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BULLETIN NO. 18-13

TO: **ALL HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, HEALTH INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS, DENTAL SERVICE CORPORATIONS, DENTAL PLAN ORGANIZATIONS, ORGANIZED DELIVERY SYSTEMS, BROKERS, MULTIPLE EMPLOYER WELFARE ARRANGEMENTS, THIRD PARTY ADMINISTRATORS, AND OTHER INTERESTED PARTIES**

FROM: **MARLENE CARIDE, COMMISSIONER**

RE: **ASSOCIATION HEALTH PLANS**

The recent federal rulemaking, as discussed below, does not preempt New Jersey law as it relates to the regulatory oversight of MEWAs, regardless of whether the MEWA is fully-insured, partially-insured, or self-funded.

The purpose of this Bulletin is to advise carriers, brokers, and other interested parties that the recent federal rulemaking related to association health plans ("AHPs"), as discussed below, does not modify or preempt New Jersey's existing regulatory authority and oversight regarding Multiple Employer Welfare Arrangements ("MEWAs").[1] Therefore, an AHP purporting to operate, expand, or otherwise market in New Jersey pursuant to recent federal rule changes can do so only if it fully complies with all relevant New Jersey laws.

On June 21, 2018, the United States Department of Labor ("USDOL") adopted "Definition of 'Employer' Under Section 3(5) of ERISA--Association Health Plans," 83 Fed. Reg. § 28912 (June 21, 2018) (to be codified at 29 C.F.R. § 2510) ("Final Rule"), which modifies the definition of "employer" under the Employee Retirement Income Security Act, Pub. Law 93-406, 88 Stat. 829 (Sept. 2, 1974) ("ERISA"), regarding entities—such as associations—that could sponsor group health coverage. Under the Final Rule, an association may be formed for the sole purpose of offering an association health plan to its members, provided that the association maintains a commonality of interest. The Final Rule makes it easier for association-sponsored MEWAs that

[1] "AHPs are one type of MEWA, and they are single ERISA-covered plans." 83 Fed. Reg. at 28919, n. 18.

offer group health coverage to be treated as a single "employer" for purposes of ERISA, permitting same to be regulated under federal law as large-group coverage. The Final Rule also establishes criteria for allowing sole proprietors and other business owners who do not have employees to qualify as employers for purposes of participating in an AHP.

The new federal rule has raised questions as to whether the USDOL's adoption of an additional "pathway" for MEWAs alters New Jersey's regulatory authority with respect to MEWAs when formed as an AHP. The Department of Banking and Insurance ("Department") hereby advises carriers, brokers, and other interested parties that the Final Rule explicitly states that it does not displace the traditional oversight and regulatory authority that states have over AHPs/MEWAs and does not modify or limit existing state authority under ERISA. Specifically, the Final Rule states that it "does not modify or otherwise limit existing State authority as established under section 514 of ERISA." See 83. Fed. Reg. at 28936. The USDOL notes that, like any MEWA, when an AHP is fully insured, State laws that regulate specific contribution and reserve levels, and enforcement thereof, may apply, and state insurance laws are generally saved from preemption with respect to health coverage that is purchased by an AHP from a carrier, which will provide benefits. Moreover, the USDOL states that when an AHP is not fully insured, any State law regulating insurance may apply to the AHP to the extent that it is not inconsistent with ERISA, similar to any other MEWA. Therefore, the Final Rule does not preempt New Jersey law as it relates to the regulatory oversight of MEWAs, regardless of whether the MEWA is fully-insured, partially-insured, or self-funded.[2]

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[2] The Final Rule strongly suggests that the USDOL will not interfere with any state rules that limit the formation of AHPs and expects states to prevail in court challenges on such issues. Specifically, the Final Rule states that "[t]he provisions in ERISA section 514 are clear and well established, and both the [USDOL]'s interpretations and federal court rulings generally have upheld such State laws when they have been challenged as preempted by ERISA." 83 Fed. Reg. at 28937. Moreover, the Final Rule acknowledges that while

> ERISA section 514(b)(6)(B) provides that the [USDOL] may prescribe regulations under which non-fully-insured MEWAs that are employee benefit plans may be granted exemptions, individually or by class, from certain State insurance regulations[,] ERISA section 514(b)(6)(B) does not . . . give the [USDOL] unlimited exemption authority. Significantly, ERISA section 514(b)(6)(B) does not give the [USDOL] any authority to exempt any fully-insured AHP from any state insurance laws that can apply to a fully-insured MEWA plan under ERISA section 514(b)(6)(A). Furthermore, section 514(b)(6)(B) does not allow the [USDOL] to exempt self-insured AHPs from state insurance laws that can be applied to fully-insured AHPs, *i.e.*, laws related to reserve and contribution requirements that must be met in order for the fully-insured MEWA plan to be considered able to pay benefits in full when due, and provisions to enforce such standards. Notwithstanding these limitations, ERISA section 514(b)(6) provides a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by

