THE
NATIONAL LAW REVIEW

Association Health Plans: Self-Funded vs. Fully-Insured

Article By
Alden J. Bianchi
Mintz
Employment Matters Blog

- Health Law & Managed Care
- Labor & Employment

- All Federal

Monday, February 12, 2018

Recently proposed Department of Labor (Department) regulations governing Association Health Plans (AHPs) would, if made final, permit small employers to be regulated under more favorable, large group rules. The proposed regulations modify the rules governing fully-insured AHPs; they do not change the way that self-funded AHPs are regulated. But in the preamble to the proposal, the Department invites comments on whether the standards that govern fully-insured AHPs should be extended to self-funded AHPs. Such an extension would be a step into unchartered regulatory territory—which is the topic of this post.

Background

The debate over AHPs can be boiled down to a single question: to what extent, if any, should small employers be permitted to join with other small employers to form, maintain and participate in a single, large group health plan, i.e., an AHP. Once regulated as large groups, fully-insured plans enjoy certain advantages (which we explain in a previous post). For example, large groups are not required to offer all

ten “essential health benefits” (also addressed in our previous post), and they are free to set premiums based on the experience of the group rather than being limited to a community rate based on location, age, family size, and tobacco use. Large group, fully-insured plans would still be required to comply with state-mandated benefit requirements and other consumer protections rules. In contrast, self-funded AHPs would not be bound by any state insurance requirements.

Current law limits the extent to which small groups can combine into large groups for at least two reasons: first, is belief such combinations tend to attract fraudulent schemes and operators, and second is the concern that only employers who are better actuarial risks will establish AHPs, thereby leaving the remaining small group market with far less desirable higher risk profile.

- *The propensity to attract fraudulent schemes and operators*

We addressed this issue at some length in last week’s post. There, we explained that AHPs, which are regulated as multiple employer welfare plans (MEWAs), have “a long history marred by financial instability and even fraud.” The problem is that AHPs/MEWAs were historically regulated less stringently than traditional insurers. As a result, they were more prone to insolvency. The result was unpaid medical bills, which forced doctors and hospitals to pass costs along to insured patients in the form of higher fees, which in turn drove up already high insurance premiums. Congress sought to curb these abuses in a 1983 amendment to ERISA that we describe below.

- *Fragmentation of the small group risk pool*

This is also addressed in last week’s post. To summarize, the concern is that AHPs will be more likely to form in industries with younger, healthier employees, as employers and their employees will gain access to more affordable coverage than is available in the individual and small group markets. If this happens, the small group market will be left with a degraded risk pool.

Under current law, for an association to be deemed to be a single large group, the Department currently requires that the association be established for a purpose or function *unrelated* to providing health benefits. There must also be a “common economic or representational interest” among the association members, and the members must control the association. In addition, an association cannot include self-employed individuals with no other common law employees. Under the proposed rule, however, an association may sponsor an AHP even if its only purpose or function is to provide group health benefits, and sole proprietors and other self-employed individuals can also participate if certain minimal requirements are satisfied.

ERISA Preemption: Before and After 1983

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 was intended to sweep aside state laws to encourage uniform, nationwide standards governing the regulation of all manner of employee benefit programs. ERISA’s preemptive force is

not absolute, however. Congress saved from preemption state laws governing insurance, banking and securities. At the same time, Congress also forbade states from deeming an employee benefit plan from constituting insurance for the sole purpose of reasserting regulatory power.

Following ERISA's enactment, there arose a number of self-funded MEWAs—many of which were fraudulent—that claimed immunity from state regulation. In 1983, Congress clarified the authority of states to regulate MEWAs. An amendment to ERISA enacted in 1983 established the following rules.

- In the case of a self-funded MEWA, *any* state that regulates insurance may apply to the extent it is not inconsistent with ERISA.
- In the case of a fully-insured MEWA, a state could only enforce those state laws that provide standards requiring the maintenance of specified levels of reserves, and provisions to enforce such standards. Thus, in the case of a fully-insured MEWA, a state's regulatory power is limited to mandating and enforcing reserve requirements.

The intent of these changes was to prevent MEWA promoters from claiming immunity from state law by reason of ERISA's preemptive force.

In most states, MEWAs are subject to the same requirements as commercial insurance companies. Still other states establish separate rules that apply to MEWAs, principally, though not exclusively, related to reserves. These laws vary from restrictive to permissive. To be clear: in most states, a self-funded MEWA is currently an unlicensed insurance company.

