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USI Insurance Services Employee Benefits Compliance Practice

In This Issue

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Association Health Plan Final Regulations Issued

In brief:

- DOL finalizes regulations that will make it easier for employers and certain self-employed individuals to come together under a single-employer, large group association health plan, based on being in the same industry **or** in the same limited geographic area, to avoid the application of certain ACA individual and small group market rules, such as modified community rating and required coverage of all essential health benefits at a prescribed metal level of actuarial value.
- Final regulations are almost identical to rules previously proposed earlier this year, with only a few slight modifications and clarifications.
- The new rules become applicable in stages on September 1, 2018, January 1, 2019, and April 1, 2019, for various types of AHPs, which should enable broader groups of individuals access to lower cost (but perhaps less rich) group health insurance coverage.
- Due to the complex dual federal-state regulatory scheme applicable to MEWAs that are ERISA plans, AHPs under these new rules will be more prevalent in some states than other states.

The Department of Labor (DOL) published its association health plan final regulations on June 21, 2018. Consistent with the directive included in President Trump's October 12, 2017 executive order, these new rules broaden the definition of ERISA's definition of "employer" to create more flexibility for employers and certain self-employed individuals to combine through an association to sponsor a single group health plan. As a single plan, an association health plan (AHP) formed under these rules will avoid the certain market reforms imposed by the Affordable Care Act (ACA) that apply to just individual and small group health plans, but not large group health plans, such as modified community rating and requiring coverage of the full suite of essential health benefits at one or more of the metal level (bronze, silver, gold, or platinum) actuarial values. The final regulations are substantially similar to the previously proposed rules, and provide for staggered applicability dates over the next nine months.

Background

AHPs are "multiple employer welfare arrangements" (MEWAs) in which a group health insurance policy is held by an association to extend coverage to its otherwise unrelated member employers, or through which an association self-insures group health plan benefits for the benefit of its member employers. In turn, the association issues certificates of coverage to the enrolled employees of each participating member employer. As a MEWA, AHPs are subject to the same federal and state rules applicable to any other MEWA.

Under the existing law, health plan coverage under an AHP typically is considered to exist at the participating member employer level and not at the association level. As a result, the Centers of Medicare and Medicaid Services (CMS) looks through the association and applies the ACA's individual and small group market reforms applicable to insured plans, based on the size of each participating member employer. However, if certain strict commonality of interest and control tests are satisfied such that the AHP qualifies as a "bona fide" group or association of employers, then the status of the AHP is determined by aggregating together the employees from each participating member employer. In turn, if the aggregate number of employees exceeds the state's large group market threshold (50 total employees in most states, but 100 in a few states), then the AHP is only subject to federal regulation as a large group health plan.

Without eliminating these existing types of AHPs, the final regulations create a new third category of AHPs that make it easier for them to be entitled to large group status under the ACA, and extend coverage to certain self-employed individuals. In turn, this would allow these new AHPs to potentially offer more affordable health insurance by not only taking advantage of the economies of scale of combining multiple employers together, but by also having the ability to offer less robust coverage that is more closely targeted to the needs of the association's membership.

Bona Fide Associations Under New Rules

To qualify as a bona fide group or association of employers under the new final regulations, the following requirements must be satisfied:

- Primary Purpose. Rather than allowing AHPs to be established for the sole purpose of offering health coverage as initially proposed, the final rules require

that the group or association must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its membership and their employees. The DOL indicated this change in the final regulations was to reduce the increased risk of fraud by sole-purpose associations. However, the primary purpose of the group or association may be to offer health coverage and the final regulations provide, as a safe harbor, that a "substantial business purpose" exists merely by the association being viable without sponsoring an employee benefit plan. Thus, activities as simple as offering conferences or providing educational materials to association members are sufficient.

