Compliance Corner Webinar:

Are Association Health Plans the Cure?

August 16, 2018

Q: What is the impact of the recent Connecticut DOI ruling on AHPs. It basically seems to have eliminated the benefits for small groups to join an Association Health Plan.
A: Connecticut's new bulletin states that, "any small employer insured under a fully insured association health plan in Connecticut shall still be rated as a small employer". In CT, small employer includes any employer sized 1 – 100 employees on the first day of the plan year. It does not include sole proprietors have no employees, other than themselves or their spouse. Thus, small employers groups must still abide by the premium rate filings required by the state. Out-of-state plans must also file rates and forms for approval.

CT requires all self-insured association health plans to obtain a license as an insurer in the state since they do the business of insurance. This places significant requirements on these plans regarding filings, reserves, etc. Additionally, the

Q: So an employer formed working group within the association...even better than just voting?
A: According to ERISA, a bona fide association is one whose employers have enough control necessary to satisfy the requirement that the group or association act "in the interest of" the employer members. The Departments indicate that facts and circumstances will decide the presence of adequate control.

Q: Is the fact that Employers are voting members of an association considered indirectly exercising control?
A: Under ERISA, to "exercise control" encompasses things like control over the amendment process, plan termination, and other functions. Although there is no exclusive list of these activities, they mention a few examples in the final rule. These include, regular nominations, elections, and ability to remove directors and officers of the employer group or association or plan. Additionally, the distinction as to whether they have the authority to approve or veto decisions or activities relating to the formation, design, and amendments to the plan, including changes in coverage, benefits, and premiums.

Q: Will a former employee that is on COBRA be able to access the AHP?
A: AHP access for former employees will be available only if their previous employer is a current employer member of the group or association and the individual was an employee at the time that they first became entitled to coverage under the group's or association's group health plan. This seems to conflict with the rule that the COBRA participant be entitled to the same offer of benefits that active employees receive. The Department of Labor anticipates releasing additional guidance on this issue in the future.

Q: How are the major carriers are responding to this new AHP rule? I had them coming at me, now they are all backing off due to lawsuits. Even with a clear-cut 70 year old major business association.
A: It really depends on the state laws and the overall receptivity of the insurance commissioner and lawmakers in a given state to association health plans. Some states have a much better climate and we are seeing many new ones forming under the new rules while other states, through existing or new regulation, remove any benefit from this new regulation.

Q: Can owner-only business purchase through and AHP, or do they have to enroll at least one common law employee in addition to ownership?

A: If the association forms or modifies itself to follow this new regulation, then sole proprietors/owners with no common law employees are eligible to participate provided they meet the rules of a "working owner". The final rule makes explicit that working owners without common law employees may qualify as both an employer and as an employee for purposes of participating in an AHP.

The term "working owner" means any person who a responsible plan fiduciary reasonably determines is an individual:

1. Who has an ownership right of any nature in a trade or business, whether incorporated or unincorporated, including a partner and other self-employed individual
2. Who is earning wages or self-employment income from the trade or business for providing personal services to the trade or business; and
3. Who either:
    a. Works on average at least 20 hours per week or at least 80 hours per month providing personal services to the working owner's trade or business, or
    b. Has wages or self-employment 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 sponsored by the group or association in which the individual is participating.

Q: If a former employee is on the plan a COBRA member are they allowed into the association plan?
A: No, they would have had to participate in the AHP as an employee first. However, this seems to conflict with current COBRA rules. The Department of Labor anticipates releasing additional guidance on this subject.

Q: How will insurers rate a group that forms based on geographic proximity, not similarity of industry or trade?
A: Under the rule, premiums may vary if they are not based upon a health factor and all people that are similarly situated are treated the same. Presumably then, carriers could, and would, want to rate by geographic region or location to allow for the best management of the risk and associated cost of care.

Q: Interesting - so only employers who do not have COBRA employees can participate. That may eliminate a lot of eligibility!
A: The rule does not exclude employers with COBRA participants. However, if an employer cannot bring the COBRA member onto the plan at the time of enrollment, the employer would be in violation of COBRA laws. We assume the Department of Labor's forthcoming advice will address this.

