
Association Health Plans
"Time To See Them
From A Whole New View Point"
guidingposts
THE capstone GROUP
Another Capstone division making things simpler ™
Association Benefits Consultants

Mark J. Lamberth

- 42 years in the Health & Welfare industry
- Served employers of all sizes from Fortune 100 companies to 2 employee groups
- **20+ years in building & managing AHPs, MEWAs & Multi-Employer Plans (Labor)**
- **Successful record of building and growing Health Plans**
- Active in Industry Trade Groups (NAHU) and Lobbying efforts in DC & local
- Listed twice in the “Journal of Who’s Who of America’s Healthcare Executives”

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Driven by faith
to make things simpler™

Formed in 2005 to makes things simpler.

- Driven by our faith & welcoming ***everyone*** with open arms.
- Clients transferred from Principle Life

Privately held

- Corporate office in Indianapolis, IN
- Locations in Wake Forest, NC and Lexington, KY
- Industry experts

”…while practicing a staunch commitment to the belief in the right, ***that every human*** be treated with ***dignity…”***

guidingposts

Our Divisions

3 Operating Divisions:

Capstone Administrators, LLC

- Serving Associations for 3 decades
- AHP Clients in 3 states and expanding
- Offer a top technology benefit administration platform

Compliance Dashboard, LLC

- Proprietary H&W compliance tool
- Over 5,000 employers subscribed
- 70% of the major benefits consulting firms

Guiding Posts, LLC

- Consults with organizations interested in creating an AHP or MEWA
- Provides a “blueprint” to avoid compliance issues
- Assists Association growth and small employer competitiveness

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Agenda

- **AHP:** It's Not a New Solution!
- So what's the Excitement? A new pathway for AHPs
- Administration's Goal: Market Place equity for small employers
- **Why? Problem:** The Health Insurance Landscape
- The New DOL AHP Rule
- MEWA vs. AHP
- Comparing the AHP rules: Old vs. New
- **AHP Solutions Vary:** Be cautious of the compliance
- **Summary:** Value of selecting an AHP for your business

Learning Objectives

- **Learn What an Association Health Plan (AHP) Is**
  - DOL New Final Rule's impact & key dates
- **Understand the difference between AHPs & MEWAs**
  - How states might modify the Final Rule
- **Learn the Goals of the New Rule**
  - The Small Group Health Insurance Landscape
  - AHP Growth Potential
- **Describe how AHPs open a new Market for employers**
- **Identify the value of an AHP or MEWA**

What is an AHP?

Only a small part of the market

- **A Group health plan that employer groups and associations offer to provide health coverage for their members' employees.**
  - Small employers, through associations, gain regulatory & economic advantages available to large employers.

AHPs, MEWAs and other labels

AHP's may be called Trusts, Purchasing Alliances or Cooperatives

Compare to:

- MEWA (multiple employer welfare arrangement)
- Union Plans (Multi-employer Plans)
- PEOs (Professional Employer Organization) (co-employment arrangement)
- Captive Insurance
  - Shared risk corridors

AHPs Have Long Existed.
What's the Buzz?

- Newly published **AHP Final Rule from the DOL**
  - Allows for new options:
    - Provides **new pathway but** retains existing AHP pathway.
      - Continues to **allow Bona Fide Associations (BFA)**
    - AHP can now also form based on a **geographic test**.
      - Common state, city, county, or metropolitan area across state lines
      - Loosens **"commonality"**
    - **Working owners** without employees can join.
      - **Including sole proprietors**
      - **Limits rating use**

First: A Few Myths

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Myth1:
Health Insurance is Unregulated

Fact: Health insurance is one of the most regulated products and services in the market.

Regulated at the state level and federal level by:

- The States' Department of Insurance
- The States' Attorney General
- The Department of Labor and EBSA
- The Treasury Department and IRS
- The Health and Human Services and CMS
- Extensive Federal, State, and Labor Law, etc.

105 Years of Insurance Reform

1912
Teddy Roosevelt and his Progressive party endorse social insurance as part of their platform, including health insurance.

1929
Baylor Hospital introduces a pre-paid hospital insurance plan for a group of school teachers, which is considered the forerunner of future nonprofit Blue Cross plans.

1935
Social Security Act passed by Congress. The Act includes grants for Maternal and Child Health.

1939
Physicians start to organize the first Blue Shield plans to cover the costs of physician care.

1949
Supreme Court upholds National Labor Relations Board ruling that employee benefits can be included in collective bargaining.

1954
Revenue Act of 1954 excludes employers' contributions to employee's health plans from taxable income.

1960
Federal Employees Health Benefit Plan (FEHBP) initiated to provide health insurance coverage to federal workers.

1965
The Medicare and Medicaid programs are signed into law by President Johnson.

1974
Employee Retirement Income Security Act (ERISA) exempts self-insured employers from state health insurance regulations.

1986
COBRA (Consolidated Omnibus Budget Reconciliation Act) contains specific regulations that allow employees who lose their jobs to continue with their health plan.

1988
Medicare Catastrophic Coverage Act (MCCA) expands Medicare coverage to include prescription drugs and a cap on beneficiaries' out-of-pocket expenses. MCCA is repealed the following year, retracting these major provisions. However, the requirement that states pay Medicare premiums and cost-sharing amounts for poor beneficiaries through Medicaid is maintained.

1993
President Clinton's proposal, named the Health Security Act, is introduced in both houses of Congress in November, but gains little support.

1996
Health Insurance Portability and Accountability Act (HIPAA) restricts use of pre-existing conditions in health insurance coverage determinations, sets standards for medical records privacy, and establishes tax-favored treatment of long-term care insurance.

2003
Medicare legislation creates Health Savings Accounts which allow individuals to set aside pre-tax dollars to pay for current and future medical expenses. The plans must be used in conjunction with a high deductible health plan.

March 21, 2010
The House of Representatives passes the Senate bill, the Patient Protection and Affordable Care Act (voting 219-212) and sends it to the President for signature. House also passes the Health Care and Education Reconciliation Act of 2010 that amends the Senate bill to reflect House and Senate negotiations. The reconciliation bill is sent to the Senate for a final vote.

March 29, 2010
President Obama signs the ACA Reconciliation bill. The bill becomes an eight-year implementation of significant reform.

- **Myth2:**
  The Affordable Care Act – created more choices and made group health insurance more affordable

Fact: Since 2010 choice has dramatically shrunk for small employer and prices have significantly increased[1].