- Employer-Based Membership. Rather than being an individual membership organization (such as Sam's Club, Costco, or AAA), each participating employer member in the AHP must be acting directly as an employer of at least one employee who is a participant covered under the plan. However, the new rules allow certain self-employed individuals (referred to as "working owners") who do not otherwise have any common-law employees to consider themselves to be both an employer and an employee. These working owners must (i) work on average at least 20 hours per week or at least 80 hours per month (reduced from 30 hours and 120 hours, respectively, that were previously proposed) providing personal services to a trade or business, or (ii) have earned income from such trade or business that is at least equal to the cost of the coverage purchased from the AHP. Note that hours worked within the same trade or business for different employers (such as drivers for multiple ride sharing entities, or musicians who both teach private lessons and perform) can be aggregated. Importantly, the final regulations drop the previously proposed requirement that disqualified an individual from being a working owner if he or she was eligible to participate in any subsidized group health plan maintained by any other employer of the individual or his or her spouse.
- Formal Structure and Control. Under the new rules, the association must have a formal organization structure with a governing body and by-laws. In addition, consistent with existing law, the functions and activities of the AHP must be controlled by its participating member employers. Thus, the association itself cannot unilaterally make structural plan design and operational designs with respect to the program, but generally must defer to some type of representative group of participating member employers.
- Modified Commonality of Interest. Provided it is not implemented as a subterfuge for prohibited discrimination, member employers are considered to satisfy ERISA's commonality of interest requirement if: (i) employers are within the same industry, trade, or profession (regardless of their geographic location), OR (ii) the principal place of business of the employers are in the same geographically limited area (such as a single state or certain multi-state metropolitan areas) even if they are in unrelated industries. Under existing law, employers need to satisfy both same industry and same geographic proximity requirements, and working owners are not allowed.
- Participant Eligibility Requirements. An employee or former employee of a current participating member employer, working owner, and their beneficiaries (such as spouses and dependent children) may all be eligible participants in an AHP. However, eligibility ceases once the member employer (including working owner) ceases its membership in the association.
- Nondiscrimination. As discussed further below, the AHP must comply with the HIPAA nondiscrimination rules otherwise applicable to large group health plans.
- Prohibited Sponsors. In an effort to distinguish AHPs from group health programs already commercially available in the marketplace by health insurance issuers, an AHP cannot be sponsored by a health insurance issuer, or any entity owned or controlled by a health insurance issuer, subsidiary, or affiliate.

Nondiscrimination

Bona fide associations under the final regulations, and any health coverage they offer, are subject to the same HIPAA nondiscrimination rules that apply to other large group health plans. Thus, membership in the association, as well as eligibility to participate in the AHP, cannot be based on any health factor (such as health status, medical condition, claims experience, evidence of insurability, etc.). Nevertheless, AHPs can differentiate based on bona fide employment-based classifications. This means that, absent a bona fide employment-based classification, all employees (and their dependents) of participating member employers within

an AHP must be subject to the same benefits, premiums, and eligibility rules. In addition, the new rules prohibit experience rating at the participating member employer level.

On the grounds that they were trying to put AHPs on equal footing with large group plans, the DOL rejected requests to apply tighter nondiscrimination laws with respect to other distinctions, such as age or gender, which can be indirect proxies of health factors. The DOL clarified that AHPs could apply wellness program differentials that were permissible under the HIPAA nondiscrimination rules. At the same time, however, the DOL clarified that the HIPAA nondiscrimination rules did not apply to bona fide AHPs created under existing law, which would have been disruptive to some current market practices.

