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Department of Labor Issues Final Association Heath Plans Regulations

By Alden J. Bianchi, Esq.[*]

On June 19, 2018, the Department of Labor, Employee Benefits Security Administration issued a final regulation, entitled *Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans*, the purpose of which, according to the DOL, is to remove "undue restrictions on the establishment and maintenance of Association Health Plans (AHPs) under ERISA."[1] This final regulation is as much a political statement as it is a legal standard. Where prior administrations moved cautiously respecting AHPs, and with a great deal of deference to state regulators and the National Association of Insurance Commissioners (NAIC), this new final regulation aggressively enables the expanded adoption of AHPs. This article explores the uses of AHPs, explains the final regulation's content, and speculates on the newly minted rule's impact.

BACKGROUND

AHPs are group health plans that make coverage available, typically to a collection of small businesses that share some affinity or common interest, e.g., membership in a business or trade association or industry organization. For example, a local or regional Chamber of Commerce or farm bureau may offer association-type health insurance to its members. The purpose of an AHP is to enable small businesses to band together to purchase group health insurance coverage collectively to, at a minimum, reap the benefit of reduced administrative expenses. Under the final regulation, small employers should also be able to benefit from greater plan design and underwriting flexibility.

Executive Order 13813

On October 12, 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," stating that "[i]t shall be the policy of the executive branch, to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people." According to the preamble to the final regulation:

> To advance this policy, the Executive Order directed the Secretary to consider issuing regulations or revising guidance, consistent with law, that would expand access to more affordable health coverage by permitting more employers to form AHPs. The Executive Order specifically directed the Secretary to consider expanding the conditions that satisfy the commonality of interest requirements under existing DOL advisory opinions interpreting the definition of an "employer" under ERISA section 3(5) and also to consider ways to promote AHP formation on the basis of common geography or industry.

This statement encapsulates the policy change that the final regulations embody. Rather than viewing AHPs with suspicion, they are to be encouraged for the purpose of allowing employees of small employers and working owners "to obtain coverage that is not subject to the regulatory complexity and burden

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[1] 29 C.F.R. Part 2510, RIN 1210-AB85, 83 Fed. Reg. 28,912 (June 21, 2018) (the "final regulation").

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that currently characterizes the market for individual and small group health coverage.''[2]

The Proposed Regulation

On January 4, 2018, the DOL issued a proposed regulation,[3] wherein the DOL estimated that the new AHP rule had the potential to impact the health coverage of more than 40 million individuals, whether by expanding coverage to the uninsured, by making coverage available to sole proprietors and small employers, or by cutting back some individuals' benefits. The DOL received over 900 comments in response to the proposed regulation from a wide range of stakeholders, including group health plan participants, consumer groups, employer groups, individual employers (including sole proprietors), employer associations and other business groups, individual health insurance issuers, trade groups representing health insurance issuers, state regulators, and existing AHPs. (The public comments are available on the DOL's website at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85.)

The Regulation of AHPs

Both at the federal and state levels, the regulation of group health insurance is segmented among the individual, small group, and large group markets. In part because of the Affordable Care Act,[4] large groups enjoy materially greater design and underwriting flexibility when compared to small employers and self-employed individuals. Under prior law (i.e., before the final regulation), small groups generally retained their status as such even where coverage was purchased through an association. Thus, the coverage remained subject to more restrictive, state-mandated small group insurance rating and other rules. But under a narrow, prior law regulatory exception (explained below), AHPs established or maintained by ''bona fide groups or associations'' were treated as single, large groups for purposes of federal law. As such, these AHPs are subject to less onerous, large group rules.

Under prior law, health insurance coverage provided through a trade or industry, chamber of commerce, or similar organization, was generally regulated under the same standards that apply to each member of the group. This regulatory framework — referred to as the ''look-through doctrine''— disregarded the group or association in determining whether coverage obtained by each participating individual or employer is individual, small group, or large group market coverage. But under a narrow exception, coverage sponsored by ''bona fide'' groups or associations was regulated as a single ERISA-covered plan.