1. Peterson-Kaiser. Health System Tracker Issue Brief: Trends in Employer-Based Coverage. January 30, 2019

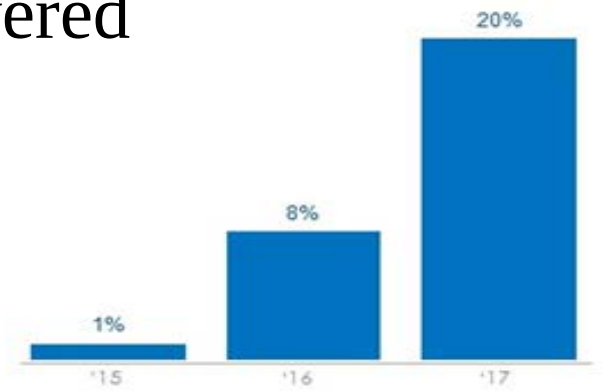
2017 Average Premium Increases

The Group VS. Non-Group Market 2017

NON-GROUP MARKET

Benchmark premium growth

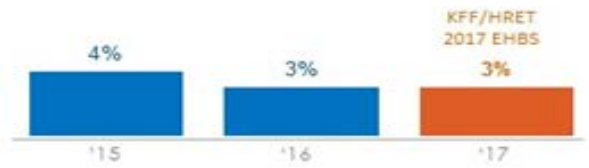
10 Million Covered



EMPLOYER PROVIDED COVERAGE

Increase in family coverage

151 Million Covered

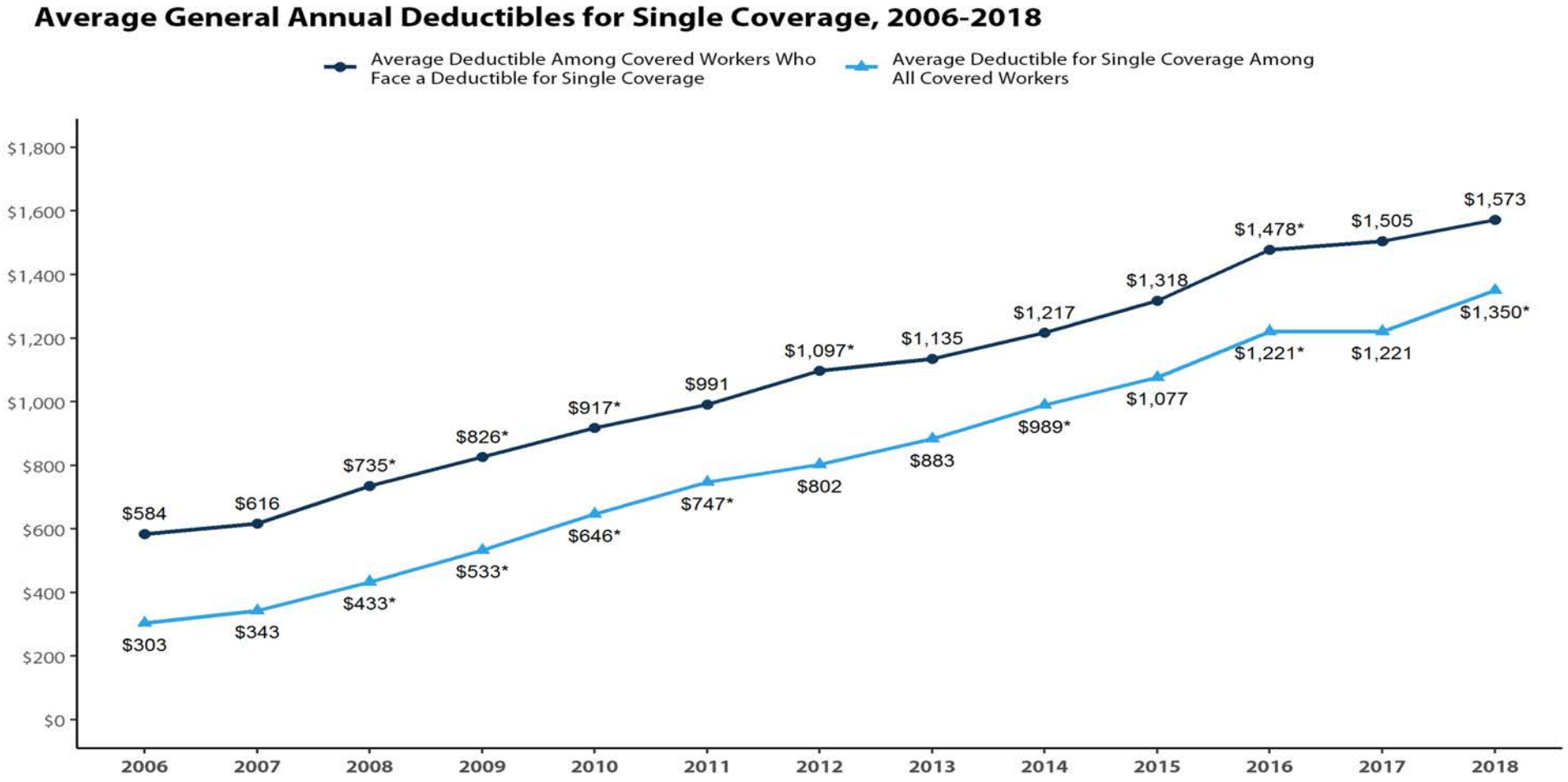


SOURCE: (1) Non-Group Market; 2014 – 2017 Marketplace Average Benchmark Premiums, Kaiser Family Foundation (2) Employee Provided Coverage; 2014, 2015, 2016, 2017 Employer Health Benefits Survey; Kaiser Family Foundation

* Kaiser Family Foundation.

Data: KFF Surveys : Non-Group Market 2014-2017 Marketplace Benchmark Premium; Employer Provided Coverage(2014, 2015, 2016 and 2017).

