I previously examined the proposed rule by the U.S. Department of Labor (DOL) to expand so-called Association Health Plans, or AHPs, under the Employee Retirement Income Security Act of 1974 (ERISA). In a nutshell, the proposed rule was designed to make it easier for employers to form a group in order to provide health benefits to their employees through an AHP. These new AHPs would have more freedom to restrict benefits in order to provide more affordable coverage.

On June 19, 2018, the DOL released its final rule on AHPs, officially creating 29 C.F.R. 2510.3-5, as of Aug. 20, 2018. The final rule clearly makes it easier for employers and sole proprietors to come together to provide health benefits. But the extent to which AHPs will be able to restrict benefits remains to be seen, due to the far-reaching ability of states to regulate AHPs. In this article, I’ll take a look at the final rule, including:

- A description of the final rule, including what changed from the proposed rule and additional guidance offered by the DOL;
- The DOL’s guidance on the application of other federal laws; and
- The future of AHPs.

What changed?

The DOL received over 900 comments on the proposed rule and consulted with other federal agencies. Not surprisingly, the DOL made several important changes in the final rule.

Pre-rule guidance still good law. The DOL has clarified that it is not supplanting its prior guidance on bona fide employer groups, but supplementing such guidance. AHPs formed under the old law are still valid, and new employer groups can still be formed under such rules. The final rule merely sets forth an additional method of forming an employer group. AHPs established under the pre-rule guidance would face different requirements than those established under the final rule. For example, such groups cannot
have membership based solely on geography, and they have greater flexibility to discriminate among employers through their premium rating.

**Commonality of interest.** In maybe its biggest change from pre-rule guidance, the proposed rule would have allowed employer groups to form based on either: (1) being in the same trade, industry, line of business, or profession, regardless of state boundaries; or (2) having a principal place of business within the same state or the same metropolitan area (even if the metropolitan area includes more than one state). Allowing employer groups to form based solely on geography was an entirely new concept. The final rule retained this basic approach with some important clarifications.

First, while the DOL refused to explicitly define “the same trade, industry, line of business, or profession,” it did state that it “intends for these terms to be construed broadly to expand employer and employee access to AHP coverage.” The DOL approved use of the following:

- North American Industry Classification System (NAICS) codes (also used in Form 5500 Annual Reports);
- Standard Industrial Classification codes (which precede the NAICS);
- The OECD International Standard Industrial Classification;
- Any other “generally-accepted classification system” of the same sort; and/or
- The “line of business” test set forth in Treasury Regulations governing membership in a voluntary employees’ beneficiary association (VEBA). Specifically, “employees of one or more employers engaged in the same line of business in the same geographic locale will be considered to share an employment-related bond for purposes of an organization through which their employers provide benefits.”

Second, for employer groups based on metropolitan areas, the DOL stated that “an area that matches a Metropolitan Statistical Area or a Combined Statistical Area, as defined by the OMB” suffices. But the DOL intentionally left the door open for other areas to qualify based on the facts and circumstances, “[f]or instance, the area from which a city regularly draws its commuters may qualify as a metropolitan area.”

Finally, the DOL clarified that *subgroups* of an otherwise bona fide employer group can also constitute a bona fide group and establish an AHP (provided it is not a pretext for discrimination on a health factor). For example, a subgroup might consist of employers owned by women minorities, veterans, or employee stock ownership plans (ESOPs).

**Substantial business purpose now required.** Under pre-rule guidance, employer groups could not form for the purpose of providing health benefits; they had to exist for an entirely different reason. The proposed rule would have allowed employer groups to form for the *exclusive* purpose of creating an AHP.
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The final rule walks that back a step and now requires an employer group to have at least one “substantial business purpose” other than establishing an AHP, although the AHP can still be the primary purpose of the group. The change was made to prevent fraudulent associations, as groups formed with a business purpose — such as more traditional industry and trade groups — “have strong incentives to maintain their good reputation.”

