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Key Employer Questions After Association Health Plan Ruling

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In *State of New York v. United States Department of Labor*, the District Court for the District of Columbia held that the U.S. Department of Labor's ("DOL") final regulations on association health plans ("AHPs") issued on June 21, 2018 (the "Final Rule") impermissibly expanded the definition of "employer" beyond what the Employee Retirement Income Security Act of 1974 ("ERISA") allowed, and effectively created a workaround intended to help small businesses and sole proprietors avoid many of the requirements of the Affordable Care Act ("ACA") applicable to health coverage available in small group and individual insurance markets.

Background

ERISA, the key statute at issue in the case, regulates employee benefit plans, including health and welfare plans, arising out of employment relationships. The ACA regulates health insurance markets more broadly, and among other things, subjects individual and small-group healthcare plans to stricter rules and coverage guidelines than apply to large employer-sponsored plans. ERISA's definitions of "employer" and "employee," which have not changed since ERISA was enacted back in 1974, are incorporated into the ACA's statutory scheme.

AHPs are group health plans that are offered through an association of employers, such as an industry group. Under longstanding prior DOL guidance, only "bona fide associations" that had certain employer-like characteristics could sponsor an AHP under ERISA, since ERISA focuses on employment-based arrangements.

Whether a bona fide association existed had traditionally been analyzed by the DOL based on three criteria: "(1) whether the group or association

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[was] a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits; (2) whether the employers share[d] some commonality and genuine organizational relationship unrelated to the provision of benefits; and (3) whether the employers that participate[d] in a benefit program, either directly or indirectly, exercise[d] control over the program, both in form and substance." The Court referred to these three criteria as the "requirements for purpose, commonality of interest, and control," respectively.

At the time of the ACA's passage, the majority of AHPs were not sponsored by associations that satisfied the bona fide association test, meaning that each employer that purchased coverage through an AHP had to separately satisfy the ACA's small group or individual market requirements—i.e., the AHP effectively just served as a mechanism for each employer to obtain benefits and administrative services for its own, separate plan. Very few associations satisfied the DOL's prior, more stringent criteria for bona fide associations; but in those instances, an AHP sponsored by such an association was treated as a single, ERISA-covered group health plan, in which the association was treated as the "employer" for purposes of the ACA, meaning that the total number of employees of all employer members could be used to determine whether the ACA's small group or large employer rules applied. This allowed AHPs sponsored by bona fide associations that satisfied the "large employer" threshold (by averaging 50 or more employees) to avoid some of the ACA's more stringent healthcare coverage rules, such as the requirement that plans in the small group and individual markets provide coverage of "essential health benefits" in ten categories.

Overview of the Final Rule

The Final Rule was promulgated in response to an Executive Order issued by President Trump in October 2017, which directed the DOL to expand access to AHPs by, among other things, expanding the criteria used to determine whether associations qualify as bona fide associations. The DOL did so in the Final Rule, by widening two of the three applicable criteria: the "commonality of interest" and "purpose" criteria.

Specifically, the Final Rule stated that associations could meet the "commonality of interest" criteria so long as their members were in the same trade or business or in the same geographic area (even if that area included multiple states), in a drastic change from the DOL's prior guidance, where geography on its own had not been enough to establish commonality. Similarly, under the Final Rule, an association could qualify as a bona fide association even if its primary purpose was to "offer and provide health coverage to its employer members and their employees," so long as it had "at least one substantial business purpose" unrelated to the delivery of health care, in stark contrast to the DOL's prior guidance, which required that associations be viable organizations on their own (i.e., without providing an AHP).

In addition, the Final Rule further expanded the availability of AHPs by treating working owners (i.e., self-employed individuals with no common-law employees) to qualify both as an "employer" for purposes of participating in the AHP and as an "employee" for purposes of qualifying for the group health coverage offered by the AHP, effectively allowing such individuals to enroll in an ERISA plan not subject to the ACA's requirements for the individual market.

District Court Decision

Eleven states and the District of Columbia (collectively, the "States") sued the DOL alleging that the Final Rule, and in particular the Final Rule's bona fide association and working owner provisions, conflicted with the text and purpose of both ERISA and the ACA, and exceeded the DOL's statutory authority. The DOL disagreed, arguing that because Congress granted the DOL statutory authority to interpret ERISA, its interpretation was reasonable and should be given deference by the Court.

The Court agreed with the States, holding that the DOL had failed to reasonably interpret ERISA, that the Final Rule exceeded the DOL's authority, and was therefore unlawful. The Court found that the Final Rule's expanded bona fide association criteria "failed to establish meaningful limits on the types of associations that may qualify to sponsor an ERISA plan, thereby violating Congress's intent that only an employer association acting 'in the interest of' its members falls within ERISA's scope."

The Court was clearly unpersuaded by the DOL's arguments, stating that the DOL had so greatly expanded the "purpose" criteria in the Final Rule that "virtually no association could fail to meet it," and that the geography standard set forth in the Final Rule "effectively eviscerates the genuine commonality of interest required by ERISA." The Court likewise found that the working owner provisions of the Final Rule unlawfully extended ERISA's coverage allowing working owners with no common-law employees to be protected by ERISA, "despite Congress's clear intent that ERISA cover benefits arising out of employment relationships."