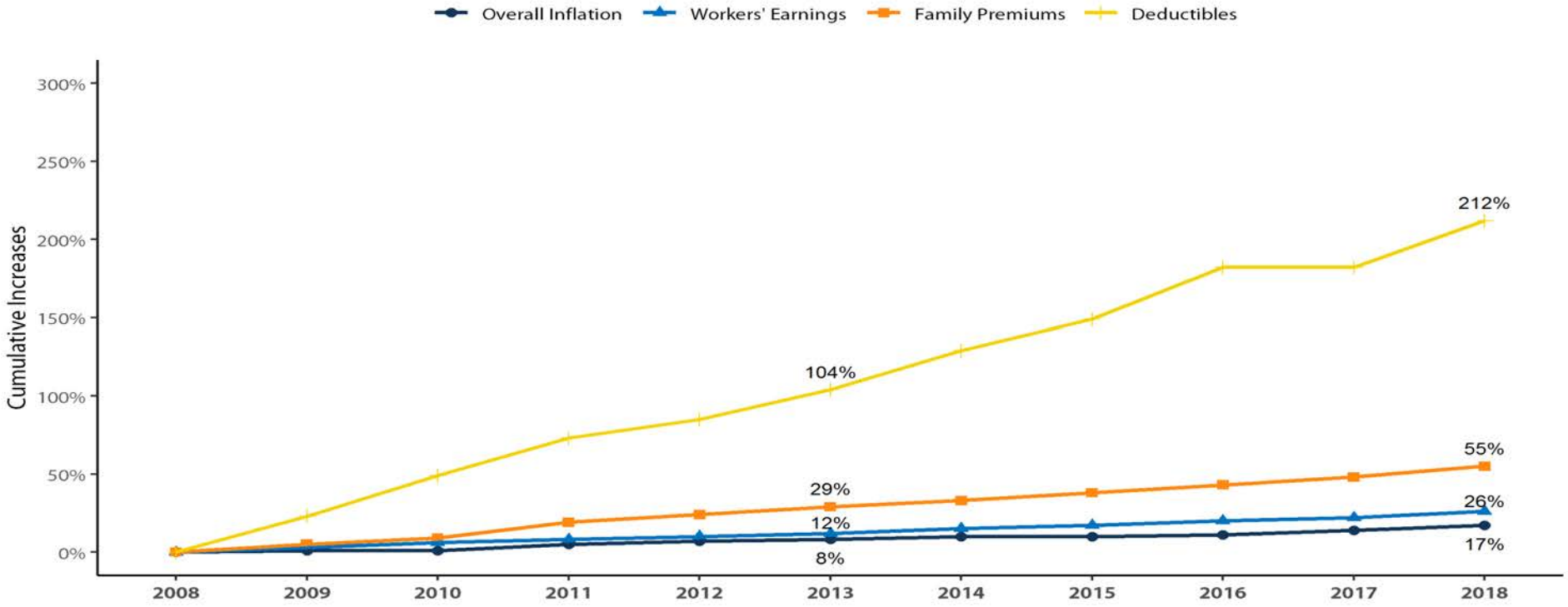
Deductibles continue to grow



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

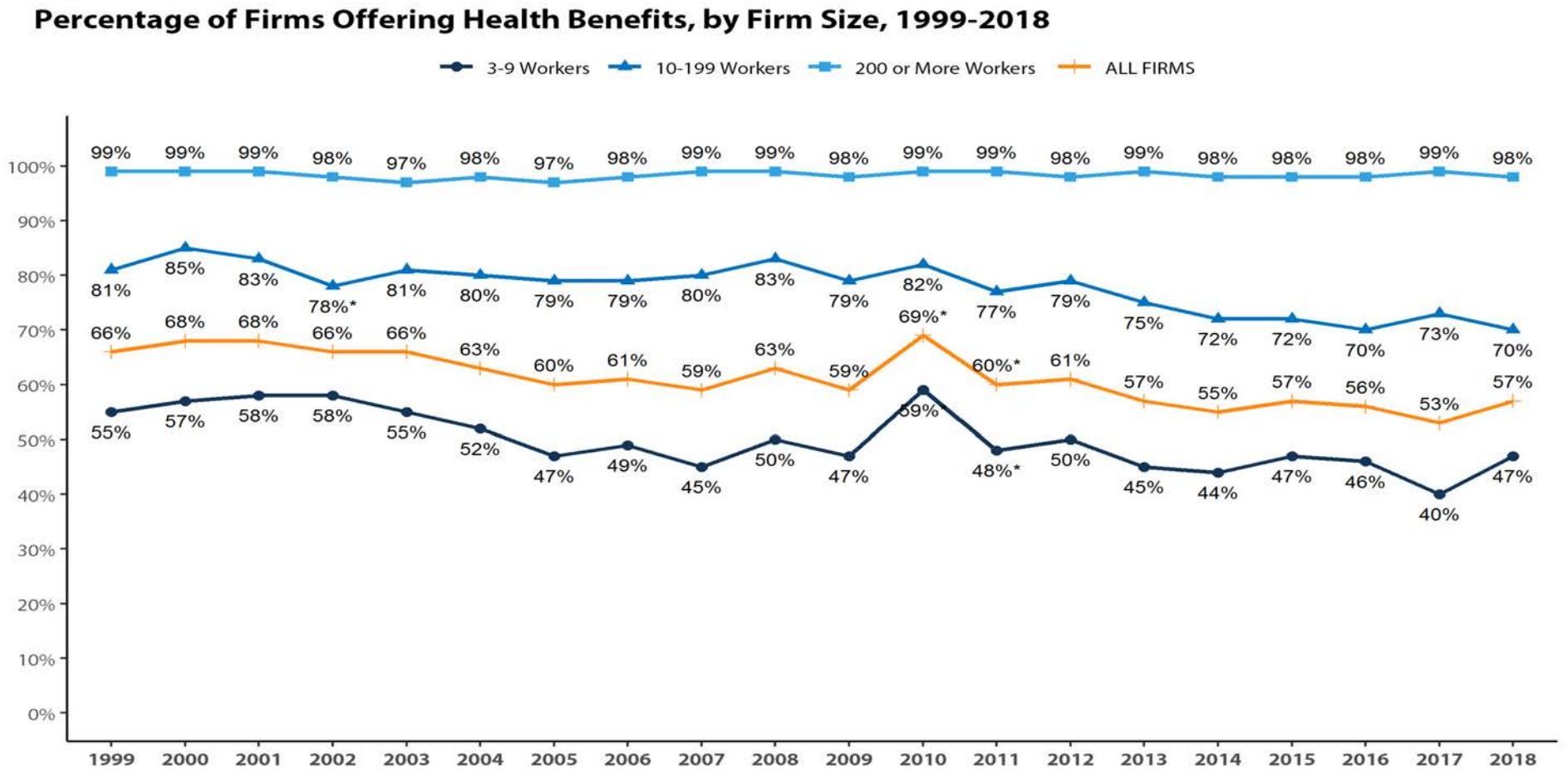
Premiums outpace Earnings

Cumulative Increases in Family Coverage Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2008-2018



