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Association Health Plan Perspectives (Part 1): Determining the Status of an AHP as “Fully-Insured”

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This is the first post in a blog series exploring the U.S. Department of Labor’s recently issued final regulation governing Association Health Plans (AHPs). While AHPs can be either fully-insured or self-funded, the final regulation provides rules that are generally more useful to the former than the latter. Because of the preemptive force of ERISA, fully-insured arrangements are more lightly regulated under state law than their self-funded counterparts. This post addresses the question of what certification is needed, if any, to establish that an AHP is fully-insured.

- ***Background on the Final Regulation***

The final regulation was adopted in response to Executive Order 13813, wherein the Trump Administration sought, among other things, to facilitate “the adoption and administration of AHPs and expand access to affordable health coverage, especially

for employees of small employers and certain self-employed individuals." The final regulation seeks to expand access to employer-sponsored health insurance coverage, particularly for small businesses, by allowing these employers to band together to purchase health coverage. According to the preamble to the final regulation:

> By participating in AHPs, employees of small employers and working owners are able to obtain coverage that is not subject to the regulatory complexity and burden that currently characterizes the market for individual and small group health coverage and, therefore, can enjoy flexibility with respect to benefit package design comparable to that enjoyed by large employers.

The purpose of the final regulation is to remove "undue restrictions on the establishment and maintenance of Association Health Plans (AHPs)," which it does by modifying prior law definitions, thereby enlarging the number of employer groups and associations that may qualify as AHPs. The principal, though not only, beneficiaries are plans maintained by Chambers of Commerce and farm bureaus. For the first time, these groups will have the option to be subject to the more flexible underwriting and plan design rules that apply to large groups.

We described the prior law and explained the details of the final regulation in an article published by Bloomberg Tax available here.

- ***ERISA Preemption: Fully-insured vs. Self-funded***

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 swept aside state laws to encourage uniform, nationwide standards governing the regulation of all manner of employee benefit programs. Congress saved state laws governing insurance, banking and securities from preemption, however.

Following ERISA's enactment, promoters of self-funded multi-employer welfare arrangements, or MEWAs, routinely (though not always legitimately) claimed categorical immunity from state regulation based on ERISA preemption. 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 law that regulates insurance may apply to the extent it is not inconsistent with ERISA; and
- 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 more generous rules governing fully-insured MEWAs apply only if the AHP itself is an employee welfare benefit plan. That is, the plan must be sponsored by an employer or an association of employers. This was relatively uncommon under prior

law, which construed the terms “employer” and “association of employers” narrowly. An AHP-sponsored local business group, for example, was subject to all applicable state laws irrespective of whether it was fully-insured or self-funded because it was not deemed to be sponsored by an employer or an association of employers. The final regulation changes this. Such a plan, *if fully-insured*, may now qualify as an association, thereby enabling the plan to be free from state regulation other than with respect to the setting or reserves, etc.

There is, however, a separate, prior legal requirement that the final regulation left undisturbed relating to an AHP’s status as “fully-insured.” The requirement is found in ERISA § 514(d)(6)(D), which provides as follows:

> [An AHP] shall be considered fully-insured only if the terms of the arrangement provide for benefits *the amount of all of which the Secretary determines* are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

Simply put: no determination by the Secretary of Labor, no fully-insured AHP. The Department of Labor has not established a mechanism for applying and obtaining the Secretary’s determination. It has, however, issued advisory opinions on the subject (e.g., Ad. Op. 2005-20A).

Before the issuance of the final regulation, few AHPs had to worry about the Department of Labor’s determination of a plan’s status as fully-insured, since coverage was provided on a “look-through” approach. Small groups and individuals were covered under the state’s small group and individual markets, respectively. So, the plan’s status as fully-insured for federal purposes was of little interest to the states. As a practical matter, only a handful of single-ERISA-plan AHPs found it necessary to request a determination from the Department of Labor.

Going forward, the calculus has changed. Now, *any* AHP that seeks to combine small groups into a single, large-group plan will need a determination from the Department of Labor of its status as “fully-insured” if the AHP wants to limit state regulation. Without such a determination, the arrangement remains subject to the full panoply of state laws. With such a determination in hand, however, only state laws governing “the maintenance of specified levels of reserves, and provisions to enforce such standards” are permitted. For example, absent a Department of Labor determination of an AHP’s status as fully-insured, a state could require the AHP itself to register as an insurance company.

- ***Fully-insured Status under the Final Regulation***

It is possible that the Department or Labor will be inundated with advisory opinion requests from applicants seeking to establish their association’s status as fully-insured. One wonders whether this is a good use of the Department of Labor’s resources. There may be another way: might the Department of Labor instead issue a rule adopting a “notice” approach under which AHPs would be required to register with the Department of Labor and provide (by way of example):

- A certification from a licensed actuary to the effect that all the AHP’s benefits

are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a state; and
- An attestation by the applicant (perhaps backed-up by, or in the form of, an opinion of counsel) that the requirements of the final regulation have been satisfied.

The Department of Labor could then respond with a “no-action” letter of some sort, or it could presume that the application is approved unless denied within a specified period of time.

Whether the Department of Labor will need to make any change to its current practices for the determination of fully-insured MEWA status will depend on the demand for AHPs under the new rules.