SATURDAY, FEBRUARY 9
8:30 a.m. - 9:30 a.m.

HEALTH CARE UPDATE

The Affordable Care Act ... it’s still here! The panelists will address the continued viability of the ACA, the regulations permitting association health plans and skinny plans (and related lawsuits), cease and desist orders that DOL can issue to MEWAs pursuant to ACA regulations, surprise billing, and the continued litigation surrounding wellness programs.

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Outline

I. The continued viability of the ACA
   A. Texas v. United States & other structural ACA litigation
   B. The status of the contraceptive mandate
   C. Wellness program litigation

II. MEWAs: Cease and desist orders that DOL can issue to pursuant to ACA regulations

III. Association health plans and skinny plans

IV. Surprise Billing

I. ACA LITIGATION CHALLENGES

A. Texas v. United States

1. Texas District Court Judge Holds ACA Unconstitutional

   On December 14, 2018, Judge Reed O’Connor of the Northern District of Texas held that the ACA’s individual mandate was unconstitutional. Texas v. United States, 340 F. Supp. 3d 570 (N.D. Tex. 2018). The court held further that the entire ACA was invalid, based on its determination that the individual mandate was non-severable from the rest of the ACA. See id. The court did not enjoin its continued enforcement, however, and the ACA remains in effect. See id. The decision is stayed pending appeal. Texas v. United States, --- F. Supp. 3d ---, 2018 WL 6844173, *13 (N.D. Tex. 2019).

   Texas v. United States sets up the possibility or even the likelihood of another Supreme Court decision on the validity of the ACA. The plaintiffs include 18 Republican states and 2
Republican Governors, while the intervenor defendants include 18 Democratic states and the U.S. House of Representatives.

2. The City of Columbus and Maryland Attorney General Suits for a Declaration that the ACA is Constitutional

In response to Texas v. United States, the cities of Columbus, Baltimore, Cincinnati, Chicago, and two Democracy Forward Foundation staff sued the Trump administration on August 2, 2018, in the District of Maryland. See City of Columbus et al. v. Donald J. Trump, Case No. 1:18-cv-02364-DKC (D. Md., filed Aug. 2, 2018) (ECF No. 1). The complaint alleges that President Trump is deliberately undermining his executive obligation to “faithfully execute the law,” by sabotaging the ACA, contrary to the Administrative Procedure Act and the “Take Care Clause,” U.S. Const. art. II, § 3. Defendants filed a motion to dismiss based on lack of jurisdiction (on standing grounds), and for failure to state a claim. (ECF No. 40.) Plaintiffs will file an amended complaint by January 25, 2019. (ECF No. 43.)

Separately, the State of Maryland brought suit for a declaration of the constitutionality of the ACA, or, in the alternative a declaration that the part of the December 2017 tax reform bill that zeroed out the individual mandate is unconstitutional. State of Maryland v. United States of America, et al., ELH-18-2849 (D. Md., filed Sept. 13, 2018) (ECF No. 1). Contending lack of standing, the United States has moved to dismiss the case, but Maryland argues the uncertainty as to the status of the ACA is causing it harm in its budgetary and other planning. (ECF No. 51.) The case is before Judge Ellen L. Hollander. The federal government moved for a stay based on the government shutdown, which the Court denied. (ECF No. 49.)

3. Other ACA Premium Stabilization Litigation – Risk Adjustment, Risk Corridor Payments & Cost Sharing Reductions

Litigation is also continuing over risk adjustment methodologies under the ACA, including those shown in Appendix 1, below.

B. ACA Contraceptive Mandate (as of January 10, 2018)

Rules issued by the Obama administration defined the preventive care and wellness provisions of the ACA as requiring most employers to cover contraceptives with no cost sharing by the individual.1 The Obama Administration regulations provided an exception to this contraceptive mandate for houses of worship based on religious objections and provided that religiously-affiliated nonprofits could opt out of providing contraceptive coverage by electing an accommodation under which the insurer, not the employer, pays for the contraceptive

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1 42 USC § 300gg-13(a)(4), 45 CFR. § 147.130(a)(1)(iv) (coverage of preventive health services); ACA FAQ 36.
coverage. The right to elect an accommodation was extended to closely held for-profit corporations after *Burwell v. Hobby Lobby*, 134 S.Ct. 2751 (2014).  

