ASSOCIATION HEALTH PLANS: An Opportunity, With Risks

by Ross D. Weiler

A new regulation for association health plans (AHPs) has the stated purpose of expanding access to more affordable, high-quality health insurance. This article explains the new rules and looks at their potential impact on insurance markets.

Reproduced with permission from Benefits Magazine, Volume 55, No. 10, October 2018, pages 40-45, published by the International Foundation of Employee Benefit Plans (www.ifebp.org), Brookfield, Wis. All rights reserved. Statements or opinions expressed in this article are those of the author and do not necessarily represent the views or positions of the International Foundation, its officers, directors or staff. No further transmission or electronic distribution of this material is permitted.
Association health plans (AHPs) are not new. In fact, associations have had the attention of policymakers as a potential yet risky way to way to address the problem of the uninsured and help small businesses cope with rising premiums since the 1980s. AHPs are viewed by proponents as a way to expand coverage and reduce costs for individuals and small businesses. But some AHPs have been subject to fraud and abuse, resulting in significant changes over the years that strengthened how they are regulated at the federal and state level. With the new AHP regulation released this summer that once again significantly changes how AHPs are regulated, we will now see firsthand whether the good outweighs the bad—or vice versa.

What Is an AHP?

An AHP is defined as “health insurance coverage offered to collections of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements (MEWAs), purchasing alliances or purchasing cooperatives.”

Where Have We Been

Prior to the Affordable Care Act (ACA), millions of individuals and small employers bought health insurance through associations. Many business and trade associations offered coverage as part of their broader mission to serve the economic or professional needs of their members; others existed exclusively to sell health insurance. Some served the best interests of their members; others did not.

Prior Federal Law Governing AHPs

Under federal law and regulations in force prior to the effective dates of the new AHP regulation, health insurance coverage offered or provided through an employer trade association, chamber of commerce or similar organization to individuals and small employers was generally regulated under the same standards that apply to insurance coverage sold by health insurance issuers directly to these individuals and small employers, unless the coverage sponsored by the association constituted a single Employee Retirement Income Security Act (ERISA)-covered “welfare benefit plan.”

According to the Department of Labor (DOL), for a group or association to constitute a single welfare benefit plan, there must be a bona fide group or association of employers acting in the interest of its employer members to provide benefits for their employees. This is referred to as a commonality of interest.

DOL advisory opinions and court decisions have applied a facts-and-circumstances approach to determining whether there is a sufficient common economic or representational interest or genuine organizational relationship for there to be a bona fide employer group or association capable of sponsoring an ERISA plan on behalf of its employer members. To pass this test, the group or association must:

1. Be a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits
2. Include employers that share some commonality and genuine organizational relationship unrelated to the provision of benefits
3. Have employers that participate in a benefit program, either directly or indirectly, and exercise control over the program both in form and substance.

If an AHP could not meet these standards, ACA requirements applied at the individual employer level and were based on each individual employer’s size (i.e., AHP plans offered to individuals and small employers were required to meet the ACA’s individual and small group requirements, while plans offered to large employers have more flexibility). Thus, AHPs covering a mix of employer members were required to meet a variety of ACA requirements.

The ACA made many AHPs less attractive—especially to individual and small group members—but the new AHP regulation makes it easier for employers to:

1. Band together to form (or join existing) AHPs for the primary purpose of obtaining health coverage (even across state lines)
2. Avoid ACA individual and small group requirements.

According to the new regulation, its “principal objective is to expand employer and employee access to more affordable, high-quality coverage.”

Effective Dates

Fully insured AHPs were allowed to begin operating under the new regulation on September 1, 2018. Existing self-insured AHPs may begin operating under the new regulation on January 1, 2019 and new self-insured AHPs on April 1, 2019.
Will AHPs accomplish this goal? The answer is yes and no.

**AHPs and the ACA**

The ACA included several insurance and market reforms. These reforms were designed to provide a certain amount of protection for health plan enrollees. Some of the ACA provisions have applied only to individual and small group coverage (generally employers with fewer than 50 full-time employees) and not large group (generally employers with 50 or more full-time employees), including a requirement to cover ten essential health benefits, rating restrictions, a requirement for insurers to combine individual and small group coverage into one risk pool for rating purposes, and required participation in the ACA risk adjustment program.

Rather than one set of rules applying at the AHP level, unless an AHP is considered a “single Employee Retirement Income Security Act (ERISA) covered plan” (which is rare), ACA requirements have applied to each employer enrolled in an AHP depending on whether it is a self-employed individual, a small group or a large group. Thus, AHPs covering a mix of employer members have had to meet a variety of ACA requirements, and those requirements impact the cost of coverage for individual and small group members. This is similar to how the ACA applies to individuals and groups purchasing coverage outside of an AHP, such as directly through a commercial insurer or through a state or the federal exchange.

The ACA also included reforms designed to curb past abuses and solvency concerns raised by AHPs. These included greater enforcement authority for DOL, criminal penalties for false statements to state or federal officials, federal registration and additional reporting requirements.