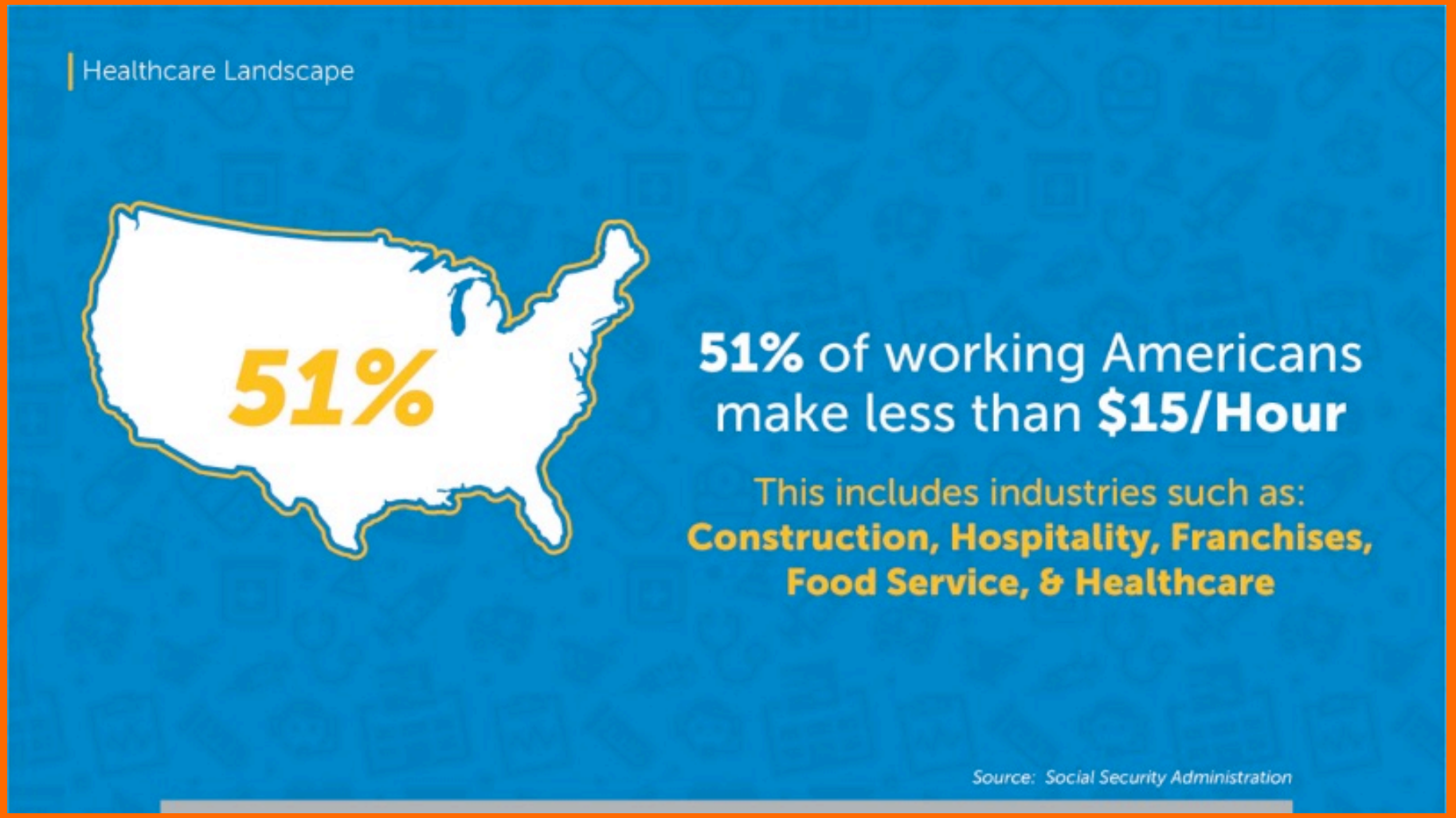
NOTE: Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2008-2018; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2008-2018 (April to April).

Covered by Private Health Insurance



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

American Worker Income: ~ $32,000



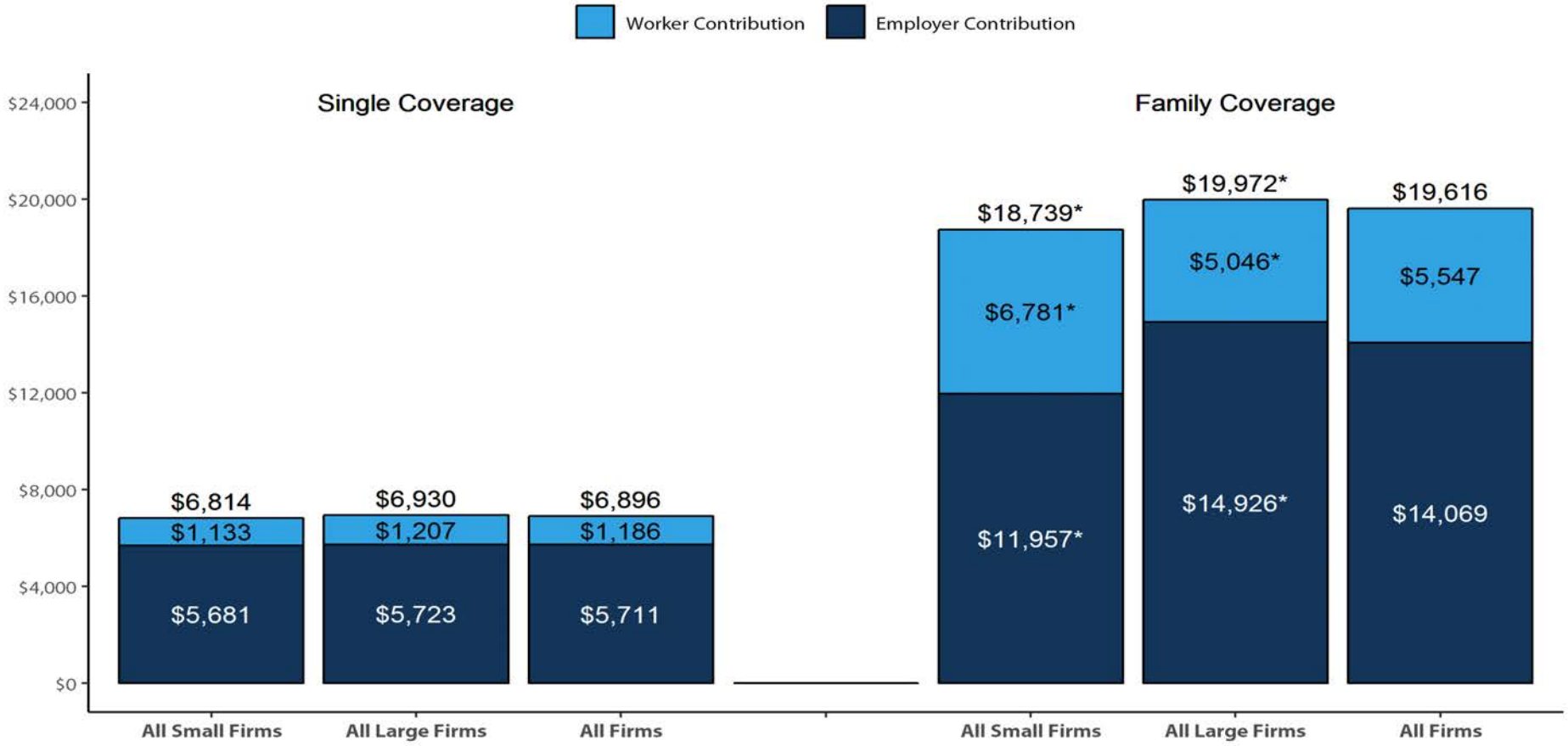
The Problem: Health Insurance Landscape

- **The escalating cost of Health Care outpaces all services**
- **Premiums continue to rise** at high rates
- Employers are **dropping coverage** or;
- Employers are **passing on greater shares** of the cost
  - Higher percentage of the premium
  - Larger copays, deductibles and out-of-pocket (required under ACA)
- **Economics don't work**
  - Average American worker earns $15/hour → $31,200/year
  - Average annual employer health insurance premium =

    $6,896 single; $19,616 family (KFF 2018 Empr. Survey)

Premium Contributions

Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Firm Size, 2018



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018

Why is this a problem?

- A robust economy
  - Unemployment is low, and
  - Workforce Participation is low
- Small and Medium employers struggle to:
  - Attract and Retain the best Talent
  - Benefits are a large part of compensation, and;
  - Health Insurance is critical for workers
- How can we compete with the large employer? What's the solution?

What actions has Congress and the current Administration taken?