The obligation to offer even the accommodation was challenged by a number of nonprofit employers. President Trump issued an executive order directing the agencies to consider amended rules addressing conscience-based objections to the contraceptive mandate. On October 6, 2017, two new interim final rules (IFR) were issued. The religious exemption IFR expanded the full exemption to all entities “with sincerely held religious beliefs objecting to contraceptive or sterilization coverage” and makes it optional for the entity to offer the accommodation. The moral exemption IFR expanded the exemption to “include additional entities and persons that object based on sincerely held moral convictions” on the same terms as for religious organizations. These IFRs are set to expire January 14, 2019.

The interim final rules were challenged on several grounds including as invalid under the Administrative Procedure Act. On December 13, 2018, the Ninth Circuit affirmed in part an injunction issued by the District Court for the Northern District of California because they were issued without a notice of rulemaking.

On November 15, 2018, while *California v. Azar*, was pending in the 9th Circuit the Departments of Treasury, Labor and Health & Human Services issued final rules on the religious and moral objection exceptions. The final rules provide that employers other than religious entities that have a religious or moral objection to providing contraceptive coverage are exempt from the requirement to provide such coverage under the ACA and they do not need to provide an accommodation. Entities that have been providing coverage with an accommodation may terminate such accommodation with 60 days’ notice or on the first day of a plan year with 30 days’ notice. The rule specifically applies to student health insurance provided by an educational institution. State governmental entities are not covered by this exception.

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2 Coverage of Certain Preventive Services Under the Affordable Care Act, 26 CFR 54, 29 CFR 2510 and 2590, 45 CFR 147 and 156 (July 2, 2013).

3 Accommodations in connection with coverage of certain preventive health services, 45 CFR 147.131 (b)(4) (July 14, 2015).


8 *California v. Azar*, 2018 U.S. App. LEXIS 35077 (9th Cir, December 13, 2018) (affirming the injunction as to the five plaintiff states, vacating as overbroad as to the rest of the country, and remanding). After the opinion was issued, eight additional states and the District of Columbia moved to be added as plaintiffs and all the plaintiffs filed a motion for a nationwide preliminary injunction as to the final rule.


10 State laws may require that such coverage be provided.
After the Ninth Circuit remanded *California v Azar*, eight additional states and the District of Columbia moved to be added as plaintiffs and all the plaintiffs filed a motion for a nationwide preliminary injunction as to the final rule.

The IFR was also enjoined on December 15, 2017 by the United States District Court for the Eastern District of Pennsylvania in *Pennsylvania v. Trump*, 281 F. Supp. 3d 553 (E.D. Pa. 2017), appeal filed at Third Cir. Appeal Nos. 17-3752 (Dec. 21, 2017) and 18-1253 (Feb. 15, 2018). The case was initially stayed but the stay was lifted on December 14, 2018. A preliminary injunction hearing was held on January 10, 2019. On December 27, 2018 the defendants were granted an extension to February 28, 2019 to file an answer or otherwise respond to the complaint.

C. Wellness Litigation – see accompanying power point

II. MEWAS AND THE AFFORDABLE CARE ACT [FROM EMPLOYEE BENEFITS LAW BOOK]

The Affordable Care Act gave the DOL new authority with respect to MEWAs. Specifically, the ACA gives the Secretary of Labor the authority to issue a cease-and-desist order if it appears that a MEWA is fraudulent; if a MEWA creates an immediate danger to public welfare; or if a MEWA can be reasonably expected to cause significant, imminent, and irreparable harm. The Secretary was also given the authority to issue a summary seizure order when a MEWA is in a financially hazardous condition. The MEWA regulations define the three statutory grounds for the issuance of a cease-and-desist order, with examples; define “financially hazardous condition”; set forth the general scope of a summary seizure order; and explain circumstances in which a summary seizure order may be issued without prior judicial authorization. DOL regulations establish the procedures to be used by administrative law judges and the DOL when a request for an administrative hearing to challenge a cease-and-desist order is timely made.