Single Plan MEWAs vs. Non-Plan MEWAs

ERISA's definition of ''employer'' is at the heart of the regulation of AHPs. ERISA regulates ''employee benefit plans,'' which include ''employee welfare plans'' and ''employee pension plans.''[5] Because the term ''employee welfare plan'' includes ''medical benefits,'' group health plans are employee welfare plans when they are maintained by an ''employer.'' ERISA defines the term ''employer'' to include ''a group or association of employers acting for an employer in such capacity.''[6] AHPs are generally regulated as ''multiple employer welfare arrangements'' (with certain exceptions not here relevant), which ERISA §3(40) defines to mean:

> [An] employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing [welfare benefits] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries. . . .

The reference to ''two or more employers'' means and refers to two or more **unrelated** employers, because ERISA treats trades or businesses under common control as a single employer.

ERISA §3(1) defines the term, ''employee welfare benefit plan'' to include:

> [A]ny plan . . . **established or maintained by an employer** . . . to the extent that such plan . . . was established or is maintained for the purpose of providing for its participants

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[2] *Id.*

[3] 83 Fed. Reg. 613 (Jan. 5, 2018) (the ''proposed regulation'').

[4] Pub. L. No. 111-148 (PPACA), 124 Stat. 119–124 Stat. 105, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029–124 Stat. 1084 (collectively, the Affordable Care Act or ACA). ACA and I.R.C. sections added by it also have been amended by the TRICARE Affirmation Act, Pub. L. No. 111-159, the Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Pub. L. No. 112-9, the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Pub. L. No. 112-10, and the 3% Withholding Repeal and Job Creation Act, Pub. L. No. 112-56.

[5] ERISA §3(2).

[6] ERISA §3(5).

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> or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death . . . (Emphasis added).

Thus, while a MEWA may provide group health benefits, it is an employee welfare benefit plan only if it is ''established or maintained by an employer.'' Conversely, a MEWA that is established or maintained by an entity that is not an ''employer'' is not an employee welfare benefit plan. The preamble to the final regulation refers to the former as ''single-plan MEWAs'' or, simply, ''plan MEWAs,'' and the latter as ''non-plan MEWAs.''[7] Under prior law, whether a MEWA was single plan or non-plan MEWA was determined under a series of advisory opinions holding that, for a group or association to constitute an ''employer,'' the group must satisfy two criteria, commonality of interest and control. The final regulation retains these terms, but it expands their meaning.

Regulation of Small vs. Large Groups

While the Affordable Care Act adopted a series of insurance market reforms that apply to all markets, there are a subset of reforms that apply only to the individual market and the small and group markets. These include the obligation to provide essential health benefits, a risk adjustment program (that transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees), guaranteed issue/renewability requirements, a single risk pool (under which the claims experience of all individuals enrolled in plans offered by the issuer in the individual market to be in a single risk pool), and modified community rating (premiums may vary only by location, age (within certain limits), family size, and tobacco use (within certain limits)). Due to the application of the look-through doctrine, non-plan MEWAs are usually regulated under the small group or individual market rules based on the size and character or the constituent member.

THE FINAL REGULATION

The final regulation makes the following changes to prior law.

Definition of ''Employer''

The final regulation in 29 C.F.R. 2510.3 clarifies which persons may act as an ''employer'' within the meaning of ERISA §3(5) in sponsoring an AHP. A group or association of employers may qualify as an ''employer'' within the meaning of ERISA §3(5) provided that it is a ''bona fide association of employers,''[8] with the requisite commonality of interest.[9] The plan must also satisfy certain nondiscrimination rules,[10] and it may include self-employed individuals who qualify as ''working owners.''[11]

The rules governing what constitutes a bona fide association of employers incorporate and refer to the other requirements. These rules include those discussed below.

> **1. Primary Purpose.** The primary purpose of the group or association may be to offer and provide health coverage to its employer members and their employees; however, the group or association also must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees.

This rule represents a major departure from prior law. The proposed regulations did not add any qualifications. An AHP could, under the proposed rule, be established to provide group health benefits. The final regulation, in response to comments, added the requirement that there be at least one substantial business purpose unrelated to offering and providing health coverage. The final regulation established a safe harbor under which a substantial business purpose is considered to exist if ''the group or association would be a viable entity in the absence of sponsoring an employee benefit plan,'' which need not be a for-profit activity. According to the preamble, the other purpose or activity must be sufficiently substantial such that the association could be a viable entity even in the absence of acting as a plan sponsor. This can be satisfied, for example, if the association ''convenes conferences and provides educational materials and opportunities to its members.''

