Will Courts and States Prevent the Trump Administration from Playing Humpty-Dumpty with the ACA: Responses to the Association Health Plan Final Rule

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In late March, U.S. District Judge John Bates rejected the Trump Administration's policy promoting Association Health Plans (AHPs), holding its interpretation of the Employee Retirement Income Security Act (ERISA) violated the Administrative Procedure Act (APA) and undermined the Affordable Care Act (ACA). This post analyzes implications of the Trump Administration's Final Rule on AHPs, looks at the U.S. District Court's response to litigation challenging the rule, and considers state options for regulating AHPs.

The AHP Final Rule: Implications for Consumers, Providers, and States

As The Source previously covered, the Department of Labor (DOL) issued a June 2018 Final Rule that made it easier for employers and associations to offer health insurance to their employees and members via AHPs, particularly AHPs that operate in the large group market, which is not subject to the ACA's individual market consumer protection requirements. The Final Rule did this in two ways: 1) it loosened the requirements for becoming a bona fide association that can offer AHPs and 2) it allowed sole proprietors, called working owners, to qualify as employers and participate in AHPs.

Administration officials argued that the existence of more AHPs would reduce health care spending and increase access to coverage (see Executive Order 13,813: Promoting Healthcare Choice and Competition Across the United States). However,

many consumers, providers, and states saw the Final Rule as a way to undermine the ACA's coverage gains. They highlighted two main concerns: potential for unpaid medical bills and disruption to the individual market.

AHPs could result in unpaid medical bills in two ways. First, AHPs have long been associated with fraud, abuse, and insolvencies that left plan members and health care providers with outstanding claims. For example, between 2000 and 2002, fraudulent plans left consumers and providers with $252 million in unpaid medical bills. Second, because the Final Rule made it easier for AHPs to operate in the large group market, they are able to bypass ACA individual market requirements like guarantee issue, community rating, and coverage for the 10 essential health benefits. As a result, AHPs may offer less robust coverage than ACA marketplace plans, putting consumers at risk for high unexpected medical bills if their AHP does not cover a service that the consumer assumed would be covered.

Another concern is that more AHPs could raise the price of premiums in the individual and small group market. AHPs are expected to lure consumers out of the ACA marketplaces, particularly consumers who are healthy and do not perceive a need for more comprehensive ACA marketplace coverage. As has been well documented, when healthier people leave a health insurance market, insurers lose a key source of funding used to help pay the bills of those who require more health care services. As a result, insurers raise premiums, which in turn forces more people to leave the market. Eventually, the market ceases to function (aka the insurance death spiral). It is estimated that, under the Final Rule's policies, 3.2 million people would leave ACA marketplace plans by 2022. This would raise premiums for those remaining in the ACA marketplaces by 3.5 percent. DOL predicted that individuals remaining in the individual and small group markets could see a combined premium increase of between $7.7 billion and $14.1 billion as a result of healthier people leaving the marketplaces.

Legal Challenge to the Final Rule: *State of New York et al. v. U.S. Department of Labor*

The Final Rule is not only concerning for policy reasons, but it is also problematic

because it departed from established law and precedent. In July 2018, 12 Attorneys General sued DOL, claiming that the Final Rule's amended definition of "employer" is impermissible under ERISA. Judge Bates, ruling for the U.S. District Court for Washington D.C., agreed, finding that the Final Rule was inconsistent with ERISA's text and purpose. He also found the Final Rule's "tortured" reading of the ACA undermined Congress's effort to put in place a stable health insurance market structure. The opinion, laid out like a comprehensive answer to an administrative law exam, first held the plaintiffs have standing, then found ERISA's definition of "employer" is ambiguous under Chevron, and finally concluded that DOL failed the reasonableness test under Chevron step two.

Specifically, Judge Bates focused his analysis on the Final Rule's changes to the bona fide association requirements and working owner requirements and held that the new broad interpretation of those requirements went beyond what ERISA intended and is therefore impermissible under the APA.

Bona Fide Association

The Final Rule changed the standard for determining if a group of employees or an association may offer an AHP as a "bona fide association." Before the Final Rule, such a group was required to have a "nexus" to the plan members. Nexus was determined by three factors: 1) if the group existed for reasons other than providing insurance (the primary purpose test), 2) whether the members of the group had common interests other than providing benefits (the commonality of interest test), and 3) whether the members of the group controlled the program (the control test).

First, the Final Rule changed the primary purpose test so that a group wishing to sponsor an AHP need only have a substantial business purpose in common (substantial business purpose is not defined in the Final Rule). This is significant because it means that a group with a primary purpose of selling insurance could satisfy the primary purpose test under the Final Rule, which was not previously permissible. "The problem with the [Final Rule's primary] purpose test," Judge Bates wrote, "is that it fails to set meaningful limits" on who can form a group offering an AHP. As such, it permits groups that may not necessarily "act 'in the interest of' employers," to sponsor AHPs, which was not what Congress intended.