The final regulations set forth numerous examples of how the HIPAA nondiscrimination rules apply. There are separate examples illustrating impermissible discrimination based on claims experience to deny an otherwise eligible entity membership into the bona fide association and to deny enrollment at the participating employer level into the AHP. There are also examples illustrating permissible distinctions allowed based on:

- Employment classifications or job classifications (providing for different eligibility waiting periods for full-time and part-time employees of participating member employers, as well as for different employees based on their occupation, such as cashier, stocker, and sales associates)
- Geography (charging different premiums to employers in different locations)
- Industry subsectors (charging different premiums to employers in different industries or in different subsectors within an industry, such as crop farming, livestock, fishing, and forestry within the agricultural industry)
- Multiple stacked permissible distinctions (charging different premiums to employers based on their industry subsector, as well as employment classification as full-time and part-time)
- Wellness program differentials

Impact on Other Federal and State Laws

Although the primary purpose of these new rules is to treat an AHP as a single-employer plan with the bona fide association as the plan sponsor, the arrangement nevertheless will still constitute a MEWA. This means that AHPs must comply with all of ERISA's reporting and disclosure requirements, such as maintaining a written plan document, distributing a Summary Plan Description (SPD) and a Summary of Benefits and Coverage (SBC), and filing a Form 5500. ERISA's fiduciary responsibility, trust, and plan assets requirements will also apply, which may require AHPs to establish and maintain trusts to hold and transmit employee contributions.

In addition, without providing much guidance, the preamble to the final regulations notes that AHPs will remain subject to federal and state mandate laws applicable to large group employers, such as the ACA's no-cost preventive care mandate, cost-sharing limitations, and prohibition on annual and lifetime dollar limits on essential health benefits, as well as the Newborns' and Mothers' Health Protection Act and Title VII of the Civil Rights Act (as amended by the Pregnancy Discrimination Act). For purposes of applying coverage mandates under ERISA that include small employer exceptions, the preamble suggests that headcounts should be based on the aggregate number of employees across all participating member employers, using the Mental Health Parity and Addiction Equity Act as an example. However, official guidance is still forthcoming from the Department of Treasury and the Internal Revenue Service with respect to COBRA continuation coverage since these agencies have interpretative jurisdiction over that federal law.

It is also important to note that these new AHP rules do not change the existing federal income tax laws. For example, even if working owners may participate in AHPs, self-employed individuals (such as partners, more-than-2% shareholder-employees of S corporations, sole proprietors, and independent contractors) are still prohibited from participating in Code §125 cafeteria plans and therefore cannot make pre-tax premium payments for any coverage they elect.

Due to an AHP still constituting a MEWA, it must comply with the federal Form M-1 filing requirement and any applicable state laws regulating MEWAs (or health insurance policies in general). It is with respect to the compliance with applicable state laws where most of the potential challenges

to the success of AHPs will initially arise. For example, the DOL notes in the preamble that state health insurance mandates that apply to fully-insured large group plans would also apply to AHPs, and that states can extend these mandates to self-insured AHPs.

This is consistent with the existing dual federal-state regulatory scheme imposed on MEWAs under ERISA following widespread fraud and abuse in the early 1980s. In a modification to its otherwise broad power to generally preempt state laws affecting benefit plans, ERISA allows states to fully regulate self-insured MEWAs that are ERISA plans to the extent not inconsistent with ERISA. However, ERISA limits the ability of states to regulate insured MEWAs that are ERISA plans (solely because they are MEWAs) to licensing, registration, certification, financial reporting, examination, audit, and other requirements necessary to enforce standards regarding reserves and contributions. How states have implemented this dual federal-state regulatory scheme varies significantly from state to state. Not all states currently regulate MEWAs, but those states that do generally impose significant limitations (if not outright prohibitions) on self-insured MEWAs. With respect to insured MEWAs, state regulation is modest since the products that can be sold by the insured MEWA are insured policies issued by carriers who are already subject to state insurance regulation.

Under this regulatory scheme, states potentially could regulate AHPs created under this new rule in various ways. This might include:

- Prohibiting or limiting self-insured AHPs to be sold or offered in a given state (regardless of where the association is located) if they fail to meet some or all of the requirements applicable to health insurance issuers;
- Subjecting health insurance issuers that sell policies to insured AHPs to comply with state-level benefit mandates; and
- Applying a state-level "look though" requirement to insured coverage offered to an AHP that would apply state-level small group insurance rules to participating members who are small employers.

