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Client Alert

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New Year, New Rule, Same Old Questions? What the Proposed Rule on Association Health Plans Means for Employers and the Health Insurance Marketplace

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Under a new proposed rule, unrelated employers—regardless of size—will find it easier to band together to offer health coverage to employees. This type of arrangement, often called an "association health plan" (AHP), may become more common if the regulation proposed by the Department of Labor (DOL) on January 5, 2018, (the Proposed AHP Rule) is finalized.

The Proposed AHP Rule would amend the definition of "employer" to expand the types of groups and associations that would qualify as single employers for purposes of sponsoring an ERISA health plan. A key advantage of the Proposed AHP Rule is the opportunity for small employers who participate in association health plans to follow the "large group" coverage rules under the Affordable Care Act (ACA) and avoid certain costly mandates that are only applicable to small-group and individual coverage. The DOL has requested that public comments on the proposed rule be submitted by March 6, 2018. We have outlined the highlights and potential implications of the proposed rule below.

Requirements for Establishing an Association Health Plan

To establish an AHP that qualifies as a single "group health plan" under ERISA, the group or association of employers (referred to in this alert simply as an "association") must meet the following requirements:

1. ***Purpose*** – The association must exist for the purpose (in whole or in part) of sponsoring a group health plan to offer its employer members.

> **Drinker Biddle Comment:** This is a significant change from prior DOL guidance that required that a bona fide association be established for a purpose unrelated to the provision of benefits. Even so, the Proposed AHP Rule makes it clear that an association cannot be a "health insurance issuer" (i.e., a health insurance company or health maintenance organization licensed to engage in the business of insurance in a state) or owned or controlled by such an issuer.

2. ***Employer Members*** - Each employer member of the association must employ at least one employee who is a participant covered under the AHP. Employer members may be any size and can operate in any form (e.g., sole proprietor, or an incorporated or unincorporated business).

Access for the Self-Employed and Similar "Working Owners"

Under the Proposed AHP Rule, a person who qualifies as a "working owner" will have dual status as both a member employer and a covered employee. Working owners may include, for example, self-employed individuals, sole proprietors, and partners in a partnership. To be a "working owner," the individual must have an ownership right in a trade or business, must be earning wages or self-employment income by providing personal services to that trade or business, must not be eligible to participate in any other subsidized group health plan (e.g., a plan maintained by another employer, including a spouse's employer), and must either work for that trade or business at least 30 hours per week (120 hours per month) or have income from that trade or business at least equal to the cost of coverage for the individual (and any of his or her covered beneficiaries).

3. ***Formality*** – The association must have a formal organizational structure (e.g., bylaws or similar governance structure).

4. ***Governance*** – The association must be controlled by its employer members (e.g., the employer members elect the organization's directors, officers or similar representatives).

5. ***Commonality of Interest*** – The employer members of the association must either:

- be in the same trade, industry, line of business, or profession; or
- have a principal place of business within the same state or metropolitan area (even if the metropolitan area includes more than one state).

Drinker Biddle Comment: The Proposed AHP Rule significantly expands the current definition of "association" by permitting employers whose only connection is physical location to group together to form an association. The DOL's proposal provides that this determination will be made based on relevant facts and circumstances.

In addition to the above requirements, access to health coverage under the AHP must be limited to employees, former employees, and their family members and beneficiaries.

Also, both the association and the AHP coverage itself must comply with the HIPAA nondiscrimination rules. Specifically, under the Proposed AHP Rule, an association is prohibited from restricting membership based on any health factor (e.g., health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability), and the AHP coverage eligibility terms and premium or contribution requirements cannot discriminate against an individual based on any health factor. For purposes of satisfying these requirements, the Proposed AHP rule provides that an association cannot treat different employer members as distinct groups of similarly situated individuals.

ERISA & ACA Implications

If finalized, the Proposed AHP Rule would provide an association of unrelated employers with a more streamlined, efficient and affordable way to provide group health coverage to their employees. In particular, the association, through its governing body, becomes the plan sponsor responsible for administering the program, rather than the individual member employers. As the sole plan sponsor, the association or its delegate is responsible under ERISA for plan administration, such as annual reporting obligations and similar administrative obligations (e.g., preparing enrollment materials with various required annual notices and Summary Plan Descriptions for distribution to eligible employees).

In addition, because the association will be treated as the plan sponsor of a single health plan under the Proposed AHP Rule, it will be possible for small employers to offer insured coverage under the "large group" coverage rules (if the AHP covers at least 51 employees) of the ACA and state and federal insurance laws. Examples of current ACA requirements that an insured AHP would avoid if it qualified as a large group include: the requirement to cover all services and treatments that are considered "essential health benefits," the single risk pool requirement, and certain health insurance premium rules that prohibit issuers from varying premiums except with respect to location, age (within certain limits), family size, and tobacco usage (within certain limits).

