ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

Come Together: Executive Order Raises Potential Opportunities for Association Health Plans

Oftentimes, otherwise unrelated employers may seek to join together to create economies of scale and pool risk for purposes of providing health coverage. Unfortunately, with limited exceptions (e.g., for a controlled group employers) current law imposes significant limitations on what entities can share health risk. An October Executive Order (EO)[1] seems to indicate that the ERISA rules may soon become more relaxed for certain association health plan (AHP) arrangements.

Current laws regarding AHPs involve a number of different federal and state laws, including ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (the "Code"). The starting point is the definition of employer under ERISA § 3(5). The EO specifically directs the Department of Labor (DOL) to review and revise existing guidance under this definition so that more employers may offer coverage through an AHP.

A change in DOL position in this area will have a number of implications, the full extent of which will not be known until the DOL acts. Some will welcome greater ability to use AHPs under current law, e.g., some small employers may appreciate lower premiums and fewer insurance mandates as a result of qualifying as a large group health plan ("LGHP"); however, changes from current guidance may also generate controversy.

For example, we expect some commentators to be concerned about erosion of the small group market due to the splitting off of lower risk individuals into AHPs, as well as erosion of some ACA consumer protections. In light of some recent high profile MEWA failures, some states may be concerned if DOL action undermines current state laws that regulate self-funded MEWAs.

The following is a high-level summary of current law and analysis of possible DOL action, including issues under federal and state law:

- **Change to ERISA interpretation:** The DOL has been directed to enable more employers to form AHPs that are considered a group health plan at the association level, thus presumably allowing the group health plan to be considered a single LGHP (rather than individual small group plans). This will likely be accomplished by relaxing existing tests used to determine whether the association is considered an "employer" under ERISA § 3(5). Currently the DOL (as well as case law) looks to whether there is sufficient "commonality of interest" among the employers unrelated to benefit plans and whether the employers "control" the association. The DOL has issued guidance specifically

relating to general business leagues such as chambers of commerce, and has typically concluded that the nature of the relationship of the employers (which is largely geographical) is not sufficient for a health plan sponsored by the chamber to be a single LGHP. This guidance may be revisited pursuant to the EO.

- Note that despite the DOL position (and the Department of Health and Human Services (HHS)), some states may nevertheless continue to classify association coverage as small group health plans. Even if states do not take enforcement action against the issuer in such cases, this approach creates risks for participating employers, who may be subject to enforcement actions. Clarifying guidance from the DOL can help reduce these risks substantially.

- In implementing the EO, DOL could potentially make changes without going through the regulatory process, because existing guidance is in advisory opinions rather than regulations. However, DOL will also need to consider the impact of case law in this area and the likelihood of potential legal challenges.

- **Impact on PHSA requirements:** Under the PHSA, including regulations issued under the Affordable Care Act (ACA), the state-law characterization of association coverage is not relevant; rather, it is necessary to look through the association to determine how the underlying coverage is classified, i.e., as individual, small group, or large group. The Centers for Medicare and Medicaid Services (CMS) has stated their view that only in rare cases will the AHP be considered a single LGHP. Changes to the DOL interpretation of AHP status under ERISA should automatically carry over to the PHSA based on the statutory definition of employer under the PHSA, which cross references the definition of employer.

- **MEWA issues:** Under current law, the DOL considers an AHP to be a multiple employer welfare plan (MEWA), even if the AHP is considered a single plan at the association level. Based on the relevant statutory provisions we do not expect the DOL position to change on this point. Thus, for planning purposes, MEWA status should be considered. ERISA has specific preemption provisions that allow states to regulate MEWAs.

  - For fully insured plans, states may impose and enforce requirements relating to reserves and contributions.

  - Permitted state regulation of self-funded MEWAs is much broader. State laws relating to self-funded MEWAs are preempted *only to the extent* that the state law is inconsistent with ERISA. State laws that provide more participant protections are not considered inconsistent ERISA.

- By statute, DOL has the authority through regulations to exempt self-funded MEWAs from state laws. DOL has not ever provided any exemptions; however, it is possible that they will do so in response to the EO. DOL does not have the authority to exempt self-funded MEWAs from state laws relating to reserve and contribution requirements. Depending on what action the DOL takes, new issues may arise as to whether certain of these provisions would become preempted by federal law.

- **Guaranteed renewability requirements:** Under the PHSA, an insurer is not required to renew group coverage offered only through a "bona fide association" in the case of an employer whose membership in the association terminates. The definition of bona fide association for this purpose is distinct from the definition of an employer. That is, even if an AHP is considered a group health plan under new DOL guidance, the exception to the guaranteed renewal requirement will be available only if the association meets the specific definition of "bona fide association" under the PHSA.

The next several weeks should prove interesting as the agencies issue guidance pursuant to the EO directive. ■

References:

1 https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition