Association Health Plan Proposed Rule: Summary and Implications for States

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In response to President Trump's October 12 executive order (EO), the U.S. Department of Labor (DOL) has published proposed rules to expand the availability of health coverage sold through associations to small businesses and self-employed individuals. The public has until March 6, 2018 to submit comments on these proposed rules.

What's in the Association Health Plan Proposed Rule?

The President's EO asks DOL to expand the conditions under which a group of employers can join together to be considered a single employer under the Employee Retirement Income Security Act (ERISA). The proposed rule has the primary aim of allowing more groups to form association health plans (AHPs) so that they can offer coverage that is regulated under federal law as large-group coverage. As a result, such arrangements would be exempt from Affordable Care Act (ACA) requirements, such as the essential health benefits standard, premium rating restrictions, the single risk pool requirement, and the risk adjustment program, and would raise new challenges for states attempting to regulate this business under state law. See Table 1.

Table 1. Application of ACA Insurance Protections by Market Segment (Fully Insured)

ACA Market Reform	Description	Individual Market*	Small-Group Market*	Large-Group Market*
Guaranteed Issue	Insurers must accept every individual or employer that applies for coverage, regardless of their health status or claims experience	Yes	Yes	Yes**
Essential Health Benefits	Insurers must provide coverage that includes 10 categories of defined benefits***	Yes	Yes	No
Rating Rules	Insurers cannot vary rates based on health status or gender; age rating is limited to 3:1	Yes	Yes	No
Single Risk Pool	Insurers must consider claims experience of all enrollees in all plans in setting premium rates	Yes	Yes	No
Risk Adjustment Program	Transfers funds from insurers with relatively low-risk enrollees to insurers with relatively high-risk enrollees	Yes	Yes	No

*Applies to fully insured, non-grandfathered, non-grandmothered products. The small-group market is defined in most states to be groups of up to 50 employees; the large-group market is composed of fully insured groups with 51 or more employees.

**The ACA requires insurers that market in the large-group market to accept all employers that apply for coverage.

***The 10 categories of benefits outlined in the ACA are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive services and chronic disease management, and pediatric services, including vision and oral care.

Gaining "Large-Group" Status Under ERISA: Proposed Change

Under current DOL rules and guidance, the criteria for determining whether a group of employers can be considered a bona fide single employer group focus on three key issues:

1. Whether the group or association is a bona fide organization with a purpose and function other than the provision of benefits;

2. Whether the employers share some commonality and organizational relationship unrelated to the provision of benefits; and
3. Whether the employers that participate in the benefit program either directly or indirectly exercise control over the program.

Furthermore, guidance issued by the Obama administration in 2011 clarifies that coverage sold via AHPs to small-group employers must be regulated under small-group market rules; coverage sold through AHPs to individuals must be regulated under individual market rules. DOL refers to the 2011 policy as the "look through" guidance. In other words, the size of each individual employer determines whether the AHP is subject to large-group market or small-group market rules, not the size of the AHP as a whole.

Under the proposed rule, AHPs could form an association solely to provide insurance benefits and gain the regulatory advantages of being treated as a large group. Additionally, DOL proposes to expand what it means for employers to "share some commonality." To be considered a single employer AHP, employer-members could be either: (1) in the same trade, industry, line of business, or profession; or (2) have their principal place of business in the same geographic region, either within a state or a metropolitan area that includes more than one state, such as the Washington, D.C., New York, or Kansas City metropolitan areas. If the former, the AHP could sell coverage nationwide, so long as its members are in the same trade, industry, line of business, or profession.

DOL proposes to retain the third criteria, requiring that the employer-members exercise control over the program. Furthermore, the AHP must have a "formal organizational structure," governing body, and by-laws in order to ensure that the AHP is acting "in the interest" of participating employers.

Expanding AHPs to the Individual Market: Membership for the Self-Employed

Under current federal rules, employers who want to purchase small-group coverage must have at least one employee who is not a spouse. The proposed rule reverses the DOL's past interpretation of ERISA, providing that the self-employed can elect to be treated as "employers" in order to join the association and at the same time be treated as "employees" in order to be covered under the benefit plan. The proposed rule would require "worker-owners" to earn a minimum income from the relevant trade or business, or work a minimum number of hours. However, AHPs could rely solely on a written attestation from the individual that he or she meets these requirements.