> **2. Employer Members.** Each employer member of the group or association participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the plan.

This requirement reinforces that nexus of employer and group health plan. The reference to an employer

[7] 83 Fed. Reg. at 28,917.

[8] 29 C.F.R. 2510.3-5(b).

[9] 29 C.F.R. 2510.3-5(c).

[10] 29 C.F.R. 2510.3-5(d).

[11] 29 C.F.R. 2510.3-5(e).

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having at least one ''employee'' does not mean that the employer must have at least one common law employee, however, because elsewhere in the final regulations ''working owners'' are treated as both employers and employees. (The treatment of working owners is explained below).

> **3. Organizational Structure.** The group or association has a formal organizational structure with a governing body and has bylaws or other similar indications of formality.

The emphasis here is on a formal structure. The DOL is of the view that this is necessary to satisfy the statutory requirement in ERISA §3(5) that the group or association must act ''in the interest of'' employers in relation to the employee benefit plan. It is also a safeguard against the formation of commercial enterprises that claim to be AHPs but operate in a manner similar to traditional insurers selling insurance in the group market. In the DOL's view, an AHP that lacks a formal structure neither acts directly as an employer, nor in the interest of employers.

> **4. Control.** The functions and activities of the group or association are controlled by its employer members, and the group's or association's employer members that participate in the group health plan control the plan. Control must be present both in form and in substance.

Prior law generally required that the employers that participate in an AHP exercise control over the program, both in form and substance. This requirement could be satisfied, for example, where the AHPs adopt bylaws under which the plan's functions and activities maintenance are controlled by a fiduciary committee that is elected by the association's members under bylaws approved and adopted by the members. The final regulation embraces this standard. According to the preamble to the final regulation, this requirement is satisfied if employer members regularly nominate and elect directors, officers, trustees, etc.; they have authority to remove any such director, officer, or trustee; and they have the authority and opportunity to ''approve or veto decisions or activities which relate to the formation, design, amendment, and termination of the plan, for example, material amendments to the plan, including changes in coverage, benefits, and premiums.''[12]

> **5. Commonality of Interest.** The employer members have a commonality of interest.

The ''commonality of interest'' requirement is fleshed out in a separate provision of the final regulation.[13] This provision is at the epicenter of the new rule. It replaces a restrictive, prior rule with a new, expansive definition under which members of a group or association are treated as having a commonality of interest if the employers are in the same trade, industry, line of business, or profession, or each employer has a principal place of business in the same region that does not exceed the boundaries of a single state or a metropolitan area (even if the metropolitan area includes more than one state).

> **6. Coverage.** Coverage under the group or association's plan must be limited to employees of a current employer member of the group or association, former employees of a current employer member of the group or association who became entitled to coverage under the group's or association's group health plan when the former employee was an employee of the employer, and beneficiaries of such individuals (e.g., spouses and dependent children).

In response to comments, the DOL modified this requirement to make clear that this provision is intended to provide participating employers and their employees with the same basic rule for defining participants as would apply if the employer member of the association established its own separate group health plan.

> **7. Nondiscrimination.** The group or association and health coverage offered by the group or association must comply with certain nondiscrimination provisions.

This provision was contentiously debated in the comments to the proposed regulation, which barred AHPs from conditioning employer membership based on an employee's health status. The proposal adopted the nondiscrimination rules first established in the Health Insurance Portability and Accountably Act of 1996 (HIPAA). These rules generally require that group health plans cannot discriminate against participants and beneficiaries on the basis of health status, which the proposed regulation expanded to prohibit AHPs from making distinctions between groups of participants for purposes of eligibility, benefits, or premiums, if such distinctions are directed at individual participants or beneficiaries based on any health factor. The effect of this requirement is to bar AHPs from rating employer-by-employer based on health factors. Importantly, the preamble to the final

[12] 83 Fed. Reg. at 28,920.

[13] 29 C.F.R. 2510.3-5(c).

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regulations, as well as newly-added examples, make clear that discrimination based on non-health related factors (e.g., industry subsectors) is permitted.

