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Association Health Plan Perspectives (Part 2): The Look-Through Rule and the Limits of State Regulatory Power

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In a summary of the recently issued Association Health Plan (AHP) **final regulations**, the U.S. Department of Labor (DOL) rightly observed that AHPs are a species of multi-employer welfare arrangements, or **MEWAs**, that are subject to regulation under both federal and state laws. The insurance regulators in a handful of states have recently issued guidance that, in most cases, purports to prohibit AHPs from operating as "large group" plans. (The attached **table** summarizes and provides links to the guidance, state-by-state.) A common, though not universal, theme is that in no case may a collection of small employers be combined to form a large group. Certain states address collateral issues. Pennsylvania, for example, makes the further claim that in no case may a self-employed individual with no employees participate in an AHP. We think that the states have overreached. This post explains why.

Background

Prior law and the purpose of the final AHP regulations

An AHP is a type of MEWA that is offered by employer "groups and associations" to provide health coverage for employees. According to the FAQ on the DOL's website:

> **AHPs allow small employers to band together to purchase the types of coverage that are available to large employers, which can be less expensive and better tailored to the needs of their employees.** *The rule allows more employer groups and associations to form AHPs, based on common geography or industry* **(emphasis added).**

The debate over AHPs can be reduced to a simple question: under what circumstances may a collection of small employers and self-employed individuals – or "working owners" in the parlance of the final regulations – band together to form a "large group" for underwriting and other regulatory purposes? Under prior law, the ability of small employers to combine for these purposes was severely constrained, and self-employed individuals were entirely excluded. The purpose of the final regulations, as this above stated passage suggests, is to expand access to AHPs for small employers and, for the first time, permit self-employed individuals with no employees to participate in the AHP. (We described the prior law governing AHP and explain the details of the final regulations in an article published by Bloomberg Tax, available **here**.)

Advantages of large group status

Both at the federal and state levels, the regulation of health insurance is segmented among individual, small group, and large group markets. The Affordable Care Act (ACA) imposed essential health benefits, actuarial value, and modified community rating requirements on small groups and individuals but not on large groups. As a result, large group health plans enjoy materially greater design and underwriting flexibility when compared to their small group and individual market counterparts. The large group market can take advantage of administrative efficiencies that are unavailable to small groups and individuals. Individuals and small employers often drop in and out of the insurance markets at high rates. In addition,

individuals and small groups routinely change insurance carriers, sometimes every year. This sort of volatility – which drives up administrative costs – is not present in the large group market.

The look-through rule and its exceptions

Under prior law (i.e., before the newly promulgated final AHP regulations), small groups generally retained their status as such even where coverage was purchased through an association. This is the case due to the application of the so-called look-through rule. According to a CMS Insurance Standards **Bulletin** issued on September 1, 2011, an insurance carrier underwriting an AHP must "look-through" the group sponsoring the fully-insured AHP to the underlying size of the AHP member. If the AHP member employs 50 or fewer employees, the insurance carrier must apply the ACA's small group market reforms to the AHP health coverage. In addition, if an individual is an AHP member, the insurance carrier is required to impose the ACA's individual market reforms to this individual's coverage.

The CMS Bulletin includes an important exception to the look-through rule: where a fully-insured AHP is sponsored by a "bona fide group or association of employers" as defined under the Employee Retirement Income Security Act (ERISA), an insurance carrier must treat the AHP health plan as one, single group health plan. According to the CMS Bulletin, in this case, the number of employees employed by all the employers participating in a bona fide group are aggregated to determine whether the AHP health coverage is subject to the small group or the large group market rules. If – upon aggregating the employees employed by all of the employer members – an insurance carrier determines that the bona fide group includes 51 or more employees, the insurance carrier must treat the fully-insured AHP health plan as a large group market plan (and thus apply the large group market insurance rules to the AHP health coverage).

The final AHP regulations did *not* revoke or modify the look-through rule, but they did expand the universe of groups that may qualify as a bona fide group or association of employers, and by extension, the number of plans that may qualify for treatment as large groups. The final regulations accomplish this by amending the definition of "employer" in ERISA section 3(5).

State responses to the bona fide group exception

The September 2011 CMS Bulletin offered the following definition of the look-through rule:

> **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.**
>
> *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* **(emphasis added). 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.**

While it is not clear to us whether the various state regulators would agree with this statement of the prior-law look-through rule, some states now intend to disregard the exception for bona fide associations of employers. This application of the look-through rule without respecting an exception for bona fide groups is more stringent than that intended by at least CMS' view of the prior law. As a result, existing AHPs may now be non-compliant in one or more states.

