Association Health Plans (AHPs)

New Department of Labor (DOL) rule expands the ability of employers, including sole proprietors and self-employed workers, to participate in Association Health Plans (AHPs). These plans are subject to important state and federal consumer protection rules and requirements. An AHP is a specific type of Employee Retirement Income Security Act (ERISA)-covered group health plan that is sponsored by a group or association of employers, instead of a single employer, to provide health coverage to the employees of the AHP's employer members. Under ERISA, an AHP is both a group health plan and a multiple employer welfare arrangement (MEWA). *MEWAs are not preempted from state regulation by ERISA. A MEWA must comply with all state insurance laws.*

Pathways to set up AHPs

1. Pathway One is referring to existing AHPs, that were allowed under prior guidance. These plans can continue.
2. Pathway Two is new and includes safeguards that generally apply to large employer health plans and healthcare nondiscrimination protections.

Reporting Rules

AHPs must file both a Form 5500 and a Form M-1 with the DOL.

- Form 5500 is an annual report containing information about the plan, its finances, and its operation.
- Form M-1 is to register and report certain compliance information before operating in a new state, and annually thereafter. Form M-1 must be certified by the DOL before any activity is undertaken by the AHP.

Becoming an AHP

- May offer coverage to some or all employers in a state, city, country or a multi-state metro area
- Or to businesses in a common trade, industry, line of business, or profession in any area, including nationwide.

Forming an Association

- *While the primary purpose of an AHP can be to offer members health coverage, it must also have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits, such as promoting common business or economic interest in a trade or employer community.*
- Each member participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the plan.

- The group has a formal organizational structure with a governing body and has by-laws or other similar indications of formality.
- The functions and activities of the association are controlled by its employer members. Control must be present both in form and substance.
- Employer members of the association will be treated as having a Commonality of Interest.

Safeguards included in the New Rule

- AHPs may not charge higher premiums or deny coverage to people because of pre-existing conditions.
- AHPs cannot cancel coverage because an employee or covered family member becomes ill.
- AHPS cannot cancel coverage because an employee or family member becomes ill

Disclosure Rules

The three most important disclosures are:

1. Summary Plan Description – plain language summary of the plan and explanation of the plan's rules.
2. Summary of Material Modification – to inform participants any time there is a material change to the plan.
3. Summary of Benefits and Coverage – a plain-language summary of the key features of the plan, such a covered benefits, cost-sharing provisions and coverage limitations.

Administration

- Claims Benefits – must establish and maintain a claims procedure following the issued rules setting minimum timing and content standards.
- COBRA – plans must include COBRA coverage for those that qualify.
- Consumer Health Care Protections – ERISA Part 7 includes various consumer protection provisions, including HIPAA, the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protections Act, and the Women's Health and Cancer Rights Act, among others.

Fiduciary Rules

ERISA establishes standards and rules governing the conduct of individuals and companies responsible for running the plans, including selling the plans and administrating the claims.

Employers that are members of the AHP have a fiduciary duty to monitor the AHP and get periodic reports on the fiduciaries' management and administration of the AHP.

Insured AHPs

- Approved M-1 by the DOL
- Meets the West Virginia definition of a Bona Fide Association, by having a minimum of 200 persons and has been actively in existence for at least five years.
- Health Insurance is provided by an approved insurance company that has filed the required documents and received approval from the West Virginia Office of the Insurance Commissioner (WVOIC)
- Has the protection of the WVOIC for the handling of complaints and compliance

Self-Insured AHPs, i.e. a MEWA

- *Under current WV law, AHPs and/or MEWAs are not specifically authorized to self-insure.*
- *In WV, no person or entity may act as an insurer or transact insurance in WV without being authorized to do so by having a valid license issued by the Insurance Commissioner, unless specifically exempted from the licensing requirement. See W.Va. Code 33-3-1.*
- *WV law does not have an exemption specifically designed for AHPs and/or MEWAs. Accordingly, an AHP and/or MEWA must be fully insured by offering its members coverage through a licensed insurance entity. Alternatively, a self-funded MEWA could risk being deemed an unlicensed insurance company.*
- *Further, it is unlawful for any person to engage in any act which constitutes the transaction of insurance unless authorized by a license. An AHP and/or MEWA that is found to be transacting insurance without a valid license may be subject to the WV Unauthorized Insurance Act. See W.Va. Code 33-44-4.*
- *If the AHP has solvency issues, the responsibility for payment can fall on the insurance agent, the TPA, the employers making up the association, the employees, or any person assisting the unauthorized insurer*[1].
- Link to DOL Website for more information: https://www.dol.gov/general/topic/association-health-plans
- Does not have protection of the WVOIC for the handling of complaints and compliance
- All complaints and compliance are handled directly by the DOL

[1] § **33-44-4. Unlawful transaction of insurance**.
(b) It is unlawful for any person to, directly or indirectly, represent, aid, counsel, opine, administer, assist in any manner or capacity or otherwise act as an agent for or on behalf of an unauthorized insurer in the unauthorized transaction of insurance. Any person who represents, aids or assists, in any manner or capacity, an unauthorized insurer in violation of this article shall be subject to the provisions and penalties set forth in this article.