for in-network provision of that benefit toward the maximum out of pocket limit (MOOP). Any EHBs in excess of the MOOP must be covered without cost-sharing.
- The DOL will consult with the IRS and U.S. Treasury and will issue guidance in the future on how COBRA would apply to employers with fewer than 20 employees who join a bona fide group or association whose member employers, collectively, employ 20 or more employees.

AHPs as MEWAs

Currently, some states permit groups of unrelated employers to offer group health plans under a plan known as a "multiple employer welfare arrangement" or MEWA. ERISA gives the DOL and state insurance regulators joint authority over MEWAs, including AHPs, to ensure consumer protections for employers and employees who rely on an AHP for healthcare coverage. The final rule maintains this joint structure and reiterates the historically broad role of the states when it comes to regulating MEWAs.

MEWAs are subject to strict state and federal scrutiny and are an enforcement priority for the DOL. Further, the final rule expressly states that AHPs are plan MEWAs and subject to existing federal regulatory standards governing MEWAs.

For example, the ACA expanded reporting and required registration for MEWAs with the DOL. Plan MEWAs and non-plan MEWAs must file Form M-1. All AHPs under the final rule will be MEWAs and will be required to file the Form M-1 regardless of the plan size or type of funding. Further, all employee welfare benefit plans that are MEWAs subject to the Form M-1 requirements, including AHPs under the final rule, will be required to file Form 5500, regardless of the plan size or type of funding.

State Regulation

The final rule does not change existing ERISA preemption rules that authorize broad state insurance regulation of AHPs, either through the health insurance issuers through which they purchase coverage or directly in the case of self-insured AHPs.

If an AHP is fully insured, ERISA provides that state laws that regulate the maintenance of specified contribution and reserve levels (and that enforce those standards) may apply. Further, state insurance laws are generally saved from preemption when applied to health insurance issuers that sell policies to AHPs and when applied to insurance policies that AHPs purchase to provide benefits. In the case of fully-insured AHPs, ERISA clearly enables states to subject AHPs to licensing, registration, certification, financial reporting, examination, audit, and any other requirement of state insurance law necessary to ensure compliance with the state insurance reserves, contributions, and funding obligations.

If an AHP is not fully insured, then any state law that regulates insurance may apply to the AHP to the extent that such state law is not inconsistent with ERISA. The final rule provides the following two examples of state regulation. First, states can require self-insured AHPs to meet the same solvency and governance standards as issuers and to participate in guaranty funds that protect policyholders when issuers fail. Second, states can also clarify or enact laws allowing their insurance departments to place AHPs into receivership, if needed.

Conclusion

For small employers and self-employed individuals, this final rule may increase their access to more affordable healthcare coverage.

For risk-averse employers who want to join an AHP, the best approach would be to join a fully-insured AHP on or after September 1, 2018, the date when this final rule will apply to fully-insured AHPs. The DOL explains that it expects fewer oversight and operational issues for fully-insured AHPs because many fully-insured AHPs already exist and issuers – who are currently regulated by the state insurance agencies – have developed products and services tailored to those plans. Also, fully-insured AHPs have traditionally been less likely to experience fraud.

An employer should exercise caution and consult with its attorney before joining a self-funded AHP. Historically, self-funded AHPs have been at greater risk of fraud and financial mismanagement. Further, the DOL anticipates that states will implement regulations and strengthen their enforcement of self-funded AHPs before April 1, 2019, the date when this final rule will apply to new self-funded AHPs.

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