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ISSUE BRIEF

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ASSOCIATION HEALTH PLANS

Alternative Coverage for Small Businesses?

On October 12, 2017, President Donald Trump issued Executive Order 13813, entitled *Promoting Healthcare Choice and Competition Across the United States*. It announced his administration's intent to facilitate the purchase of health insurance across state lines and to increase the coverage options available to Americans.

The order identified association health plans (AHPs) as one way to provide more affordable options to small businesses—including self-employed individuals—and it directed the Secretary of Labor to consider proposing regulations to allow more employers to form associations and participate in AHPs. The order asserted that expanding access to AHPs would allow small businesses to band together to self-insure or purchase large group health insurance, which could give them increased bargaining power with insurers and would help them avoid many of the requirements the Affordable Care Act (ACA) imposes on small group and individual health plans.

In response to the order, the U.S. Department of Labor (DOL) issued a proposed rule on January 5, 2018, that would modify provisions of the Employee Retirement Income Security Act of 1974 (ERISA) to expand access to AHPs. The public comment period for the proposed rule ended on March 6, and the rule could be finalized at any time, either as written or modified in response to comments received.

Proposed changes to federal law would allow small businesses to band together across state lines or across industries for the sole purpose of sponsoring association health plans (AHPs).

Association Health Plans

AHPs are a form of multiple employer group health plans, which fall under the umbrella of multiple employer welfare arrangements (MEWAs) under ERISA. AHPs provide health coverage for their members' employees by being either fully insured (i.e., by purchasing a health insurance plan from an insurance company) or self-funded (i.e., by directly paying the employees' health care claims).

Unlike most insurance products, AHPs generally fall under the jurisdiction of the federal government instead of state insurance commissioners. However, ERISA does grant states some limited authority to regulate AHPs that operate in a state.

KEY POINTS

- ✓ Expanded access to association health plans (AHPs) will allow small businesses to band together to provide insurance for their employees and may give them increased bargaining power with insurers and providers.
- ✓ Proposed changes to federal law would also allow self-employed individuals to participate in AHPs.
- ✓ Under the proposed rule AHPs regulated under federal law would not have to comply with many of the Affordable Care Act's (ACA) consumer protection and benefits requirements.
- ✓ An expansion of AHPs could result in the loss of healthy individuals from the ACA-compliant individual and small group markets since AHPs could offer plans with reduced benefits and lower premiums.

Under the ACA, AHPs that market insurance to individuals and small businesses are treated as individual or small group insurance and are required to comply with the insurance standards and consumer protections established under the ACA, including coverage for essential health benefits, community rating and rate review. The ACA also imposed reporting requirements on MEWAs (including AHPs), criminal penalties on MEWA fraud, and authorized the DOL to take immediate action to address fraudulent MEWAs.

Under Kansas law (K.S.A. 40-2222, *et. seq.*), certain longstanding trade or professional associations that provide health coverage for their members, and other associations or groups subject to the jurisdiction of the federal government under ERISA, are not subject to the jurisdiction of the Kansas insurance commissioner. These associations are required to provide written notices to covered individuals to ensure they understand their plan is not regulated by the commissioner and, therefore, is not subject to the consumer protections provided for individuals covered by health insurance companies doing business in the state. Under the statute, the associations must pay a premium tax of 1 percent per year on the annual gross premium collected during the preceding calendar year. During the 2014 session, the Kansas Legislature amended K.S.A. 40-2222 to expand the list of entities eligible to provide health coverage for their members outside of the jurisdiction of the commissioner.

Proposed Changes

The proposed DOL rule broadens the criteria for determining when employers can come together as an employer group or association and be treated as an "employer sponsor" of a single group health plan, as defined under ERISA, that would not need to be ACA-compliant. The proposed rule also allows individual "working owners" of a business, including partners and sole proprietors, to act as employers for the purpose of participating in an association and to be treated as employees for the purpose of being covered by the association's health plan.

Definition of "Employer"

Under existing rules, an employer, defined as "any person acting directly as an employer, or any person acting indirectly in the interest of an employer in relation to an employee benefit plan," can sponsor or establish multiple employer group health plans, including AHPs. Section (a) of the proposed rule adds a group or association of employers as one of the "persons" able to act in the interest of an employer to establish or maintain a benefit plan.

Section (b) of the proposed rule establishes the requirements for a "bona fide group or association" that can establish a group health plan. Currently, the definition of a "bona fide association" requires the association to have a bona fide purpose apart from simply providing health coverage. The proposed rule would allow new groups or associations to form for the sole purpose of sponsoring a group health plan if:

- Each member employer is acting directly as the employer of at least one employee participating in the plan;
- The association has an organizational structure with a governing body and by-laws or other indications of formality;
- The activities of the association, including the establishment and maintenance of the group health plan, are controlled by the employer members, either directly or indirectly through

The proposed rule would allow new groups or associations of small businesses and self-employed individuals in the same trade or in the same geographic region to form for the sole purpose of sponsoring a group health plan.

the nomination and election of directors or officers that control the association and the plan;

- The employer members have a "commonality of interest" (as defined in the proposed rule);
- The association does not make health coverage available to anyone other than employees and former employees of the employer members and their family members or other beneficiaries;
- The coverage provided by the association complies with the nondiscrimination requirements set forth in the rule; and
- The association is not a health insurer or owned by a health insurer.

