Association Plans:
Are They Right for You?

Frequently Asked Questions
from Employers

New federal rules allow the formation of association health plans, creating a lot of interest. The new rules have also generated many questions from organizations, wondering if they might be candidates for these new programs.

This FAQ addresses questions HUB International received in their August 2018 webinar, Association Health Plans: Are They Right for You?

1. What can be done to stabilize association health plans?

As employers consider association programs, natural concerns focus around financial stability, especially with self-funded plans. But even with fully-insured plans, there is a risk of employers exiting the program if they can get a better rate outside of the association program. [Please note, the term "fully-insured" is sometimes abbreviated to "FI" in our webinar slides.]

Greater stability of the risk pool can be attempted by various means. A specific stability tactic would be imposing a time-period "handcuff" for member groups during which the employer cannot leave the group – absent an onerous financial penalty associated with the exit. We have also seen similar group arrangements require a large financial buy in at the outset.

An association also could make participation in the plan a condition of association membership, which presumably provides other financial and other benefits to the employer. However, even these powerful hooks won't operate to stabilize an association when members are able to access alternate coverage less expensively. Moreover, an association that's so laden with barriers precluding exit may serve to chill incoming membership.

2. Do association health plans need to incorporate the essential health benefits required under the ACA, or will they be limited benefit plans? Will pre-existing condition rules apply?

No. Association health plans do not have to provide all of the ten (10) essential health benefits required for small employers under the ACA. The key underlying concept for the new association plan rules is that the enterprise is considered a type of large employer. As a functional "large plan" it would be subject to all ACA rules applicable to large employer programs, but avoid the often costly ACA provisions governing small group programs.

As a result, the new association plans must provide minimum value coverage. The health coverage must "actuarially equate" to bronze level coverage available through the ACA marketplace. This option drives greater design flexibility and probably a less expensive mix of essential health coverage elements, but it remains robust "real" health coverage. Because of this "minimum value" requirement, association health plans will not deliver extremely restrictive, bare-bones coverages.

Other federal mandate rules will apply such as post-mastectomy breast reconstruction and mental health parity obligations. Pre-existing conditions cannot apply to employees or their family members.

Please note that in addition to avoiding the essential health benefits, another objective is to avoid state mandates that only applied to small employers. To the extent that states do not want to permit such a loophole, the states may close off that avenue of savings.

3. What is the current status of the state attorney generals' lawsuit against the Department of Labor? (This lawsuit was filed July 26, 2018.)

As of the date these FAQs are published (August 9, 2018), the complaint has been filed in federal district court and is still waiting for a preliminary hearing.

4. What is considered a small employer?

ACA originally mandated a "phased-in" requirement that all small groups to be designated as under 100 employees using a standard national definition. Later, this requirement was modified to give states the ability to define the size of their own small group. Most states immediately shifted to under 50, but key states like New York and California elected to leave the definition at under 100. For employers stuck in the 51-99 size category this put them into much more expensive pools from which many organizations have since been trying to escape.

Association health plan complexity, as the HUB International compliance officers described on the webinar, is exacerbated by the fact that there are different standards at the federal and state levels regarding who is considered a small employer or an employer that must buy health insurance in the small group market. For example, some states have specialized "counting" rules for being considered a small employer.

Please note, other federal laws and state rules addressing health plan related issues (such as family leave, medical benefit continuation, etc.) also are not always consistent across the board.

5. There are currently association health plans in various states, including the state of Washington. What will be the impact of the new rules on what is currently being allowed for association health plans in these states?

The new federal rules do not necessarily supersede association health plans currently in existence in the various states. The federal association health plan rules are simply an avenue an employer association (or an association of individuals) may wish to satisfy in order to avoid providing the essential health benefits level of coverage, in order to be treated as a single large employer. Some associations are set up more like purchasing cooperatives, to leverage negotiating power and to take advantage of administrative efficiencies. In other cases, these association plans are designed to provide benefit continuity to workers in industries such as agriculture where workers move from job to job throughout the year.

6. Can individuals who are members of an association join together to form an association health plan, even if they do not share an employer?

Yes, provided these individuals are working owners.

The new rules impose very specific requirements for such individuals, including either W-2 income as a sole proprietor, or 1099 independent contractor type income. Such individuals would be required to work a minimum of hours a week or a month, for example in support of their enterprise. Note that these types of mandated conditions mean that the association program concept would be unavailable for other types of association arrangements. (For example, a weekend bicycling club would not be able to offer its member's health insurance.)

7. Can association health plans be self-funded?

Yes, association health plans can be self-funded under the new federal rules. However, many states specifically precluded self-funded arrangements such as these. (Note: As explained during the webinar, associations are considered a type of Multiple Employer Welfare Arrangement, or MEWA. The States have long held authority to regulate MEWAs as they see fit, including outlawing them.)