Q: Who is responsible for COBRA application, the employer, or the association? Does a group with fewer than 20 have to provide continuation coverage because they participate in a large group plan?
A: Great question. The employer is responsible for COBRA continuation. However, under the new rule, the AHP would be the employer so conceivably would bear the responsibility. This, however, is one of the things that is up in the air and that the Department of Labor promises to address in upcoming guidance.

Q: So company A is healthy and company B is unhealthy, they will both pay the same rates correct?
A: Yes, as long as they are in the same class or subclass as designated by the AHP.

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Q: 1099 vs. customer - If an organization has a multi state network of professionals selling their product and the Y sellers are not considered 1099 contractors can they set up and association of "customers if the Customers each has an EIN and operate as individuals?
A: Essentially, this rule is for employer groups. The singular exception is for working owners. This entity could set up the association, under this rule, for and define the eligible class as a group of sales professionals selling this product. All sales professionals meeting eligibility would be able to participate as long as they were employers and had at least one employee or met the definition of a "working owner". Those who do not meet either of the criteria would be ineligible.

Q: On the discrimination page does the second bullet mean to say "must discriminate"?
A: No. This should read that the group health plan must not discriminate with respect to eligibility for benefits.

Q: Can rates differ from one group to another based on demographics?
A: Yes, so long as the demographic distinction is not based on a health factor. Example: if there was and AHP with two different geographic groups but there is only one person in the one with the higher premium, it would appear that this practice is discriminatory since it is singling out a specific individual for higher rates.

Q: They seem to be similar in that they bring small employers into a Large Group for price breaks. Pretty much what carriers do with their ACA Pool of lives. There must be something that the new Law for Association Plans allows carriers to do that lowers the cost of coverage otherwise they would end up with the same cost if benefits did not differ. So different Maximums, MLR's, covered services, something is different?
A: The difference is the ability to aggregate employees across multiple employers making them eligible for the large group market. The large group market is not required to include state mandated coverage or all essential health benefits in their health plans. Additionally, they are not required to use community rating or age banding when setting rates. Both of these features allow flexibility in coverage and pricing that may reduce cost. The carrier and association may also segment the group and create different offerings and different rates to different subclasses or subsectors provided the segmentation is not based on a health factor.

Q: What about a single employer (ex realtor) in which the employees are paid by contract/commission. The realtor group would have a common purpose. Can the owner of the realtor business offer a group health plan for the individuals who are paid by the realtor business?
A: The association is for group employees. To participate, the individual would have to satisfy the definition of either a common law employee or working owner.

Q: I am in an area that already has an AHP available 9/1/18. I am getting a lot of inquiries from sole proprietors that would best be categorized under adverse selection. Specifically they want to join the AHP immediately (currently uninsured). This is a dilemma for me as an agent knowing full well these people are wanting to join to have immediate coverage for preexisting conditions.
A: Since the association cannot discriminate based on health factor in the eligibility, rating, or participation rules, these employers are entitled to participate if they meet the eligibility criteria. Most AHPs know that this type of program

would first appeal to those who need an immediate solution. Their actuaries should consider this when setting rates the first few years. You can prepare your group by letting them know that they may see a bit of rate fluctuation until there is a good mix of healthy individuals.

Q: Participation requirements on each employer?
A: Participation will be based upon the eligibility criteria set by the association.

Q: I know they cannot be denied coverage, but I am concerned with the number of these sorts of inquiries I am getting. What advice can you offer?
A: Under the ACA, plans must offer coverage on a guaranteed issue basis in the large group, small group, and individual health care markets. For AHPs, it is guaranteed issue if the group meets all eligibility criteria. You may want to prepare these groups for some annual rate fluctuations until the group becomes more established and has a good mix of health and sick individuals.

Q: RE: non discrimination would stop loss contract allow for layering of a member?
A: The new rule applies to health plans not the stop loss contract. Stop loss is reinsurance to help the association remain financially sound. It does not affect the rules of participation or the actual health plan itself.

