



**ASSOCIATION HEALTH PLANS FINAL RULE**  
Connie Akridge  
August 1, 2018

## Trump Executive Order



- Final Rule issued June 19, 2018 as a new regulation at 29 C.F.R. § 2510.3-5 (Final Rule),
  - Issued in response to President Donald Trump's October 12, 2017 Executive Order "Promoting Healthcare Choice and Competition Across the United States"
    - stating that "[i]t shall be the policy of the executive branch, to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people."
- Executive Order 13813 at 82 FR 48385 (Oct. 17, 2017).

The Patient Protection and Affordable Care Act (PPACA), however, has severely limited the choice of healthcare options available to many Americans and has produced large premium increases in many State individual markets for health insurance. The average exchange premium in the 39 States that are using [www.healthcare.gov](http://www.healthcare.gov) in 2017 is more than double the average overall individual market premium recorded in 2013. The PPACA has also largely failed to provide meaningful choice or competition between insurers, resulting in one-third of America's counties having only one insurer offering coverage on their applicable government-run exchange in 2017.

## Executive Order: 3 areas of improvement



- 1. **AHPs.** Expand access to AHPs to help small businesses and working owners to band together to self-insure or purchase large group insurance so as to compete with large employers.

- 2. **Short-term limited-duration insurance**

### Proposed Rule

<https://www.federalregister.gov/documents/2018/02/21/2018-03208/short-term-limited-duration-insurance>

- Comment deadline: April 23, 2018
- 3. **Health reimbursement arrangements**

(b) Among the myriad areas where current regulations limit choice and competition, my Administration will prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs).

(i) Large employers often are able to obtain better terms on health insurance for their employees than small employers because of their larger pools of insurable individuals across which they can spread risk and administrative costs. Expanding access to AHPs can help small businesses overcome this competitive disadvantage by allowing them to group together to self-insure or purchase large group health insurance. Expanding access to AHPs will also allow more small businesses to avoid many of the PPACA's costly requirements. Expanding access to AHPs would provide more affordable health insurance options to many Americans, including hourly wage earners, farmers, and the employees of small businesses and entrepreneurs that fuel economic growth.

(ii) STLDI is exempt from the onerous and expensive insurance mandates and regulations included in title I of the PPACA. This can make it an appealing and affordable alternative to government-run exchanges for many people without coverage available to them through their workplaces. The previous administration took steps to restrict access to this market by reducing the allowable coverage period from less than 12 months to less than 3 months and by preventing any extensions selected by the policyholder beyond 3 months of total coverage.

(iii) HRAs are tax-advantaged, account-based arrangements that employers can

establish for employees to give employees more flexibility and choices regarding their healthcare. Expanding the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare.

## Today's Agenda



- Background: DOL's existing sub-regulatory guidance on/State regulation of association health plans (AHPs)/multiple employer welfare arrangements (MEWAs)
- Summary of DOL 198-page Final Rule on AHPs issued on June 19, 2018.
- Concerns about the Proposed/Final Rule

### MEWA—multiple employer welfare arrangements

Sub-regulatory guidance largely issued through advisory opinions. Small group employers could band together and form MEWAs under ERISA to be treated as a large group under the ACA. Under DOL guidance strict requirements on MEWAs to be treated as a single employer, few MEWAs have been treated as a single employer and treated as a large group. Instead, DOL “looked through” the MEWA to each individual employer group’s size to determine whether large or small ACA market rules apply.

Among MEWAs operating as single large group health plans (hereafter, “plan MEWAs”), total enrollment averaged just 3,437 in 2016. Twenty-eight had more than 10,000 enrollees, and four had more than 50,000, but many of these were dispersed across multiple States. (Final Rule page 116)

-Facts and circumstances test focused on whether the association was a bona fide group, whether the employers share some employment-based relationship, or genuine organizational relationship separate from provision of insurance and whether the employers that participated in the benefit program exerted control over the program in both form and substance.

## Final Rule doesn't supplant previous DOL guidance.



- Does not supplant the DOL's previously issued guidance for AHPs under ERISA section 3(5). Instead, it establishes an *additional* mechanism for groups or associations to meet the definition of an "employer" within the meaning of ERISA section 3(5).
- Staggered applicability dates are established under the Final Rule:
  - September 1, 2018, for fully-insured AHPs,
  - January 1, 2019, for existing self-insured AHPs, and
  - April 1, 2019, for new self-insured AHPs.

## Forming single employer MEWAs under DOL existing sub-regulatory guidance



- Under ERISA covered employee welfare benefit plans (group health plans) sponsored by individual employers--the number of employees determines whether the Affordable Care Act (ACA) small group (generally those with 50 or fewer employees) market rules (Essential Health Benefits and community rating, etc.) or large group market rules apply.
- Group of employers may come together to form single employer AHP, employers must be:
  - Members of a bona fide group or association with a commonality of interest beyond the provision of health benefits and must exercise control over the administration and management of the AHP. Employers must be in the same industry
  - DOL advisory opinions and court decisions use a facts and circumstances review to determine whether a bona fide group or association exists.

6

HOLLAND & HART 

### Essential Health Benefits

EHB requirements ensure that everyone in the individual and small group health insurance markets has access to comprehensive coverage that actually covers the services they need. These essential health benefits fall into 10 categories:

- Ambulatory patient services (outpatient services)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

**Community rating** is a method of setting premiums so that risk is spread evenly across the community, with all individuals paying the same rate regardless of their health status and other factors such as age, gender, and lifestyle characteristics.

Beginning for plan years (in the individual market, policy years) on or after Jan. 1, 2014, the Affordable Care Act (ACA) required adjusted community rating for nongrandfathered policies in the individual and small group insurance markets. Most large fully insured and self-funded employers are exempt from this requirement.

Under the ACA's adjusted community rating (ACR) provisions, the use of actual or expected health status or claims experience to set group premiums is prohibited.

Health

insurance issuers may vary the premium rate charged to a specific non-grandfathered individual or small group from the rate established for that particular plan only on the following factors: family size (individual or family), geography (rating area), age (within a ratio of 3:1 for adults) and tobacco use (within a ratio of 1.5:1).



## Forming single employer MEWAs under DOL existing sub-regulatory guidance



- Biggest benefit for AHPs that qualify under existing-sub regulatory guidance may be able to continue to set premium rates employer by employer based on the claims experience of each employer.
- Relying on “facts and circumstances” analysis by DOL instead of more precise Final Rule provisions could be problematic.

## Forming single employer MEWAs/AHPs under state law



- States may not fully regulate MEWAs pursuant to ERISA's which preempts all state laws "relating to" employee benefit plans.
- Under ERISA "savings clause" nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities."
- Regulators acknowledge they can't regulate a fully insured MEWA directly, but can regulate an insurance policies issued to a MEWA by a licensed carrier. See ERISA section 514(b)(6)(A)(i)
- To guard against fraud and abuse, a number of states provide that self-insured MEWAs must be licensed, registered, hold certificates of authority, have a minimum number of participating employers, obtain an actuarial opinion that the MEWA can meet promised benefits and require that the MEWA keep a minimum level of reserves

## Forming single employer MEWAs/AHPs Under State Law



- The Final Rule Preamble: (i) if an AHP self-insured, any state law that regulates insurance may apply to AHPs to the extent such law is not inconsistent with ERISA; (ii) Final Rule does not modify or otherwise limit existing state authority established under section 514 of ERISA to regulate MEWAs/AHPs; and (iii) indicates that under ERISA section 514(b)(6) provides the DOL authority to preempt state insurance laws that go too far in regulating self-insured AHPs in ways that interfere with the Final Rule's important policy goals.
- Some states have "true" group/association statutes which require the association to be formed for a purpose other than providing health insurance coverage to be eligible to form a MEWA; and/or may require the association to be in existence at least (3-5) years before the association may offer health insurance to its members. These kind of requirements likely preempted by the Final Rule.

9

HOLLAND & HART 

Page 96 Preamble: 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 by class, from certain State insurance regulations. ERISA section 514(b)(6)(B) does not, however, give the Department unlimited exemption authority. Significantly, ERISA section 514(b)(6)(B) does not give the Department any authority to exempt any fully-insured AHP from any state insurance laws that can apply to a fully-insured MEWA plan under ERISA section 514(b)(6)(A). Furthermore, section 514(b)(6)(B) does not allow the Department to exempt self-insured AHPs from state insurance laws that can be applied to fully-insured AHPs, *i.e.*, laws related to reserve and contribution requirements that must be met in order for the fully-insured MEWA plan to be considered able to pay benefits in full when due, and provisions to enforce such standards. Notwithstanding these limitations, ERISA section 514(b)(6) provides a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule. But, as noted in the Proposed Rule, doing so at this time lies outside the scope of this proceeding.

## Level the playing field



- As compared with the DOL's existing AHP guidance, the Final Rule removes restrictions on the establishment of AHPs and creates a more flexible "commonality of interest" test under Title I section 3(5) of the Employee Retirement Income Security Act (ERISA) for determining when an association of employers will be treated as an "employer" sponsor of an employee welfare benefit plan or a group health plan.
- Allows working owners without common law employers to be both employer and employee.
- Frequently mentions its rationale for changes made in the Final Rule as necessary to draw a line between traditional health insurance issuers (which typically exist only to underwrite and sell insurance) on the one hand, and association health plans that qualify as an "employer" under section 3(5) of ERISA on the other.
- Protections necessary to prevent fraud and abuse--entrepreneurial MEWAs from being able to establish a bona fide group with access to large group treatment.

HOLLAND & HART 

10

Under the Final Rule, working owners genuinely engaged in a trade or business [(i) an ownership right of any nature in a trade or business, whether incorporated or unincorporated; and (ii) who is earning wages or self-employment income from the trade or business for providing personal services to the trade or business] for an average of 20 hours per week or 80 hours per month or has earned income from such trade or business that at least equals the working owner's cost of coverage for participation by the working owner and any covered beneficiaries in the group health plan. Plan fiduciaries have a duty to reasonably determine the eligibility condition met.

The stated aim of the Final Rule is to expand access to affordable healthcare to small employers and self-insured persons ("working owners") by making it easier for them to join together to create associations to sponsor large employer group health plans free from many of the Affordable Care Act (ACA) individual and small group insurance plans mandates including essential health benefits and federal pricing rules (e.g., modified community rating rules). Allowing associations of small employers and self-insured persons sponsoring an AHP the same kind of benefit package design flexibility, reduced costs due to increased bargaining power with providers and facilities, economies of scale and administrative efficiencies that large group employers enjoy is one of the primary objectives of the Final Rule.

## Title 1, Section 3(1) ERISA Employee welfare benefit plan



- “employee welfare benefit plan” is defined in section 3(1) of ERISA to include, among other arrangements, “any plan, fund, or program ... established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants, or their beneficiaries, through the purchase of insurance or otherwise ... medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .”

## Title 1, Section 3(5) ERISA Definition of Employer



- The term “employer” is defined in section 3(5) of ERISA 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.”

## Elimination of "Look Through" Doctrine



- Unless the AHP constitutes a single ERISA-covered plan, the current regulatory framework discounts the group or association and focuses on the size of each individual participating employer to determine whether coverage is individual, small group, or large group market coverage.
- The Final Rule allows associations to form AHPs that are treated as large group health plans exempt from ACA's small group and individual mandates.



## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- **"substantial business purpose" unrelated to provision of health benefits.** 29 C.F.R. § 2510.3-5(b)(1)
- A bona fide group or association of employers must have at least one "substantial business purpose" (SBP) [*undefined term*] unrelated to the provision of health benefits
- Group or association's principal purpose *may be* the provision of health benefits.
- Safe harbor: SBP deemed to exist when the group or association could be a "viable entity" without sponsoring an employee benefit plan.
- SBP includes promoting members' common business interests or trade/employers' common economic interests.
- Evidence of a SBP exists if, prior to sponsoring an AHP, the group or association operated with an active membership.
- SBP does not have to be for profit.



## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- Might be tax-exempt organization IRC section 501(c), with a purpose unrelated to the sponsorship of the AHP, if it meets all the requirements for exempt status.
- Could offer other services to its members, such as:
  - convening conferences or offering classes or educational materials on business issues of interest to the association members.
  - act as a standard-setting organization that establishes business standards or practices.
  - engage in public relations activities such as advertising, education, and publishing on business issues of interest to association members unrelated to sponsorship of an AHP.
- A bona fide group or association's purpose could be advancement of the industry in which its members operate, although, in that case the group/association would need to advance that well-being through substantial non-health coverage activity.
- A pre-existing group or association could create a wholly owned subsidiary to administer an AHP, even if the subsidiary exists solely to administer the group health plan. In this circumstance, the group or association's SBP unrelated to the provision of healthcare benefits is not eliminated by its decision to create a subsidiary under its control to administer the AHP.

## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- ***Must have at least one employee covered under the AHP*** 29 C.F.R. § 2510.3-5(b)(2)
- Each employer member of the group or association acts as the employer of at least one employee who is a covered participant in the AHP.

## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- ***Must have a formal organizational structure.***

29 C.F.R. § 2510.3-5(b)(3)

A group or association must adopt "a formal organizational structure with a governing body and by-laws or other similar indications of formality" appropriate for the group or association's legal form.

17

HOLLAND & HART 

Commenters generally supported these provisions on the basis that having such formalities will not only serve to clarify the rights and obligations of members of the association or group, but to promote accountability by enabling regulators and others to readily identify those parties who are responsible for operations, including the establishment and maintenance of the group health plan. These commenters suggested that the existence of formalized and robust organizational structures could be an important form of **protection against fraud and insolvency**. For these reasons, the final rule adopts these provisions without modification. There were requests for minor wording changes to paragraph (b)(3) to ensure that certain ongoing entities clearly fit within the final rule, and similarly, there were requests to clarify the meaning of certain words or phrases in paragraph (b)(3) as applied to specific fact patterns. The Department declines in this preamble to address the application of the final rule to specific fact patterns. The Department has procedures to answer inquiries of individuals or

organizations affected, directly or indirectly, by ERISA as to their status under ERISA and as to the effect of certain acts and transactions

## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- ***Employer members must have control over the AHP in form and substance.***
- 29 C.F.R. § 2510.3-5(b)(4)
- Employer members must control the group or association's functions and actions, but they are not required to control or manage the group or association's day-to-day affairs.
- The following non-exclusive factors are relevant for determining whether the employer members exercise sufficient control to qualify as bona fide:
  - whether employer members regularly nominate and elect directors, officers, trustees, or other similar persons that constitute the governing body or authority of the employer group or association and plan;
  - whether employer members have authority to remove any such director, officer, trustee, or other similar person with or without cause; and
  - whether employer members that participate in the plan have the authority and opportunity to approve or veto decisions or activities which relate to the formation, design, amendment, and termination of the plan, for example, material amendments to the plan, including changes in coverage, benefits, and premiums.
- Fiduciary status of the group or association's key officials or board members is irrelevant to whether the group or association's members exercise the necessary control.

## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- ***Employer members must have a commonality of interest.***
- 29 C.F.R. § 2510.3-5(b)(5)
- There must be a "commonality of interest" (COI) among employer members of a group or association to sponsor an AHP.
- COI may be established by employer members that:
  - (1) "are in the same trade, industry, line of business, or profession"; or
  - (2) have "a principal place of business in the same region that does not exceed the boundaries of a single State or a metropolitan area (even if the metropolitan area includes more than one State)."
- A subset of a trade, industry, or profession is permitted, and groups and associations have substantial flexibility to cover segments of a geographic area that otherwise satisfies the definition of COI as long the subset or segmentation are not a smokescreen for discrimination based on a health factor.
- In the case of a group or association sponsoring a group health plan and is itself an employer member of a group or association, the group or association will be deemed for purposes of COI the same trade, line of business or profession, as applicable, as the other employer members of the group or association.

## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- ***Must have limited participant eligibility***
- 29 C.F.R. § 2510.3-5(b)(6)
- Eligible participants include:
  - (a) an employer member's current employees;
  - (b) a current employer member's former employees who were entitled to coverage under the group's or association's group health plan during their employment; and
  - (c) beneficiaries of such individuals (e.g., spouses and dependent children). When applicable, an AHP must provide eligible persons with COBRA continuation coverage and certain other post-employment coverage.