III. ASSOCIATION HEALTH PLANS – SEE ACCOMPANYING POWER POINT

A. The Final Rule

On June 21, 2018, EBSA issued the final rule governing Association Health Plans (AHPs). 83 Fed. Reg. 28,912 (“Definition of ‘Employer’ Under Section 3(5) of ERISA – Association Health Plans). As the summary to the final rule describes:

This . . . final regulation under Title I of the Employee Retirement Income Security Act (ERISA) . . . establishes additional criteria under ERISA section 3(5) for determining when employers may join together in a group or association of employers that will be treated as the “employer” sponsor of a single multiple-employer “employee welfare benefit plan” and “group health plan,” as those terms are defined in Title I of ERISA.
Id. at 28,912. The regulation establishes “a more flexible ‘commonality of interest’ test for the employer members than the Department of Labor (DOL or Department) had adopted in [prior] sub-regulatory interpretive rulings under ERISA section 3(5),” with the purpose of “[f]acilitat[ing] the adoption and administration of AHPs.” Id.

The rule allows for a “bona fide group or association of employers” to establish a group health plan if it meets all of the following criteria:

(1) It has at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees. If the entity would be a “viable entity” in the absence of providing employee benefits, it is considered to have a bona fide purpose. Such purposes may include “promoting common business interests of its members or the common economic interests in a given trade or employer community, and is not required to be a for-profit activity.” 29 C.F.R. § 2510.3-5(b)(1).

(2) Each employer member must act directly as an employer of at least one employee who is a participant covered by the plan. 29 C.F.R. § 2510.3-5(b)(2).

(3) The group or association must have a formal organizational structure with a governing body, and have “by-laws or other similar indications of formality.” 29 C.F.R. § 2510.3-5(b)(3).

(4) The employer members must control the “functions and activities” of the group or association, and such control “must be present both in form and in substance.” 29 C.F.R. § 2510.3-5(b)(4).

(5) The employer member must have a common interest as defined in the regulations. 29 C.F.R. § 2510.3-5(b)(5). Such common interests may include:

(i) The employers are in the same “trade, industry, line of business or profession”;

(ii) “Each employer has a principal place of business in the same region that does not exceed the boundaries of a single State or metropolitan area (even if the metropolitan area includes more than one state)”. 29 C.F.R. § 2510.3-5(c).

Controversially, the rule allows for working owners, such as sole proprietors and other self employed individuals, to be deemed employers capable of participating in AHPs. 83 Fed. Reg. at 28,914.
Also controversially, the rule allows members of AHPs to avoid the stricter standards that apply to insurance provided by small groups, by making them subject to the ACA large group standards, including granting AHPs an exemption from covering the ACA’s essential health benefit package.

B. AHP Litigation

In *State of New York et al v. United States Department of Labor*, 18-cv-01747 (filed Jul. 26, 2018), a coalition of 12 Democratic attorneys general, led by Attorneys General Barbara D. Underwood of New York and Maura Healey of Massachusetts, filed a lawsuit challenging the final regulation. Other Plaintiffs include the District of Columbia, California, Delaware, Kentucky, Maryland, New Jersey, Oregon, Pennsylvania, Virginia and Washington. Defendants are the United States Department of Labor and Alexandra Acosta, in his official capacity as Secretary of the DOL.

The lawsuit alleges that the final rule is meant to undermine the ACA and that the Department of Labor wants to shift small employers and individuals into the large group market where ACA major protections don’t apply. In doing so, the suit alleges, the DOL is changing long-standing interpretations of federal law. Additionally, the rule undermines ACA protections that would otherwise apply to plans from true large employers.