Q: Iowa (and I think Tennessee) now has/have laws that allow the Farm Bureau to establish AHPs. In the Iowa case, the Farm Bureau has come out stating individuals will be underwritten and could be denied coverage. How is this legal based on the final rules?
A: This is legal due to a special law passed in the state and under the previously established association plan rules. The Farm Bureau did not form for insurance purposes. It has been in operation for more than five years. Additionally, this is individual health care coverage, not group health. To participate, all individuals need to be members of the Farm Bureau living in the state who are not eligible for Medicare, Medicaid, or an employer health plan. Without the individual mandate penalty in 2019, Iowa is pushing to find more cost-effective alternatives to the populations who receive no subsidization.

Q: Is there not a rule that the association must be in force for 5 years in order to qualify?
A: To qualify as bona fide association under the prior rules, an association would need to be in existence for five years. Some states indicate a fewer number of years. This rule is still in effect. The new rule, however, eliminates this requirement. Associations may form under either the prior rule or the new rule.

Q: how would the Association know of the health conditions of the examples being explained? If there's no health statement, they wouldn't know.
A: They may know based upon claim history and other loss information.

Q: Rates would be different by employer, due to their census, correct? Wouldn't that be the only criteria?
A: Yes, but they could also vary by other non-health-factor-related subclasses like geographic area, type of job, location, etc.

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Q: I hear the term of similarly-situated individuals being used. Can you give some more examples of this?
A: HIPAA uses similarly situated to determine discriminatory treatment. Therefore, if there is a question of discrimination, the courts would compare the treatment of that employee to those who are of similar position or standing in the company to determine if their treatment was different or unfair. For example, let's say an employer offers health plan A to full-time employees and plan B to part-time employees. If a part-timer claimed discrimination because they failed to offer the option to participate in plan A, this would not be considered discriminatory since only plan B is offered to other similarly situated employees, i.e. part time employees. Other comparisons might include location, division, job title or job duties, or other responsibilities.

Q: Who decides if a plan would pass or fail discrimination testing?
A: Nondiscrimination rules exist in a number of places: the AHP rule, cafeteria plan §125, self-funded plans under §105(h), and HIPAA. It is both the plan's and the employer's responsibility to adhere to these rules and avoid the consequence of taxation or other reparations. Part of the due diligence of the member-run board should be the oversight of the plan and adherence to all rules including nondiscrimination rules. It is assumed that all plans and board members will take the steps appropriate to verify nondiscrimination in both plan design and in the operation of the plan.

Q: For all of these examples, say, you just have to have business in the same state, what is an example of the "one substantial business purpose" for the AHP existing?
A: According to the final rule:

> *"The primary purpose of the group or association may be to offer and provide health coverage to its employer members and their employees; 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 employer members and their employees. For purposes of satisfying the standard of this paragraph (b)(1), as a safe harbor, a substantial business purpose is considered to exist if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan. For purposes of this paragraph (b)(1), a business purpose includes promoting common business interests of its members or the common economic interests in a given trade or employer community, and is not required to be a for-profit activity."*

Q: Can you get in to the weeds on the definition of "preemption," how it relates to ERISA, the DOL, MEWA's & a State's laws & regulations?

A: The final rule in no way limits the ability of States under State insurance laws to regulate AHPs, health insurance issuers offering coverage through AHPs, and insurance producers marketing that coverage to employees. If an AHP is fully insured, ERISA section 514(b)(6)(A)(i) provides that State laws that regulate the maintenance of specified contribution and reserve levels (and that enforce those standards) may apply. Additionally, State insurance laws are generally saved from preemption when applied to health insurance issuers that sell policies to AHPs and when applied to insurance policies that AHPs purchase to provide benefits.

In addition, in the case of fully-insured AHPs, it is the view of the Department that ERISA section 514(b)(6) clearly enables States to subject AHPs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of State insurance law necessary to ensure compliance with the State insurance reserves, contributions and funding obligations. If an AHP established pursuant to this final rule is not fully insured, then,

under section 514(b)(6)(A)(ii) of ERISA, any State law that regulates insurance may apply to the AHP to the extent that such State law is "not inconsistent" with ERISA.