Second, the Final Rule changed the commonality of interest test so that groups wishing to sponsor AHPs would satisfy the test if they were in the same line of business *or* in the same geographic location. Before the Final Rule, being in the same geographic location alone was not sufficient. Similar to his rejection of the modified primary purpose test, Judge Bates held the Final Rule's relaxation of the commonality of interest requirement was not in line with ERISA's intent to limit insurance provision to groups that had economic or reputational ties. It makes sense that Congress intended to require groups sponsoring AHPs to have some sort of common purpose and interest. As discussed above, AHPs have been prone to fraud and insolvency. If groups sponsoring AHPs consist only of people who have relationships and common goals, it is more likely they would sell quality products and hold each other accountable.

Finally, Judge Bates held that the control test in the Final Rule also failed precisely because it is ineffective where members may not have a commonality of interest. If a sponsoring group has divergent interests, it is less likely to control the AHP in a way that meets the needs of all AHP members.

Working Owners

The Final Rule also broadened the interpretation of "working owners." Previously, only employees employed by someone else were eligible for AHPs, but the Final Rule made working owners eligible to participate in AHPs. As a result, working owners could band together to offer AHPs to themselves. Judge Bates found that DOL's broad interpretation of working owners went beyond what Congress intended, which was to allow employers to provide people with whom they have working relationships – their employees – health insurance benefits. He further opined that DOL's "magic trick" is impermissible because both ERISA and the ACA require employees to be employed by another person. The Final Rule allowed an association of working owners, who have zero employees, to function as an association offering an AHP to more than 50 employees in the large group market. That, said Judge Bates, is "pure legerdemain" (it means, in a word, sketchy).

DOL has filed notice that it will appeal Judge Bates's decision.

The Role of States in Regulating AHPs

In addition to the legal challenge, states are taking their own action in anticipation of federal policies that promote AHPs. Many states adopted regulations against AHPs before the Final Rule, due to problems with AHP fraud and abuse. With the implementation of the Final Rule, states are expected to step up their efforts out of concern that new AHPs would create problems for consumers.

State AHP regulations tend to cluster in two areas: preventing plan insolvency due to fraud and abuse, and instituting consumer protections (See Table 1). Regulations that seek to prevent plan insolvency are those that focus on requirements such as licensing, registration, certification, financial reporting, and maintaining reserves. For example, in California, ERISA-covered AHPs that are self-insured must meet several requirements under the California Insurance Code (see section 742.24), including maintaining stop loss insurance, reserves, and surpluses. State regulations that institute consumer protections for AHPs include benefit standards, rating regulations, and market standards. For example, a California law passed after the Final Rule prevents working owners and small employers from forming AHPs, thereby preserving small group market standards.

However, states have approached AHP regulation with great care because AHP benefit plans are governed under ERISA, which generally preempts state regulation. While ERISA includes specific provisions that allow states to regulate some aspects of ERISA-covered AHPs, many states have been wary to test the limits of ERISA's very complex preemption scheme. State regulations that walk the fine line of preventing plan insolvency and instituting consumer protections, without raising ERISA preemption problems, may be the most reliable way to maintain stability in the insurance market. This is especially true given that it is unclear how the D.C. Court of Appeals will respond to Judge Bates's decision.

Taken together, state regulations, and the possibility of the court again striking down the Final Rule, will likely incentivize those planning to form AHPs to adhere to the old regulatory regime, or at least one that avoids the most significant concerns raised by AHPs. These incentives are an important source of stability in a federal

health policy landscape that is likely to remain uncertain under the current Administration.

Table 1: Examples of State AHP Regulations and Risk of ERISA Preemption[1]

State Action	Effect	Risk for Preemption	State
Require groups or associations to exist for an identified number of years before selling AHPs	Prevent plan insolvency	Low	NY, UT
Require a licensed insurer in the state to sell products to AHPs	Prevent plan insolvency	Low	PA
Require AHPs to have stop loss insurance, surpluses, and/or reinsurance	Prevent plan insolvency	Low	CA, VT
Require disclosure of financial information	Prevent plan insolvency	Low	VT
Prohibit self-funded AHPs	Prevent plan insolvency and consumer protection	Medium	PA, UT
Impose rating requirements	Consumer protection	Medium	VT, MA
Require fully insured AHPs to provide essential health benefits	Consumer protection	Medium	NY
Require groups of associations to have a primary purpose other than selling insurance	Prevent plan insolvency and consumer protection	Medium	NY, VT

Prohibit sole proprietors from operating in the large group market	Prevent plan insolvency and consumer protection	Medium	CA, NY

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[1] Current through December 1, 2018