THE
NATIONAL LAW REVIEW

DOL Releases Final Regulation Expanding Association Health Plans

Ballard Spahr LLP
Article By
Jean C. Hemphill
Edward I. Leeds
Ballard Spahr LLP
Legal Alerts

- Health Law & Managed Care
- Labor & Employment

- All Federal

Friday, June 22, 2018

The U.S. Department of Labor (DOL) on Tuesday released final regulations modifying the Association Health Plan (AHP) rules to expand their availability for small and large employers and to address their affordability by eliminating certain coverage requirements applicable to qualified health plans under the Affordable Care Act (ACA).

The regulations aim to balance the need for more affordable health care coverage options for small employers and working owners, while maintaining many of the existing quality of coverage, disclosure, and plan solvency protections of current law. With a few exceptions, the regulations generally track the proposed regulations, which were summarized in our alert released January 5, 2018. They become effective for existing insured plans as of September 1, 2018, for existing self-insured plans on January 1, 2019, and for any other new AHP on April 1, 2019.

Bona Fide Groups and Associations. In the preamble and final regulations, the DOL confirmed that employers desiring to form an AHP must consist of employers engaged in either the same trade, industry or line of business, or have a principal place of business in the same region that does not exceed the boundaries of a single state or a metropolitan area (which may include more than one state).

- The employers' membership criteria may be narrowly defined, as long as it is not a subterfuge intended to eliminate employees based on their health status.

- In a modification from the proposed rule, the association must have a least one substantial business purpose unrelated to offering and providing benefits, even if the primary purpose of the AHP is to offer coverage to the group. The other purpose could be education or promotion of the industry, but it should be a viable entity even in the absence of acting as a sponsor of an AHP. It is allowable to have a pre-existing group or association to form an AHP as a wholly owned subsidiary to administer the health plan.

Employer Control and Governance. The DOL declined to dictate specific governance structures for the associations but stated the following:

- The association is intended to be member-governed and cannot be controlled by a health insurance issuer, subsidiary or affiliate, a provider network, health care organization, or other part of a health care delivery system. Such entities are permitted to provide administrative services to an association.

- The group or association members are not required to manage the day-to-day affairs of the organization or the AHP to qualify under the rules.

Eligible Participants.

- The final rule reduces the "working owner" hours worked criteria to 20 hours per week or 80 hours per month and permits aggregation of hours worked to be consistent with the principles of the "gig" economy and incorporates the definitions of wages and self-employment income from the Internal Revenue Code.

- The DOL eliminated the provision of the proposed rule that an individual would not be considered a working owner if the individual had access to any subsidized group health plan (through a spouse or other employer) because the other coverage may not be as affordable as the AHP.

- The AHP's own employees may participate (even if not in the industry of the group).

- The preamble includes assurances that the mere participation in an AHP shall not give rise to joint employer status under any federal or state law, rule, or regulation.

Premiums. AHP premiums may not differ by employer member based on claims experience underwriting, but an AHP may charge its employer members different premiums based on non-health factors, such as age, case size, industry, and gender. The final rule includes 10 examples of circumstances under which an AHP could or could not charge different premiums.

Benefits. Although AHPs are exempt from the ACA's essential health benefits and minimum value coverage requirements of ACA, AHPs, as large group health plans, remain subject to ACA provisions aimed at assuring the quality of coverage, including:

- preventive services without the imposition of cost-sharing

- a ban on charging higher premiums or denying coverage based on a pre-existing condition
- maximum out-of-pocket and the prohibition on annual and lifetime dollar limits on any essential health benefits that the plan covers
- Coverage for dependents through age 26; and
- prohibitions of waiting periods in excess of 90 days

AHPs also may be subject to various state benefit mandates.

Application of Other Laws. Numerous federal laws only apply to employers of a certain size, such as the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The rule states that the determination of whether such laws apply to the AHP will be based on the number of employees employed in the aggregate during the preceding calendar year by the employer members of the group or association. Additionally:

- It is anticipated that most AHPs will be treated like large employers as a result of this determination.
- COBRA continuation coverage requirements are within the interpretative jurisdiction of U.S. Department of the Treasury and the IRS, with whom the DOL will consult. Further guidance is anticipated.

Fully insured and self-funded AHPs remain subject to any applicable general insurance statutes or MEWA-specific state laws. AHPs also are subject to the ACA MEWA reporting and registration requirements.

An AHP is subject to all ERISA provisions applicable to group health plans, including the fiduciary responsibility and prohibited transaction provisions. AHPs are subject to the ERISA disclosure requirements, including summary plan disclosure requirements. An AHP also must furnish ACA Summary of Benefits and Coverage and Uniform Glossary. In these documents, the AHP must describe the services that it does not cover or excludes.