The Departments state that the final rule is not the appropriate vehicle to issue opinions on whether any specific State law or laws would be superseded because of the final rule. Therefore, there is no ruling on States' prohibition on self-insuring MEWAs, prevention of MEWAs, or establishing other rules pertained to MEWA allowance or operation.

Q: Can you discriminate by SIC code?
A: You may segment a group based on SIC code since this is a subsection, or classification, that is not health-related. If it not, health related and the plan treats everyone in that subclass or subsection the same, then it is not discriminatory.

Q: If in example 7 they add a non agriculture union is there an impact?
A: Example 7 is based on an association that has a commonality of interest that is a business or trade. Since this is AHP is an agriculture industry association, they would not be able to add a business that is not in the agriculture industry.

Q: Example 8 allows discrimination of the potentially highly compensated?
A: There is nothing in the AHP regulation that prohibits discrimination in favor of highly compensated individuals. The AHP discrimination rules are based on the HIPAA nondiscrimination rules that only prohibits discrimination based on a health factor. However, one would need to put this together with the other laws and rules that govern health plans or employers. Cafeteria plan and self-funded §105(h) rules prohibit discrimination in favor of highly compensated individuals. The departments anticipate additional guidance in this area.

Q: How does participation requirements factor in? Does that depend on the carrier? Can an association just leave off those employees that waive or decline?
A: Participation rules will be decided by the plan sponsor/association and the carrier/administrator.

Q: Are AHP's, either those currently in existence or those that are created under the new rules, permitted to adjust a member group's premiums based on that group's claims experience? Meaning some member groups will see higher rate increases than others if they have higher claims than others. If so, is this a form of discrimination based on health factors that is not permitted?
A: AHP rules prohibit experience rating on a group-by-group basis under the new rule. Certainly the experience of the plan, in its entirety, will dictate new premiums. However, each similarly situated group will have uniform premiums. Those groups that alter their plan offer or contribution based on subclasses would be able to charge different premiums so long as everyone in the subclass is treated the same.

Q: Health questions cannot be basis for denial into association?
A: That is correct. Associations must offer and take all groups that meet the eligibility requirements.

Q: Who establishes a new association and where is the association going to obtain benefit and premium quotes - carriers?

A: The entity, i.e. trade industry, industry, community organizations, etc. would establish the AHP. Before doing so, it is prudent to solicit feedback from the local carriers regarding their appetite for AHPs, in general, and then their desire to work with their specific organization. Some carriers are interested and moving forward and others are not. Some entities/organizations would be a good risk while others may not be. Suffice it to say, there needs to be quite a lot of due diligence done on all sides to determine viability before proceeding.

Q: these classifications are all done on association level, correct? And each employer needs to work in those parameters?
A: Yes, the associations would determine whether there are subclasses and who is eligible for what plan. The offer then to eligible employers would exist of the plan(s) for which each employer and their employees are eligible.

Q: As a follow-up question, in Idaho, a realtor business is not considered a employer and thus can't offer a group health plan for the individual persons who are working under the umbrella of the Realtor business. The only healthcare that can be accessed by each person is an individual plan.
A: Assuming this is the case because all the realtors working in the business are 1099s and not common law employees, each individual could apply on their own to a trade or geographic association provided they meet the definition of a "working owner", their state allows that, and the association includes these individuals as part of the eligible class.

Q: Can you explain how a state's rules regarding AHP's can override or negate the new rules approved at the federal level. For example, do you know if the new rules will be permitted in AHP's sold in the California market?
A: The new rule does not prohibit of override the state laws on AHPs or MEWAs. It just provides another opportunity. We saw CA pass SB1375 this fall eliminating eligibility of working owners from AHP plans and establishing that all employers under 100 lives are small groups and not a single large group.

Q: What are the effective dates of Association Health Plans?
A: New or existing fully-insured plans may begin under the new rule as of September 1, 2018. Self-funded plans that were in existence as of June 21, 2018, the date of the proposed rule, who meet the criteria may offer under this rule effective January 1, 2019. All other plans may form under these rules effective April 1, 2019.

