



Gregory  
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INSURANCE

## Federal Legislative Update – Employer’s Forum

**Presented by:**

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Vice President, Employee Benefits

September 11<sup>th</sup>, 2018



# Agenda



- Individual Mandate Penalty to be Eliminated in 2019
- Suspension of a three ACA-related taxes
- State of the Individual Market & ACA Marketplaces/Exchanges
- State of the Small Group Market (2-50)
- Association Health Plans

# Individual Mandate Penalty



- Several historical failed attempts to repeal and replace the ACA
- On December 22<sup>nd</sup>, 2017, President Trump signed into law the tax reform bill, called the Tax Cuts and Jobs Act, which made significant changes to the tax code
- Bill does not impact the majority of the ACA tax provisions, however, it does **reduce the ACA's individual shared responsibility (or individual mandate) penalty to zero, effective beginning in 2019**
- Individuals must comply with mandate (or pay a penalty) for 2017 and 2018
- Employer shared responsibility (pay or play) rules and related Section 6055 and 6056 reporting requirements are still in place



# Suspension of three ACA-related taxes



- Lawmakers in the Senate and the House struck a deal on a continuing resolution this past January that helped prevent an impending government shutdown
- As part of that resolution, three ACA-related taxes were addressed:
  - **Medical Device Tax:** 2.3% excise tax levied on the sale of medical devices
    - Two year delay of the tax expired on December 31, 2017, and the continuing resolution reestablishes that delay through December 31, 2019
  - **Cadillac Tax:** 40% excise tax levied on health insurance plans if their value is above a certain threshold, and is designed to tax high-end employer-sponsored health plans.
    - Tax has never been implemented and is now delayed until January 1, 2022
  - **Health Insurance Tax:** Annual fee on certain for-profit health insurers based on their market share and the value of their business.
    - Previous legislation suspended the tax for 2017, but will be in effect for calendar year 2018 and is estimated to generate \$14.8 billion.
    - Continuing resolution suspends this tax for 2019
    - Should positively impact the fully insured individual and group market – 2.5%-3% of premium cost

Source: <https://taxfoundation.org/affordable-care-act-taxes-delayed/>

# State of Individual Market - Nationally



- Remains highly volatile – insurer participation is biggest issue
- In 2017, insurance company losses led to a number of high profile exits from the market – Ex. Anthem, UHC
- Avg. number of exchange/marketplace insurers per state is 3.5
  - Only one insurer in eight states: Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina and Wyoming
  - New York has the most at twelve insurers
  - There were no counties nationwide without at least one insurer in 2018
- In 2018, national costs for a individual silver level plan, prior to a tax credit ranges anywhere from \$311/month to north of \$600/month

*Source: <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/>*

# State of Individual Market - Nationally



## Insurer Participation on ACA Marketplaces, 2014-2018

Year

2014

Number of Insurers

One

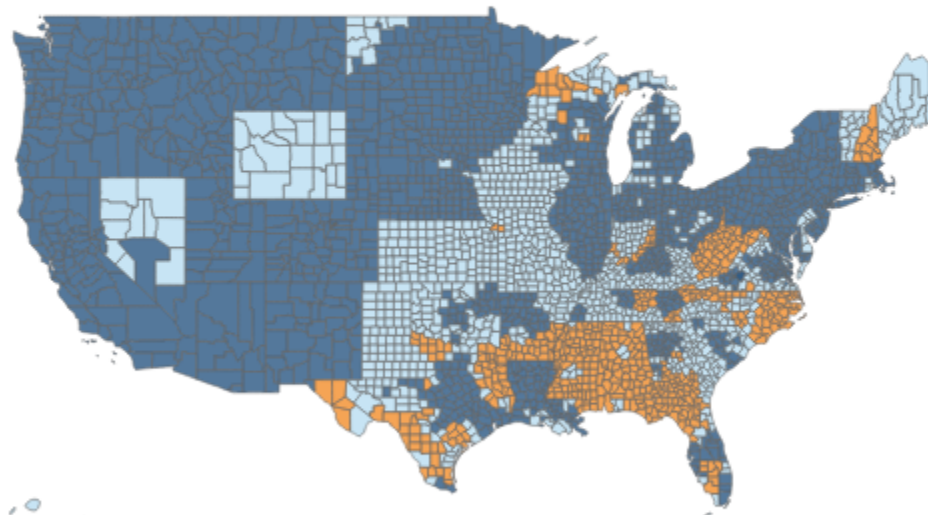
Two

Three or more

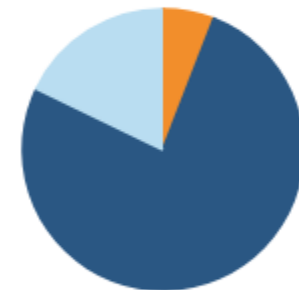
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Percent of Enrollees