Certain commenters urged the DOL to abandon the nondiscrimination requirement noting the many existing AHPs that establish premiums on a member-by-member basis. The DOL responded that existing AHPs are free to operate under the prior law rules.

> **8. No Health Insurance Issuers.** The group or association is not a health insurance issuer, or owned or controlled by such a health insurance issuer or by a subsidiary or affiliate of such a health insurance issuer, other than to the extent such entities participate in the group or association in their capacity as employer members of the group or association.

The DOL's concern here is obvious — to avoid carrier control of AHPs. This provision also was hotly contested in comments to the proposed regulation. Opponents claimed that control tests made this provision unnecessary. The DOL disagreed, saying that the provision would help prevent formation of commercial enterprises that claim to be AHPs but, in reality, merely operate as traditional health insurance issuers, in all but name.

Self-Employed Individuals

Under prior law, ERISA's reference to ''employees'' was interpreted to exclude self-employed individuals who do not employ others. Under the proposed regulation, this interpretation was modified to allow for the dual treatment of working owners as employers and employees. Under the proposal, a ''working owner of a trade or business'' could qualify as **both** an employer and as an employee of the trade or business. This provision represents a reversal of prior law.

The final regulation defines the term ''working owner'' to mean an individual that is both an employer and an employee of a group or association member who (1) has an ownership right in the trade or business that is a group or association member, (2) earns wages or self-employment income from the trade or business that is a group or association member for providing personal services to such trade or business, and (3) either works on average at least 20 hours per week or 80 hours per month providing personal services to the trade or business that is a group or association member, or has wages or self-employment income from the trade or business that is a group or association member that at least equals the working owner's cost of coverage for participation by the working owner any of his or her covered beneficiaries in the AHP.[14]

The final regulation adopted the proposed regulation's definition of working owner with only minor modifications principally intended to ensure that the provision apply only to genuine work relationships, and not to sanction individual coverage masquerading as employment-based coverage.

Applicability Dates

The final regulation takes effect for fully insured AHPs beginning on September 1, 2018. Existing self-insured AHPs can begin operating under the new rule on January 1, 2019; and new self-insured AHPs can begin on April 1, 2019. The final regulation's reference to self-funded plans is misleading. The DOL did nothing in the proposed or final regulation to enable self-funded AHPs. As the DOL went out of its way to emphasize more than once in the preamble to the final regulation, self-funded AHPs are subject to **all** applicable state laws, which in most states means that a self-funded AHP is treated as an unlicensed insurance company.

The final regulation takes effect in short order. Certain commenters urged the DOL to delay the rule's implementation because carriers would be unable to factor the rule's impact into 2019 premiums. (Most carriers develop premiums between March and May.) Other commenters noted that state legislatures seeking to increase AHP oversight will not have sufficient time to do so in advance. The DOL appeared unmoved by these concerns.

IMPACT OF THE FINAL REGULATION

The final regulations change the standards to be applied in determining the extent to which small employers are permitted to join with other small employers to form, maintain, and participate in single, large group health plans. Under prior law, large-group AHPs were able to be maintained only by an existing trade or industry association (typically of long standing), whose members had a common bond and the membership of which was limited to members who were engaged in the association's business or plied the association's trade. These associations were formed for some purpose other than for the purchase of health insurance. The final regulation changes this. Going forward, heterogenous groups whose purpose is to offer health benefits in addition to a substantial, unrelated business purpose will qualify. Commercial AHPs, i.e., AHPs organized by promoters to sell

[14] 29 C.F.R. 2510.3-5(e).

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health insurance to unrelated groups of employers, are not allowed under prior law, nor do they get any relief under the final regulation.

Executive Order 13813 sits atop something of a political minefield. Prior law generally deferred to, or at least aligned with, the wishes of state insurance regulators. These regulators are generally concerned with, among other things, the integrity of their individual and small group markets, which could be harmed by the exodus of small groups with younger, heathier employees and younger, healthier working owners. State legislators and regulators, with their large swaths of regulatory power over the business of insurance, will in all likelihood push back. The final regulation has merely established a framework for AHPs. It may take years of litigation to determine how AHPs will finally be regulated.

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