Health Nondiscrimination Protections

Currently, federal rules allow AHPs that achieve bona fide large-group status to separately rate each employer member of the AHP based on its claims experience or other rating factors. In expanding the ability of AHPs to achieve large-group status, however, DOL is proposing new rules that would prohibit discrimination between employer-members based on health status. Specifically, DOL is proposing that AHP membership, eligibility for benefits, benefit designs, and premiums cannot be based on any health factor. However, as a large group exempt from the ACA's rating restrictions, AHPs could charge different premiums to small groups or individuals based on age, industry, gender, or other non-health factors. Furthermore, AHPs would not be required to cover the ACA's essential health benefits and could establish different membership criteria or plan benefit designs based on other classifications, such as full-time versus part-time status, date of hire, and different occupations. For example, the rules appear to allow an AHP to offer a plan that covers maternity services to small employers and one that does not to self-employed individuals, because the separate classification would not be based on a health factor. The DOL is seeking comment on whether these nondiscrimination requirements could result in "involuntary cross-subsidization" across firms, discouraging their formation.

On the Horizon: Potential Broad Preemption of State AHP Regulation

The preamble to the proposed rule includes a "Request for Information" on whether DOL should exempt certain self-insured AHPs from state insurance regulation. This federal exemption authority could preempt state benefit standards, rating rules, and marketing restrictions, but would not preempt states' authority over AHPs' financial solvency. DOL says it is interested in "the potential for such exemptions to promote health care consumer choice and competition…as well as in the risk such exemptions might present to appropriate regulation and oversight of AHPs…" DOL further notes that, in the event of such an exemption, AHPs would continue to be subject to federal regulatory standards governing ERISA plans and AHPs.

Implications for States

States are the primary regulators of health insurance, and have broad authority to regulate AHPs, including financial solvency, marketing and rating practices, and insurance contracts. The proposed rule raises several issues likely to be of interest to states seeking to retain that authority and potentially amend their current rules and standards related to AHPs; DOL specifically asks for comments on the interaction and consequences of the proposed rule for other state and federal laws.

Who Decides? Determining Which AHPs Meet New Federal Standard

The proposed rule does not lay out a process by which AHPs would apply for or receive a federal designation as a bona fide employer sponsor of a "single multiple employer" health plan. Currently, an AHP seeking such a designation can request a DOL Advisory Opinion, a process that can take many months, if not years. In some cases, state departments of insurance (DOIs) have required AHPs to receive a formal DOL designation before being allowed to operate in the state; other DOIs have made their own determination of whether the entity meets the federal criteria for single employer, large-group status. Without a clear, new process for AHP certification prescribed by DOL, state DOIs may be on the front lines for determining whether AHPs meet the new criteria.

Potential Preemption of State Insurance Oversight: How Far Can States Go in Regulating AHPs?

The preamble to the proposed rule states that it would have a "limited" effect on state regulation because it would not modify states' authority to regulate insurers or the policies they sell to AHPs. AHPs may be "self-insured," meaning that the employer-members bear the risk of paying employees' medical claims. In other cases, the AHP is "fully-insured," meaning that it purchases insurance from an insurance company. In either case, states currently have broad authority to regulate the coverage sold through AHPs.

For the first time, DOL has signaled that it could exercise its authority to exempt certain self-insured AHPs from most insurance regulation. If it does, DOL would be the primary regulator of coverage marketed through AHPs. States would not be permitted to require AHPs to meet state rating, insurance contract, or marketing standards, and consumers who run into problems with their AHP would need to appeal to a federal agency, not their DOI, for help.

Additionally, while DOL states that the rule in its current form would not affect state regulatory authority over AHPs, there are some questions about how far state regulation could go. The proposed rule notes that state regulation must not be "inconsistent with ERISA." It is thus not clear whether a state's law or standard could be in jeopardy if it runs counter to DOL's new interpretation of ERISA for AHPs. For example, some states currently prohibit new self-insured AHPs from operating. Other states require all AHPs marketing coverage to small businesses to comply with small-group regulations and standards. A critical question for these states is whether they could be sued for having laws that are now deemed "inconsistent with ERISA."

Impact on State Premium Tax Revenue

Finally, to the extent that AHPs gain significant membership and shift small businesses and individuals away from the state-regulated group or individual markets, states could experience a resultant decline in revenue from premium taxes. This shortfall could impact state budgeting and planning.

Conclusion

The proposed rule could dramatically expand the number of AHPs that market insurance to small businesses and individuals but are regulated as large-group, single employer health plans. It will have significant implications for the small businesses and individuals enrolled through these AHPs, as well as for the markets subject to the ACA and state small-group and individual market standards. It further raises questions about the extent of state authority to assess whether AHPs meet the new federal test for single employer status, as well as states' ability to subject AHPs to small-group or individual market rules. It also raises the prospect of future federal rules that could broadly preempt state regulation of AHPs.

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