This will make it slightly more challenging to establish an employer group, as the member employers must decide what other business purpose the group will serve and what “substantial” activity it will perform in furtherance of that purpose. Notably, the DOL did not define “substantial business purpose,” but the regulation does provide some guidance:

[A]s a safe harbor, 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. … [A] business purpose includes 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.

The preamble to the final rule includes several illustrations of the concept:

- Offering services to member employers, “such as convening conferences or offering classes or educational materials on business issues of interest to the association members”;
- Being “a standard-setting organization that establishes business standards or practices”;
- “[P]ublic relations activities such as advertising, education, and publishing on business issues of interest to association members unrelated to sponsorship of an AHP”; and
- Advancing the well-being of the members’ industry through substantial activity (other than providing an AHP).

**Working owners.** In another major break with pre-rule guidance, the proposed rule would have allowed certain sole proprietors and partners in a partnership (i.e., “working owners”) to join an employer group and enroll in the AHP, even though they have no common law employees. The final rule changed four aspects of the proposed rule.

First, under the proposed rule, the employer group could rely on a person’s written representation of his or her eligibility as a working owner. The DOL deleted this provision, believing it could be inconsistent with the fiduciary duty to act with reasonable care, skill, prudence, and diligence. In its place, the final rule requires a working owner’s continued eligibility to be “periodically confirmed pursuant to reasonable monitoring procedures.” The DOL declined to specify what these reasonable monitoring procedures must look like, except that reliance on a written representation might be reasonable, if there is nothing to question its accuracy.
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Second, the proposed rule required that a working owner either: (1) work at least 30 hours per week or 120 hours per month providing personal services to the business; or (2) have earned income from the business that at least equals the cost of covering the owner and any of his or her dependents on the group health plan. To provide flexibility to industries that would make it difficult to satisfy the 30/120 rule, the DOL lowered it to a 20/80 rule. This can be shown by “evidence of a work history or [by] a reasonable projection of expected self-employment hours worked in a trade or business.”

Third, the proposed rule barred working owners from being eligible for the AHP if they were eligible to enroll in subsidized group health coverage maintained by another employer or through a spouse. This was opposed by many commenters and was deleted due to its harshness and the difficulty of enforcement.

Finally, if it is determined that a working owner participating in an AHP no longer meets the requirements, the working owner will be unable to participate in the AHP the following plan year (not the current year). However, assuming COBRA continuation coverage is available to the working owner (see below), he or she could still enroll in COBRA coverage under the AHP after his or her regular coverage expires.

Essential health benefits. Health plans in the individual and small group markets have to provide essential health benefits (EHBs) under the Affordable Care Act (ACA). Large group plans (more than 50 employees) do not have to provide EHBs. Under pre-rule guidance, if an employer group was formed based on geography or if such group included working owners, the sole proprietors and any small employers in the group would still be required to provide EHBs, even though the AHP covered more than 50 employees in the aggregate among all member employers.

One of the main purposes of the proposed rule was to allow AHPs based on geography and/or including working owners to still be treated as a single large plan, so that they will not have to provide EHBs at all. Many commenters opposed this. However, the DOL declined to change it. Besides being contrary to the purpose of the rule, the DOL noted that AHPs will face other coverage mandates under federal and state laws, including:

- To the extent an AHP chooses to cover any EHBs, the AHP will also have to comply with the ACA’s limit on maximum out-of-pocket costs and the prohibition on annual or lifetime dollar limits with respect to such covered EHBs.
- The ACA requires AHPs to cover certain preventive services for adults and children without cost-sharing.
- The ACA requires AHPs to provide “minimum value,” which means: (1) covering at least 60 percent of the cost of covered benefits; and (2) providing substantial coverage for inpatient hospitalizations and physician services.
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- The Pregnancy Discrimination Act (PDA) requires pregnancy-related expenses for employees and their spouses to be reimbursed in the same manner as other medical conditions. The DOL asserted that the PDA would only apply to individual member employers with 15 or more employees (not the total number of employees covered by the AHP in the aggregate), but that the AHP could provide such benefits across all member employers for administrative simplicity.

