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Association Health Plans—Can The Trump Administration Expand Access Without Congress?

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In recent weeks, the Trump Administration has been considering allowing health insurance to be purchased across state lines and expanding access to "Association Health Plans" (AHPs) that could take economic advantage of cross-border purchasing. President Trump is expected to issue an executive order this week to make that happen without legislation.

This post addresses the key issue of whether the administration has the authority under existing law to act on its own initiative, and in doing so, it will address the seminal legal issues affecting AHPs under federal and state law. As explained below, we conclude that the administration has some—and perhaps even ample—authority to act without Congress, and that any legal constraints will depend on how the AHPs are structured.

Background

After the Senate's most recent attempt to "repeal and replace" the Affordable Care Act (ACA) fell short, CNN **reported** on President's Trump announcement that "he may soon sign an executive order on health care that would affect millions of people." CNN reported the President as saying:

> "I'll probably be signing a very major executive order where people can go out, cross state lines, do lots of things and buy their own health care, and that will be probably signed next week," he told reporters Wednesday. "It's being finished now. It's going to cover a lot of territory and a lot of people. Millions of people."

The President appeared to be referring to proposals separately made by Sen. Rand Paul (R-KY) and in an earlier Senate bill that would have allowed insurance carriers to sell a health plan to a broader set of small employers seeking to band together to form an AHP. Association health plans, claim the proponents, will enable small groups to harness market forces to provide greater plan design freedom, enhance network access, and lower provider costs that will drive down premiums.

Association Health Plans—A Primer

Association health plans are programs providing health coverage, typically within an industry organization, to businesses that share an affinity or common interest. For example, a local or regional Chamber of Commerce may offer an association-type plan to its members that is generally subject to the state's small group rules. (For an excellent, if dated, explanation of the regulation of association health plans, please see the 2006 issue paper entitled, "Association Health Plans: What's All The Fuss About?," by Mila Kofman, Kevin Lucia, Eliza Bangit and Karen Pollitz, published by Health Affairs.) For a discussion of the underwriting and other challenges of such plans, see the **issue paper** on AHPs by the American Academy of Actuaries)

Applicable Laws

The design and operation of AHPs are constrained by the following laws:

- ***State insurance laws and regulations.***

AHPs that are fully-insured are subject to State benefit mandate requirements and insurance regulations applicable to the carrier underwriting the AHP health coverage. Self-funded AHPs, on the other hand, are not subject to State benefit mandates on account of ERISA preemption. Self-funded AHPs, however, are subject to State MEWA statutes, which typically regulate the MEWA like an insurance company operating within the State (more about MEWA regulation below).

Critical to the regulation of AHPs is whether they are regulated as a small or large group. At least in theory, a carrier might issue separate policies to each association member or it may issue a single umbrella policy to the association, which would then issue certificates of coverage to its members. In the former case, a state's small group rules would apply; in the latter case, the rules governing large groups would apply (for this discussion, we assume that all association members are small groups and all associations are large groups.) Thus, where a single policy is sold to an association, it means that several small groups have been combined into a single large group.

- ***The Public Health Service Act (as amended by the Affordable Care Act)***

The Public Health Service Act (PHSA) establishes rules that apply to "health insurance issuers," i.e., state-licensed carriers in the individual and small group insurance markets. Specifically, the ACA amended the PHSA to require small groups, but not large groups, to (i) refrain from developing premiums based on health status, and instead, only vary premiums by age (subject to a 3:1 ratio), tobacco (subject to a 1:1.5 ratio), and geography, (ii) cover ten "essential health benefits," (iii) satisfy pre-established actuarial value standards, and (iv) employees covered by a small group plan must be a part of a single risk pool. These requirements put small groups at a disadvantage relative to larger plans when seeking access to health insurance.

In a **bulletin** dated September 1, 2011, CMS announced its view that most AHPs, consist of a collection of small groups, saying:

> "CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules."

But the bulletin went on to recognize that,

> "In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the 'employer,' the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules."

This latter reference is to groups in which there is a "commonality of interest" among the employers in the group or association and in which the employer-members exercise the requisite "control" over the group health plan. (These requirements are explained below). Thus, for example, if an association consists of employers in unrelated industries, (e.g., broad-based business associations like chambers of commerce) it will not have commonality of interest; and if an entity such as an insurance company or benefits consulting firm organizes and operates an association plan, it will lack the necessary control. In each case, the association would be deemed to be comprised of a series of small groups. Thus, the CMS bulletin does not allow such associations to be treated as large groups, even in states that would otherwise permit it.

