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

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 of Labor's (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.[1] 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).[2] 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

[1] PHS Act section 2703, as enacted by the Patient Protection and Affordable Care Act (PPACA), and PHS Act sections 2712 and 2742, as enacted by the Health Insurance Portability and Accountability Act (HIPAA).
[2] 45 CFR 147.106(h)(1).

through the master policy with the association or through separate contracts with each employer-member on an outside-the-association basis.[3]

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.[4]

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[3] This approach implements the PPACA in a manner that is generally consistent with the approach to guaranteed renewability under HIPAA. *See, e.g.*, CMS Insurance Standards Bulletin 02-03, available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/hipaa_02_03_508.pdf, and CMS Insurance Standards Bulletin 02-05, available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/hipaa_02_05_508.pdf.

[4] While there is generally year-round enrollment in the group market, small employers that cannot meet an issuer's minimum participation or contribution rules, as allowed under applicable state law, may be restricted to an annual enrollment period from November 15 to December 15, with coverage effective January 1. For working owners considering switching to individual market coverage, the annual open enrollment period is November 1 to December 15, with coverage effective January 1, unless an individual qualifies to enroll through a special enrollment period. Short-term, limited duration insurance coverage may allow some individuals to bridge these gaps.

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 the Employee Benefits Security Administration at askebsa.dol.gov or toll free at 1-866-444-3272. The Department of Labor will update its website at https://www.dol.gov/agencies/ebsa as more information becomes available.