Drinker Biddle Comment: Historically, many employers looked for ways to overcome the constraints of the DOL's limited interpretation of "association." Under current DOL rules (which will not change with the Proposed AHP Rule), any time two or more unrelated employers join together to offer health coverage to their employees, the resulting arrangement, even if subject to ERISA, is also a "multiple employer welfare arrangement" (MEWA) subject to additional compliance obligations under both ERISA (i.e., annual Form M-1) and state insurance laws. When faced with a desire to incentivize contingent workforce members – whether an IT worker who provides services as a consultant, an independent sales person, a non-employee physician, or otherwise – organizations often choose not to offer such coverage because of the additional complexities related to MEWAs.

Limits of the Proposed AHP Rule

The DOL was clear that the Proposed AHP Rule does not (at least not yet) alter the state law compliance landscape. In other words, an AHP – because it will provide coverage to employees of multiple unrelated employers – generally will be subject to state insurance laws. This is because although ERISA generally preempts state law, ERISA carves out an exception to ERISA preemption for MEWAs, and most, if not all, AHPs will be MEWAs. For employee welfare benefit plans that are MEWAs and are fully insured, state laws that regulate the maintenance of specified contribution and reserve levels may apply, but other state non-insurance laws are preempted. For employee welfare benefit plan MEWAs that are not fully insured (i.e., self-funded MEWAs), any state law that regulates insurance may apply to the MEWA to the extent the state law is not inconsistent with ERISA.

Under ERISA, the DOL has the authority to issue exemptions from the exception to ERISA preemption for self-funded MEWAs. The DOL is soliciting input on possible ways to exercise this authority.

Drinker Biddle Comment: The lack of ERISA preemption could be a significant impediment to cost-effective implementation of self-funded AHPs. Currently, many states highly regulate (or prohibit altogether) self-funded MEWAs. On the other hand, implementation of insured AHPs could be a viable structure for some employer groups.

Over the last 20 years, including as recently as last year, legislation has been proposed by Congress multiple times addressing AHPs. For example, H.R. 1101, which passed the House of Representatives last year, would have preempted state laws that preclude insurers from offering health insurance in connection with a certified AHP, or offering health insurance of the same policy type to other employers in the state that are eligible for coverage under AHPs. Such legislation has in the past met with opposition from the National Association of Insurance Commissioners (NAIC), among others.

The NAIC has opposed AHPs on the grounds of consumer protection—for example, the potential to destabilize the small group insurance market. Similarly, since under these (failed) legislative proposals, states would not have had regulatory authority over AHPs, including their solvency, the

NAIC noted the possibility of AHP failures such as with MEWAs in the 1990s. In addition, previous AHP legislation did not include additional federal regulatory resources for oversight of AHPs, and AHPs were not subject to state mandatory health benefit requirements. For these reasons, the NAIC also reacted skeptically to President Trump's Executive Order calling for AHPs, and some state insurance commissioners (e.g., California and Pennsylvania) followed suit. Other states, such as Oklahoma, have come out in support of the President's proposal (although not yet the Proposed AHP Rule).

> **Drinker Biddle Comment:** The same issues noted by the NAIC with respect to past legislative attempts are also present in the current Proposed AHP Rule. Given the lack of express preemption of state laws in the Proposed AHP Rule, we can expect to see both the NAIC and individual states weighing in with their own reactions in comment letters to the DOL. If the issue of preemption of state laws is not resolved by final rule, then it is difficult to see how permitting self-funded AHPs on the federal level would accomplish much, given that many states would continue to require such AHPs to be regulated as insurers.

Next Steps

The Proposed AHP Rule has the potential to significantly expand access to affordable coverage for the self-employed, sole proprietors, and those employed by small employers, by allowing unrelated employers to offer coverage through associations.

The impact of the Proposed AHP Rule is likely to be felt throughout the health insurance industry, and may also create new opportunities for greater use of MEWAs (particularly fully insured MEWAs) and for larger employers to offer benefits (through associations) to their contingent workers. But, questions remain—particularly regarding the feasibility of implementing self-funded AHPs. As noted above, the DOL has requested public comments on this proposed rule by March 6, 2018, and we would recommend that stakeholders who may be affected take advantage of this opportunity to provide comments.

Please contact a member of the DBR employee benefits or insurance teams, or your regular DBR contact, to discuss your questions about the Proposed AHP Rule, or if you would like assistance in preparing a comment letter to the DOL.

Employee Benefits and Executive Compensation Team

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