# State of Individual Market - Nationally



## Insurer Participation on ACA Marketplaces, 2014-2018

Year

2018

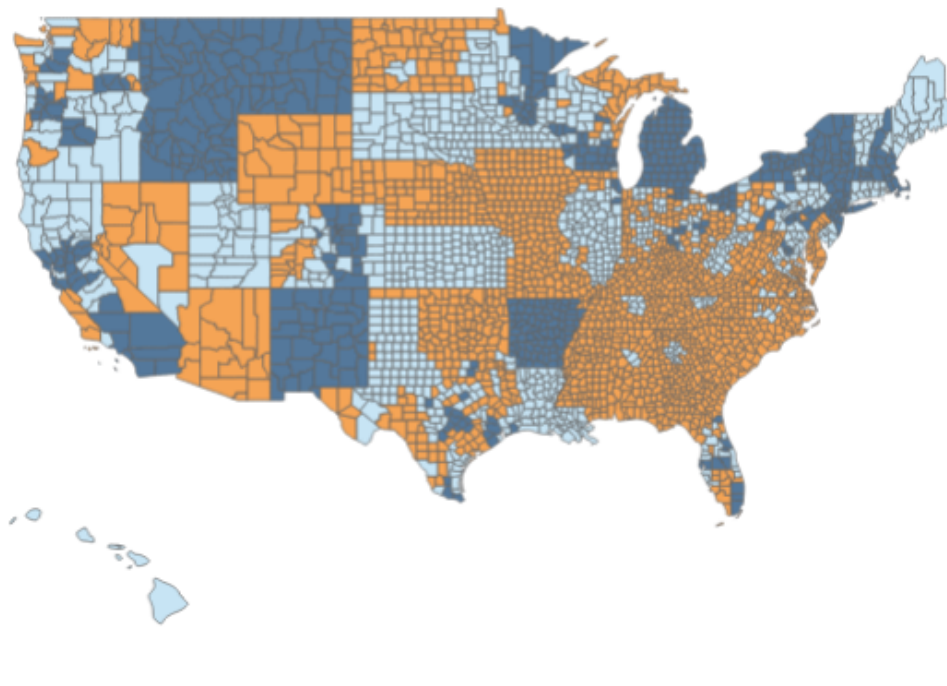
Number of Insurers

- One
- Two
- Three or more

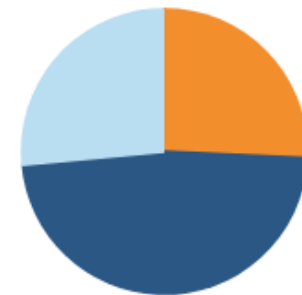
Select State

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Highlight Insur...