Q: If an employer wants to join an AHP, they must have a statutory employee in order to purchase coverage?
A: It depends. If the AHP formed, or forms, under the original AHP rules, then they would need to two or more employees to be eligible. If the AHP forms under this new rule, the employer need only have one employee or have no employees but satisfy the definition of a "working owner".

Q: If the plan cannot be owned or controlled by the issuer does that mean an AHP cannot be fully insured?
A: No. The plan may be fully-insured. The association itself cannot be a health insurance issuer or owned or controlled by a health issuer.

Q: In your opinion, how likely is it for an association to be audited? Has there been any word of how many auditors there will be or what priority has been placed on this?

A: There is a lot of focus and scrutiny on these since there are many failed ones in history. The states want to be careful. We've seen some oversight and audit requirements in many of the states that are moving forward. Additionally, the fully-insured plans will need to file rates and plans in the states.

An AHP offered by a bona fide group or association under the final rule is subject to all of the ERISA provisions applicable to group health plans, including the fiduciary responsibility and prohibited transaction provisions in Title I of ERISA. AHPs are MEWAs and, as such, are subject to existing federal regulatory standards governing MEWAs. Sponsors of AHPs will need to exercise care to ensure compliance with those standards, including those established in the ACA. All these plans require specific reporting and filings. Therefore, the state and various agencies will be monitoring effectiveness.

Q: I understand that the Pennsylvania DOI has stated today that they will not allow AHPs. What have you heard regarding this latest information?
A: Pennsylvania's insurance commissioner stated they would continue to enforce their current rules regarding AHPs and prohibit formation under these new rules until the pending lawsuit is decided. In addition, they would require plans to cover all the minimum essential coverage and prescription drugs. They will continue to enforce their current AHP rules.

Q: In Pennsylvania, the insurance commissioner has sent a letter to HHS indicating how she intends to implement the Final Rule. Since the state has final jurisdiction, she has essentially block implementation under the rule as intended. Is this likely to stick?
A: Yes. This rule in no way prohibits the states from enforcing additional rules and requirements.

Q: Our state has released its AHP. The carrier will not allow a husband and wife group. They have told us that they will accept husband-wife groups only if there are additional W2 employees. Now, those additional employees can waive coverage. Ok, so we enroll group like that and now they are not being offered a renewal due to non compliance and being a husband-wife group. How can the carrier get away with that?
A: The ACA requires guaranteed renewal of health plans in the individual and small group markets. This requirement does not apply to the large group market. Therefore, if the association aggregates all the employees and is considered a single large employer, they are not required to provide guaranteed renewal.

Q: What about tobacco vs. non tobacco use? Can they charge more for smokers or those over a certain weight?
A: They may not discriminate due to health factors. However, the final rule addresses wellness programs. Specifically, it states, *"The wellness program provisions permit plans to vary benefits (including cost-sharing mechanisms, such as a deductible, copayment, or coinsurance), and the amount of premium or contribution they require similarly situated individuals to pay, based on whether an individual has met the standards of a wellness program that satisfies the HIPAA health nondiscrimination rules."*

Q: My state currently has one company offering a MEWA. Do we anticipate more companies offering these in the near future?
A: We are seeing the introduction of more association health plans in the states where they are favorable.

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Q: Can AHP's construct rates by Age, Gender, and smoking status?
A: AHPs may use age to determine rates. They cannot base rating on any health related factor. The term health factor means, in relation to an individual, any of the following health status-related factors: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, or disability.

Q: If the fully insured premium is static throughout the state, are you saying the Association can charge members different rates for non health related reasons?
A: The AHP may charge different rates to different classes or subsectors of the association as long as those subclasses are not based on a health factor and all individuals within that class are treated the same.

Q: Can a new AHP be established in a MEWA favorable state and include eligible small businesses in other states? My example is a group of 18,000 small businesses in a common line of business operating in all 50 states.
A: Yes, as long as all the employers are part of the same trade, industry, line of business, or profession.