The DOL declined to include any specific open enrollment period requirements.



## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



- ***Group/association & health coverage must comply with the nondiscrimination provisions; 29 C.F.R. § 2510.3-5(b)(7)***
- Group health plans, including AHPs, are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) nondiscrimination rules.
- Under the Final Rule's nondiscrimination provisions, groups or associations are prohibited from basing membership, eligibility for benefits, and premiums on any health factor, including but not limited to health status, condition, and claims experience of its employees.
- AHPs cannot treat employer members as distinct groups of similarly-situated individuals based on a health factor.
- AHPs may distinguish between employer members based on factors other than a health factor, such as bona-fide employment based factors, including geographic location, occupation, and industry. Age and gender are not considered health factors.

21

HOLLAND & HART 

One commenter stated that omitting a risk adjustment mechanism to address differences in enrollees' aggregate health conditions would make AHPs unstable and would lead to their failure. Another commenter argued that this would disincentivize large employers, whose plans can be experience-rated, from participating in an AHP unless their risk pool was significantly sicker than that of the AHP. Some commenters also stated that experience rating was necessary due to the fact that AHPs have a smaller risk pool as compared to a commercial insurer and without the ability to manage risk by experience rating, they will be unable to compete with commercial issuers. Another commenter claimed that without the ability to experience-rate each member employer, AHPs would be left to compete with other coverage options on the basis of benefits, such as by offering less generous benefit packages to achieve lower prices. A few commenters were also concerned that the Proposed Rule could interfere with AHPs' ability to

establish wellness programs by preventing AHPs from rewarding those groups that do participate, or by reducing the incentive to offer wellness programs.[39](#)

Commenters also claimed that a prohibition against experience-rating was not necessary to distinguish AHPs from commercial insurance arrangements because the Proposed Rule retained the requirements of commonality and control. Also, several commenters pointed out that some States, including Washington and Kentucky, appear to allow such practices pursuant to laws and regulations applicable to MEWAs. Many commenters suggested that the Department should

include a type of grandfather rule to accommodate AHPs that already use experience-rating for each employer-member, to prevent market disruption and burdens associated with coming into compliance with new rules that are inconsistent with long-standing business practices.

The final rule gives ten(10 examples of how the nondiscrimination rules work:

The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) 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.

(ii) 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 does not satisfy 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. (i) 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 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.

(ii) 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 does not satisfy 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. (i) Facts. Association E offers group health coverage to all plumbers working for plumbing companies in a State, if the plumbing company employer chooses to join the association. 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.

(ii) Conclusion. In this Example 3, making a distinction between part-time versus full-time 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) and, as a consequence, satisfies paragraph (d)(2) of this section.

Example 4. (i) 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.

(ii) Conclusion. In this Example 4, the employees of Business I cannot be treated as a separate group of similarly-situated individuals from other members based on a health factor of one or more individuals 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 does not satisfy the requirements in paragraph (d)(4) of this section.

Example 5. (i) 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.

(ii) 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 satisfies paragraph (d)(3) and (d)(4) of this section.

Example 6. (i) Facts. Association L sponsors a group health plan, available to all its 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.

(ii) Conclusion. In this Example 6, cancer is a health factor under § 2590.702(a) of this chapter. Making a distinction between groups of otherwise similarly situated individuals that on its face is based on geography (which is not a health factor), but that is directed at one or more individuals based on a health factor (cancer), 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, the conditions of paragraphs (d)(3) and (d)(4) of this section are not satisfied.

Example 7. (i) Facts. Association P is an agriculture industry association. It sponsors a group health plan that charges employers different premiums based on their primary agriculture subsector, defined under the terms of the plan as: crop farming, livestock, fishing and aquaculture, and forestry. The distinction is not directed at individual participants or beneficiaries based on a health factor.

(ii) Conclusion. In this Example 7, the premium distinction between members is permitted under paragraphs (d)(3) and (d)(4) because it is not based on a health factor and is not directed at individual participants and beneficiaries based on a health factor.

Example 8. (i) Facts. Association Q is a retail industry association. It sponsors a group health plan that charges employees of employers different premiums based on their occupation: cashier, stockers, and sales associates. The distinction is not directed at individual participants or beneficiaries based on a health factor.