Percent of Enrollees



# State of Individual Market - Nationally

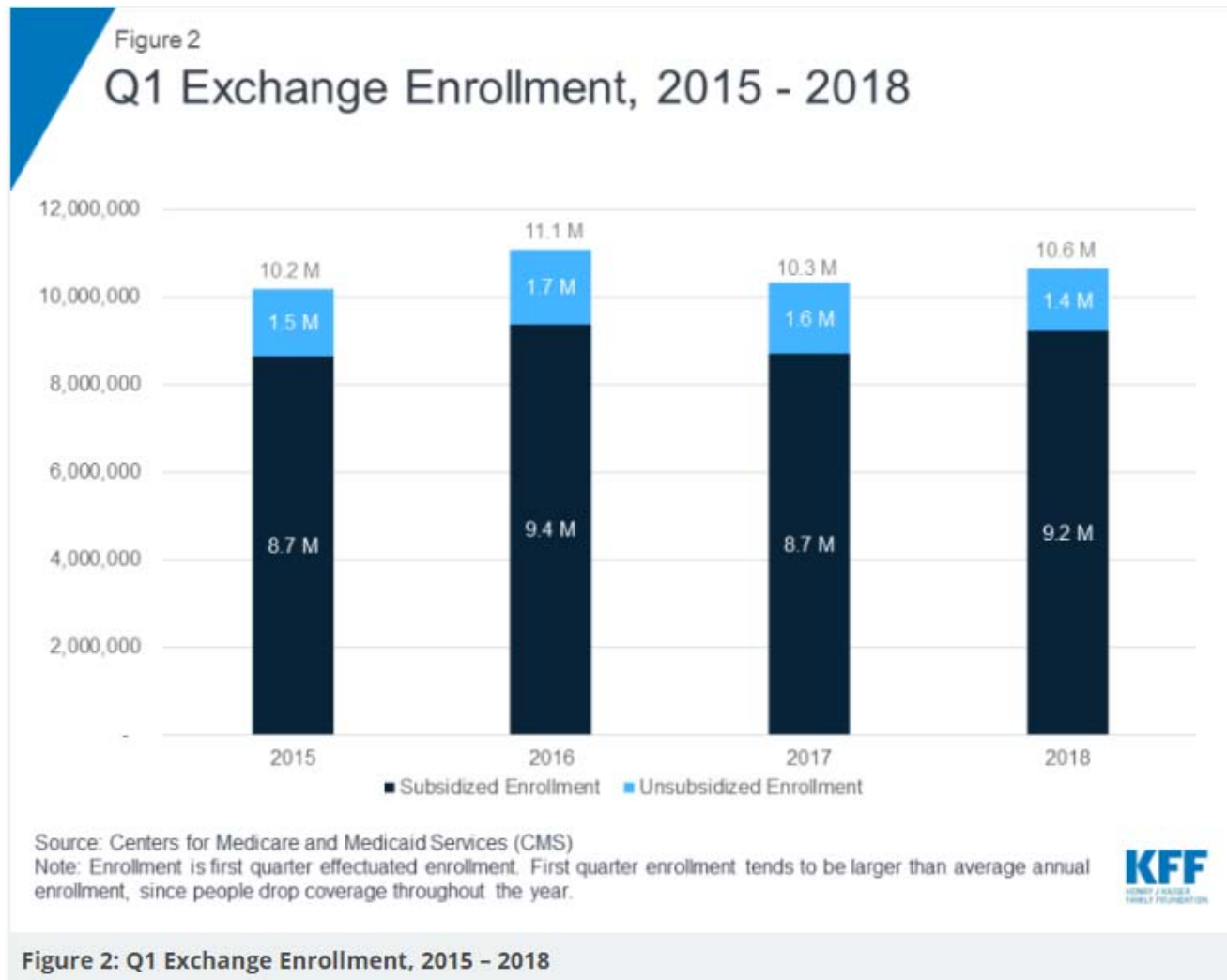


Figure 2: Q1 Exchange Enrollment, 2015 - 2018



# State of Individual Market - Indiana



- 166,711 enrolled in coverage for open enrollment 2018
  - By February 2018, effectuated open enrollment was at 142,270
- Proposed overall average rate increase for 2019 Indiana individual marketplace is 5.1%
- IN DOI anticipates that all 92 counties in Indiana will be covered by one or more insurers
- Two ACA Exchange/Marketplace Insurers left in Indiana (8 at its peak – 2015)
  - Caresource:
    - Covering 79 counties & approx. 76,000 members
    - 10.2% avg. rate increase for 2019; \$540.15/month/avg. before APTC
  - Ambetter from MHS:
    - Covering all 92 counties & approx. 66,000 members
    - -0.5% avg. rate increase for 2019; \$479/month/avg. before APTC
- Anthem has filed an off-marketplace, catastrophic plan in a rural area of the state (Benton, Jasper, Newton, Warren and White Counties) – just a few participants

Source: <https://www.in.gov/doi/files/Indiana%202019%20ACA%20Filings.pdf>

Additional Source: <https://www.healthinsurance.org/indiana-state-health-insurance-exchange/#enrollment>