Q: Can an employer pay 50% for their full time employee and 25% for their part-time employee under AHP Charging different premiums to different classes?
A: Each individual employer will decide the level of contributions for the business and their employees and may vary that with regard to a bona fide business classification of employees, like full-time and part-time.

Q: Are you stating that salaried vs. hourly is a bona fide job classification under an AHP? And can charge different rates for those separate groups?
A: Yes. The final rule provides examples of bona fide classifications of employees for which different benefit offers and premium contributions may vary. *"Examples in the HIPAA health nondiscrimination rules of classifications that may be bona fide, based on all the relevant facts and circumstances, include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations."*

Q: Does the employer have to file the 1094/1095 or does the association do it for all covered members?
A: Each employer group, as part of a MEWA, is responsible for filing their 1094 and 1095 forms, regardless of their size.

Q: How would an association know how much a member employer is charging the employees for purposes of the 1095-C?
A: They would have no knowledge. It is the employer's responsibility to report. However, it is possible for the association to offer this as a service to participating employers but would need to gather that type of information from each group.

Q: What about having to offer Essential Benefits?
A: Only health plans offered in the small group and individual markets are required to offer essential health benefits. If the AHP has enough members to warrant a large group plan in their state, then those plans would not need to offer all the essential health benefits.

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Q: Is there any impact on PEO providers?
A: There is no specific mention of PEOs or PEO providers in the final rule.

Q: Wouldn't ALL members be subject to COBRA and MSP since it's one large group, not based on the individual employer size?
A: It seems like it. However, the final rule states that the Departments will address COBRA in future guidance. The current MSP rules state that small employers are exempt even if they are part of an association but we anticipate seeing clarification or confirmation of this.

Q: What states are actually allowing AHP's?
A: Some States offering AHPs include Nevada, Texas, Indiana, Iowa, and Missouri.

Q: I was told a small member company with fewer than 20 employees would not be subject to COBRA, your slide seemed say different. Can you clarify?
A: The Departments address this by stating that this rule is not the place to address how COBRA will work with the AHP rule and anticipate releasing future guidance to clarify its applicability.

Q: State of Nevada: no consistency between carriers. Sierra/ HPN will not take a husband-wife group. Anthem and Prominence will look at it. Sierra has our AHP.
A: Each carrier can establish their rules of engagement and each association can establish the rules for participation.

Q: Can employee age be a factor in determining premium?
A: Premiums may vary based on age. Age is not a health factor. The rule states, *"The term health factor means, in relation to an individual, any of the following health status-related factors: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, or disability."*

Q: None of the carriers in our state have come forward indicating a willingness to get into this area of business. Are those states just out of luck?
A: If states have not yet pushed forward with AHPs, and you have groups wanting to form associations under this new rule, it may be worth meeting with your insurance commissioner and lawmakers to help affect change

Q: Do 1095-C forms really need to be issued to participating employers that are not ALEs, even if the sum of all the AHP membership is well over 50 FTEs?
A: Yes. The rule considers an AHP to be a MEWA. For MEWAs, each participating employer, regardless of size, must report.

Q: When you are talking about state, are you referring to the domicile state or the state participating in any national AHP?

A: Domicile state. The state where the plan is situsued will typically be the governing state. Although, we are now seeing some states requiring outside plans, that cover residents of the state, to register or provide some filing information.

Q: It appears the employees are allowed to work 40 hours per week to be eligible under new AHP plans, and not be required to meet the ACA minimum of 30 hour per week requirement, correct?
A: The ACA's employer shared responsibility applies to employers with 50 or more full-time or full-time equivalents. It defines full-time employee as one who averages 30 hours or more of service per week. Participation in an AHP does not remove the requirements for ALEs to offer coverage under an AHP. If an individual participating employer is an ALE, then they would want to offer to those averaging 30 hours or more in order to avoid any ACA penalty. Employers who are not ALEs do not have this requirement.

