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Association Health Plans: Opportunity, Risks, and Upcoming Battles

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States' rights versus expansive federal regulatory power. The little guys versus some of the largest corporations in America. Expanded access to health coverage choices and better pricing versus limited, but more robust, coverage.

Who knew that a relatively small change in the regulatory interpretation of a single clause in a single law could establish such battles and that the traditional liberal and conservative positions on employer-based health care coverage would be all but flipped? But that is exactly what has happened when the federal Department of Labor (DOL) issued its final regulation late last month, making it much easier for small employers and sole proprietors to join together to offer association health plans (AHPs) to their workers. The Final Rule will become effective for new AHPs on September 1, 2018.

ACA And ERISA Primer

Under the Affordable Care Act (ACA), small group employers (those with 50 or fewer employees) face more requirements than large group employers when it comes to the health benefits they must provide to their employees, most notably the requirements that such coverage include essential health benefits and generally not be medically underwritten (e.g., subject to "community rating").

While small group employers could previously band together and form multiple employer welfare arrangements (MEWAs) under the Employee Retirement Income Security Act (ERISA) in order to be treated as a large group for ACA purposes, prior DOL guidance imposed very strict requirements for MEWAs to be treated as a single employer, and in most instances, the DOL did not recognize MEWAs as a single employer sponsored group health plan but rather "looked through" to each underlying employer's size as an individual employer to determine if the coverage would be considered either a small or large group. As such, very few MEWAs have obtained in the past recognition as sponsoring a single employer benefit plan under ERISA and therefore the benefit of large employer group status.

New Interpretation Of "Employer" Under The Final DOL Rule

However, pursuant to the DOL final rule published on June 21, 2018 (Definition of "Employer" under Section 3(5) of ERISA--Association Health Plans) (Final Rule), the Trump administration has modified the DOL's prior interpretation of "employer" such that a qualified association can now be formed for the primary purpose of offering an association health plan to its member employers' employees. The Final Rule goes much farther and now allows sole proprietors, those businesses without any common employees, to become members of a qualified association health plan.

In general, an AHP will be treated as a single ERISA-covered group health plan under the Final Rule so long as there is:

- **Commonality of Interest:** All the members of the AHP must be employers (i) in the same trade, industry, line or businesses, or profession or (ii) or have the a principal place of business 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). While some of the examples of AHPs found in

the Final Rule suggest that a same trade, industry, line or businesses, or profession includes a group of restaurants, plumbing services businesses, and agricultural industry businesses, the DOL will likely need to provide more guidance on where outer lines are for the requisite homogeneity of employers engaged in a "common" industry or profession.

- **Additional Purpose:** In a change from the proposed version of the rule, which had allowed associations to be formed for the sole purpose of providing health insurance coverage to its members—which was in stark contrast to the prior DOL positon that a bona fide association had to be formed for the purpose of providing "real," non-insurance benefits to its members—the Final Rule requires that the sponsoring association 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.
- **Member Control:** As with prior MEWAs, the group health plan must be controlled by the members of the AHP, both in substance and form.
- **No Control by Health Carriers:** Traditional health insurance carriers are prohibited from forming an AHP; although they can act as third party administrators for such AHPs.

Looming Battle over Federalism, States Rights, and Stated Based Insurance Regulation

In general, states are prohibited from regulating fully-insured MEWAs pursuant to ERISA, which preempts all state laws "relating to" employee benefit plans. However, under ERISA's "Saving's Clause," nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities."

Consequently, state insurance departments have taken the position that, while they cannot regulate a fully-insured MEWA directly, they can regulate the insurance policy that is issued to a MEWA by a licensed carrier in their state. Furthermore, a number of states also take the position that self-insured MEWAs are "unlicensed" insurance carriers (bearing health benefits risks transferred among all participating employers) and are prohibited from operating without holding an insurance company certificate of authority. This position is explicitly recognized in the preamble to the Final Rule, which provides that it "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."

In addition, some states have insurance statutes that recognize "true" associations as permissible group health insurance policyholders, but under these statutes, an association must be formed for a purpose other than serving as a vehicle to provide health insurance coverage to the association's members, and some states impose a seasoning requirement, effectively as a proxy for testing the validity of an association's non-insurance purpose, by requiring that an association must have existed for a minimum number of years (3 to 5 depending on the state) before the association may offer health insurance to its members. The Final Rule may preempt these state statutes.

As such, it is not surprising that a number of states, most notably California, have taken the position that this change in interpretation of federal law cannot supersede the states' authority to restrict and otherwise regulate MEWAs operating in their state. Other states, including Massachusetts and New York, have threatened litigation to enjoin the implementation of the Final Rule.

Opportunities for Small Group Businesses

Despite such uncertainty, there are a number of opportunities that association organizers, traditional insurance carriers, and small group employers can pursue:

- **Existing Chambers of Commerce:** State and local chambers of commerce are logical organizations for sponsoring new AHPs. Metropolitan-based chambers of commerce now have

the ability to facilitate AHPs for all their business members, regardless of what types of industries or professionals they engage.

- **Existing, but Questionable, "True" Associations:** Associations formed before the effective date of the Final Rule, which may be providing questionable non-insurance benefits in order to achieve "true" association group status, now have the opportunity to regroup and securely comply with the Final Rule's more relaxed requirements.
- **Independent Third Party Administrators (TPAs):** TPAs that are not affiliated with health insurers or health maintenance organizations can now spearhead formation of, and effectively exert substantial control over, AHPs.
- **Captive Insurance Managers:** Consultants to and managers of captive insurance companies now have a new AHP solution in their toolkits to augment conventional captive insurer arrangements for health benefits.

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