Association Health Plans

An association health plan (AHP) is a type of ERISA-covered group health plan sponsored by a group or association of employers (instead of a single employer) to provide health coverage to employees of the AHP's employer members. Under ERISA, an AHP is both a group health plan and a multiple employer welfare arrangement (MEWA).

As ERISA-covered plans, AHPs are subject to reporting and disclosure requirements, claims procedure rules and fiduciary rules. In addition, AHPs must comply with other federal employee benefit laws, including COBRA, HIPAA and the Affordable Care Act (ACA).

When an AHP is treated as a **single ERISA plan**, all employees covered by the plan are considered when determining the insurance market rules (that, is small group or large group) that apply to the plan. Also, the plan itself (and not the participating employers) is responsible for ERISA compliance when the AHP is treated as a single plan. The Department of Labor (DOL) has established two different ways—a narrow pathway and a more expansive pathway—for an AHP to qualify as a single ERISA plan. However, due to a court ruling, only the narrow pathway is currently available to employer groups and associations that establish AHPs.

LINKS AND RESOURCES

- DOL's final rule on AHPs (and subsequent court ruling)
- IRS guidance on how the ACA's employer shared responsibility rules apply to AHPs

Single ERISA Plan

Unless an AHP is considered a single ERISA plan, it is treated as a collection of plans that are separately sponsored by each of the participating employers. This means that, unless the AHP is treated as a single ERISA plan:

- The size of each individual employer participating in the group or association determines whether that employer's coverage is subject to the small group or large group market rules; and
- Each participating employer is treated as maintaining a separate plan for ERISA purposes and is independently subject to ERISA's compliance requirements (for example, the requirement to provide a summary plan description, or SPD).

Advantages of Single ERISA Plan

Having an AHP qualify as a single ERISA plan is advantageous to the employers participating in the plan because ERISA's compliance requirements (such as the SPD and the Form 5500) will fall on the plan itself, not on each participating employer. Also, when an AHP is treated as a single ERISA plan, all employees covered by the plan are considered when determining the insurance market rules that apply to the plan (that is, small group or large group). This allows small businesses to join together and enjoy many of the regulatory and negotiating advantages that large employers experience. For example, coverage in the large group market is not subject to the ACA's reforms regarding premium rating restrictions and coverage of essential health benefits (EHB) items and services.

To be treated as a single ERISA plan, an AHP must be maintained by a group or association that is considered an "employer" under DOL guidance. There are two methods, or pathways, for forming AHPs that are plans, as described below:

- **Pathway One: Sub-regulatory Guidance**—DOL advisory opinions establish a narrow set of criteria for determining whether an AHP is a single plan. Although the DOL expanded these criteria in a final rule issued in June 2018, key parts

of that rule have been invalidated by a federal court. Currently, employer groups and associations must satisfy the narrow factors in this sub-regulatory guidance to sponsor a single ERISA plan.

This is called "sub-regulatory guidance" because it is not included in official regulations.

- **Pathway Two: Final Rule**—In June 2018, the DOL issued a final rule that made it easier for an AHP to be considered a single ERISA plan. However, in March 2019, a federal district court vacated key provisions of the final rule. Due to this ruling, employer groups and associations cannot form single plans using these expanded criteria.

Currently unavailable

Pathway One: Sub-Regulatory Guidance

This analysis has focused on three broad sets of issues, in particular:

- 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.

These factors are satisfied when an organized group or association of employers with common interests unrelated to the provision of benefits, acting in the interest of its employer members, establishes a benefit program for the employees of member employers and exercises control over the amendment process, plan termination, and other similar functions on behalf of these members with respect to the plan. See, e.g., DOL Advisory Opinion 2008–07A.

Pathway Two: Final Rule

On June 21, 2018, the DOL issued a final rule that expanded the criteria for an AHP to be treated as a single ERISA plan. According to the DOL, the final rule provided small businesses with a greater ability to join together and gain many of the regulatory advantages enjoyed by large employers, as well as increased bargaining power.

This final rule did not replace or change the DOL's sub-regulatory guidance for determining whether an AHP is a single ERISA plan. Rather, the final rule created a new, less restrictive test as an alternative to the DOL's sub-regulatory guidance.

Court Ruling and Current Status

On March 28, 2019, a federal district court vacated key portions of the final rule. The court specifically ruled that the DOL's expansion of the term "employer" to include associations of disparate employers and working owners without employees was an unreasonable interpretation of ERISA. On April 26, 2019, the DOL appealed the court's decision to a higher court.

After the court's ruling, the DOL released a policy statement and questions and answers (Q&As) about the impact of the court ruling on AHPs that were established under the final rule's expanded criteria. According to the DOL, employers participating in insured AHPs could generally maintain that coverage through the end of the plan year or, if later, contract term that was in force on March 28, 2019. However, at the end of this period, health insurance issuers can renew coverage for small employer members of AHPs that were formed pursuant to the final rule only if the coverage complies with the small group market requirements (that is, the EHB coverage requirement and premium rating rules).

In addition, according to the DOL, the court's ruling does not affect AHPs formed under the DOL's sub-regulatory guidance. Employer groups and associations that meet these narrow criteria may continue to form AHPs that are single ERISA plans.

Expanded Criteria

The following is a summary of the final rule as issued by the DOL in June 2018. As explained above, employer groups and associations currently **cannot use these criteria** for creating AHPs.

Eligible Employers

The final rule allows more employer groups and associations to form AHPs. Employers may join together to form an AHP that is a single ERISA plan if either of the following requirements is satisfied:

- The employers are in the same trade, industry, line of business or profession; or
- The employers have a principal place of business within a region that does not exceed boundaries of the same state or the same metropolitan area (even if the metropolitan area includes more than one state).