Some states, such as Oregon, have announced that they will respect the bona fide group exception as described in the CMS Bulletin, but only with respect to bona fide groups that satisfy the pre-final AHP rule definition of a bona fide group. Under prior law, a bona fide group was limited to groups in the same industry, trade, or profession (which has been recently clarified to us by the DOL as not necessarily being limited to a geographical location as we previously thought). The final AHP regulations expand the definition of a bona fide group to include national organizations and nationwide franchise-based corporations in the same industry, trade, or profession, as well as groups of employers across different industries, provided the employers are in the same state or metropolitan area. Significantly, groups of self-employed individuals who satisfy the final AHP regulations' definition of "working owner" can form their own bona fide group or participate in a bona fide group of employers.

Unlike Oregon (and other states like Pennsylvania, Connecticut, and New York), Louisiana has publicly stated in recent guidance that they will respect the bona fide group exception (discussed above). Louisiana will also follow the new definition of a bona fide group as set forth under the final AHP

regulations. Joining Louisiana is Nebraska, which recently announced that the Nebraska Farm Bureau is contracting with the insurance carrier Medica to offer a fully-insured large group plan to self-employed farmers in the State. This announcement tells us that Nebraska is also respecting the bona fide group exception and the final AHP regulations.

The power of the states to regulate MEWAs

ERISA preempts or renders unenforceable state laws that "relate to" employee benefit plans. This provision of ERISA represents a broad exercise of federal power under the Supremacy Clause of the U.S. Constitution that sweeps aside state laws to encourage uniform, nationwide standards governing the regulation of all manner of employee benefit programs. Congress saved state laws governing insurance, banking, and securities from preemption, however. This provision is referred to as the ERISA "saving clause," under which states are generally free to regulate insurance contracts and carriers. This provision is important since if state AHP laws, regulations, and other guidance are found to regulate insurance, then they are saved from preemption. But if they regulate something other than insurance (e.g., an ERISA-covered plan), then the state rules will be preempted - or rendered unenforceable - by ERISA's broad preemptive force. The last prong of the ERISA preemption statutory scheme is the "deemer clause" that prohibits states from deeming non-insurance activities (i.e., operating a group health plan) to be in the business of regulating insurance for the purpose of exercising authority that ERISA otherwise preempts.

The U.S. Supreme Court, in *Kentucky v. Miller*, 538 U.S. 329 (2003), established a standard to determine which laws regulated insurance for purposes of ERISA's saving clause. According to the Court, a law regulates insurance if it focuses on entities in the insurance industry and it alters the scope of permissible bargains between insurers and insureds (e.g., by affecting the type of risk-pooling arrangements that insurers may offer). A law satisfying these tests would constitute the regulation of the "business of insurance" under ERISA.

The newly-issued state AHP guidance seems to us to clearly satisfy the *Miller* test's second prong, since the guidance affects the type of risk-pooling arrangements that insurers may offer. But it also seems to us the guidance fails the first prong: AHPs maintained by a bona fide group are not only not entities in the insurance industry, they also enjoy a particularly exalted status under ERISA as employee welfare plans. This is a distinction that the Court first recognized and approved more than 30 years ago in *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1985).

But what exactly, is an "employee benefit plan?" In a case decided in 2000, the U.S. Supreme Court gave us an answer, saying:

> **One is thus left to the common understanding of the word "plan" as referring to a scheme decided upon in advance . . . Here the scheme comprises a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan.** *Pegram v. Herdrich*, **530 U.S. 211, 223 (2000).**

As any first-year employee benefits lawyer quickly learns, the ERISA-covered plan (here, the AHP) is not the insurance contract. Rather, the plan is a separate legal structure. As originally enacted, ERISA's saving clause preserved the rights of the states to regulate insurance contracts and carriers, but it did not empower the states to regulate ERISA-covered plans.

A 1983 amendment to ERISA (the Erlenborn-Burton Amendment) conferred on the states the broad though not unlimited powers to regulate MEWAs. In so doing, Congress distinguished between MEWAs that are fully-insured and those that are not, i.e., those that are self-insured. In the case of a self-funded MEWA, any state law that regulates insurance may apply to the extent it is not inconsistent with ERISA. In the case of a fully-insured MEWA (i.e., a fully-insured AHP), however, a state can only enforce those state laws that provide standards requiring the maintenance of specified levels of reserves and contributions and provisions to enforce these standards. (We discuss what is required for a MEWA to be fully-insured in a previous **post**.)

