Association Health Plans
Legal Update & Analysis

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On October 12, 2017, President Trump issued Executive Order 13813, “Promoting Healthcare Choice and Competition Across the United States.”

- Stated goal: To expand affordable coverage across state lines.
- To Achieve that goal, the Executive Order directed the Secretary of Labor to consider:
  - Expanding the conditions that satisfy the commonality of interest requirements under existing guidance defining the term “employer,” effectively expanding the universe of entities that sponsor large association health plans; and
  - Promoting AHP formation on the basis of common geography.
Pre-Rule Limits on AHPs

- Under 2011 federal guidance, regulators and insurers are generally to “look through” an association to members to determine whether health insurance coverage is considered sold in individual market, small group market, or large group market.

- For healthy risks, moving to the large group market can reduce costs by avoiding essential health benefits package, community rating, and risk adjustment, which apply only in individual and small group market.

- Forming an association seemed to be avenue for individuals and small employers to access the large group market, but 2011 guidance largely eliminates.

- One exception: the association is the “employer” that sponsors the plan, within the meaning of ERISA § 3, which 2011 guidance calls “rare.”
Definition of employer under ERISA § 3(5):

“... 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.”

- Very broad definition. Almost any entity could be deemed an “employer.”
- Employer sponsorship is the key distinction between an insurance company and an ERISA-governed plan.
DOL and state insurance authorities issued guidance limiting the definition of a “employer” by providing factors defining *bona fide* association plans.

**Key factors** include: commonality of interest among the membership and governance by the membership.

**Other factors** also include: how membership is recruited, who is entitled to participate and who actually participates, and purpose of the association.
Final regulations redefine the term “employer” principally by expanding who can sponsor a large plan.

Does not replace existing guidance; just provides “additional” mechanism to achieve *bona fide* association status for the purpose of being deemed a large ERISA-covered plan.
Association Health Plan – Final AHP Regulations

- Expands definition of *bona fide* association by expanding commonality of interest standard to 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).

- Commonality of interest and control requirements are retained in the final rule as elements that distinguish employment-based benefit arrangements from commercial insurance marketing programs.

- The second factor lacks definition and problems related to state insurance laws complicate its implementation.
Association Health Plan – Final AHP Regulations

- Allows an association to form for the purpose of providing insurance provided the association has at least one substantial other business purpose.
  - A purpose that would allow AHP to continue to operate if the health plan ceased.
- Requires the AHP to have a “formal organization structure with a governing body” as well as by-laws or other indications of formality.
- Allows “working owners” to participate.
- The group or association must not condition employer membership in the group or association on any health factor, as defined by HIPAA.
### Rule Does Not Eliminate Pre-Rule Path

<table>
<thead>
<tr>
<th>Pre-Rule Guidance</th>
<th>AHP Rule</th>
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<tbody>
<tr>
<td>Members must be employers (or partnerships)</td>
<td>Members can include sole proprietors or working owners (with no employees)</td>
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<tr>
<td>Regional chambers of commerce are too broad a commonality of interest</td>
<td>Associations defined by region or state are permitted</td>
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<tr>
<td>For insured AHPs, insurers could set different rate for different employer-members</td>
<td>For insured AHPs, insurers cannot set different rates for different employer-members (though can still set different rates based on other factors, like geography or industry type)</td>
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Association Health Plan– Expectations and Reality

- **Expectations:**
  - A greater number of small groups could band together and be deemed a large group.

- **Results small groups could:**
  - Avoid state mandates.
  - Avoid ACA 10 essential benefits.
  - Leverage pricing.
  - Transfer day-to-day plan obligations from small employer to AHP manager.
Association Health Plan -- Reality

- ERISA Preemption does not apply in the context.

- State and Federal laws govern MEWAs.

- Crossing state lines not possible—unless you use national carrier.
Applicable deadlines:

September 1, 2018, for employee welfare benefit plans that are fully insured and that meet the requirements for being an association health plan sponsored by a bona fide group or association of employers.

January 1, 2019, for any employee welfare benefit plan that is not fully insured, is in existence on June 21, 2018, meets the requirements that applied before June 21, 2018, and chooses to become an association health plan sponsored by a bona fide group or association of employers.

April 1, 2019, for any other employee welfare benefit plan established to be and operated as an association health plan sponsored by a bona fide group or association of employers.
On July 26, 2018, 16 states and D.C. initiated a lawsuit in the District of Columbia challenging the AHP regulation.

Basis of lawsuit:

- Rule conflicts with the statutory structure that Congress adopted in the ACA to apply fundamental protections to the individual and small group markets.
- Rule conflicts with the ACA, ERISA, and established case law by enabling a purportedly self-employed individual (denominated a “working owner”) with no other employees—and with minimal income and verification—to be both an “employer” and “employee” under ERISA with the authority to establish a group health plan.
- Rule unlawfully expands ERISA to allow all employers (including self-employed individuals described) in a State or “metropolitan area” to group together into a profit-making commercial insurance enterprise.
- Fully-insured plans not considered a problem and as long as the carrier is licensed in the state, MEWA can operate in the state.
- Self-funded MEWAs are scrutinized and some states don’t allow them to operate at all.
States and MEWA Legislation –

Subject to confirmation with State DOI, the following three states allow self-funded association plans and DO NOT impose state mandates on those plans:

- Colorado
- New Hampshire
- Georgia
- Kentucky

The following states allow self-funded association plans, but either impose small group mandates or statute is unclear:

- Indiana
- Nevada
- Maine
- Ohio
- Missouri
The following states do not allow self-funded MEWAs or impose the full panoply of laws applicable to a licensed carrier:

- Connecticut
- New York
- Virginia
- Wisconsin
Association Health Plan Examples (New)

- Transcend Michigan (Small Business Association of Michigan & Mich Business, in partnership with BCBS)
- Nebraska Farm Bureau (in partnership with Medica)
- Local Nevada Chambers of Commerce have formed BCCC AHP (in partnership with Health Plan of Nevada and Sierra Health & Life)
- Reno + Sparks Chamber Association Health Plan (partnership with Prominence Health Plan)
- North Carolina Restaurant & Lodging Association (partnership with United Healthcare)