Q: Utah has several associations that have been in existence for many years who ask a series of health questions to determine which tier the group will be priced at. How are they able to do this if there can be no discrimination based on health?
A: If an AHP formed under the previous AHP rules, and their State allows it, medical underwriting may exist. If the AHP is forming under the new rule, they would not be allowed to ask health questions.

Q: If the employer joins the AHP and is not considered an ALE, will the AHP still be required to do the Employer Mandate Reporting for that single employer?
A: All employer members of an AHPs, regardless of size, must report.

Q: Who supplies the ERISA SPD - the AHP or does each individual employer within the AHP have to furnish their own?
A: The plan sponsor provides the SPD. The AHP would supply the SPD because that is the level at which the plan exists.

Q: Where do we find our state laws for MEWAs? Which state governing body controls this?
A: You would need to look at the part of the state's website that display the state regulations. Then you should be able to search by associations or MEWA.

Q: Is the certificate of authority obtained from our state DOBI?
A: Usually the certificates of authority are available at whichever state agency is responsible for oversight of the AHP and health plans, e.g. department of insurance, department of banking and insurance, etc.

Q: So with all the non-discrimination rules, does that mean the association has to take on any and all risks without a way to underwrite?
A: They may only underwrite based on non-health factors as previously described.

Q: I was told that New Jersey is blocking AHPs. Is this true? I can't find confirmation.
A: Eleven states and the District of Columbia filed suit claiming the rule's focus is to undermine and dismantle the ACA. Additionally, they claim that the Department lacks the authority to modify ERISA's definition of an employer. New Jersey is part of this lawsuit.

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Q: In much of this webinar the association and the health plan have been referenced as the same entity, but they are not necessarily the same. The association has rules and regulations, and the plans offered through the association are also governed by their own rules and laws but indeed are two separate things or entities.
A: The association is the group or entity of employers and has specific rules about who can participate in that association. The actual plan is the vehicle by which they offer health insurance. Group health plans have a separate set of rules and laws that govern them.

Q: Are many carriers in Florida offering plans to associations?
A: At least one carrier has stepped forward and one new association has formed. It will continue to be a work in progress for most states as they figure out how they want to operate and whether to allow new MEWAs that will fit their state's individuals.

Q: Discuss State Views of Fully Insured vs. Self Funded AHPs. Is a MEWA always Self Funded?
A: A MEWA is a multiple employer welfare association. The MEWA may offer a health plan. That plan may be either fully-insured or self-funded as long as those funding options are allowable in the given State.

Q: Are AHP's allowed to use any form of medical underwriting for rates or plan acceptance for the AHP?
A: No, they cannot. The only caveat on the rating side would be the inclusion of a HIPAA-compliant wellness program.

Q: Does the AHPs board have fiduciary responsibilities/liabilities?
A: Yes, the same as any other plan sponsor. The final rule specifically clarifies that an AHP offered by a bona fide group or association under the final rule is subject to all of the ERISA provisions applicable to group health plans, including the fiduciary responsibility and prohibited transaction provisions in Title I of ERISA. The Department notes that the bona fide group or association that sponsors the AHP assumes and retains responsibility for operating and administering the AHP, including ensuring compliance with these requirements. AHPs are responsible for associated filings, disclosures, and notices such as the MEWA M-1 filing, Form 5500 filing, distribution of SBCs, SPDs, SMMs, etc.

Q: Can Chambers of Commerce form an AHP for their members?
A: Yes. They may form based on geography, i.e. all businesses within a city or state or metropolitan area.

Q: Nevada has already rolled out 10 AHP via three of our Chambers and the main Clark County Chamber has made it known that they are ready to unveil their program. These plans will be open to all small group employers in Clark County.
A: Nevada appears to lead the country with the most newly formed AHPs.

Q: Can employers with common law not eligible for coverage be part of an association plan if the only covered folks are the owners, partners, shareholders, etc?
A: Yes, if they meet the definition of a working owner

Compliance Corner Webinar:

Are Association Health Plans the Cure?

August 16, 2018

Q: What if someone is on COBRA prior to their previous employer joining?
A: They would not be eligible. To be covered, they had to have been an active employee when the employer became a participating member of the association and offered coverage.