What Led to the DOL Final Rule

- **Four Passed House Bills** in 2016 & 2017
- **Trump Executive Order:** 10/12/17
- **DOL Proposed Rule:** 01/05/18
  - 60-day comment period → >900 comments
- **DOL Final Rule:** 6/19/18
  - 60-day wait to be effective on 8/20/18

4 House Bills in 2016 -17

1

HR 1628
American Health Care Act – reconciliation of ACA

2

HR 1313
Preserving Employee Wellness Programs Act – defines and protects a “safe harbor”

3

HR 1304
Self-insurance Protection Act – exempts some Reinsurance from definition of “health insurance”

4

HR 1101
Small Business Fairness Act – expands definition of Association Health Plans, simplifies set-up and establishes new certification requirements

Trump's Executive Order 10/12/17

Three areas of concentration:

- **Association Health Plans (AHPs);**
- Short-term, limited-duration insurance (STLDI); and
- Health Reimbursement Arrangements (HRAs)

Goal: to promote competition by

- Expanding **access** to less expensive alternatives
- Increasing **competition** by lowering barriers to entry
- Creating more price/cost **transparency**

Executive Order Objectives

- Expand access to **less expensive alternatives**
- **Increase competition** by lowering barriers to entry
- Create more **price transparency**
- Give small employers access to **large group** market
- Allow **sole proprietors** and independent contractors to participate
- **Avoid market reforms/mandates** that make individual and small group coverage more costly

DOL Final Rule: Broad Outcomes

- **Modified** the Proposed Rule of 1/5/18 : looked at >900 comments
- **Expanded** the Prior Rules for AHPs
- **Staggered** Effective Dates – to allow state reactions
  - Beginning 9/1/2018 through 4/1/2019
- Didn't expand ERISA preemption – joint control
- Maintained dual regulation with states as the lead
- Now Subject to lawsuit by some states

What changed from the Proposed Rule

- **Clarified that pre-rule guidance is still law.**
- **Two tracks for AHP**/MEWAs
  - **Follow New AHP Final Rules –** limits underwriting/pricing
  - **Use Existing Rule (prior)** and presumably future rulings
- **Three types of AHP**/MEWAs
  - **Bona Fide** AHP (BFA) under pre-rule guidance (Plan Sponsor)
  - AHPs under final regulations **(new pathway)**
  - **Non-Plan Level MEWAs** under pre-rule guidance

What changed from the Proposed Rule

- Associations must **have at least one substantial business purpose** unrelated to providing health insurance
- Rules for qualifying **sole proprietors** for AHP coverage – new pathway
- **Clarifies:**
  - AHPs may discriminate against 1 or more individuals based on **non-health factors** (age, gender, industry, occupation, geography)
  - Open enrollment periods to limit adverse selection
  - AHPs under pre-rule guidance have more flexibility to discriminate in premium rating by individual employers
  - Wellness incentives allowed
  - Employer members must have control in form & substance

DOL Final Rule: Effective Dates

- **Important dates for AHP expansion under Final Rule:**
  - **All associations (new or existing)**
    - May establish a fully-insured AHP on **Sept. 1, 2018**
  - **Existing associations** that sponsored an AHP on or before the date the Final Rule was published:
    - May establish a self-funded AHP on **Jan. 1, 2019**
  - **All other associations (new or existing):**
    - May establish a self-funded AHP on **April 1, 2019**
      - While AHP rules are final at federal level, state activity is increasingly hostile.

DOL gives green light to AHP's

August 20, 2018
New Rule takes effect

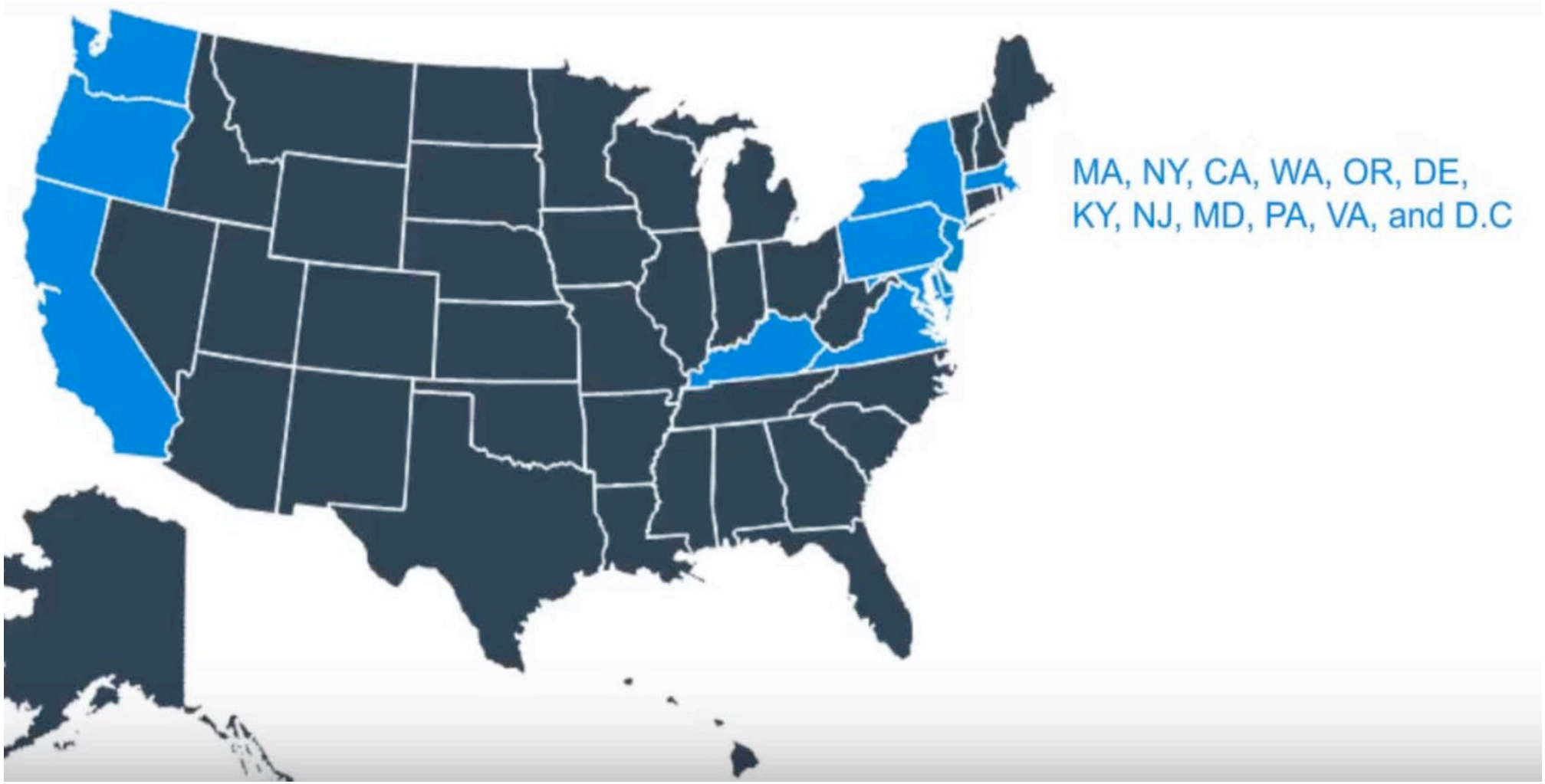
January 1, 2019
Existing associations that sponsor an AHP may establish a self-insured plan