As of this writing, the case is pending summary judgment rulings, with a hearing held on January 24, 2019.

C. State Regulation of AHPs

AHPs, as MEWAs, are subject to state regulation and a relaxed ERISA preemption standard applies. Under ERISA Section 514, a MEWA that is fully insured is generally subject to state insurance regulation, while self-funded MEWAs are also subject to state insurance law to the extent not inconsistent with ERISA.

The states have long regulated MEWAs, and several have passed new legislation that would impose restrictions on fully-insured MEWAs. See [https://www.mintz.com/sites/default/files/media/documents/2018-10-02/State_AHP_Guidance_Table.pdf](https://www.mintz.com/sites/default/files/media/documents/2018-10-02/State_AHP_Guidance_Table.pdf) for a summary as of October 1, 2018.

D. Examples of AHPs: See Appendix 2

IV. SURPRISE BILLING

A surprise bill is when an individual gets services from an out-of-network provider at an in-network hospital or facility. This is often in the context of emergency room physicians and ancillary providers such as radiologists, pathologists, and anesthesiologists. With these ancillary
providers the individual is often not in a position to ensure that they are in-network or even to ask if they are. This creates an issue for both individuals and for health plans.

This paper addresses the impact and some possible responses to these bills by self-insured ERISA plans. A surprise bill also refers to a situation where an individual is surprised when their insurer or group health plan denies benefits such as denial of emergency room charges as not being related to an emergency. Another surprise bill for the individual is an unexpected balance billing of amounts not covered by the insurer or group health plan.

When Insurers or Group Health Plans do not get discounts and then cover the benefit under the same co-insurance or co-pay structure as an in-network claim they are faced with unpredictable costs because there are no controls. On the other hand, if the plan pays on an allowed amount based on UCR or R&C then the individual can be exposed to liability for a huge amount based on the difference between billed and allowed charges.

In the context of construction trade multi-employer plans, many boards of Trustees are struggling with the tension between protecting the participant by paying the extra costs and protecting the assets of the plan by limiting what is paid. Strategies for approaching the issue include:

- Paying these non-network providers at the same level of benefits as the facility where the services were performed on the allowed amount and considering the payment of additional amounts on appeal;
- Trying to negotiate with the non-network providers and paying on the negotiated amount;
- Paying these non-network providers at the same level of benefits as the facility where the services were performed on the billed amount;

In the past when doing a search for a network provider plans often focused on the size of the network (the number of hospitals and other providers), the extent of the discount, the fees, and the other services that could be provided such as wellness. Some Plans are now also looking at the exposure to these non-network providers when comparing networks.

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11 Some states are addressing the issue in relation to insured plans. Those laws are preempted as to self-insured ERISA Plans.
Appendix 1: Insurer Cases

Risk Corridors Payment (RCP) Cases

**Moda Health Plan v. United States** (892 F.3d 1311)
**Blue Cross and Blue Shield of North Carolina v. United States** (729 Fed.Appx. 939)
**Land of Lincoln Mutual Health Insurance Co. v. United States** (892 F.3d 1184)
**Maine Community Health Options v. United States** (729 Fed.Appx. 939)

**Status:** All denied en banc review (908 F.3d 738), so likely seeking cert.

**Details:** In all cases, Federal Circuit panels concluded that government’s obligation to make risk corridors payments to insurers was suspended by subsequent appropriations riders requiring net risk corridors payments to be budget neutral.

Note on **Maine Community:** Also a CSR case (17-cv-02057-MMS), scheduled hearing on 1/29/2019 alongside **Common Ground Healthcare** and **Community Choice Health Options** (below).

Cost-Sharing Reductions (CSR) Cases

The following cases are all plaintiff insurers alleging that the government failed to pay them cost-sharing reduction payments as entitled under the ACA.

**Common Ground Healthcare Cooperative v. United States**
17-cv-00877

**Current Status:** Hearing on Cross Summary Judgement motions set for 1/29/2019. Will be heard alongside CSR challenges brought by **Maine Community Health Options** (under RCP cases) and **Community Choice Health Options** (below).