The Court further reasoned that by stretching the definition of "employer" "beyond what [ERISA] can bear," the Final Rule "creates absurd results under the ACA," giving an example in which, under the Final Rule, 51 working owners could form an association and offer a "large employer" AHP to those working owners that would be exempt from the ACA's small group and individual market requirements.

The Final Rule contained a severability provision, pursuant to which a provision found entirely invalid shall be severable from, and not affect the remainder of, the Final Rule. Therefore, even though the Court vacated the Final Rule's bona fide association and working owner provisions, the Court remanded the Final Rule back to the DOL to determine how the Court's ruling will impact the other provisions of the Final Rule.

The DOL's Post-Decision Guidance

Not surprisingly, the DOL has already filed an appeal of the Court's decision to the federal appeals court. In addition, the DOL issued a statement on April 29, 2019, indicating that employers participating in existing AHPs can continue their coverage through the end of the plan year or, if later, the contract term. However, the DOL statement also makes clear that any coverage renewed after the current plan year for an employer member of an AHP will be required to comply with the relevant market requirements applicable for that employer's size (such as, for example, insurance sold to small employers, the essential health benefits requirements and premium rating rules). In subsequent FAQs issued by the DOL on May 13, 2019, the DOL further clarified that, while AHPs cannot market to or sign up new employer members while the appeal is pending, existing employer members may continue to enroll new employees in health coverage through an AHP while the enforcement relief remains in effect.

In the DOL's April 29, 2019 statement, the DOL indicated that it will not pursue enforcement action against affected parties for potential violations stemming from actions taken before the Court's ruling in reliance on the Final Rule, so long as the parties fulfill their contractual obligations under the terms of the applicable policies or plans. The DOL's April 29, 2019 statement also stated that the Department of Health and Human Services has advised the DOL that it will similarly not pursue enforcement of such plans for violations of the ACA caused by reliance on the Final Rule prior to the Court's decision through the end of the applicable plan year or contract term.

Takeaways for Employers

The aspect of the Final Rule that had not yet gone into effect as of the date of the Court's decision—i.e., the portion that would have allowed the formation of new self-insured AHPs beginning on April 1, 2019—is clearly delayed until the future of the Final Rule is determined. However, the impact of the Court's decision on existing AHPs formed in reliance on the provisions of the Final Rule which were specifically vacated by the Court was less clear, until the DOL's statement came out in late April.

AHPs covering thousands of participants have been formed since the Final Rule came out last summer. Based on the DOL's post-decision guidance, it appears that existing AHPs founded in reliance on the Final Rule may continue to operate while litigation continues, at least through the end of the plan year or, if later, the contract term. However, because the DOL has not yet asked for a stay of the Court's decision while the case is on appeal, the Court's decision is technically in effect; further, the DOL's post-decision guidance only provides enforcement relief for violations caused by actions taken before the Court's decision came out. As such, existing AHPs founded in reliance on the Final Rule should stop marketing and new enrollment efforts going forward, and their future remains uncertain.

As the DOL notes in its post-decision guidance, employers currently participating in existing AHPs should carefully consider their near-term coverage options, since changes to coverage (such as voluntarily dropping coverage through the AHP) could create gaps in coverage if the employer has to wait to obtain new coverage in the small group market.

June and July 2019 Filing and Notice Deadlines for Qualified Retirement and Health and Welfare Plans

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Employers and plan sponsors must comply with numerous filing and notice deadlines for their retirement and health and welfare plans. Failure to comply with these deadlines can result in costly penalties. To avoid such penalties, employers should remain informed with respect to the filing and notice deadlines associated with their plans.

The filing and notice deadline table below provides key filing and notice deadlines common to calendar year plans for June through July. If the due date falls on a Saturday, Sunday, or legal holiday, the due date is

usually delayed until the next business day. Please note that the deadlines will generally be different if your plan year is not the calendar year. Please also note that the table is not a complete list of all applicable filing and notice deadlines (including any available exceptions and/or extensions), just the most common ones. King & Spalding is happy to assist you with any questions you may have regarding compliance with the filing and notice requirements for your employee benefit plans.

Deadline	Item	Action	Affected Plans
June 30 (last day of 6th month following the plan year)	Excess Contributions	Deadline for plan administrator to distribute EACA excess contributions and earnings from the prior year to avoid 10% excise tax.	401(k) Plans with EACA
July 29 (no later than 210 days after the end of the plan year in which the change was effective)	Summary of Material Modifications	Deadline for plan administrator to distribute summary of material modifications reflecting any changes to the summary plan description (SPD) arising from any plan amendments adopted during prior year (unless a revised SPD is distributed that contains the modification).	Retirement Plans Health & Welfare Plans
July 31 (the last day of the 7th month following the plan year)	Form 5500	Deadline for plan administrator to file Form 5500 (Annual Return/Report of Employee Benefit Plan) for prior year. This deadline is extended 2 ½ months if the plan administrator files Form 5558.	Retirement Plans Health and Welfare Plans
	IRS Form 8955-SSA	Deadline for plan administrator to file Form 8955-SSA (Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits). This deadline is extended by 2 ½ months if the plan administrator files a Form 5558.	Retirement Plans
July 31	Patient Centered Outcomes Research Institute (PCORI) Fee	Deadline for self-insured health plans to pay a fee for 2018 plan year using IRS Form 720. Note that the fee is not tax deductible. Insurers are responsible for paying the fee on behalf of insured plans.	Self-Insured Group Health Plans (including retiree plans)