- The Newborns’ and Mothers’ Health Protection Act requires an AHP covering hospital stays in connection with childbirth to cover hospital stays for at least 48 hours following a vaginal birth or 96 hours following a caesarian section.

- Applicable state-level mandates on AHPs also will require compliance.

**ERISA pre-emption remains unchanged.** An AHP is considered a multiple employer welfare arrangement (MEWA) under ERISA. In an effort to combat fraud and abuse by MEWAs, Congress gave states substantial authority to regulate such entities. Specifically, fully insured plans can be regulated with respect to certain aspects (e.g., contribution and reserve levels, licensing, registration, financial reporting, etc.), while self-insured and partially insured plans can be regulated in any manner so long as not inconsistent with ERISA. The final rule does nothing to change the ability of states to regulate AHPs. Neither was the DOL willing to opine on the enforceability of particular state laws.

**Membership control.** Similar to pre-rule guidance, the proposed rule required the member employers to control the employer group. The final rule slightly modifies the rule, consistent with such pre-rule guidance, by clarifying that control must exist in “form and substance.” The DOL will determine this based on all the relevant facts and circumstances, including:

- “[W]ether employer members regularly nominate and elect directors, officers, trustees, or other similar persons that constitute the governing body or authority of the employer group or association and plan”;

- “[W]ether employer members have authority to remove any such director, officer, trustees, or other similar person with or without cause; and

- “[W]ether employer members that participate in the plan 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.”

The proposed rule also barred the employer group from being a health insurance issuer or being owned or controlled by a health insurance issuer. The final rule adds subsidiaries or affiliates of health insurance issuers to the list of banned entities but also clarifies that banned entities can still participate in an AHP in their capacity as member employers of a bona fide employer group.
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In addition, the DOL emphasized in the preamble to the final rule that any employer group or AHP controlled by a “network provider, a healthcare organization, or some other business entity that is part of the U.S. healthcare delivery system” would not qualify as a bona fide employer group. However, such entities could provide administrative services to an AHP.

**Nondiscrimination.** To combat adverse selection, the proposed rule barred employer groups from discriminating against employers or individuals based on health factors with respect to membership or benefits. The final rule clarifies that AHPs may discriminate among member employers on non-health factors, such as “industry, occupation, or geography,” provided it is not a pretext for discriminating against one or more individuals. The DOL added several examples to the regulation illustrating this ability. At one point, the DOL also suggested that rating premiums on gender is permissible, such that young women, for example, could be charged significantly higher premiums than young men.

Under pre-rule guidance, there is nothing barring an AHP from treating individual member employers as distinct groups of similarly situated individuals. In other words, it is easier for individual employers to be excluded from the group and therefore be ineligible for the AHP, and also for benefits and premiums under the AHP to vary from one employer to another. To the extent employer groups choose to form under pre-rule guidance, it may increase adverse selection by pushing sicker individuals out of AHPs and back into the individual and small group markets.

**Formal organizational structure.** The proposed rule required the employer group to have a formal organizational structure, similar to pre-rule guidance. The final rule made no change to this requirement.

**Guidance on other federal laws**

**Mental Health Parity and Addiction Equity Act (MHPAEA).** The MHPAEA is a complicated law that generally bars group health plans from treating mental health and substance use conditions differently from medical conditions (although it does not require mental health and substance use conditions to be covered in the first place). However, the MHPAEA exempts certain small employers (up to 50 employees) from its requirements.

After consulting with the Department of Health & Human Services (HHS), the DOL determined that whether the small employer exception to the MHPAEA applies depends upon the aggregate size of the AHP — more specifically, the number of employees employed during the preceding calendar year by all member employers. As a result, as long as there are more than 50 employees in the aggregate, the AHP will have to comply with the MHPAEA.