September 1, 2018
Existing and new associations can start a fully-insured plan

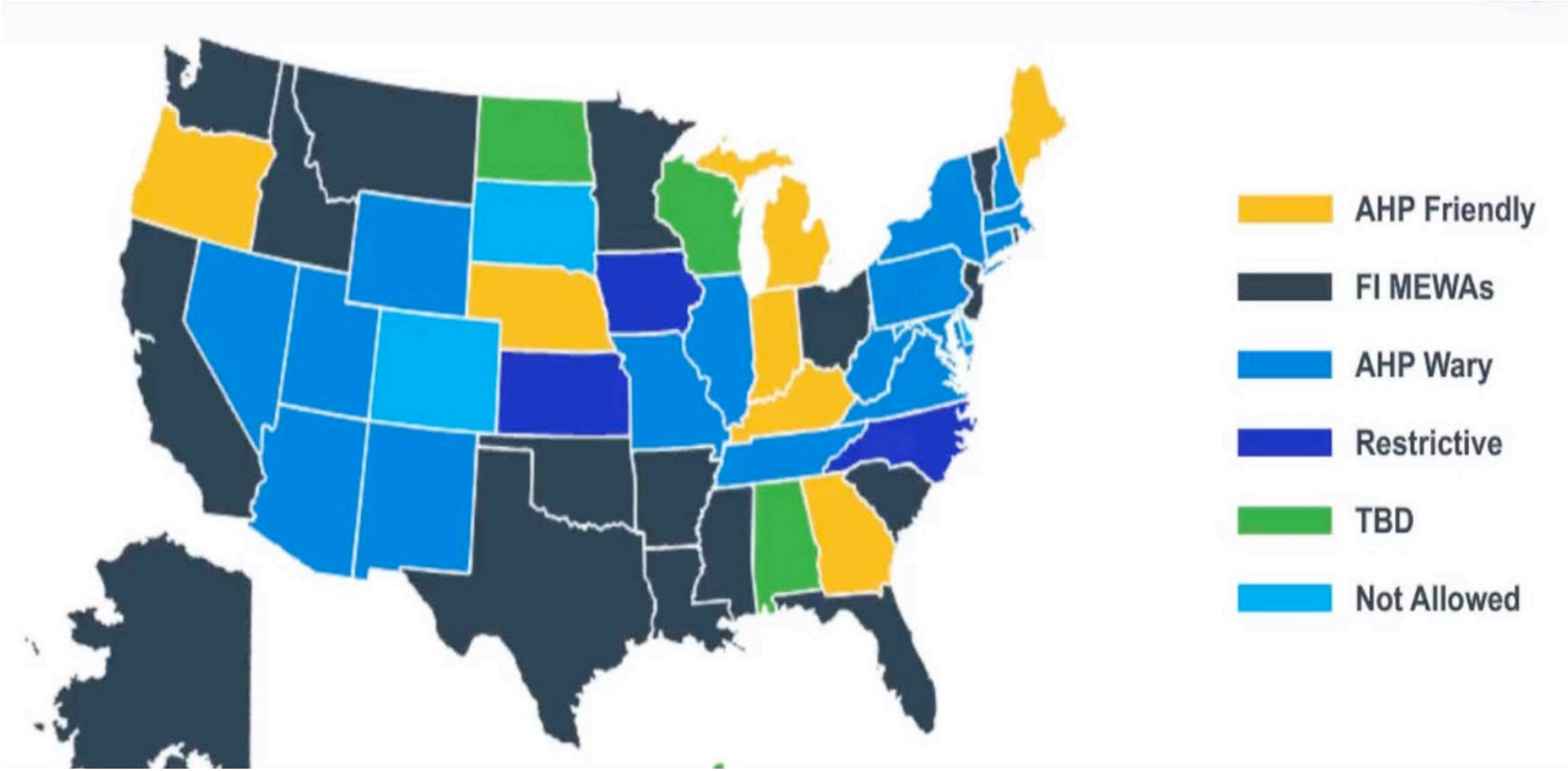
April 1, 2019
All other associations (new or existing) may establish a self-insured AHP

Ahh, But what about the States?

States Suing the DOL



Snapshot of State's General Attitude



Understanding Some Basics about MEWA's and AHP's
What are they?

Pre-Rule AHP/MEWAs: Issued by DOL Since 1985

Multiple Employer Welfare Arrangement (MEWA):

(1) An employee welfare benefit plan or **(2)** other arrangement that is established or maintained for the purpose of offering or providing medical or other welfare benefits **to employees of TWO OR MORE unrelated employers, including self-employed individuals**.

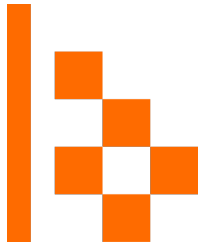
Unintentional MEWA

- (Un)related employers
- Independent Contractors

Intentional MEWA

- **Self-Funded Trade Association Plan**
- **Insured Trade Association Plan**
- **Self-Funded Commercial MEWA**
- **Insured Commercial MEWA**

Basics of a MEWA and AHP



- All MEWAs under **Pre-Rule Guidance** are Either a **“Plan”** or **“Non-Plan”** MEWA
  - ERISA applies to “employee benefit plans”
- To be an “employee benefit plan,” you need an **“employer” sponsor**.
- A MEWA can be one employee benefit plan sponsored by one employer (**a “Plan MEWA”**) – or; A MEWA can be multiple employee benefit plans sponsored by each employer in the MEWA (**“Non-Plan MEWA”**)
- **AHPs under the Final Rule** are generally treated as Plan MEWAs
  - Pre-Rule MEWAs apply to any welfare benefit program, **but AHPs under Final Rule are limited to health plans**
    - Ancillary benefits in an AHP are at the employer level for ERISA compliance as a Non-Plan MEWA

Basics of a MEWA: A Bona Fide AHP - Pre rule

- Group or Association of Employers as a “Single Employer” under ERISA
- DOL views only a very small # of MEWAs at the Plan-level and as sponsored by single employer: **3 general factors** in DOL & Court rulings:

1. “Bona fide” group or association of employers

- Not formed for purpose of obtaining insurance - pre-existing relationships
- Not treated the same as “association plans” for underwriting/HIPAA

2. Commonality of Interest

- How members solicited, purposes for which organization formed, who actually participates

3. Control

- Employer-members must have special status and control (in form and substance) over the MEWA

DOL Advisory opinion 2003-13A provides any MEWA covering a working owner with no common law employees cannot be a Plan-level MEWA.