## State of Small Group Market (2-50 ee's)



- Seems to be alive, well and thriving in Indiana – multiple carrier options and plan designs available
- Top carriers offering small group, fully-insured, community-rated plans: Anthem, UHC, IU Health Plans and Physicians Health Plan (PHP)
- Small group, fully-insured, community-rated plans and pricing for 01/01/2019 were filed with state DOI back in the Winter/Spring
- Approvals aren't back yet, but anticipated to be in the next 60 days
- Pending DOI approval, should have plans and pricing by October 1<sup>st</sup> for a January 1, 2019 effective date
- There are a substantial amount of transitional or "grandmothered" plans still in place – medically underwritten and do not have to comply with all of the ACA's essential health benefit requirements
  - A fourth extension was issued in April 2018, allowing grandmothered plans to renew until as late as October 1, 2019, as long as they terminate by the end of 2019
- Variety of alternative funding options available for smaller employers

# DOL's Final Rule on Association Health Plans (AHPs)



- On June 21<sup>st</sup>, 2018, the Department of Labor (DOL) published a final rule that expands the ability of employers to join together to form an Association Health Plan (AHP).
  - This was in response to an executive order by President Trump directing federal agencies to expand the availability of AHPs back in October, 2017
- Why?
  - Goal of the administration was to provide small business owners, employees of small businesses and family members of working owners/employees more coverage options, more affordable pricing, enhanced ability to self-insure, less regulatory burden and complexity, and reduced administrative costs
  - Congressional Budget Office estimates that 4 million Americans, including 400,000 who otherwise would lack insurance, will join an AHP by 2023

Source: NAHU Webinar – August 2018

# DOL's Final Rule on Association Health Plans (AHPs)



## KEY POINTS:

- Participating in an AHP does not cause a small employer to become subject to the ACA's employer shared responsibility rules
- An AHP is a group health plan and a multiple employer welfare arrangement (MEWA) that is subject to ERISA's requirements
- New final rule does not diminish state oversight and the states have the authority to regulate MEWA's
  - States can regulate health insurers and the health insurance policies sold to AHPs, and they can regulate self-insured AHPs to the extent the regulation is consistent with ERISA.
  - Some states may be more favorable than others...

Source: NAHU Webinar – August 2018

# DOL's Final Rule on Association Health Plans (AHPs)



## Old Rules vs. New Rules:

- Any AHPs currently operating are grandfathered
- May be possible for a new AHP that has not yet been formed to choose its own pathway – Existing Rules or New Rules
  - More clarity needed but existing rules may be more viable due to more ideal non-discrimination rules
- New rules offer more flexibility in its bona fide criteria for association health plans

# Qualifications Criteria for Bona Fide Associations



1. May exist, in whole or in part, for the purpose of sponsoring a group health plan, however, it must also have at least **one substantial business purpose** unrelated to the offering and providing of health insurance or another employee benefit;
2. Each participating employer member is a person acting directly as an **employer of at least one employee** who is a participant covered under the plan;
3. The group or association has a **formal organizational structure with a governing body and has by-laws** or other similar indications of formality;
4. Functions and activities are **controlled by its employer members** and participating health plan members control the plan;
5. The employer members have a **commonality of interest**;
6. It **limits participation to only** of member's current and former employees and their beneficiaries;
7. Health coverage offered **complies with the nondiscrimination provisions**; and
8. The group or association is **not a health insurance issuer** or owned or controlled by such a health insurance issuer.

Source: NAHU Webinar – August 2018

# Commonality of Interest Definition



1. Employers being in the same trade, industry, line of business or profession;  
or

2. Employers having a principal place of business in a region that does not exceed the boundaries of the same State or the same metropolitan area (even if the metropolitan area includes more than one State).