- ***ERISA, AHPs and MEWAs***

Under ERISA, group health plans that cover employees of two or more unrelated employers are referred to and regulated as "multiple employer welfare arrangements," or "MEWAs." For a comprehensive explanation of MEWAs, see the **paper** published by the U.S. Department of Labor entitled, "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation." The regulation of MEWAs is surprisingly complex and nuanced, and this guide explains the topic in a thorough and understandable manner.

MEWAs are subject to regulation under both state and Federal law (i.e., ERISA). Under a 1983 amendment to ERISA, states are generally free to regulate self-funded MEWAs, but they are limited to establishing reserve requirements in the case of fully-insured MEWAs that are subject to ERISA. States are also free to comprehensively regulate a fully-insured MEWA that does not qualify as a MEWA under ERISA. For a MEWA to be subject to ERISA requires that the arrangement be an ERISA-covered welfare plan, which means among other things that the MEWA be sponsored by a group of employers. Thus, an association established and operated by a commercial promoter would not be subject to ERISA.

ERISA defines the term "employer" to mean:

> [A]ny 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*. (Emphasis added).

For a group or association to constitute an "employer" there must, in the view of the U.S. Department of Labor, be a bona fide group or association of employers acting in the interest of its employer-members to provide benefits for their employees. In addition, the association members must themselves exercise "control," both in form and substance, over the activities and operations of the employee welfare benefit

plan. The DOL determines the existence of a bona fide group or association of employers based on a series of criteria that are generally easy for association health plans to satisfy. (See, e.g., DOL Advisory Opinion 2005-20A.)

An Association Health Plan Model: the Senate Better Care Reconciliation Act (BCRA)

The BCRA, which the Senate rejected in July, included a proposal for a new association health plan option, which it calls "small business health plans" (SBHPs). Under the proposal, SBHPs would have been deemed to be large groups and therefore would not be subject to the ACA's small group rules. The BCRA would have accomplished this by amending ERISA. Key features of SBHPs include:

- SBHPs would not have to cover the ACA's 10 categories of "essential health benefits" or meet the actuarial value requirements. In addition, the SBHP would have been able to develop premiums based on the "claims experience" of the group.
- SBHP sponsors must be certified by the Secretary of Labor, but certification is deemed approved after 90 days unless the Secretary denies the application for cause.
- Like many existing state law requirements, an SBHP must be organized for a purpose *other* than providing health benefits. This would make it difficult for commercial promoters to operate SBHPs. Rather, a sponsoring entity would most likely be a trade association, organized primarily for professional or industry-related purposes.
- SBHPs must be fully-insured; states would remain free to impose reserve requirements, and state regulators would continue to have regulatory authority over the insurance product, but they could not impose their small group requirements.

Can Association Health Plans Be Enabled by Executive Order or a Regulation?

They likely can, within limits:

- ***Fully-insured programs***

Presumably, CMS could on its own initiative, without the need of legislation, reverse the position taken in the September 2011 bulletin described above. But this would have only limited utility, since it would allow AHPs to be regulated as large groups only in states whose laws permit this approach.

- ***Self-funded programs***

Although the authority has never previously been used, ERISA section 514(b)(6)(B) confers on the Secretary of Labor broad powers to shield self-funded MEWAs from state law:

> (B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies

While the Secretary of Labor's powers are not without limit, this provision of ERISA does appear to be sufficiently robust to enable a class of self-funded association health plans that would be generally immune from state law. Applying current law rules to determine whether a MEWA is ERISA-covered would constrain membership in the class based on the bona fide association and control requirements explained above. These requirements are also the product of Department of Labor guidance, so the Labor Department presumably could enlarge the class of self-funded MEWAs by adopting a more liberal reading of these requirements. This would, however, require the Department to upend decades of guidance affirming and limiting the above-described commonality of interest and control rules.

While it does not appear that the President could accomplish these objectives simply by issuing an executive order, he could certainly direct CMS and the Department of Labor to develop guidance and regulations to do so.

Conclusion

We have considered here only the narrow question of whether the administration may expand access to association health plans without legislation. We conclude that it may have that authority. Although the details of the president's proposed executive order are not yet known, we do know one thing: when it comes to purchasing group health insurance, small employers are at a disadvantage and steps should be taken to improve their position in the marketplace.

Authors