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CLIENT ALERT

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Association Health Plans: New Proposed Rule to Help Convert Small Businesses and Self-Employed Individuals into a Status Similar to Large Group for Access to Affordable Health Insurance

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Executive Summary

The Trump Administration has published a proposed rule allowing a significant change to the definition of "employer" under ERISA that would enable small businesses[1] and self-employed individuals to band together to create associations that would be considered “employers” for the purpose of being offered access to large group health plans, which are typically less expensive but have fewer protections under the Affordable Care Act (“ACA”) than small group or individual health plans. There is a 60-day period to submit comments on the proposed rule, ending on March 6, 2018.

These new types of association health plans (“AHPs”) could result in individuals and small groups leaving exchanges/marketplace products and/or the AHPs could provide a new alternative for individuals and small groups with affordability concerns to access health insurance through the exchanges/marketplace market. The proposed rule includes protections intended to remedy historical challenges with association health plans (e.g., requiring an AHP to be controlled by its members) in order to make AHPs an attractive opportunity and to prevent AHPs from discriminating against individuals based on health reasons.

[1] Although intended to benefit small employers and the self-employed, the proposed rule does not preclude large employers from creating their own AHPs for the sole purpose of obtaining health insurance coverage, thus superseding current DOL restrictions. For example, current DOL guidance restricts the creation of AHPs only to obtain health insurance coverage and states that the definition of employer does not cover groups with memberships that include persons who are not employers of common-law employees.

Summary of Requirements for AHPs

Key requirements under the proposed rule that AHPs must meet include the following:[2]

1. Exists for the purpose, *in whole or in part*, of sponsoring a group health plan that it offers to its employer members.

2. Has a *formal organizational structure* with a governing body and has by-laws or other similar indications of formality.

3. The *functions and activities* of the association, including establishment and maintenance of the plan, are *controlled by its employer members*, either directly or indirectly, through the regular nomination and election of directors, officers, or other similar representatives that control the association and the establishment and maintenance of the plan.

4. The employer members have a *commonality of interest* that will be determined based on relevant facts and circumstances and may be established by:

    a. employers being in the *same trade, industry, line of business, or profession*; or

    b. employers having a *principal place of business* in a region that does not exceed the boundaries of the *same state or same metropolitan area* (even if the metropolitan area includes more than one state).

5. Complies with the following *nondiscrimination* provisions:

    a. Must not condition employer membership based on any health factor of an employee or employees or a former employee or former employees of the employer member (or any employee's family members or beneficiaries)

    b. Must comply with 702(b) and (c) of the same chapter with respect to nondiscrimination in eligibility, premiums, or contributions and may not treat different employer members of the group or association as distinct groups of similarly-situated individuals.

[2] 83 Fed. Reg. 614, 634 (Jan. 5, 2018). Other requirements include:

1. Each employer member is a person acting directly as an employer of at least one employee who is a participant covered under the plan.
2. The association does not make health coverage through the association available other than to employees and former employees of employer members and family members or other beneficiaries of those employees and former employees.
3. The association is not a health insurance issuer or owned or controlled by such an issuer.

The proposed rule also explicitly allows individuals who are "working owners" to qualify as both an employer and employee of the trade or business.[3]

Some of these requirements currently are in place but have been interpreted by the Department of Labor ("DOL") very narrowly, to date. This proposed rule reinterprets prior guidance more broadly and modifies some of the requirements. The DOL expects associations will save money through economies of scale, large group pricing, and offering fewer benefits.

Fewer ACA Requirements Would Apply

By enabling AHPs to qualify as large group health plans, AHPs would avoid some of the market-wide insurance requirements imposed under the ACA on individual and small group market plans that are alleged to have driven up the cost of purchasing insurance. Two of the key provisions that under the proposed rule would no longer apply to plans considered AHPs are the requirement to provide coverage that meets the plan's state Essential Health Benefits ("EHB") benchmark and the premium rating limitations. Current regulations require that individual and small group market plans must cover the full range of EHB as reflected in a state's adopted benchmark plan and any needed supplemental benefits.[4] Premium rating limitations, for example, prohibit individual and small group market plans from premium rating based on age in excess of a 3:1 variation.

[3] Working owner is defined as "any individual:

(i) who has an ownership right of any nature in a trade or business, whether incorporated or unincorporated, including partners and other self-employed individuals;
(ii) who is earning wages or self-employment income from the trade or business for providing personal services to the trade or business;
(iii) who is not eligible to participate in any subsidized group health plan maintained by any other employer of the individual or of the spouse of the individual; and
(iv) who either: (A) works at least 30 hours per week or at least 120 hours per month providing personal services to the trade or business, or (B) has earned income from such trade or business that at least equals the working owner's cost of coverage for participation by the working owner …"

The proposed rule states that an association may "reasonably rely on written representations from the individual seeking to participate as a working owner …" Id at 636.