(ii) Conclusion. In this Example 8, the premium distinction is permitted under paragraph (d)(3) and (d)(4) of this section because it is not based on a health factor

and is not directed at individual participants and beneficiaries based on a health factor.

Example 9. (i) Facts. Association R sponsors a group health plan that is available to all employers with a principal place of business in State S. Employers are charged different premiums based on their industry subsector, defined under the terms of the plan as: construction, education, health, financial services, information services, leisure and hospitality, manufacturing, transportation, natural resources, and other. In addition, within any employer, employees are charged different premiums based on part-time versus full-time status (part time status is defined, under the terms of the plan, as regularly working at least 40 hours, but less than 120 hours, per month). These distinctions are not directed at individual participants or beneficiaries based on a health factor.

(ii) Conclusion. In this Example 9, the premium distinctions between employer members of a State AHP based on industry, and between employees of employer members who are working part-time versus full-time, are permitted under paragraphs (d)(3) and (d)(4) of this section because these distinctions are not based on a health factor or directed at individual participants and beneficiaries based on a health factor.

Example 10. (i) Facts. Association T sponsors a group health plan that offers a premium discount to participants who participate in a wellness program that complies with section 2590.702(f) of this chapter.

(ii) Conclusion. In this Example 10, providing a reward (such as a premium discount or rebate, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive, as well as avoiding a penalty such as the absence of a premium surcharge or other financial or nonfinancial disincentive) in return for adherence to a wellness program that satisfies conditions of § 2590.702(f) of this chapter is permissible under this paragraph (d).

## Criteria to Establish a Bona Fide Employer Association Qualified to Sponsor an AHP



### ▪ *Health insurance issuers may not sponsor AHPs*

#### **29 C.F.R. § 2510.3-5(b)(7)**

- Health insurance issuers or entities owned or controlled by health insurance issuers are prohibited from sponsoring AHPs.
- Except in limited circumstances, an insurance issuer representative may not serve on an AHP board.
- A health insurance issuer may participate as an employer member of a bona fide association of insurers that sponsors an AHP.
- Groups or associations controlled by entities that are part of the U.S. health care delivery system, including network providers and health care companies, do not qualify as bona fide groups or associations.
- A health insurance issuer or other business entity that is part of the U.S. health care delivery system may provide certain services to AHPs, including administrative services, provider and pharmacy network design, recordkeeping, reporting and disclosure services, wellness program administration, 24-hour nurse helplines, audit services, and/or AHP set up assistance.

HOLLAND & HART 

## Concerns About the Proposed/Final Rule



- In the Final Rule, the DOL responds to many of the 900 comments it received in response to its January 5, 2018 proposed regulation ([Proposed Rule](#)) and explains how it arrived at the Final Rule.
- While the DOL expresses its view that the Final Rule adequately protects plan participants and beneficiaries from imprudent, abusive, or fraudulent arrangements, a number of commenters questioned whether the Proposed Rule contained adequate consumer protections against mismanagement and abuse.
- The day after the adoption of the Final Rule, the New York and Massachusetts Attorney Generals announced their intent to bring an action to block implementation of the Final Rule, which they say will result in fraud, mismanagement, and deception.
- Anticipating that AHPs will provide more affordable coverage, the Congressional Budget Office (CBO) predicts that an additional 4 million people will enroll in AHPs. Some predicted that Final Rule will destabilize the insurance market by siphoning off young healthy insureds from the ACA individual and small group markets causing premiums to increase for those who remain.

## Opportunities under Final Rule



- Associations formed prior to the Final Rule, whose bona fide association status is questionable, can convert to an AHP under the new rules.
- Third party administrators not associated with health insurers may find additional opportunities.
- Captive insurance industry may want to look at the value of forming AHPs under the new rules.
- Groups that never considered forming before because they are not in same industry group may now form.

## Thank You



Constance L. Akridge  
Holland & Hart  
9555 Hillwood Drive, 2<sup>nd</sup> Floor  
Las Vegas, NV 89134  
(702)222-2543  
[clakridge@hollandhart.com](mailto:clakridge@hollandhart.com)

HOLLAND & HART 