In addition, states that implement a state-level individual coverage mandate requirement, such as New Jersey, can indirectly discourage AHPs by providing that coverage obtained from them fails to satisfy the state individual mandate unless such coverage satisfies various state individual or small group insurance mandates.

At the same time, however, the DOL noted in the preamble to the AHP final regulations that it has the authority under ERISA to issue a class exemption to preempt state insurance laws that go too far in regulating self-insured MEWAs and frustrate the purpose of the new AHP rules. Unless and until such a class exemption is issued, the ability to offer a truly national self-insured AHP is significantly impaired.

Effective and Applicability Dates

While the AHP final regulations become effective on August 20, 2018, the DOL established a staggered schedule before they become applicable:

- September 1, 2018, for fully-insured AHPs established under these new rules;
- January 1, 2019, for self-insured AHPs initially established under the preexisting rules that choose to become a bona fide association under the new rules (for example, to extend coverage to a broader group of individuals, such as working owners); and
- April 1, 2019, for newly established self-insured AHPs created under the new rules.

These applicability dates do not leave much time for industry groups, existing associations, health insurance issuers, and third-party administrators to complete market and underwriting feasibility assessments, draft necessary organizational and plan documentation, obtain any required state insurance approvals, and commence marketing and enrollment activities to offer AHP coverage under these new rules as soon as allowed. At the same time, the staggered implementation date schedule also does not leave states very much time to potentially modify their existing regulation of AHPs or update their authority and resources to regulate these new products if they are concerned that the new rules will usher in a new generation of fraud and abuse.

If the EEOC Wellness Regulations are Vacated, What Happens Next?

In brief:

- The incentive provisions in the EEOC's ADA and GINA wellness program regulations will be vacated at the end of 2018, unless the regulations are replaced or better justified to a federal district court judge.
- If the EEOC regulations are vacated, employers with incentive-based wellness programs face two sources of concern – the EEOC and private legal actions from employees.
- To limit exposure, employers should consider keeping premium differentials in wellness programs modest in size, eliminating aggressive positions in their wellness program, moving towards a "point-based" wellness design, and consulting with their employment law counsel to assess potential risks.

Many employers are currently evaluating the design strategy for their 2019 group medical plan, but there is uncertainty (and maybe even anxiety) if the design includes an incentive-based wellness program.

The problem is the case of *AARP v. EEOC* wherein the federal district court judge ordered that existing regulations from the Equal Employment Opportunity Commission (EEOC) concerning the compliance of incentive-based wellness programs with the Americans with Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA) must be vacated (i.e., terminated) at the end of this calendar year, unless the regulations are replaced or better justified to the judge. Incentive-based wellness programs implicate the ADA regulations by conditioning incentives on employees providing health risk assessments or medical examinations, and they implicate the GINA regulations by providing incentives to the employee if the spouse discloses information about the spouse's current or past health conditions. See our January 2018 and September 2017 Employee Benefits Compliance Updates for more details about this lawsuit.

Note that the court ruling only vacates the 30% incentive limit effective January 1, 2018, on the grounds that the EEOC failed to prove that this level of incentive was consistent with the "voluntary" standard set forth in the applicable statutory language under the ADA and GINA. The other provisions in the EEOC wellness regulations, such as the notification and confidentiality rules, will remain in effect, but may need to be modified slightly if the incentive limitation rules are eliminated. This leaves various potential scenarios that could play out, such as the EEOC:

- Re-issuing their existing regulations with a better justification of the incentive limitations;
- Taking a new position and permitting wellness incentives pursuant to the ADA safe harbor language set forth elsewhere in the statute, which they previously argued did not apply in the wellness program context;
- Issuing new regulations with more restrictive incentive-based wellness program limitations;
- Appealing the district court ruling; or
- Letting the existing rules to become vacated and going back to their less defined, discretionary enforcement policy.

Until any of these scenarios become clearer, there are various aspects of the *AARP v. EEOC* case that affected employers should consider during their 2019 plan design strategy planning.