Class includes any insurer that offered a qualified health plan in 2017 or 2018 and did not receive a CSR payment to account for the amount it paid out in CSRs to enrollees. As of September 2018, 91 insurers had opted in to the class action lawsuit.

**Date filed:** 6/27/2017

**Details:** Class action against government alleging that government ceased making cost-sharing reduction payments to insurers as entitled under the ACA.

**Sanford Health Plan v. United States**
139 Fed.Cl. 701

**Status:** **Appeal filed to Federal Circuit.** Appellant’s brief due 2/11/2019. Likely consolidated with **Montana Health**.

**Details:** Action against federal government for $1.6 million that insurer was allegedly entitled to receive under ACA cost-sharing reduction section. Judge (also decided **Montana Health Co-Op**) held that ACA cost-sharing reduction section obligated government to provide insurer its cost-sharing reduction payments, notwithstanding lack of appropriations
to fund such payments. Decision distinguished *Moda* as, unlike net risk corridor payments, there are no appropriations riders requiring CSR payments be budget neutral.

**Montana Health Co-op v. United States**  
139 Fed. Cl. 213

**Status:** Appeal filed to Federal Circuit. Appellants brief due 2/11/19. Likely consolidated with *Sanford*.

**Details:** Action against federal government for $5 million that insurer was allegedly entitled to receive under ACA cost-sharing reduction section. Judge (also decided *Sanford*) held that ACA cost-sharing reduction section obligated government to provide insurer its cost-sharing reduction payments, notwithstanding lack of appropriations to fund such payments.

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**Community Choice Health Options v. United States**  
18–cv-00005-MMS

**Status:** Hearing on Cross Summary Judgement motions set for 1/29/2019. Will be heard alongside CSR challenges brought by *Maine Community Health Options* (under RCP cases) and *Common Ground Healthcare* (above).

**Details:** Seeking $9,773,000 in unpaid CSRs

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**Molina Healthcare of California, Inc v. United States**  
18-cv-00333-TCW

**Status:** Currently stayed until the decisions in *Land of Lincoln* and *Moda Health Plan* become final and non-appealable.

**Details:** Seeking nearly $160 million in unpaid CSRs.

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**Local Initiative Health Authority for Los Angeles County v. United States**  
17-cv-01542-TCW

**Status:** Hearing scheduled for 1/04/2019 re: cross motions for summary judgment.

**Details:** Seeking $25,765,000 in unpaid CSRs

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**Guidewell Mutual Holding Corporation v. United States**  
18-cv-1791 C

**Status:** Pending summary judgment motion, response due 1/11/19.

**Details:** Guidewell (which includes Blue Cross and Blue Shield of Florida, Florida Health Care Plan, and Health Options) seeks about $223 million for unpaid CSRs from 2015, 2016, and 2017.

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**Harvard Pilgrim Health Care v. United States**  
18-cv-1820 C

**Status:** Answer due by 1/28/19.
Details: Seeking $1,160,000 in unpaid 2017 CSRs.

**Health Alliance Medical Plans, Inc. v. United States**
18-cv-00334

Status: Pending cross-motions for summary judgment (nothing on docket since 10/26/18).

Details: Seeking $4,824,000 in unpaid CSRs.

**Blue Cross & Blue Shield of Vermont v. United States**
18-cv-00373-MBH

Status: Pending cross-motions for summary judgment (nothing on docket since 10/26/18).

Details: Seeking $4,613,000 in unpaid CSRs.

**Risk Adjustment Program Challenges**

**New Mexico Health Connections v. United States Department of Health and Human Services**
D. NM, 16-cv-00878-JB-JHR

Status: Appeal filed to 10th Cir., filing deadline currently stayed due to lapse of appropriations. Docketing statement due 1/22/19.