Analysis

Typically, we would not pick through statutory detritus in a blog post. In this instance, however, the language of the statute will help. ERISA section 514 (29 U.S. Code §1144(b)(6)(A) (emphasis added)) provides:

> (A) Notwithstanding any other provision of this section -

(i) in the case of an *employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured* (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides -

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of *any other employee welfare benefit plan which is a multiple employer welfare arrangement*, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

Based on the plain text of the statute, there are state laws that can be enforced against an AHP that is not fully-insured (i.e., a self-insured AHP) that cannot be enforced against a fully-insured AHP. To put it another way, the statute is clear that the set of state laws that can be applied to fully-insured plans is a subset of the set of laws that can be applied to self-funded plans. But which state laws are these exactly? Allow us to venture some guesses:

- Benefit mandates

A state is free to impose benefit mandates. Similarly, a state is free to impose rating rules on contracts within segmented groups (i.e., large, small, and individual). Each is a clear exercise of state power under ERISA's saving clause to regulate insurance contracts and carriers.

- Laws requiring registration and/or reporting by AHPs

While ERISA would ordinarily permit only laws imposing "standards, requiring the maintenance of specified levels of reserves and specified levels of contributions," we suspect that state insurance laws and other guidance requiring AHPs to register with or periodically report to state insurance regulators would be considered ancillary to the standards that ERISA expressly allows. Therefore, these laws would not be preempted. (There is also case law to the effect in the context of MEWAs generally.)

It is quite another matter, however, if a state, in addition to imposing registration and/or periodic reporting requirements on an AHP, also seeks to make a separate determination of an AHP's status as a fully-insured arrangement. An example of this approach is a recent Iowa regulation [191-77.4(507A) through 191-77.6(507A)]. ERISA [§ 514(b)(6)(D)] could not be clearer - it is the DOL that makes the determination of an AHPs status as fully-insured. Such a law seems to us to run afoul of the deemer clause, since the state is deeming the AHP to be an entity that the state has the power to regulate (beyond contributions and reserves). Of course, a state is free to make this determination in the absence of a DOL determination.

- Prohibiting working owners from participating in AHPs

The Commonwealth of Pennsylvania purports to prohibit working owners (i.e., self-employed individuals with no common law employees) from participating in AHPs. This type of regulation is in our view clearly preempted, since it endeavors to regulate the ERISA-covered plan (here, the AHP) other than imposing "standards, requiring the maintenance of specified levels of reserves and specified levels of contributions." This requirement strikes us as imposing an eligibility mandate on an ERISA-covered plan. The requirement thus affects plan *structure or administration*, which is a touchstone of ERISA preemption. It also endeavors to impose requirements on a non-insurance activity (establishing and operating an AHP), the purpose of which is to exercise authority that ERISA otherwise preempts in violation of the deemer clause.

- Guidance re-imposing the look-through rule without exception

Each of the state insurance bulletins noted above seeks to impose the look-through rule without the bona fide group exception. This is a closer call than the above-described ban on working owners. What is being regulated here? Is it the insurance contract or the plan? While some might differ with us, we think it is the latter. It seems that an attempt to impose the look-through rule on an AHP endeavors to affect a key feature of plan administration.

Conclusion

Whatever one's view of the arguments set out in this post, these concerns should not be dismissed out-of-hand. No amount of bravado on either side of the debate can obscure the fact that the states' laws, regulations, or other guidance are not the final word – there is way too much at stake – they are rather the opening salvo.

With the final AHP regulations, the Trump Administration is seeking to fundamentally restructure the small group and individual insurance markets. Critics of the AHP rule might be missing the point: the havoc caused to these markets is a feature of, and not a bug in, the final regulations. The small group market is

broken, they say, and we are going to fix it. The final AHP regulations strike us as a massive social experiment in real time. If state insurance exchanges are left with only the “bad” small groups, then they will effectively become high risk pools.

It should be apparent even to the most casual observer that the Administration is fully invested in the AHP rule. Should the states insist on enforcing the look-through rule without exception, the DOL could, and would likely, use a previously unexercised power under ERISA to further curb state power in the case of self-funded AHPs, either in individual cases or across-the-board. This would, in turn, likely invite retaliation by the states by imposing additional rules on self-funded arrangements to the extent they can.

The stakes are enormous, and this is a zero-sum game. Through some combination of litigation and legislation, the small group and individual markets either will survive intact or they will not. Some state lawmakers and regulators view the final AHP regulations as a naked power grab of regulatory power by the federal government. Pushback is the logical and reflexive response. From the perspective of small businesses, however, the insurance markets need an overhaul. If there is a middle ground here, it eludes us. The fight will ultimately be political, not legal - which is to say above the proverbial pay grade of the authors.

Authors

Christopher E. Condeluci

Christopher E. Condeluci is principal and sole shareholder of CC Law & Policy in Washington, DC. Prior to forming CC Law & Policy, Chris served as Tax and Benefits Counsel to the U.S. Senate Finance Committee. During his time in Congress, Chris participated in the development of portions of the Affordable Care Act (ACA), including the Exchanges, the State insurance market reforms, and all of the taxes enacted under the law. Based on his experience as an employee benefits attorney, Chris possesses a unique level of expertise on matters relating to tax law, ERISA, and the ACA.

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