For example, the EEOC does not appear to be moving quickly to reissue their ADA and GINA wellness regulations, and may wait until after the leadership at the EEOC is re-staffed. Two vacancies exist among the five EEOC commissioners, and the EEOC general counsel position is also vacant. Appointments for these positions are currently being held up in Congress. When these positions are filled, the majority of the commission will likely be Republican appointees. Thus, the EEOC is likely to become more pro-business in terms of new regulations and with respect to the EEOC's enforcement efforts on existing regulations.

If the EEOC's existing regulations are in fact vacated at the end of the year, employers may still be able to rely on those regulations for periods prior to January 1, 2019. Also, the EEOC is not expected to pursue enforcement actions against employers in 2019 or later with respect to their incentive-based wellness programs, except in cases where a wellness program has adopted an extreme position (such as requiring employees to complete a health risk assessment before they become eligible for coverage under the group health plan). In addition, employers might defend their program design by reverting back to the ADA safe harbor argument that was gaining traction in various lower court decisions prior to issuance of the EEOC regulations. Refer to our October 2016 Employee Benefits Compliance Update for a discussion of the ADA safe harbor.

In the absence of EEOC enforcement interest, the primary exposure that employers may face is from their employees in the form of a private legal action. While this is a greater risk, it may not be a particularly high risk as long as the employer's wellness program has been generally accepted by the workforce, is not designed with large premium differentials, does not require participants to obtain specific health outcomes, and does not take other aggressive positions. For example, if premium differentials under the wellness program are modest in size, the relatively small amount of damages such a legal action could generate may not attract the attention of plaintiff lawyers looking to file class action lawsuits. Moreover, an employer could quickly settle any such legal action, and – depending on how the incentive is structured – either refund surcharges back to affected participants, or have affected participants pay back to the employer any additional amounts they receive and have everyone pay more for their coverage.

Another idea is to move toward a "points-based" wellness program design that is limited to employees (i.e., excludes spouses), and does not include health risk assessments or medical examinations. Such a design would remove the most likely sources of potential violations of the ADA and GINA from the wellness program. Note, however, the HIPAA wellness rules would still apply, which means, for example, that a reasonable alternative standard must be offered with respect to any component within a "points-based" plan that is contingent on a health factor. Although a "points-based" plan tends to be complex and present challenges in employee communication, the employer could address these concerns by focusing on employee education efforts in general, and limiting the wellness program to one or two specific areas of employer concern.

Ultimately, if the EEOC does not issue new regulations on a timely basis, employer lobbying groups are expected to pressure Congress to enact legislation that accomplishes what the ADA and GINA wellness regulations intended to do. It may be asking too much, however, for such legislation to provide what most employers would want--namely, that a wellness program's compliance with the HIPAA wellness regulations is considered automatic compliance with the ADA and GINA.

A growing body of evidence suggests that many incentive-based wellness programs are not as effective as they at first appeared to be. Given the current state of confusion about the legality of certain incentive-based wellness designs, some risk-adverse employers may back away from offering incentives as part of their wellness program. On the other hand, employers that strongly believe in incentive-based wellness programs are expected to stand pat with their current plan design, and will wait to see what happens, accepting whatever modicum of risk there might be if their program is challenged before clarity in this area appears.

Finally, employers should consult with their employment law counsel to assess the potential risks associated with their 2019 wellness program, before making a final decision on a design strategy.

Anti-Assignment Clauses in Health Plans: Third Circuit Joins Numerous Other Courts in Upholding Them

In brief:

- Anti-assignment clauses are designed to prohibit plan participants from assigning their rights under the plan to healthcare providers, particularly "out-of-network" providers.
- The U.S. Court of Appeals for the Third Circuit recently upheld such a clause, joining the large majority of Circuit Courts that have unanimously done so.
- Self-insured plan sponsors looking to reduce litigation risk should review their plan documents and SPDs to ensure they have such clauses and apply them.