# AHP – Nondiscrimination Definition



1. The group or association must not condition employer membership in the group or association on any health factor of any individual who is or may become eligible to participate in the group health plan sponsored by the group or association.
2. The group health plan sponsored by the group or association must discriminate with respect to eligibility for benefits, subject to paragraph (d)(4) of this section.
3. The group health plan sponsored by the group or association must not discriminate with regard to premiums or contributions, subject to paragraph (d)(4) of this section.
4. In applying the nondiscrimination provisions of paragraphs (d)(2) and (3) of this section, the group or association may not treat the employees of different employer members of the group or association as distinct groups of similarly-situated individuals based on a health factor of one or more individuals



# DOL's Final Rule on Association Health Plans (AHPs)



## IMPORTANT DATES:

- September 1<sup>st</sup>, 2018: Final rule applies to fully insured AHPs
- January 1<sup>st</sup>, 2019: Final rule applies to existing self-insured AHPs
- April 1<sup>st</sup>, 2019: Final rule applies to new self-insured AHPs

# AHP – Nondiscrimination Examples



## Example 1:

- Association A offers group health coverage to all members.
- According to the bylaws of Association A, membership is subject to the following criteria: all members must be restaurants located in a specified area.
- Restaurant B, which is located within the specified area, has several employees with large health claims.
- Restaurant B applies for membership in Association A, and is denied membership based on the claims experience of its employees

**FAIL**

# AHP – Nondiscrimination Examples



Example 2:

- Association C offers group health coverage to all members.
- According to the bylaws of Association C, membership is subject to the following criteria: all members must have a principal place of business in a specified metropolitan area.
- Individual D is a sole proprietor whose principal place of business is within the specified area.
- As part of the membership application process, Individual D provides certain health information to Association C.
- After learning that Individual D has diabetes, based on D's diabetes, Association C denies Individual D's membership application.

**FAIL**

# AHP – Nondiscrimination Examples



## Example 3:

- Association G sponsors a group health plan, available to all employers doing business in Town H.
- Association G charges Business I more for premiums than it charges other members because Business I employs several individuals with chronic illnesses.

**FAIL**

# AHP – Final Rule Clarifications



Are the new AHPs considered MEWAs?

- All AHPs will be considered MEWAs (Multiple Employer Welfare Arrangements) under the final rule
- All MEWAs must file Form M-1, regardless of plan size or funding type
- All AHPs under the final rule will be required to file Form 5500, regardless of plan size or funding type

How does being a MEWA effect the AHP?

- MEWAs are regulated by their state
- While large group health plans are governed by federal law, namely the Employee Retirement Income Security Act (ERISA), and not subject to most state laws, the fact that an AHP is a MEWA makes them subject to state law, regardless of size
- State coverage mandates and certain consumer protections, like the establishment of funding reserves and other risk management mechanisms, apply to MEWAs
- Some states may be more favorable than others

Do states have any other authority over the new AHPs?

- State insurance departments will have regulatory authority
- There is nothing prohibiting states from enforcing existing regulations or creating new regulations that limit or prohibit these types of plans or establish additional requirements to run AHPs in their state

# AHP – Final Rule Clarifications



If a new AHP forms under the new rule, meets all the criteria, and uses the state as their commonality of interest, can the AHP charge different premiums to different member groups?

- All similarly situated groups must be treated the same
- AHPs may not use a health factor to define a similarly situated group
- AHPs may use non-health-related factors to define groups of similarly situated groups, e.g. occupation, SIC code/industry classification, zip code or county, etc.

Can an AHP charge different premiums to different classes within a given employer member?

- Different premiums may be charged to different employees of a given employer member as long as they are not based on a health factor
- Premiums based on an employment classification that exists within the business for purposes other than the health plan and that are not based on a health factor are permissible, e.g. different rates for full-time employees vs part-time employees

Are individuals eligible to participate in the AHP plan?

- Employees and beneficiaries of a participating employer are eligible for coverage
- Working owners may be considered an employee and eligible for participation if they satisfy the requirements for “working owners” under the rule
- Independent contractors may be eligible if they satisfy the definition of a working owner and are otherwise considered part of the eligible class

*Source: NAHU Webinar – August 2018*

# AHP – Final Rule Clarifications



## Biggest Opportunities:

- Greater options for employers with no common law employees
- Rectifies lack of carrier choice in the individual marketplace
- Fewer uninsured
- Potential new carriers in the marketplace
- New plan options other than metal tier plans
- Less restrictive networks
- No EHB restrictions – tailor plans to participant needs
- Composite vs. age-banded rates

## Biggest Challenges:

- Current or future regulation may prohibit or deter formation of AHPs (discrimination rules)
- State mandates – based on State of issue
- Multiple States and Cities have files suit with the Administration over AHP regulations already, more expected
- Network Issues
- Licensing
- Complexity



## Questions and Thank You

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