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# DOL Issues Proposed Regulations Regarding Association Health Plans

On January 5, 2018, the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) which oversees Title I of the Employee Retirement Income Security Act (ERISA) issued a proposed rule which would broaden the definition of "employer" and the provisions under which an employer group or association may be treated as an "employer" sponsor of a single multiple-employer employee welfare benefit plan and group health plan under Title I. The DOL is accepting public comment on this rule for 60 days following the publication. Traditionally the department would then take an unspecified period of time to review the public comments, and at a later date would issue a final rule or rules.

**Background**

Title I of ERISA covers most private sector employee benefit plans, which are voluntarily established by an employer, an employee organization, or jointly by one or more such employers. Title I applies to "employee welfare benefit plans" which requires there to be a plan (or fund or program), established or maintained by an employer, for the purpose of providing specific benefits to participants and beneficiaries. ERISA provides for a specific list of benefits, which includes medical, surgical, or hospital care or benefits.

ERISA currently defines an "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." Currently, to determine employer groups or associations that can act as an ERISA employer and sponsor a multiple employer plan, courts and the DOL analyze three sets of issues:

- Whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits;
- Whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and
- Whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program both in form and substance.

The "commonality of interest" is determined by whether or not the group or association has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan. However, under current regulations, even when an association health plan can form, it is met with


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obstacles. The Centers for Medicare and Medicaid Services' (CMS) 2011 guidance provides a test for determining whether association coverage is subject to individual, small group, or large group market coverage under the Public Health Service Act. CMS ignores the backing of the association and assigns a group size to each individual employer or member within the association. This leads to disparate requirements within the same plan as it relates to community rating, medical loss ratio (MLR) provisions, single risk pool requirements, essential health benefit requirements, risk adjustment programs, and more. The proposed regulations seek to alleviate that disparity within the plan.

**Requirements under proposed regulations**

Under the proposed regulations, association health plans (AHPs) that meet a series of requirements would be permitted to offer their employer-members and their employer-members' employees, a single group health plan subject to the same regulatory structure as other ERISA employee welfare benefit plans.

Under the proposed rule, the commonality of interest of employer members of a group or association would be determined based on relevant facts and circumstances and may be established by:

1. Employers being in the same trade, industry, line of business or profession; or
2. Employers having a principal place of business in a region that does not exceed the boundaries of the same state or the same metropolitan area (even if the metropolitan area includes more than one state).

The proposed rule would remove the prior test that looked to "whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits." Instead, associations would be permitted to join together solely for the purpose of providing health benefits. However, the group or association must have an organizational structure with a governing body and by-laws (or similar formal documentation) and the group or association's member employers must control its functions or activities, including the establishment and maintenance of the group health plan. These provisions are intended to prevent commercial enterprises from calling themselves associations and offering AHPs solely for profit.

Furthermore, the proposed regulation would require that only employees and former employees of employer members (and their families/beneficiaries) may participate in a group health plan sponsored by the association. However, in a departure from other guidance, AHPs would be permitted to provide that working owners, such as sole proprietors and other self-employed individuals, would be treated as employer members in the AHP, even if they had no other common law employees. Further, the business would be treated as the individual's employer for purposes of being an employer member of the association, and the sole proprietor or self-employed individually would be the sole employee.

However, the DOL is seeking comments on this provision, particularly in relation to whether or not sole proprietors and self-employed individuals should only be permitted to join an AHP in the absence of eligibility for another group health plan, such as through a spouse's employer.

The proposed rules would subject AHPs to the nondiscrimination provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act


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(ACA). HIPAA prohibits group health plans and health insurers from discriminating with regard to eligibility and health status factors. Under HIPAA, health factors are:

- Health status
- Medical condition (physical and mental)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability
- Disability

This means that AHPs cannot exclude individuals who participate in dangerous activities or have a history of high health claims, or hinge eligibility of enrollees on evidence of insurability or “passing” a physical exam. AHPs cannot charge individuals different premiums based on the existence or absence of health factors. Health factors may not affect eligibility rules, which include rules relating to enrollment, effective dates, waiting periods, late/special enrollment, eligibility, benefits (covered benefits, benefit restrictions, coinsurance, co-pays, and deductibles), continued eligibility and terminating coverage.

HIPAA allows group health plans to impose restrictions in benefit plans if they apply to all similarly situated individuals. Plans can, in conformance with other laws, provide different benefits for different groups of similarly situated employees if the differences are based on a bona fide employment-related classification that is consistent with the employer’s usual business practice. Bona fide employment classifications might be part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service, provided the distinction is consistent with the employer’s usual business practice.

The proposed regulations clearly state that AHPs may not treat different member employers as distinct groups of similarly situated individuals. The proposed regulations provide 6 examples on this issue.