It has been common for quite some time now for both health insurance policies and self-insured group health plans to include "anti-assignment" clauses. Such clauses are designed to prohibit covered individuals from assigning their rights under such policies or plans to third parties. An example is provided in a recent opinion filed by the United States Court of Appeals for the Third Circuit in *American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield et al.*:

> Assignment of Benefit to Providers
>
> The right of a Member to receive benefit payments under this Program is personal to the Member and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this Program be transferred, either before or after Covered Services are rendered. However, a Member can assign benefit payments to the custodial parent of a Dependent covered under this Program, as required by law.

In this case, an individual covered under an insured plan underwent shoulder surgery with an out-of-network provider, which proceeded to charge a total $58,400 for its services. The policy only allowed reimbursement with an out-of-network cap of $2,633 and, after applying a deductible and coinsurance, the insurer ultimately reimbursed only $316, leaving the individual liable for the balance. As happens in many of these types of cases, the individual apparently did not have the inclination, resources, and/or the ability to pursue the claim on the individual's own behalf against the insurer. The provider proceeded to have the individual sign an "Assignment of Benefits & Ltd. Power of Attorney" intended to assign the individual's right to the provider to pursue claims for the surgery. After the insurer apparently denied the claim and its appeal under the insurer's internal administrative process, the provider sued.

Ultimately, the insurer moved to have the court dismiss the case, arguing that the anti-assignment clause was enforceable and the provider lacked standing, and both the Federal District Court and the Third Circuit agreed. The Third Circuit observed that six other Circuit courts (citing cases from the First, Second, Fifth, Ninth, Tenth, and Eleventh Circuits) had considered the various arguments similar to those presented by the provider and rejected them "[i]n thoughtful and reasoned decisions." Thus, the Third Circuit joins these other Circuits in finding anti-assignment clauses enforceable.

It is noteworthy in the *American Orthopedic* case that the covered individual also signed a form intended to grant the provider a limited power of attorney to recover payment on the individual's behalf through an arbitration or lawsuit. On that issue, the Third Circuit observed:

> ...because he retains ownership of his claim, [the covered individual], as principal, may confer on his agent the authority to assert that claim on his behalf, and the anti-assignment clause no more has power to strip [the provider] of its ability to act as [the covered individual's] agent than it does to strip [the covered individual] of his own interest in his claim.

However, in this case, the Third Circuit held that "Appellant waived its arguments concerning the power of attorney by failing to raise them in its opening or reply brief."

Nonetheless, presumably, a power of attorney meeting state law could be used to allow a covered individual to grant a provider the power to act as the covered individual's agent in bringing a plan claim. This could be significant because the use of a power of attorney might provide an alternative way for a provider to gain standing to pursue a claim against a plan in the first place and increase the plan's exposure to litigation defense costs, regardless of the merit of the underlying substantive benefit claim.

Action Steps

While insurers under fully-insured plans have responsibility for ensuring policies contain anti-assignment clauses and for applying them, *American Orthopedic* provides a reminder to sponsors and plan administrators of self-insured plans, including:

- Review both the formal health plan document and the Summary Plan Description (SPD) to ensure that both contain an anti-assignment clause – if they do not, or it appears the clause is inadequate, consider taking steps to enhance the provisions in these documents.
- Contact legal counsel immediately when directly contacted by a provider regarding a plan claim. By actually engaging in a plan's appeals process with a provider, a court may assume the sponsor or plan fiduciary should have known the provider was acting pursuant to an assignment, and, by engaging in the appeals process, a plan may be viewed as waiving its right to enforce an anti-assignment clause.
- Watch for further developments on providers using limited powers of attorney to be able to seek recovery on behalf of covered individuals. If this is an immediate concern, consider contacting legal counsel for plan document and SPD language to address such concern.

How can we help?

To learn more about current compliance issues, please contact your local USI Benefits Consultant, or visit us at www.usi.com.