Date filed: 7/29/2016

Plaintiff: New Mexico Health Connections (non-profit organization)

Defendants: US Dept. of HHS, Centers for Medicare and Medicaid Services, Burwell, Slavitt

Amici: America’s Health Insurance Plans, Blue Cross Blue Shield Association

Details: Consumer Operated and Oriented Plan (CO-OP) program participant sought declaratory and injunctive relief from HHS’s use of the state average premium when calculating risk adjustment transfer payments under the ACA. Insurer and HHS moved for summary judgment. Judge Browning held that HHS’s use of a statewide average premium was arbitrary and capricious, but not that there was not an issue with CMS using a budget neutral approach as a matter of policy.

(Round 2) **New Mexico Health Connections v. US Department of Health and Human Services**
D. NM, 18-cv-00773

Status: Pending a joint status report which has been delayed due to the government shutdown. Case could possibly be stayed until the 10th Cir. decides appeal.

Date filed: 8/13/2018

Plaintiff: New Mexico Health Connections

Defendants: US Dept. of HHS, Centers for Medicare and Medicaid Services, Azar, Verma
Details: Second lawsuit brought by NMHC challenging the final rule on the 2017 risk adjustment program methodology for 2017. Case had been on hold until after Judge Browning’s reconsideration decision. After he denied that request, the parties asked for a continued stay until a joint status report on January 4, 2019. This deadline was extended until after the government shutdown ends (although it is possible that the second lawsuit will be stayed while the original lawsuit is on appeal to the Tenth Circuit).

Short-Term Plans Challenge

Association for Community Affiliated Plans v. US Dept. of Treasury
D.C., 18-cv-02133-RJL

Status: Litigation is on hold until Congress has restored funding to the DOJ.

Date filed: 9/14/2018

Plaintiffs: Association for Community Affiliated Plans, National Alliance on Mental Illness, Mental Health America, American Psychiatric Association, Aids United, National Partnership for Women & Families, Little Lobbyists, LLC

Defendants: US Dept. of Treasury, DOL, HHS, Azar, Acosta, Mnuchin, US


Details: Coalition of consumer advocates and safety net health plans allege that the final rule expanding access to short-term plans is contrary to Congress’s intent in adopting the ACA and should be invalidated. Briefing schedule requires parties file cross-motions for summary judgement before Jan 11 and a motion shearing be held on Feb. 19.

Appendix 2: Examples of AHPs Formed Under Final Rules

While some states have passed laws restricting operations of AHPs, others have authorized them. Some associations have formed since the new rule, and appear to be taking advantage of the rules allowing pricing based on the entire association’s membership, i.e., pricing based on the large pool that the associations’ membership comprises, rather than requiring small group pricing for each individual member employer.
Transcend Michigan (Small Business Association of Michigan & Mich Business)
- Effective Date: October, 2018
- Carrier: Blue Cross Blue Shield
- 501c6 Nonprofit association
- Works directly with local Chambers of Commerce and Associations
- Members
  - SBAM & MB represent approximately 7 percent of the state’s 800,000 small and sole proprietor businesses
  - Includes sole proprietors and companies with 50 or fewer employees
- Plans
  - 10 different large group plans
  - Doesn’t cover pediatric dental care but covers other ACA essential health benefits
- Sources:

Nebraska Farm Bureau (in partnership with Medica)
- Effective Date: Announced in September, 2018
- Carrier: Medica
- Grassroots farm organization with more than 61,000 farm and ranch family members
- Plans
  - Cover all essential health benefits and will not charge more or exclude those with pre-existing conditions
- Rates
  - Vary based on age, geographic location and industry. Is considering varying rates based on gender in the future.
  - States premium savings of up to 25% (group of insured healthier)
- Nebraska Department of Insurance fully recognizes the new AHP rule, including allowing sole proprietors to join association plans
  - State that they aren’t worried about AHPs drawing younger and healthier people out of the Affordable Care Act market and driving up premiums on assumption that the new plans likely will attract mostly consumers who already have dropped out of the ACA market due to high premiums
- Sources:
  - https://www.modernhealthcare.com/article/20181110/NEWS/181109905
Land O’Lakes Self-Insured Association Plan