**COBRA continuation coverage.** The preamble and the final rule are clear that AHPs must comply with COBRA continuation coverage requirements when applicable. But when are they applicable? COBRA does not apply to a group health plan if “all employers maintaining such plan normally employed fewer
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than 20 employees on a typical business day” in the preceding year. Because the COBRA rules are interpreted by the IRS, the DOL declined to opine on whether the employees of all employers in the employer group are aggregated or looked at individually. Most likely, the employees will be aggregated, but future guidance may provide differently.

Wellness programs. The DOL makes clear that an AHP can offer wellness programs to incentivize participants to choose healthy behaviors. The DOL notes that, under the wellness program regulations, rewards or penalties can be as much as 30 percent of the cost of coverage under the AHP, or up to 50 percent with respect to tobacco use.

Voluntary employees’ beneficiary associations. A VEBA is a tax-exempt entity that can be used to hold plan assets for health and welfare plans, including MEWAs. The VEBA requirements under Section 501(c)(9) of the Tax Code vary from the new rules for AHPs, which may make it difficult or impossible for some organizations creating AHPs to be funded through a VEBA. Nonetheless, to the extent a VEBA is used, the AHP and VEBA requirements would have to be met.

Other federal laws. The DOL declined to opine on the applicability of other federal laws, such as employer shared responsibility payments under the ACA, premium tax credit eligibility rules under the ACA, network adequacy standards, Medicare secondary payer rules, and other federal laws.

The future of AHPs

The Congressional Budget Office (CBO) estimates that 4 million new individuals will enroll in AHPs by 2023 under the final rule, including 400,000 who would otherwise be uninsured.

Litigation. The attorneys general for New York and Massachusetts have already announced their intent to sue to block the final rule, believing that it reduces consumer health protections and invites fraud, mismanagement, and abuse. Some commenters to the proposed rule argued that the final rule violated the ACA by undoing the definitions of the individual, small group, and large group markets. The DOL, in consultation with HHS, however, disagreed.

State and federal collaboration. MEWAs have a history of fraud and abuse. Since 1985, the DOL has pursued 968 civil enforcement cases and 317 criminal cases involving MEWAs, affecting over 3 million participants. Combined, the violations yielded more than $235 million in civil restitution and $173 million in court-ordered restitution in criminal cases. Simultaneously with expanding AHPs, the DOL was concerned about the potential expansion of fraud and abuse.

To give the DOL and state authorities more time to address these concerns before the rules go fully into effect, the final rule has a staggered effective date:
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- Sept. 1, 2018: Fully insured AHPs.
- Jan. 1, 2019: Existing self-insured AHPs that seek to expand under the final rule.
- April 1, 2019: New self-insured AHPs complying with the final rule.

In addition, the DOL specifically stated its intent to “increase its focus on compliance guidance and enforcement in collaboration with the States.” As a result, expect ongoing activity at the state and federal levels to regulate and monitor new AHPs.

**State EHBs?** Also expect many states to enact new coverage mandates on AHPs, similar to EHBs. The DOL recognizes that, to the extent states adopt their own minimum benefit standards, “AHPs will have less opportunity to expand choices of more affordable coverage options for many small businesses.” AHPs spanning more than one state will face an especially difficult task of complying with multiple and sometimes conflicting sets of state requirements.

**Harmful effect on other markets.** Premiums in the individual and small group markets will rise due to the final rule, although it is not clear by how much. According to one report, premiums in the individual group market will rise 2.7 percent to 4 percent, while they will rise in the small group market between 0.1 percent and 1.9 percent. The CBO estimated that premiums will increase 2 percent to 3 percent. The chief actuary for the Centers for Medicare & Medicaid Services estimated a 6 percent increase.

But the overall effect on premiums in the marketplace will depend heavily on state regulation and the design of AHPs. For example, AHPs may use wellness programs to dissuade less healthy individuals from joining, which may increase adverse selection and intensify premium increases in the individual and small group markets.

In addition, beginning in 2019, Congress eliminated the tax on individuals for not having health insurance. This may cause some individuals to simply go uninsured rather than join an AHP.

*Please contact any of the attorneys in our Employee Benefits group if you have questions about AHPs or are interested in forming an employer group or creating an AHP.*