



## News Release

# U.S. DEPARTMENT OF LABOR STATEMENT RELATING TO THE U.S. DISTRICT COURT RULING IN STATE OF NEW YORK V. UNITED STATES DEPARTMENT OF LABOR

**WASHINGTON, DC** - The U.S. Department of Labor today released a policy statement regarding Association Health Plans (AHPs). The Department disagrees with the district court's ruling in *The State of New York v. United States Department of Labor*. The U.S. Department of Justice filed an appeal on April 26, 2019.

As set forth below, for an interim period of time, the Department will not pursue enforcement actions against parties for potential violations stemming from actions taken before the district court's decision in good faith reliance on the AHP rule's validity, as long as parties meet their responsibilities to association members and their participants and beneficiaries to pay health benefit claims as promised. Nor will the Department take action against existing AHPs for continuing to provide benefits to members who enrolled in good faith reliance on the AHP rule's validity before the district court's order, through the remainder of the applicable plan year or contract term.

The statement from the Department of Labor's Employee Benefits Security Administration (EBSA) can be read [here](#).

On March 28, 2019, in *State of New York v. United States Department of Labor*, the United States District Court for the District of Columbia vacated portions of the Department's final rule on Association Health Plans (AHPs). The AHP rule, which the Department published on June 21, 2018, established a new test as an alternative to that described in prior Department sub-regulatory guidance for determining who can sponsor an ERISA-covered AHP as an "employer." The AHP rule was intended to expand access to affordable, high-quality healthcare options, particularly for employees of small employers. The Department disagrees with the district court's ruling and, on April 26, 2019 the Department of Justice filed a notice of appeal. The policy reflected in this Statement will remain in effect for existing AHPs until their current plan year or contract term expires.

The Department recognizes that many businesses and employees have obtained health coverage from AHPs in reliance on the final rule before the district court ruling. Many of these businesses and employees have advised the Department that they are concerned that their health coverage must terminate, which will cause significant disruption. For example, new coverage would impose new deductibles and out-of-pocket maximums without giving credit for prior participant out-of-pocket expenses paid. Moreover, switching insurance can cause gaps in coverage, leaving individuals without much needed benefits for chronic diseases and emergency care until the new insurance becomes effective.

The Department is committed to taking all appropriate action within its legal authority to minimize undue consequences on employees and their families. Employers participating in insured AHPs can generally maintain that coverage through the end of the plan year or, if later, the contract term. This means their employees generally can keep their coverage in force. The Department of Health and Human Services (HHS) has advised the Department that employer members of an insured AHP have an independent right under the guaranteed renewability provision of the Public Health Service Act (PHS Act) to continue insurance coverage (including maintaining all out-of-pocket accumulators for employees and their families) through the end of the applicable plan year, unless an exception applies. That is, if an AHP purchased a large group insurance policy, then the insurer must generally continue the coverage in force for each participating employer and its covered employees at that employer's option through the end of the plan year. At the end of the plan year, the issuer would only be able to renew the

coverage for an employer member of an AHP formed pursuant to the Department's final rule if the coverage complies with the relevant market requirements for that employer's size (such as, for insurance sold to small employers, the essential health benefits requirements and premium rating rules). An insurer can satisfy the requirement to continue the coverage in force by continuing coverage for each employer-member of the association that chooses to continue coverage, either through the master policy with the association or through separate contracts with each employer-member on an outside-the-association basis.

Despite this ability to keep insurance policies in force, plans, health insurance issuers, plan fiduciaries, employers, and service providers, as well as participants and beneficiaries, may encounter a wide variety of other compliance-related issues and concerns as a result of the ruling. Accordingly, the Department will work with affected parties, HHS, and the States to mitigate any disruptions or hardships that result from confusion regarding the status of the AHP rule and legal compliance requirements. The focus of the Department's efforts will be on ensuring that participants and beneficiaries get their health benefits claims paid as promised, and on reducing the risk of adverse consequences to affected employer associations, and their employer members, that relied in good faith on the rule.

Moreover, for this interim period, the Department will not pursue enforcement actions against parties for potential violations stemming from actions taken before the district court's decision in good faith reliance on the AHP rule's validity, as long as parties meet their responsibilities to association members and their participants and beneficiaries to pay health benefit claims as promised. Nor will the Department take action against existing AHPs for continuing to provide benefits to members who enrolled in good faith reliance on the AHP rule's validity before the district court's order, through the remainder of the applicable plan year or contract term that was in force at the time of the district court's decision.

Finally, HHS has advised the Department that HHS will not pursue enforcement against nonfederal governmental plans or health insurance issuers for potential violations of title XXVII of the PHS Act caused by actions taken before the district court's decision in good faith reliance on the rule's validity, through the remainder of the applicable plan year or contract term that was in force at the time of the district court's decision. HHS has also advised the Department that HHS will not consider States to not be substantially enforcing the applicable requirements under title XXVII of the PHS Act in cases where the State adopts a similar approach with respect to health insurance coverage issued within the State.

It is important for employers to carefully consider their near-term coverage options. If a small employer or sole proprietor voluntarily drops coverage offered by or through the association, the employer or sole proprietor may have to wait to obtain new coverage in the small group or individual market, as applicable, which can create gaps in coverage.

The Department is interested in learning about any problems that AHPs and their member employers and sole proprietors may encounter after the district court's decision. To request information or assistance, members of the public may contact EBSA at [askebsa.dol.gov](http://askebsa.dol.gov) or toll free at [1-866-444-3272](tel:1-866-444-3272). The Department of Labor will update its website at <https://www.dol.gov/agencies/ebsa> as more information becomes available.

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