Question: Association Coverage: Is it Individual, Small Group or Large Group Coverage?

Most people have health coverage either through their employer (ERISA-covered group health plans), or by purchasing a plan directly from an insurer (individual plans). An alternative is to obtain coverage through a membership-based organization, like an association. This coverage is often issued through a group policy, with the organization or a trustee as the master policyholder, and is subject to state laws regulating group health insurance. This can be a source of confusion, because the phrase "group health insurance coverage" has an entirely different meaning under HIPAA and the ACA. For purposes of federal law, the distinction between "individual" and "group" coverage is not based on whether the contract is a group policy, but rather whether the coverage is issued in connection with a group health plan.[1] "Group health plan," in turn, means an employee benefit plan, as defined in ERISA, that provides medical care.[2]

Recent CMS guidance has resulted in reduction of health plans sold through associations. Since the passage of the ACA and the CMS guidance discussed below, some association plans have sought treatment as large group plans so that they can continue offering health coverage to their members. This is likely because large group plans do not have to comply with some of the more onerous requirements under the ACA that apply to individual policies and small groups, such as adjusted community rating, restrictions on actuarial value (the metal tiers) and the essential health benefit package, contained in Title XXVII of the Public Health Services (PHS) Act.

The status of association plans was addressed in a CMS Insurance Standards Bulletin (CMS Bulletin) published September 1, 2011. That bulletin stated that there is no distinct category of "association coverage" under the ACA. The CMS Bulletin explains: "Although the Affordable Care Act revised and added to Title XXVII of the Public Health Services (PHS) Act, it did not modify the underlying PHS Act framework for determining whether health insurance issued through associations was individual or group health insurance coverage." The Bulletin acknowledged that there are limited exceptions to certain provisions of the guaranteed issue and guaranteed renewability laws for coverage offered through "bona fide associations," but emphasized that "[t]he bona fide association concept has no other significance under the PHS Act, and, importantly, does not modify or affect the analysis of whether health insurance coverage belongs to the individual or group market."

What is Association Coverage?

Although there has been a reduction in association coverage as a result of ACA provisions eliminating its status as a separate market category, some insurers continue to offer it. The CMS Bulletin describes "health insurance coverage offered to collections of individuals or employers through entities that may be called associations, trusts, multiple employer welfare arrangements (MEWAs), or purchasing alliances." However, regardless of how it is structured, all such coverage is classified as either individual coverage, small group coverage or large group coverage, depending on whether it is sold to individuals and families, sold to small employers, or

[1] 42 U.S.C. §§ 300gg-91(b)(4). Some states make similar distinctions under state law. For example, in Maine, "individual health plans" include both individual policies and certificates under association, credit union, and discretionary group policies, except for coverage issued through an employer that is a member of an association or discretionary group. 24-A Me. Rev. Stat. §§ 2701(2)(C) & 2736-C(1)(C)

[2] 42 U.S.C. §§ 300gg-91(a)(1).

sold to large employers. Under the ACA, the "small group market" consists of coverage obtained "through a group health plan maintained by a small employer."[3] Just as the existence and size of the association group are irrelevant to whether the coverage is regulated as "individual" or "group" coverage, it is likewise irrelevant to whether employment-based coverage is "small group" or "large group" coverage. Small employer group law will be applied to those employer association members who meet the state definition of "small group." Health insurance coverage offered in connection with a group health plan is considered to be offered through the group market (45 CFR §144.103).

Individual Market Coverage

If health insurance coverage offered to an individual through an association is not offered in connection with a group health plan, it is defined in PHS Act section 2791(b)(5) and (e)(1)(A) as individual health insurance coverage being sold in the individual market. The ACA's "Health Insurance Market Rules; Rate Review" final rule (Market Rule final rule) provides: "Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage."[4] The individual members of the association are part of the individual market risk pool in the state and the carrier providing the association coverage must comply with individual market rating rules.

Group Market Coverage

Because the ACA has imposed more stringent requirements on individual and small group coverage, some association plans have sought treatment as large group plans so that they can continue offering health coverage without being subject to requirements such as adjusted community rating, restrictions on actuarial value (the metal tiers) and the essential health benefit package. In most situations where the coverage is offered to employer members of an association to provide coverage to their employees, the group health plan exists at the individual employer level.[5] In this case, the size of each employer determines whether the employer's coverage belongs to the individual,[6] small group[7] or large group market. The CMS guidance expressly states, "In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the "employer," the association coverage is considered a single group health plan. In that case, the number of employees

[3] 42 U.S.C. §§ 300gg-91(e)(5). Similarly, laws in some states expressly base eligibility for "small group" coverage on employer size rather than group size. *See, e.g.,* 24-A Me. Rev. Stat. §§ 2808-B(1)(D) & (H) (defining "eligible group" to include a "subgroup," defined as "an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract.")

[4] 45 CFR § 144.102(c).

[5] See CMS Bulletin http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf "CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level.

[6] Before the ACA, some states permitted self-employed individuals to obtain coverage as "groups of 1." However, although the ACA lowers the minimum small group size from 2 employees to 1, the owner of the business and the owner's spouse are not counted as "employees" for that purpose. Thus, an association of self-employed individuals would be considered "individual" coverage under the ACA, except with respect to those sole proprietor members who are providing coverage to at least one "outside" employee.

[7] As amended by the PACE Act, P.L. 114-60, the ACA defines a small employer as an employer with 1 to 50 employees, but gives states the option to raise the threshold to 100 employees. 42 U.S.C. §§ 300gg-91(e)(4) & (7); 18024(b)(2) & (3).

employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules."[8]

As a result of this guidance, states have taken different approaches to determining whether or not an association is acting as the employer and therefore can be considered a single large group health plan. If such a determination is made, it would appear to follow that the association as a single employer would have to be rated in the same manner as a single large employer plan, without discriminating between employees or groups of employees within the plan based on health status or claims experience.[9] Thus, just as a large employer's plan must be rated as a single risk pool rather than developing a separate experience rating for each office within the worksite, an association that is deemed to be a single employer should not be permitted to treat each employer member as a separate risk pool. The law remains unsettled on this point.

The CMS bulletin also discusses "mixed" associations:

> A "mixed" association exists where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member's circumstances. In this situation, the members of the association cannot be treated as if all of them belonged to same market. For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members. Accordingly, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.

Preemption

Title XXVII of the PHS Act provides that that "[Title XXVII] shall not be construed to supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage, except to the extent that such standard or requirements prevents the application of a requirement of this part." CMS, in a March 14, 2013 letter applied this preemption standard to legislation in Washington. The Washington legislation at issue deemed health plans provided through associations or member-governed groups to be large group health plans.[10] The effect of the legislation was to exempt association plans from the small group requirements under the PHS Act. CMS said that the law prevented the application of the federal law and was preempted.

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[8] For additional information on identifying the situations where an ERRISA plan exists at the association level, see (1) MEWA Guide (www.dol.gov/ebsa/Publications/mewas.html); (2) Adv. Op 2007-07A (www.dol.gov/ebsa/regs/aos/ao2008-07a.html); (3) Adv. Op. 2001-04A (www.dol.gov/ebsa/regs/aos/ao2001-04a.html); and (4) Adv. Op. 2003-13A (www.dol.gov/ebsa/regs/. aos/ao2003-13a.html).

[9] PHS Act § 2705 (42 U.S.C. § 300gg-4).

[10] House Bill 1700 and Senate Bill 5605.

In general, states are free to regulate insurance and the conduct of insurers; however, they cannot enact laws that exempt plans from the application of federal laws that would otherwise apply. Such laws prevent the application of federal laws and are preempted.