*Example 1*

Facts. Association A offers group health coverage to all members. According to the bylaws of Association A, membership is subject to the following criteria: all members must be restaurants located in a specified area. Restaurant B, which is located within the specified area, has several employees with large health claims. Restaurant B applies for membership in Association A, and is denied membership based on the claims experience of its employees.

Conclusion. In this Example 1, Association A’s exclusion of Restaurant B from Association A discriminates on the basis of claims history, which is a health factor under §2590.702(a)(1) of this chapter. Accordingly, Association A violates the requirement in paragraph (d)(1) of this section, and, therefore would not meet the definition of a bona fide group or association of employers under paragraph (b) of this section.

*Example 2*

Facts. Association C offers group health coverage to all members. According to the bylaws of Association C, membership is subject to the following criteria: all members must have a principal place of business in a specified metropolitan area. Individual D is a sole proprietor whose principal place of business is within


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the specified area. As part of the membership application process, Individual D provides certain health information to Association C. After learning that Individual D has diabetes, based on D's diabetes, Association C denies Individual D's membership application.

Conclusion. In this Example 2, Association C's exclusion of Individual D because D has diabetes is a decision that discriminates on the basis of a medical condition, which is a health factor under §2590.702(a)(1) of this chapter. Accordingly, Association C violates the requirement in paragraph (d)(1) of this section and would not meet the definition of a bona fide group or association of employers under paragraph (b) of this section.

*Example 3*

Facts. Association F offers group health coverage to all plumbers working for plumbing companies in a state. Plumbers employed by a plumbing company on a full-time basis (which is defined under the terms of the arrangement as regularly working at least 30 hours a week) are eligible for health coverage without a waiting period. Plumbers employed by a plumbing company on a part-time basis (which is defined under the terms of the arrangement as regularly working at least 10 hours per week, but less than 30 hours per week) are eligible for health coverage after a 60-day waiting period.

Conclusion. In this Example 3, making a distinction between part-time versus fulltime employment status is a permitted distinction between similarly situated individuals under §2590.702(d) of this chapter, provided the distinction is not directed at individuals under §2590.702(d)(3) of this chapter. Accordingly, the requirement that plumbers working part time must satisfy a waiting period for coverage is a rule for eligibility that does not violate §2590.702(b) or, as a consequence, paragraph (d)(2) of this section.

*Example 4*

Facts. Association G sponsors a group health plan, available to all employers doing business in Town H. Association G charges Business I more for premiums than it charges other members because Business I employs several individuals with chronic illnesses.

Conclusion. In this Example 4, Business I cannot be treated as a separate group of similarly situated individuals from other members under paragraph (d)(4) of this section. Therefore, charging Business I more for premiums based on one or more health factors of the employees of Business I violates §2590.702(c) of this chapter and, consequently, the requirement in paragraph (d)(3) of this section.

*Example 5*

Facts. Association J sponsors a group health plan that is available to all members. According to the bylaws of Association J, membership is open to any entity whose principal place of business is in State K, which has only one major metropolitan area, the capital city of State K. Members whose principal place of business is in the capital city of State K are charged more for premiums than members whose principal place of business is outside of the capital city.

Conclusion. In this Example 5, making a distinction between members whose principal place of business is in the capital city of State K, as compared to some other area in State K, is a permitted distinction between similarly situated individuals under §2590.702(d) of this chapter, provided the distinction is not directed at individuals under §2590.702(d)(3) of this chapter. Accordingly, Association J's rule for charging different premiums based on principal place of business does not violate paragraph (d)(3) of this section.


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*Example 6*

Facts. Association L sponsors a group health plan, available to all members. According to the bylaws of Association L, membership is open to any entity whose principal place of business is in State M. Sole Proprietor N's principal place of business is in City O, within State M. It is the only member whose principal place of business is in City O, and it is otherwise similarly situated with respect to all other members of the association. After learning that Sole Proprietor N has been diagnosed with cancer, based on the cancer diagnosis, Association L changes its premium structure to charge higher premiums for members whose principal place of business is in City O.

Conclusion. In this Example 6, cancer is a health factor under §2590.702(a) of this chapter. Making a distinction based on a health factor, between members that are otherwise similarly situated is in this case a distinction directed at an individual under §2590.702(d)(3) of this chapter and is not a permitted distinction. Accordingly, by charging higher premiums to members whose principal place of business is City O, Association L violates §2590.702(c) of this chapter and, consequently, paragraph (d)(4) of this section.

**Differentiation from MEWAs**

Currently, some states permit groups of unrelated employers to offer group health plans under a plan known as a "multiple employer welfare arrangement" or MEWA. MEWAs are subject to strict state and federal scrutiny and are an enforcement priority for the DOL. The proposed regulations are clear that AHPs are not the same as MEWAs. The proposed rules would not alter existing ERISA statutory provisions governing MEWAs. The proposed rules also would not modify the States' authority to regulate health insurance issuers or the insurance policies they sell to AHPs.

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