Because states have adopted different rules governing MEWAs in their jurisdiction, attention to state law is a fundamental consideration. For example, some states may forbid a program with that funding unless it was established prior to a certain year or unless the association has been in effect for at least five years. Other states choose to regulate self-funded association health plan as if it is an insurance carrier. Sometimes such regulations may include regular state auditing, reporting, and claim reserve holdings maintained at a prescribed level.

At this time, there is very limited consistency from one state to another regarding their treatment of these self-funded arrangements. Please refer to our map on the webinar slides for a visual expressing this mixed regulatory hodgepodge.

From a historic perspective, regulatory restrictions have evolved to be the most onerous in states where MEWAs imploded (sometimes high-visibility implosions). Some of these scam MEWA arrangements have been operated fraudulently as fake union arrangements or "innovative" insurance schemes that actually do not have the backing of an insurance carrier. In jurisdictions where individuals or healthcare providers incurred losses following a self-funded program default, legislation sprang up to prevent similar failures from occurring.

8. If an association health plan is created for a number of small employers, some of whom are over 20 employees in the prior year, will all the employers in that health plan need to offer federal group health plan continuation coverage under COBRA or just the groups that are subject to the law on a standalone basis?

Likely yes, but a specific answer is unclear at this time.

The reason we don't know yet is because the agency issuing these regulations specifically deferred questions pertaining to other compliance laws to future regulatory guidance. However, past experience gives us an expectation that certain laws will be mandated to all member groups. For example, we believe the rules that make COBRA applicable should make all association members subject to continuation coverage rules. By contrast, perhaps FMLA protections will not apply. We speculate about that possibility because employer size in the FMLA context takes into account avoidance of employer FMLA obligations if an employee that seeks to assert FMLA protections is sufficiently remote from other co-workers.

In the end, we anticipate the federal government will issue specific guidance about compliance burdens, perhaps with some special adaptation for association health plan members.

9. It seems as if states have a more restrictive/stronger opposition approach to association health plans compared to short-term, limited duration insurance. How are the two different in terms of risks to individuals and the health care system, and why is there a different approach?

Presumably, the limited duration health insurance would be offered by a licensed insurance carrier subject to state regulation. We believe the different comfort levels relate to historic MEWA problems. Specifically, the fact that some association plans (often also called MEWAs), have operated fraudulently has resulted in an increased level of regulation or even outright prohibition by the states. In contrast, limited duration coverage is perceived as less likely prone to criminal abuse.

10. Can I join an association health plan that is operated/based in a different state? If so, which rules will apply?

Yes, under the new guidance, and employer or an individual could join an association health plan which is headquartered and operated out of another state. The state laws that will apply generally depend on where you as the employer operate your principal place of business. As a result, it is not possible to escape all state regulation by joining an association operated out of a favorable state. We also believe that as associations form, membership is likely to be severely restricted based on the target member's jurisdiction. Although an association may want expanded membership it would be compelled to block members who would bring unwanted regulatory compliance restrictions into the Association.

11. As a small employer (under 10 employees) how do I find a MEWA or association?

We generally believe that the best avenue is to inquire about association health plans through those associations to which you currently belong or those which you could join. We also believe local and state chamber of commerce organizations will begin to offer these types of health plans under the federal regulations. We are more likely to see these operated in a single area and in a single state.

12. The state of Colorado currently does not permit most MEWA. Is the state allowed to deny the ability to operate to these new association health plans, despite the new federal rules?

Yes. The new federal rules allow states to continue to regulate and even ban programs like MEWAs that otherwise would be considered valid association health plans under the new federal regulations.

There could be future relief, along several avenues. In response to association and employer lobbying, we may see some states adopt a more lenient approach on these types of arrangements, perhaps with additional requirements beyond with the federal rules require. If the states are too restrictive and if the federal government wishes to stop state regulation, the federal rules have reserved the opportunity to supersede state laws.

13. Would the association health plan need to be funded by trust to provide self-funded benefits? To pay insurance premiums in a fully-insured program?

The answer to this question will depend in some part on state law.

For employer-based plans, federal law would require a trust for employers other than governmental and church plans providing benefits on a self-funded basis. (State laws and standards of care generally will require a trust for these other types of self-funded plans.)

The federal rules are comparatively less concrete for fully-insured plans, especially where the premiums are not paid directly to the insurance carrier. Inserting a middleman into that process could trigger a trust requirement borne, from among other reasons by the sensitive fiduciary issues that would be involved. We strongly recommend that issues such as this should be addressed by legal counsel.

14. So, an association health plan is now forbidden from asking health questions of individual employees and excluding the employers who have those bad risks? This question does not relate to premiums, but rather entry into the association health plan by those employers with ill employees or family members.