AHP Final Rule: Collaboration Clarifies a Bona Fide Plan (BFA)

- **Qualifying AHPs** as Plan-level MEWAs (or BFA) will be **exempt** from the following PHSA requirements on a federal level as **large group coverage**:
  - Community rating
  - Premium rating restrictions of 3:1
  - Requirement to provide EHBs
  - Medical Loss Ratio requirements
  - Guaranteed issue/renewability
  - Single risk pool by issuer
  - Risk adjustment program

Look Through Policy
CMS Bulletin – 9/1/2011

Status as individual, large group, or small group for federal law is based on status as an **ERISA employer**. **If association is not a single employer**, must look through to the size of each participating group or individual for status. Mixed plan doesn't qualify.

PHSA is the abbreviation for the Public Health Service Act

AHP Final Rule: New Path - Who Qualifies and How?

AHP as a "Single Employer": Although new rules materially relax ERISA definition of "employer," it's still designed to exclude commercial enterprises and focuses on **employer status**:

- **Only employers** and their employees/dependents can participate (no size limit)
- AHP must have **formal structure** and organization
- **Employers must control** the AHP in form and substance
- Must be an employer association (not a membership organization such as AAA) and **cannot be an insurance carrier**
- Same trade or industry or **geographic restrictions** (commonality)
- Must have substantial business **purpose other than insurance**
- **Working owners** must show legitimate business (sole proprietors)
- Must not discriminate on **health factors** (claims data or health)

AHP Rule Comparison: Old vs. New

Element of AHP Rule	Apply Under Prior Guidance	Apply Under Final Rule
Application of State Law	Depends on whether plan is fully-insured	Depends on whether plan is fully-insured
Application of Small Market rules to AHPs with 50+ employees		
Must provide Essential Health Benefits	No, if the plan exists at the level of the AHP. Yes, if the plan does not exist at the AHP level.	No, if the plan exists at the level of the AHP. Yes, if the plan does not exist at the AHP level.
Risk Adjustment Program		
Single Risk Pool		
Underwriting only for age, location, family size & tobacco use		
Basis for Association		
Common Trade	Yes	No
Common State or SMSA	No	Yes
Bona Fide purpose for association other than provision of health insurance	Yes	Association must have at least 1 substantial business purpose unrelated to the provision of benefits. However, provision of benefits may be the primary purpose.
Application to Self-Insured AHPs	Applies	Applies

AHP Rule Comparison: Old vs. New

Element of AHP Rule	Apply Under Prior Guidance	Apply Under Final Rule
Structural Requirements	Yes	Yes
Coverage for Working Owners of a Trade or Business		
If working owner has common-law employees	May be covered	May be covered
If working owner has no common-law employees	May not be covered	May be covered
Working Owner Defined	N/A	Yes. Personal services, min. 20 hrs/wk or 80 hrs/mo or earned income at least equal to insurance cost. Assoc. may rely on employer representations.
Nondiscrimination Protections Related to a Health Factor		
Association membership	May not discriminate	May not discriminate
Health plan eligibility, premiums & benefits	May not discriminate among similarly situated individuals	May not discriminate among similarly situated individuals
Treatment of separate employers as distinct groups of similarly situated individuals	Permitted	Not permitted
Reporting Obligations	No change	No change

AHP Final Rule: News Flash!

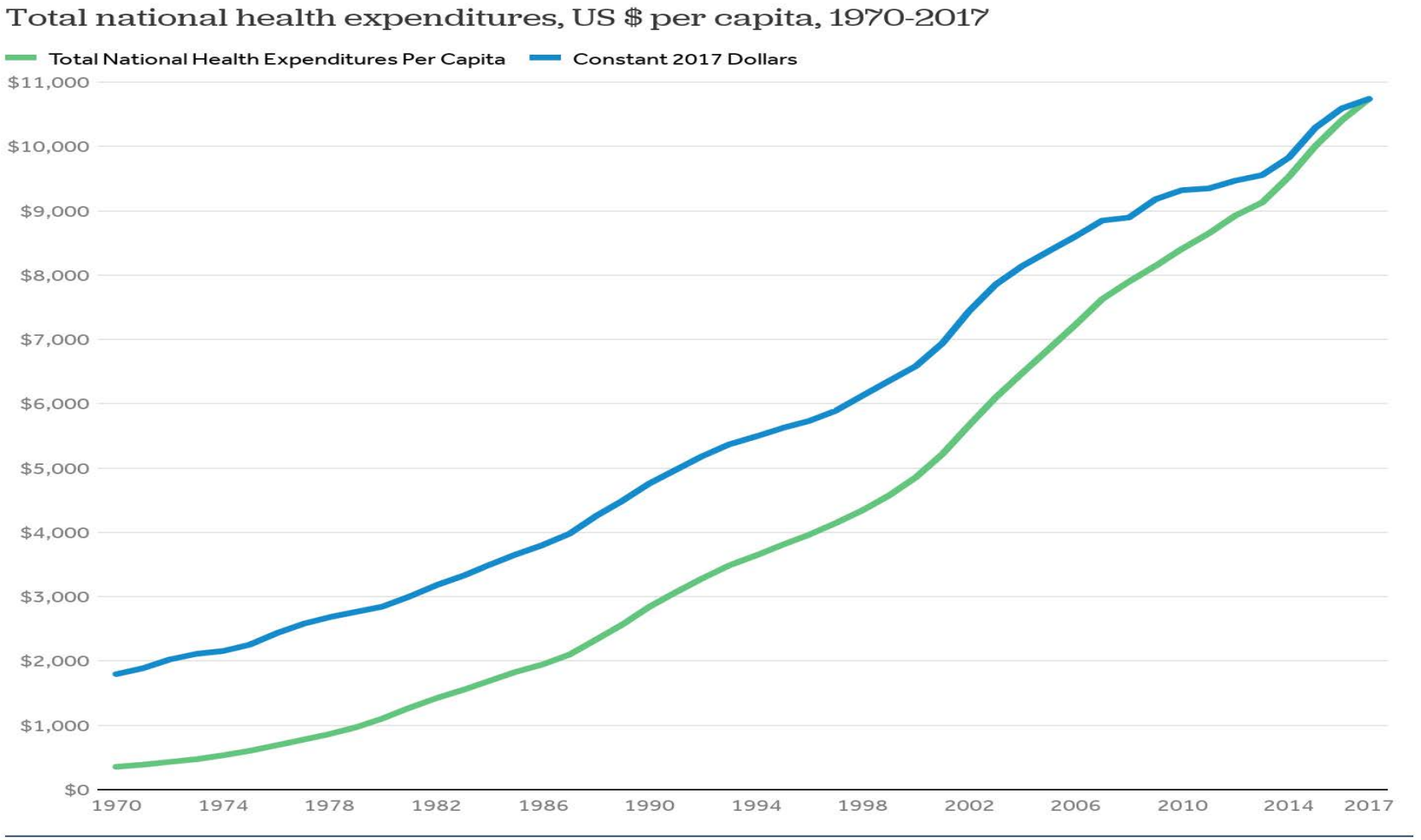
As a result of the suit by States against the DOL Rule:

- U.S. District Judge, John D. Bates Opined on March 28, 2019 that two provisions:
  - The DOL's relaxation of the Bona fide association definition; and,
  - The inclusion of a working owner as an employer
- Are unreasonable interpretations of ERISA and as such will be "set aside"
- The Rule includes a severability provision which allows these provisions to be removed without impact to the remaining provisions