- Leases network from Cigna Corp. in Nebraska and PreferredOne in Minnesota
- Effective Date: in progress of expanding (post-final rule)
- Members
  - 2018 pilot program in Minnesota
    - Offered to 12 co-ops and Minnesota dairy farmers
  - 2019 Expansion
    - Expanding to 15,000 additional eligible farmers in Minnesota and 28,000 in Nebraska who are members of cooperatives that opt-in to participating and offering coverage
- Plans:
  - Eight plans with range of deductibles which appear to provide coverage for all 10 essential health benefits
- Rates
  - Will vary based on zip code, age
    - Older members will pay as much as four times what younger members pay (ACA exchange limited to three times)
- Self-insured status avoids certain state premium taxes and avoids having to pay a “risk load” or profit margin to health insurance carrier
- Nebraska insurance commissioner seems to be partnering with Land O’Lakes as it will provide competition for Medica, which has been the only insurer offering coverage on the ACA exchange in Nebraska
- Sources:
  - https://www.modernhealthcare.com/article/20181110/NEWS/181109905
  - https://www.landolakesinc.com/Press/News/Cooperative-Farmer-Member-Health-Plan

Benefits Minnesota

- Effective Date: TBA
- Minnesota Council of Nonprofits (411 members <50 employees—84.8% of members)
- Currently in process of having Department of Commerce review and approve proposed plan structures
- Expect to send organizations plan and rate information sometime in spring 2019
- Source:

Mason Contractors Association of America Association Health Plan (Illinois)

- Effective Date: unclear but post-final rule
- Carrier: United Healthcare
- **Members**
  - Employers with between 2 and 50 employees
  - Company must be a mason contractor (SIC Code 1741) and active MCAA member
- **Plans:**
  - 40 plans all ACA compliant
  - Supplemental life, disability, dental and vision plans offered
- **Rates:**
  - Unclear, may be different for groups with 2-4 eligible employees and those with 5+
- **Source:** [https://www.masoncontractors.org/association-health-plan/](https://www.masoncontractors.org/association-health-plan/)

**Nevada**
- Nevada Insurance Commissioner Barbara Richardson has welcomed the new AHP rule as providing additional insurance options for Nevadans that may fit their personal needs and the needs of their families. Added that it creates a more competitive small group market.
- As of Nov. 21, six AHPs overseen by the state’s Division of Insurance with one more applicant to be officially approved.
- All plans were started this year and offered by professional groups or trade associations.
- Self-funded AHPs currently do not operate from inside the state.
- **General Sources:**
  - [http://doi.nv.gov/Health_Insurance_Rates/Small_Employer_Options/](http://doi.nv.gov/Health_Insurance_Rates/Small_Employer_Options/)
  - [https://www.modernhealthcare.com/article/20181110/NEWS/181109905](https://www.modernhealthcare.com/article/20181110/NEWS/181109905)

- **Local Nevada Chambers of Commerce** have formed BCCC AHP
  - Effective Date: September 1, 2018
  - Carriers: Health Plan of Nevada & Sierra Health and Life
  - Service Area: Clark County
  - **Members**
    - Three chambers of commerce (Henderson, Boulder City and Latin chambers in Clark County)
      - Represent ~20,000 small businesses, typically with 10 or less employees
      - Participating business owners must have at least one employee who is not the person’s spouse
- Hoping to allow sole proprietors to enroll
  - Plans
    - 10 plan choices including HMO, PPO and point of service plan through UnitedHealth Group
    - Reports that the plans are not “skinny”
  - Rates
    - Setting different premiums for different employer groups within the Clark County AHP based on factors of age, occupation, size of group and geographic location. They say they won’t use gender as a factor.
    - Not clear if member businesses face different rates
    - Former state insurance commissioner speculated that the chambers intend to have a rating methodology that’s attractive to some and less attractive to others resulting in a better-than-average risk pool
    - United Healthcare also expected to attract enough volume to command lower rates
    - Two-year guarantee on no premium increases
  - Sources:
    - https://www.modernhealthcare.com/article/20180817/NEWS/180819918