The answer depends on what the association health plan wishes to accomplish. The new federal rules do not eliminate all other association health plans; they simply introduce a new avenue for avoiding certain small group requirements.

As a preliminary step, any association health plan wishing to leverage the new federal rules (for example to avoid essential health benefits), must follow these new association plan regulations, including the provision preventing the plan from excluding an employer or charging higher rates based on the results of health questionnaires.

By contrast, assume there is an existing association that is not attempting to leverage the new rules (for example, they have no concerns about trying to avoid the essential health benefits under federal law). That association could continue to operate under current standards. However, in light of changing state laws, often triggered by this new set of federal regulations, and the possible new leeway given by the federal rules, this would be a good time to re-examine the program.

15. Could an association health plan work for a franchise / franchisee relationship?

Yes. An association health plan might be an appropriate consideration for a franchise/franchisee relationship. Much will depend on the location of the franchise and the locally applicable laws governing oversight of the Association.

16. What is the medi-share model? Is this not insurance at all?

We believe it is prudent for any religious organization offering a medi-share program to re-examine their arrangement in light of concerns about the nature of the coverage being offered.

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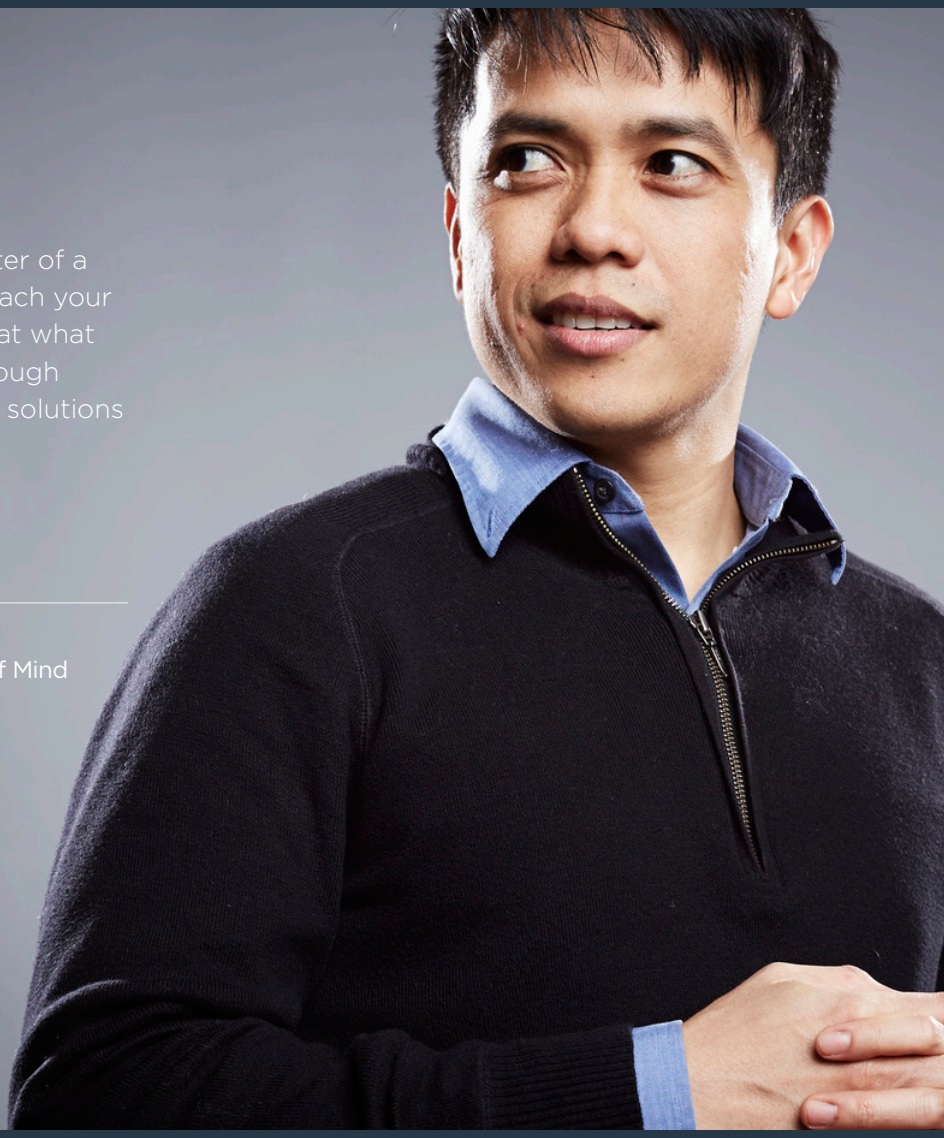

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