Q: Earlier you mentioned that ACA compliance was required. How does that work with the "no EHB restrictions" here?
A: ACA provisions that apply to large groups will apply to AHPs with enough aggregated employees to qualify as a large group plan. Essential health benefits are not required of large group plans, only small group and individual health plans.
Q: How will COBRA be handled? As a MEWA taking in existing COBRA beneficiaries, but sending them with the employer when/if they were to leave the Association?
A: The Departments indicate that forthcoming guidance will address this. Currently, there is a conflict between AHPs not allowing current COBRA participants on the plan and the COBRA law requiring employers to offer the same plan to COBRA participants as to all other active employees.

Q: Please restate how extraterritorial works.
A: Extraterritorial laws ensure that an employer's health insurance plan needs to comply with health insurance laws that exist in more than one state. States with extraterritorial laws require health insurers to pay benefits based on the laws of the state where an employee resides rather than the state in which the plan is sitused. It is unclear how this may affect the design of the AHPs health plan but it is likely that it would apply to the extent those laws apply to other large employer plans.

Q: If an employer is headquartered within the principal place of business but has employees outside of the region, are they allowed into the association plan?
A: Yes, as long as the states do not prohibit this.

Q: Would like to hear thoughts on a national AHP.
A: It will be more challenging to develop a national AHP than a regional one. There are more states and state laws to contend with, states that prohibit participation in AHPs or have specific plan requirements or consumer protections, filings and information required to the states, etc.

Q: Do you believe insurance companies will put together association plans?
A: Many carriers are working with associations and providing health plans. It is more prevalent in some states that in others.

Q: What is the difference between an AHP and captive?
A: An association health plan is a health plan covering a number of employer groups or separate entities. A captive is a funding arrangement. They share in a pool of funds but the individual members are not aggregated or participating together in the actual benefit plan.

Q: Do Chambers of Commerce qualify?
A: Yes. Under commonality of interest, employer groups in a geographic region may participate together as an AHP. A chamber is a good example of a type of geographically-based association.

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Q: Has NAHU interviewed major carriers, perhaps NAHU could help us with interview questions? I am on NAHU Employer Working Group and I think we should work on that this year.
A: A questionnaire of some type is a good idea to gain understating in what type of associations are attractive to each carrier and their rules of engagement.

Q: What is going to happen to the Associations who ARE rating based on Health Risk? (Texas)
A: Some may move over to the new rule and others will stay in this existing rule. There is no mandate for current AHPs to switch to the new model.

Q: Colorado requires MEWAs to be licensed as an insurance carrier, yet "insurance carriers" cannot create AHPs under the new law. Is that a catch 22?
A: No. They require health insurers to be licensed and to adhere to the rules that govern carriers regarding plan filings, premium reserves, and various other items that protect and foster long-term solvency of the plan. It's more about the requirements placed on insurers than being an actual insurer.

Q: After what date can employers start an AHP, re: fully funded medical plans, re: stop-loss self funded major medical plans?
A: New or existing fully-insured plans may begin under the new rule as of September 1, 2018. Self-funded plans that were in existence as of June 21, 2018, the date of the proposed rule, who meet the criteria may offer under this rule effective January 1, 2019. All other plans may form under these rules effective April 1, 2019.

Q: Will existing Association plans get to stay, or will they have to change and follow these new rules? Assuming they are grandfathered, is there any known amount of time they can stay as-is?
A: There is no mandate for current AHPs to switch to the new model. In fact, new associations may form and choose the old model. It is not prohibited.

Q: Is there an AHP handout that can be given to employers or an employer (i.e., realtor) that is interest in forming an AHP?
A: This may be in the works with one of the NAHU's working groups. We will pass that suggestion on to them.

Q: Can the federal government preempt states from opting out of AHPs if the government feels states are not following the intent of the law to offer AHP coverages?
A: It is a regulation and not a law. The regulation is clear that it does not prohibit States from imposing other restrictions on MEWAs or AHPs.

Q: Will NAHU have an association health plan?
A: No. NAHU does not compete with our brokers in selling health plans.