- The DOL has responded, "We disagree with the District Court ruling, and will continue to fight for sole proprietors and small businesses".
- The DOL is evaluating all options with the DOJ

But our Health Insurance Affordability Problem Worsens Health Care vs. Insurance

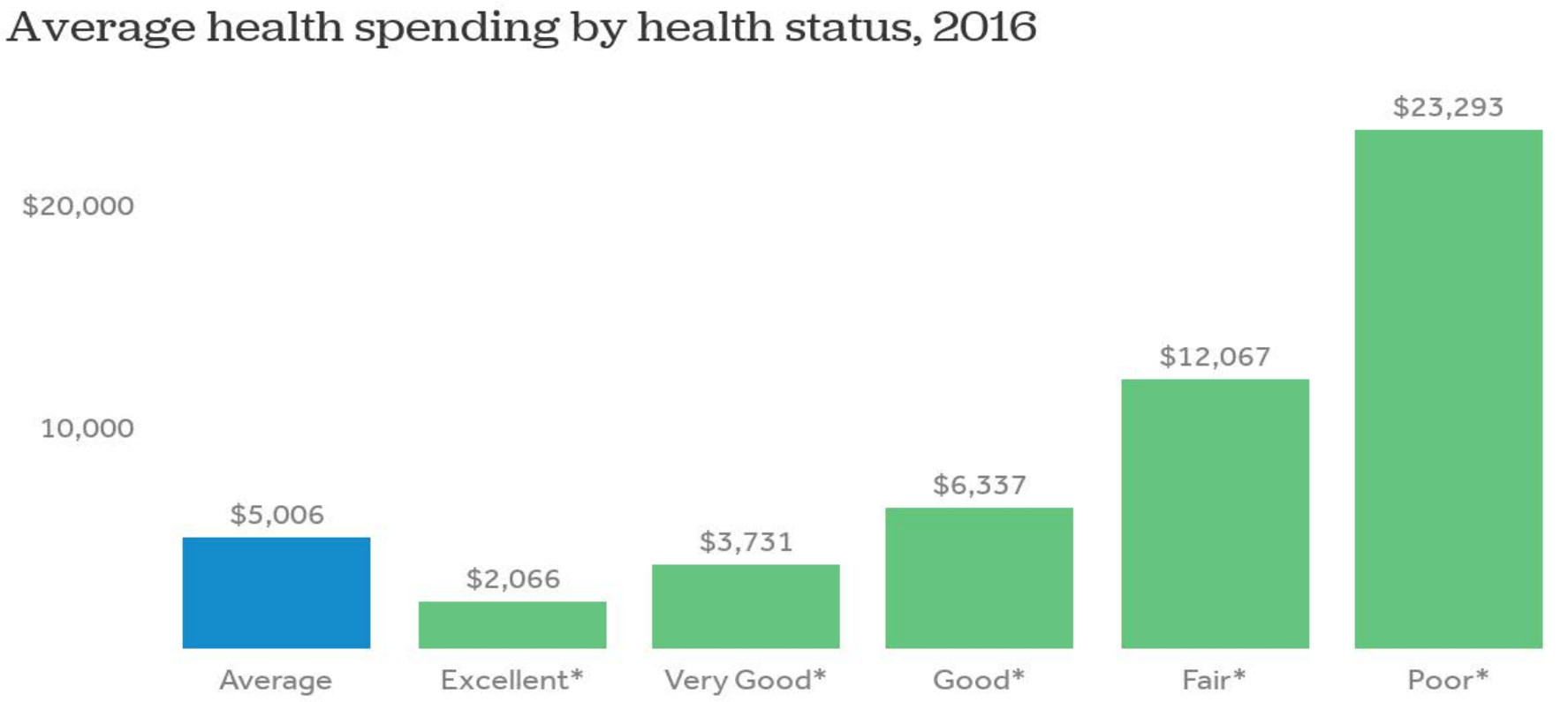
US Health Expenditures (not premiums)



Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

Peterson-Kaiser Health System Tracker

Health Care Spending by Status



*The average value of health status group is statistically significant from the population average (p<0.05).

Source: KFF analysis of Medical Expenditure Panel Survey • Get the data • PNG

Peterson-Kaiser Health System Tracker

Why AHP's are needed

- **15 million** Americans working for small business and their families lack access to health insurance coverage.
- **Less than 41%** of small businesses[1] offer health insurance to their employees.
- **4 million** Americans will join an AHP by 2023[2].

1. Data from the Kaiser Family Foundation 2016 annual employer study.

2. Estimates from the Congressional Budget Office (CBO).

Myth 3

Association Health Plans are poor value and create adverse selection.

Fact: They bring value to all; Choice and affordability

AHP Advantages for Small Employers

- **Federal Guidance:**
  - MEWAs and Associations since 1983
- **Key ACA Dividend:**
  - 2011 CMS Bulletin gave a prescript pathway out of costly small group requirements.
- **Purchasing Power improves:**
  - Administrative efficiencies
  - Volume membership – size leverages to lower cost
  - Treated like a “large group”

AHP's help the Association & Member

- **A collective force for growth:** Empowering associations to attract employers by pooling their benefits so that each of them can leverage the power of all
- **6 Primary Reasons**
  1. **Very competitive** employee benefit options: Price & design
  2. **Member Magnet:** Strong employer member benefit
  3. **Develops an Association non-dues revenue source**
  4. **Meets all compliance requirements**
  5. **Tailored** for each Association
     - Key administrative functions outsourced to trusted expertise
     - **Turnkey**
  6. **Simple for the employer and broker**
     - Consolidated billing and Trust services simplify administration

AHP/MEWA Structural Options

- **"Sponsor"** a plan: Must meet all guidance & requirements
  - Insured or alternative-funded
  - Can take longer to establish
  - Works best at the state level
- **"Endorse"** a plan: Fewer requirements, but be cautious
  - **Insured, self-funded, or captive**
  - Can go to market more quickly
  - State level or national

AHP/MEWA Funding Options

- Fully-insured: all risk taken by a Carrier
  - May use small group or large group products
  - May price individually (each employer) or collectively
- Self-insured or Partially insured: shared risk
  - May look like insured
  - Strong oversight at the State level
  - Rules can vary by State
- Captive Insurance: treated like insured
  - Has different requirements and guidance
  - Domiciled in U.S. or off-shore

AHP/MEWA: Success! Beware!

- Look closely and act carefully
- Many failures over the years
- Identify the type of Plan
- Investigate the partners/vendors
- Look at the longevity of the programs
- Understand your role and exposure
- Evaluate the proposals
- Be sure you have solid administration and compliance support

The Capstone 8

Our Faith Drives Us To:

It's Who We Are
It's How We Grow
It's How We'll Serve You
And It's How We Are Making Things Simpler

Thank You

If you would like to know more about how this new view of AHP's can serve your association or organization contact Mark Lamberth at mlamberth@guidingposts.com ; mlamberth@capstonebenefits.com ; or wecare@capstonebenefits.com