In addition, the final rule allows working owners without other employees, such as sole proprietors and other self-employed individuals, to join AHPs to receive health coverage for themselves and their families.

Additional Requirements

To distinguish single plan AHPs from commercial insurance-type arrangements, the final rule requires AHPs to satisfy the following conditions:

- The primary purpose of the group or association may be to offer and provide health coverage to its employee members; however, the group or association also must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its members.
- Each employer member of the group or association participating in the group health plan must be the employer of at least one employee who is a plan participant.
- The group or association must have a formal organizational structure with a governing body and bylaws or other similar indications of formality.
- The group or association's member employers must control its functions and activities, including the establishment and maintenance of the group health plan.
- Participation in the group health plan sponsored by the association must be limited to employees and former employees of the current employer members (and family members of those employees and former employees).
- The group or association must not be a health insurance issuer (or be owned or controlled by an issuer or by a subsidiary or affiliate of an issuer).

In addition, the final rule requires AHPs to comply with certain consumer and anti-discrimination protections that apply to the large group market. For example, AHPs may not charge higher premiums or deny coverage to people because of pre-existing conditions, or cancel coverage because an employee becomes ill. Additionally, AHPs cannot charge employers different rates based on the health status of their employees.

Applicability Date

The final rule became effective as follows:

- All associations (new or existing) were allowed to establish a fully insured AHP starting on Sept. 1, 2018.
- Associations that sponsored a self-insured AHP on or before June 21, 2018, were allowed to expand within the context of the new AHP rule starting on Jan. 1, 2019.
- All other associations (new or existing) were allowed to establish a self-funded AHP starting on April 1, 2019.

Other Compliance Issues

Employer Shared Responsibility Rules

The IRS released a Q&A on the ACA's employer shared responsibility rules to explain how these rules apply to employers that offer health coverage through an AHP. The employer shared responsibility rules apply only to applicable large employers (ALEs), which are employers with 50 or more full-time employees (including full-time equivalent employees). These rules require ALEs to offer affordable, minimum-value health coverage to their full-time employees or pay a penalty.

According to the IRS' Q&A, the employer shared responsibility rules do NOT apply if an employer that is not otherwise an ALE offers coverage through an AHP. Whether an employer that offers coverage through an AHP is an ALE subject to the employer shared responsibility provisions depends on the number of full-time employees (and full-time equivalent employees) the employer employed in the prior calendar year. The determination of ALE status is unrelated to whether the employer offers coverage through an AHP.

The only circumstance in which multiple employers are treated as a single employer for purposes of determining whether the employer is an ALE is when the employers have a certain level of common or related ownership.

ERISA Compliance

The DOL's compliance assistance for AHPs addresses ERISA's reporting and disclosure requirements for these plans. According to the DOL, three of the most important disclosures for AHPs are the following:

- **Summary plan description (SPD)** – A plain language summary of the plan and explanation of the plan's rules. It must be comprehensive enough to inform participants of their rights and responsibilities under the plan. AHPs must provide an SPD to each participant within 90 days of the individual becoming covered under the plan, and within 30 days after a written request.
- **Summary of material modifications (SMM)** – AHPs must also furnish an SMM to inform participants any time there is a material change to the AHP or the information required to be in the SPD.
- **Summary of Benefits and Coverage (SBC)** – The SBC is a disclosure that uses a uniform template to give AHP participants a clear, plain-language summary of the key features of a plan, such as covered benefits, cost-sharing provisions and coverage limitations. Plan administrators must provide an SBC as part of any written application materials, upon special enrollment, when coverage is renewed, and within seven business days of receiving a request.

In addition, AHPs, whether fully insured or self-insured, generally must file both a Form 5500 and a Form M-1 with the DOL. The Form 5500 is an annual report containing information about the plan, its finances and its operation. AHPs and other MEWAs must also file Form M-1s to register and report certain compliance information before operating in a new state, and on an annual basis.

As ERISA-covered group health plans, AHPs are generally subject to the following requirements:

- Benefits claims administration—Group health plans must establish and maintain a claims procedure that participants and beneficiaries can use to apply for and receive the plan's promised benefits. The DOL has issued rules setting minimum timing and content standards for benefit claims procedures and benefit determinations for ERISA plans (including insured and self-insured plans).
- COBRA—COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses and their dependent children when group health coverage would otherwise have been lost due to specific events. COBRA does not apply to employers with fewer than 20 employees. The DOL anticipates future guidance on the application of COBRA to AHPs that provide coverage to member employers with fewer than 20 employees.
- Fiduciary rules—ERISA establishes standards and rules governing the conduct of individuals and companies responsible for running group health plans, including AHPs. In general, employers that are members of an AHP have a fiduciary duty to monitor the AHP and get periodic reports on the fiduciaries' management and administration of the AHP.
- Consumer health care protections—Various consumer protection provisions are also included in ERISA, including those contained in HIPAA, the ACA, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act, among others.

Regulatory Authority

The DOL may issue a cease-and-desist order when it appears that a MEWA's conduct is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent and irreparable public injury. The DOL may also issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition. More comprehensive information on the MEWA provisions applicable to AHPs is available from the DOL.

In addition, states have authority to regulate MEWAs, including AHPs. States can regulate health insurance issuers and the health insurance policies sold to AHPs, and they can regulate self-insured AHPs to the extent the regulation is consistent with ERISA. Employers and plan administrators should check with the applicable state insurance department for more information on that state's insurance laws.