The 1983 amendments to ERISA also permit the Department to prescribe more liberal rules for self-funded MEWAs. That power, which heretofore has not been exercised, is set out in ERISA section 514(b)(6)(B). It allows the Secretary of Labor to issue regulations treating self-funded MEWAs in the same manner as fully-insured MEWAs, i.e., to limit the power of the states to prescribing rules governing "standards requiring the maintenance of specified levels of reserves, and provisions to enforce such standards." Under this provision of ERISA, the Department could extend the reach of the rules that currently apply to fully-insured plans to also apply to self-funded plans. The preamble to the proposed AHP regulations recognizes this Congressional grant of authority, and its limitations, saying that:

ERISA section 514(b)(6)(B) provides that the Department may prescribe regulations under which non-fully insured MEWAs that are employee benefit plans may be granted exemptions, individually or class by class, from certain State insurance regulation. *Section 514(b)(6)(B) does not, however, give the Department unlimited exemption authority*. The text limiting the Department's authority is in ERISA section 514(b)(6)(A). That section provides that the Department cannot exempt an employee benefit plan that is a non-fully insured MEWA from state insurance laws that can apply to a fully insured MEWA plan under ERISA section 514(b)(6)(A), i.e., state insurance laws that establish reserves and contribution requirements that must be met in order for the non-fully insured MEWA plan to be considered able to pay benefits in full when due, and provisions to enforce such standards. *(Emphasis added.)*

Should the Department exercise its authority under this provision of the law, self-funded AHPs would remain subject to state insurance laws that provide standards requiring the maintenance of specified levels of reserves and contributions as a means of ensuring the payment of promised benefits.

Consequences of Allowing Self-Funded AHPs

A properly designed and executed self-funded group health plan enjoys some significant advantages over its fully-insured counterparts. These generally include the minimization of the amount of fixed or sunk costs, the lowering of administrative costs, the elimination of carrier profit margins and risk charges, and the freedom from Federal and state taxes and state-insurance mandates, among others. If groups and associations have the option to self-fund, it is a safe bet that they will flock to self-funded arrangements. The savings are too big to pass up. There are consequences, however, which cut both ways:

- *Who is the primary regulator*?

Historically, the states have been the primary regulators of MEWAs. This changed, marginally, with the Affordable Care Act, which conferred on the Secretary of Labor additional enforcement authority, including the power to issue cease and desist orders and to execute summary seizures of assets in appropriate cases. The emphasis here is on "marginally." The states remain the primary regulators of MEWAs under their insurance codes. If the Department permits self-funded AHPs, the Federal government would become the primary regulator of these plans. From the perspective of regulatory policy, this constitutes a sea of change.

- *State mandated benefits*

States are currently free to, and they all do, prescribe benefit mandates that apply to fully-insured arrangements. Under current law, since states retain broad powers to regulate self-funded MEWAs, a state could impose its benefit mandates, or impose adjusted community rating rules, among others, on a self-funded AHP. This would change if states are limited to imposing only solvency and contribution standards on self-funded MEWAs. AHPs would be free to offer plans with substandard benefits. According to opponents of a broader rule, there is a risk that individuals who purchase coverage may not understand that they are buying substandard plans that will not cover some or even a broad range of services. Of course, the Department could require, as a condition of the exemption permitting self-funded ASPs, that such plans provide major medical coverage or to adhere to adjusted community rating rules—but this approach seems at odds with the governing philosophy of the Trump administration.

- *State insurance protections*

States currently impose on carriers and insurance products a wide range of consumer protections that will similarly be preempted.

- *Options for State Policy-Makers and Regulators*

If the Department does permit the operation of self-funded AHPs on par with their

fully-insured counterparts, states remain free to exercise their retained powers to regulate “the maintenance of specified levels of reserves, and provisions to enforce such standards.” For example, it has been suggested that a state might be able to assess self-funded AHPs for the purposes of establishing a reinsurance fund, or to create a sinking fund to bail out insolvent self-funded AHPs. A state might also impose a “free rider” assessment to be used to shore up cost increases resulting from the degradation of the state’s small group market. In each case, the state would need to demonstrate that the fee or assessment qualifies as solvency and contribution standards. Should states attempt to constrain self-funded AHPs too aggressively, they can expect to be challenged.

Conclusion

Fully-insured MEWAs have some advantages over small group coverage, to be sure. But it remains to be seen whether these advantages will translate into significant savings. Fully-insured AHPs will still have to pay state premium taxes, retention, and other carrier overhead, and overly conservative underwriting practices, which are not uncommon, may hobble the ability of fully-insured AHPs to produce real savings when compared to small group rates. So, it’s not clear whether the disruption of the small group market, which many on both sides of the issue predict, will happen. In contrast, the savings under a self-funded regime will be substantial when compared to small group rates in a clear majority of cases. Consequently, we expect that adoption rate of self-funded AHPs would be far higher than that of fully-insured AHPs.

For proponents of AHPs generally, significantly boosting the rate of AHP adoption is a “good” thing; for opponents, not so much. If self-funded AHPs get the green light, the disruption in the small group market that proponents are urging and opponents most fear *will* happen: health care financing policy will be rolled out, not in academic or industry papers or symposia, but in real time, in the real world, with real consequences. The stakes could not be higher—for both sides.