- **Reno-Sparks Chamber Association Health Plan**
  - Effective Date: October 6, 2018
  - Carriers: Prominence Health Plan (medical coverage) and Kansas City Life (dental, vision and life insurance)
  - Service Area: Statewide
  - Members:
    - Available to any member of the chamber with between two and 50 employees
    - 650 business chamber members eligible
  - Plans
    - Reports plans are “robust”
  - Sources:

- **Las Vegas Metro Chamber of Commerce**
  - Effective Date: October 1, 2018
Carriers: Rocky Mountain Hospital and Medical Services, Inc. D.B.A. Anthem Blue Cross Blue Shield (NV)
Service area: statewide
Previously had large AHP which was disbanded in 2014 after the ACA began requiring all individual and small business plans cover 10 categories of essential benefits
Members
Plans
  - Says that they are avoiding “skinny plans”
Rates
Sources:

- Nevada Builders Alliance
  - Effective Date: October 25, 2018
  - Carrier: Prominence HealthFirst & Prominence Preferred Health Insurance Co, Inc.
  - Service area: statewide
  - Members
    - 800 companies

- Nevada Contractors Association Health Plan
  - Effective Date: December 1, 2018
  - Carriers: Health Plan of Nevada & Sierra Health and Life
  - Service area: statewide

- Builders Association of Northern Nevada
  - Effective Date: December 1, 2018
  - Carriers: Hometown Health Plan, Hometown Health Providers Insurance Company & Delta Dental Insurance Company
  - Service area: PPO plans available statewide; HMO plans in Washoe, Carson, Douglas, Lyon and Storey counties

- BBB Northern Nevada and Utah Association Health Plan
  - Effective Date: January 1, 2019
o Carrier: Hometown Health Plan, Inc., Hometown Health Providers Insurance Company & Delta Dental Insurance Company
o Service area: PPO plans available statewide; HMO plans in Washoe, Carson, Douglas, Lyon and Storey counties
o Plan
  ▪ ACA compliant but don’t cover infertility, hearing aids, pediatric vision. Also only covers 60 days of skilled nursing instead of 100, and a separate vision plan is available for purchase.
  ▪ Rates
    ▪ Varies on age (uses age-banding)
o Source: https://www.hometownhealth.com/better-business-bureau-2/

- **Greater Las Vegas Association of Realtors**
  o Effective Date: January 1, 2019
  o Carriers: Health Plan of Nevada & Sierra Health and Life
  o Service Area: Clark County

- **Plumbers Heating Cooling Contractors of Nevada**
  o Effective Date: January 1, 2019
  o Carriers: Health Plan of Nevada & Sierra Health and Life
  o Service area: statewide

- **Nevada Realtors**
  o Effective Date: February 1, 2019
  o Carriers: Hometown Health Plan & Hometown Health Providers Insurance Company
  o Service area: PPO plans available statewide; HMO plans in Washoe, Carson, Douglas, Lyon and Storey counties

**North Carolina Restaurant & Lodging Association**
- Effective Date: Unclear, announced November 2018
- Carrier: United Healthcare
- Rates
  o Vary on multiple factors—not clear what these are
  o Attributes lower rates to the combined purchasing power of small businesses
- Sources
  o https://www.modernhealthcare.com/article/20181110/NEWS/181109905
  o http://restauranthealthcare.org/Products/Health/
Other organizations

- National Federation of Independent Business
  - Has been advocating for AHPs for two decades
  - Is NOT setting up one under the final rule, stating that “We can’t set up an AHP under the new rules any more than [we] could under the old rules”
  - Argues that final rule doesn’t go far enough to eliminate roadblocks that prevent diverse organizations from creating nationwide AHPs
    - Businesses still only allowed to band together if they share an industry or are located in the same state

- National Retail Federation & National Association of Realtors have both expressed trepidation about the complexity of AHPs under the final rule