**Where Are We Now?**

**The Final AHP Regulation**

On June 21, 2018, the DOL released a final regulation that allows AHPs to:

- Form for the sole purpose of offering health insurance without any common interest beyond shared industry or shared location rather than the more stringent standards under prior federal law, described earlier
- Cover members of all sizes, including self-employed individuals and sole proprietors (working owners), small groups and large groups (as defined by the ACA). Under prior federal law, employers that wanted to purchase group coverage must have had at least one employee who was not a spouse.
- Be considered “large group” coverage under federal law, which would allow covered individuals and small employers to avoid complying with the individual/small group requirements of the ACA. As noted earlier, under prior federal law ACA requirements applied at the employer—and not the AHP—level.
- Charge higher rates, beyond those permissible under the ACA, based on factors such as age, gender, occupation and group size. Under prior federal law, AHPs covering small groups needed to comply with the ACA rating requirements forbidding the use of these factors. Certain criteria must be met to be considered an AHP, including the following.
- AHP members must have a commonality of interest, such as being in the same trade, industry, line of business, profession or geography. This is a much less stringent standard than the “bona fide group or association” requirement under prior federal law as noted earlier.
- The AHP must have an organizational structure, governing body and bylaws; its functions and activities must be controlled by its members; and the plan must be controlled by participating members. This is consistent with prior federal requirements.
- The AHP must have at least one substantial business purpose unrelated to the provision of benefits (although the AHP’s principal purpose may be the provision of benefits). This is less stringent than the “test” described earlier but is stricter than the original proposed regulation, which had no requirement re-
lated to a business purpose other than for the provision of benefits.

- Coverage must be limited to employees of employer members (and may include working owners). Aside from the “working owner” provision, this is consistent with prior federal law.

- Existing nondiscrimination rules continue to apply, such as
  — No health-based discrimination
  — Must comply with nondiscrimination requirements contained in the Health Insurance Portability and Accountability Act (HIPAA) and the ACA.

**Regulatory Oversight of AHPs**

AHPs may be self-funded or fully insured, and the new AHP regulation applies to both. In either case, states continue to have broad authority to regulate financial solvency, marketing and rating practices, and insurance contracts. This means that any requirements that apply to insurance coverage sold in the state may be applied to AHPs. In addition, state standards of conduct, consumer protections and reserve requirements may be applied to self-funded AHPs. For example, minimum coverage requirements may apply to insured AHPs, and standards of conduct, consumer protections and reserve requirements may be applied to self-funded AHPs.

AHPs must continue to meet federal and state regulations for MEWAs. At the federal level, MEWAs (and therefore AHPs) are subject to ERISA reporting and disclosure, fiduciary, administration and enforcement, continuation of coverage, and health care requirements.

**Potential Impact on Insurance Markets**

While proponents argue that broadening access to AHPs will help small businesses and individuals obtain less expensive health coverage, many prominent organizations—such as the National Association of Insurance Commissioners, the American Academy of Actuaries and America’s Health Insurance Plans—have raised concerns including the following.

**Increased Risk of Fraud and Insolvency**

States generally have broad authority to protect their residents from insurance scams, and in the past some AHPs were used as a vehicle for this purpose. This led to a tightening of federal and state oversight over the past three decades. Today, states may regulate standards relating to AHP solvency such as actuarial soundness, proper maintenance of reserves and adequate underwriting. Although the final regulation retains states’ authority to regulate AHPs, ERISA does allow for limited federal exemptions, and some are concerned that there will be an increase in federal exemptions. The ability of the states to regulate AHPs and enforce compliance will be even more important as more AHPs develop, so maintaining state oversight by limiting these exemptions is critical.

**Reduced Consumer Protections for Small Groups and Individuals**

As mentioned earlier, under prior federal law, AHP coverage was required to comply with the consumer protections and benefit standards in the ACA based on the size of each participating employer (i.e., individual, small group, large group).

An AHP sold to small employers or individuals that is considered a large group health plan based on total membership in the future will have to comply with far fewer standards. Compared with ACA-compliant coverage, individuals and small employers pur-
chasing coverage through an AHP could now be subject to reduced benefits (by choice or otherwise) or higher rates (depending on age, gender or industry).

**Instability in Insurance Markets**

AHPs that are regulated as large group plans will have significantly more flexibility in designing benefits and setting premiums. An AHP could design its products in a way that makes them unattractive to those who are less healthy by, for example, eliminating or restricting access to one or more of the essential health benefits the ACA requires. They also could charge higher premiums based on age, gender or industry.

Through reduced benefits and/or pricing strategies, AHPs could attract younger, healthier members compared with ACA-compliant plans sold in the individual and small group markets (including Healthcare.gov and state exchanges, as well as directly through insurers). In fact, the U.S. Congressional Budget Office (CBO) predicted that 3.6 million people will enroll in AHPs who would have had other coverage. This could create an uneven playing field where healthier, younger enrollees choose AHP coverage, and older, sicker enrollees remain in ACA-compliant plans. As AHPs grow, ACA-compliant risk pools—including coverage for nearly 12 million individuals purchasing plans through Healthcare.gov and state exchanges—could worsen. This would result in higher premiums and fewer plan options for individuals and small employers buying insurance in the regulated individual and small group markets and potentially lead to a “death spiral” within the regulated markets.

**The Bottom Line**

AHPs offer an opportunity to expand health coverage options for individuals and small businesses. The DOL expects that a substantial number of uninsured people will enroll in AHPs because the coverage will be more affordable than what would otherwise be available to them. Although most AHP enrollees are expected to come from other coverage, the CBO predicted that 400,000 people who would have been uninsured will enroll in AHPs. On the other hand, AHPs have the potential to increase fraud and insolvency, reduce consumer protections, and increase instability in the individual and small group insurance markets.

Now that the AHP regulation is final, it will need to be implemented thoughtfully. It will largely be up to states, insurers and AHP operators to figure out how to move forward in a way that minimizes risks to insurance markets and the citizens they protect. Otherwise, what is being billed as good for some could be a big step back for many.

**Endnotes**

4. 29 USC §§1021(g); 1131 et seq.
6. Ibid.