[4] On a related note, the Centers for Medicare and Medicaid Services ("CMS") has proposed to revise the EHB requirements as applied to individual and small group market plans by broadening the options from which states can choose their EHB benchmark. The broadened options would include allowing states to select from among the benchmark plan options from other states and to create a benchmark plan by replacing one or more individual benefit categories from the state's 2017 benchmark plan with those of one or multiple state benchmark plan options. *See* HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51052 (Nov. 2, 2017).

Hurdles Remain

Even with the DOL's proposed rule encouraging more AHPs, it is not clear to what extent employers (large or small or individual) will move to adopt AHPs, as significant hurdles remain.

1. State benefit mandates and premium pricing rules might apply.

Exemption from EHB requirements would not relieve fully insured AHPs from compliance with state benefit mandates applicable to large group market plans. AHPs also would continue to be subject to Mental Health Parity requirements, to the extent that the plan opts to cover mental health benefits.

2. MEWA rules (federal and state) continue to apply.

Existing statutory provisions governing Multiple Employer Welfare Arrangements ("MEWAs") would still apply to AHPs.[5] A history of MEWA abuse resulted in Congress enacting reforms allowing for MEWAs to be regulated by both ERISA and state insurance laws. Section 514(b)(6) of ERISA prevents the DOL from exempting self-insured MEWAs from state insurance laws that apply to fully insured MEWAs. As a result, AHPs would still be subject to ERISA M-1 filing requirements, disclosure, and claims and appeals regulations, while also being subject to the individual state MEWA registration and disclosure requirements. Under the proposed rule, the DOL stated that it would welcome comments regarding possible approaches allowing for the exemption of self-insured AHPs from state regulation.[6] State rules governing MEWAs could limit the desirability of AHPs that operate across multiple state lines.

Under current laws and regulations, the proposed rule includes a statement that certain state laws apply to MEWAs to the extent that such laws do not conflict with ERISA.[7] States, therefore, can regulate matters such as a MEWA's solvency requirements, benefit levels, or rating. Some states heavily regulate MEWAs: for example, Michigan requires MEWAs to obtain a Certificate of Authority and maintain substantial cash reserves, among other requirements.[8] New York regulates MEWAs as small groups, which AHPs under the proposed rule would likely not be.[9] Also, the proposed rule may result in future state regulation that may require AHPs operating in the state to provide a certain level of benefit because ERISA allows for state regulation of MEWAs.

[5] Interestingly, the proposed rule defines an AHP as an employer, yet the "multiple employer" welfare arrangement (MEWA) rules continue to apply.
[6] "[W]hile beyond the scope of this proposed rulemaking," DOL "is interested in receiving additional input from the public about the relative merits of possible exemption approaches under ERISA ..."—this suggests that DOL is interested in exploring regulatory options for loosening state regulations of MEWAs.
[7] 83 Fed. Reg. 614, 617.
[8] MICH. COMP. LAWS § 500.700 *et seq.*
[9] N.Y. INS. DEPT., OFFICE OF GEN. COUNSEL, RE: MULTIPLE EMPLOYER WELFARE ASSOCIATIONS (MEWA) (Nov. 12, 2003).

3. Stop-loss insurance requirements.

In addition, stop-loss insurance can play a crucial role in allowing self-insured benefit plans to offer affordable premiums by protecting the employer (or AHP) from catastrophic claims. Some states have very restrictive stop-loss requirements (e.g., high attachment points)[10] that may limit the attractiveness of establishing a self-funded AHP.

4. Nondiscrimination rules continue to apply.

AHPs would need to be large enough to wield greater purchasing power. As discussed above, since the HIPAA nondiscrimination rules prohibiting discrimination against individual participants and beneficiaries based on a health status factor still apply to fully insured and self-funded AHPs, employers generally will not be able to charge higher premiums (or condition eligibility or benefits differently) between different employers based on claims experience (unless there is a reasonable business classification). This could be a challenge in pricing an AHP, whether fully or partly insured or through a stop-loss policy.

The HIPAA nondiscrimination rules also would make it difficult to create AHPs based on age as a method to control cost. HIPAA regulations allow group health plans to treat participants as two or more distinct groups of similarly situated individuals as long as the distinction is based on a bona fide employment-based classification consistent with the employer's usual business practice. Examples of bona fide employment-based classifications include: full-time versus part-time status; different geographic location; membership in a collective bargaining unit; date of hire; length of service, current employee versus former employee status; and different classifications.

Impact on Exchanges

Some fear that allowing small group plans to unite under AHPs will serve to weaken the individual and small group markets by attracting the younger and healthier people, since the health insurance products offered by AHPs will likely be less comprehensive and thus less costly. Individual and small group market plans may thereby be left with comparatively older, less healthy, and more costly enrollees, serving to further weaken their market positions. It is difficult to predict how many people currently enrolled in individual and small group market plans would choose to enroll in an AHP and/or whether such plans would attract individuals who would otherwise have remained uninsured.

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[10] For example, New York has an informal policy requiring at least a $25,000 individual attachment point and an aggregate claims attachment point of at least 105 or 110 percent of expected claims.

This Client Alert was authored by **Jackie Selby, Helaine I. Fingold, Gretchen Harders, Gregory R. Mitchell, Kevin J. Malone,** *and* **Cassandra Labbees.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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