Commonality of Interest

Under current DOL guidance, an association or group of employers must share or be connected by a common "economic or representational interest" unrelated to the provision of health coverage.

In the past, the DOL has focused on specific facts about the employer members to determine whether they share some genuine organizational relationship unrelated to health coverage. Under the proposed rule, an association would meet the commonality of interest requirement if the member employers:

- Are in the same trade, industry, line of business or profession, regardless of their geographic location; or
- Have a principal place of business in a geographic region within the same state or metropolitan area, including cities, counties and metropolitan areas that include more than one state (e.g., Kansas City).

Self-Employed Individuals

Under current law, self-employed individuals with no common law employees are not deemed to be employers for ERISA purposes and, therefore, cannot be members of an association.

The proposed rule would allow "dual treatment" of individuals who are "working owners" of a business, including partners and other self-employed individuals. They would be allowed to act as employers for the purpose of participating in the association, *and* as employees eligible to participate in the AHP.

Nondiscrimination Rules

To address concerns that healthy individuals will migrate to AHPs, leaving only less-healthy individuals in the ACA-compliant individual and small group health insurance markets, and to ensure that AHPs are genuine employment-based plans and not simply insurers claiming to be AHPs, the proposed rule requires health coverage offered by AHPs to comply with various nondiscrimination provisions.

AHPs would not be permitted to condition employer membership based on any health factor of an employer's employees, former employees, family members or other beneficiaries, and must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and ACA nondiscrimination rules, which govern eligibility for benefits and prohibit discrimination related to premiums or contributions required of health plan participants or beneficiaries.

Concerns about Expanding AHPs

Potential for Fraud

In the past, some associations that claimed ERISA preemption from state insurance regulation defrauded their members and were unable to pay millions of dollars of employee claims when they became insolvent. In 1983, Congress amended ERISA to give states some regulatory authority over both self-insured and fully insured MEWAs (including AHPs) related to solvency, state licensure and financial reporting. In 1996, Congress again amended ERISA to give the DOL authority to require both fully insured and self-insured MEWAs to register with the DOL. Despite this grant of authority, fraud and abuse by AHPs continued. Between 2001 and 2003 four established self-insured associations located in California, Indiana and New Jersey covering 66,000 people became insolvent and left $48 million in unpaid medical claims.

The ACA imposed additional reporting requirements on MEWAs, and authorized the DOL to take immediate action to address fraudulent MEWAs. However, concerns persist about the potential for fraud and insolvency if AHPs become more available, causing stakeholders such as the National Association of Insurance Commissioners (NAIC) and the National Governors Association (NGA) to oppose federal efforts to make AHPs exempt from state law and oversight. The DOL acknowledged in its proposed rule that it would need additional resources if the rule is finalized.

Reduced Consumer Protections

While coverage for individuals and small employers that obtain coverage through fully insured AHPs is currently regulated under the same standards that apply to traditional individual and small group markets, including compliance with the ACA's consumer protections for people with preexisting conditions, coverage for the essential health benefits, and compliance with rating rules, those standards do not apply when the coverage is sponsored by an association that constitutes a single ERISA-covered multi-employer. AHPs regulated as a group health plan under ERISA would not have to comply with many of the ACA's requirements.

Impact on the Individual and Small Group Markets

Both the NAIC and the American Academy of Actuaries (AAA) have expressed concerns about the potential impact of the proposed AHP rule, if finalized, on the traditional individual and small group markets. While the DOL asserts that the establishment and operation of more AHPs will make more affordable health insurance options available to employees of small businesses, the NAIC and the AAA are concerned that AHPs could cause a shift of healthy individuals away from the traditional markets by offering plans with reduced benefits and lower premiums. AHPs would have greater flexibility when setting premiums, and could choose to rate based on factors such as age, group size and the type of business in which an employer works.

AHPs also could choose to limit or not provide coverage for certain types of benefits, such as prescription drugs or mental health services, to make them less attractive to individuals with greater health needs. While this approach to benefit design would not violate the nondiscrimination provisions of the proposed rule, it could discourage some individuals from enrolling in AHPs and keep them in the ACA compliant markets.

Conclusion

Under Kansas law, association health plans are largely exempt from the jurisdiction of the Kansas insurance commissioner. If the proposed rule is finalized, the Kansas Legislature may want to consider the potential impact an expansion of AHPs could have on Kansans and the state's individual and small group health insurance markets. They also may want to consider expanding the commissioner's authority to regulate AHPs, such as requiring them to be licensed as a type of insurer, establishing minimum financial solvency standards, and requiring the filing of premium rates and policy forms.

ABOUT THE ISSUE BRIEF
This brief is based on work done by Linda J. Sheppard, J.D. It is available online at khi.org/policy/article/18-10.

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