New Jersey law is clear that the health benefits plans offered by MEWAs must comply with New Jersey's insurance laws, including the Individual Health Coverage ("IHC") Program Act ("IHC Act"), N.J.S.A. 17B:27A-2 to -16, and the Small Employer Health Benefits ("SEH") Program Act, N.J.S.A. 17B:27A-17 to -56 ("SEH Act"). As defined in the IHC Act, "Individual health benefits plan" includes "a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract if the eligible person pays the premium. . . ." N.J.S.A. 17B:27A-2. Since the premium for association plans is typically fully paid by the member, the result of this definition is to require that association plans, even when issued outside of New Jersey, comply with the New Jersey IHC Act. The policy or contract must be one of the standard plans, comply with an 80 percent minimum loss ratio requirement, be modified community rated with a 3:1 rate band, and not be medically underwritten. Additionally, N.J.S.A. 17B:27A-19(j)(1) provides that health benefits plans that are issued to small employers through associations, multiple employer associations, or out-of-state trusts, regardless of the situs of delivery of the health benefits plan, must comply with the guarantee issue, standard plan, guarantee renewal, participation, and rating and minimum loss ratio requirements of the SEH Act. Essentially, the IHC Act requires that carriers provide individual health benefits plans, established by the IHC Program Board, to those individuals who are paying the premium for the plan, and the SEH Act requires that carriers issue only small for employer health benefits, established by the SEH Program Board, when an employer participating in the MEWA has 50 or fewer employees. The standard plans provide comprehensive health benefits coverage, including unlimited coverage for services such as maternity, mental illness and substance use disorder, and prescription drugs. Fully-insured MEWAs are subject to the rating requirements as set forth in the Federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152.

Additionally, in New Jersey, MEWAs that choose to self-fund are subject to specific regulation in accordance with N.J.S.A. 17B:27C-1 to -12, and the rules promulgated thereunder, as set forth in N.J.A.C. 11:4-56. Specifically, N.J.S.A. 17B:27C-1 to -12, and N.J.A.C. 11:4-56 establish various standards, including conditions on when a MEWA is eligible to self-fund in New Jersey and the health benefits plans that the MEWA may offer.[3] In addition, a MEWA covering a group of 50 or fewer employees or participating persons of an individual employer who are residents of New Jersey must register with the New Jersey SEH Program Board.[4] "If the member

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this final rule. But, as noted in the Proposed Rule, doing so at this time lies outside the scope of this proceeding.

Ibid.

[3] A MEWA that fails to meet the standards for self-funding under the law is considered an unauthorized insurer.

[4] The SEH Act provides that a MEWA covering a group of 49 or fewer employees must register with the Board of Directors. See N.J.S.A. 17B:27A-48 ("A multiple employer arrangement covering a group of 49 or fewer employees or participating persons of an individual employer who are residents of this State shall register with the board of directors. . . .") However, Federal law expanded the definition of "small employer" to include 50 or fewer employees. See 42 U.S.C. §

[of a MEWA] is a small employer,[5] the health benefits to be provided by the self-funded multiple employer welfare arrangement shall at all times be equal to or greater than benefits required to be provided in the lowest benefit level standard plan promulgated by the New Jersey Small Employer Health Benefits Program." N.J.S.A. 17B:27C-8. Moreover, self-funded MEWAs providing coverage for small employers are subject to the rating requirements as set forth in N.J.A.C. 11:4-56.6.

Thus, New Jersey law requires that employer associations/MEWAs—whether insured, partially-insured, or self-funded—with small employer members must provide coverage to those small employers in accordance with the comprehensive standard health benefits plans that are approved and promulgated by New Jersey's SEH Program Board. N.J.S.A. 17B:27A-48 and N.J.S.A. 17B:27C-8. Additionally, pursuant to the New Jersey Health Insurance Market Preservation Act, Pub. Law 2018, c. 31, codified as N.J.S.A. 54A:11-1 to -10, coverage obtained through a MEWA does not qualify as minimum essential coverage for purposes of state law, unless that coverage complies with certain state consumer protections, such as benefit mandates and rating rules.[6]

18024(b)(2) ("The term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.").

[5] The term "small employer" means,

> in connection with a group health plan with respect to a calendar year and a plan year, an employer with a business location in the State of New Jersey who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year; and who employs at least one employee on the first day of the plan year.
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> Any person treated as a single employer under subsection (b), (c), (m), or (*o*) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer. Additionally, small employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers. As used in the definition of small employer, full-time means an employee works 30 or more hours per week.

See N.J.A.C. 11:21-1.2.

[6] Specifically, the New Jersey Health Insurance Market Preservation Act states:

> Health coverage provided under a multiple employer welfare arrangement, as defined in subsection (40) of 29 U.S.C. s.1002, shall

Additionally, MEWAs covering large employers (51 or more employees) are required to provide coverage for all health benefits mandated by State law in effect on October 1, 2014, See N.J.S.A. 17B:27C-8(e), but have additional flexibility with regard to rating when compared to small employer MEWAs, See N.J.S.A. 17B:27-8(f).

Ultimately, an AHP, whether insured, partially insured, or self-funded, whether organized in New Jersey or another jurisdiction, and its agents, may not market, i.e. sell, solicit, or negotiate, its plan in New Jersey unless it complies with all applicable New Jersey laws and regulations. The USDOL rule did not change this requirement.

Any carrier, broker, or other entity found to be marketing, selling, soliciting, or negotiating AHP plans to residents of New Jersey, that do not comply with New Jersey law will be subject to enforcement action.

To report the marketing, sale, solicitation, or negotiation of such plans to the Department, please file a complaint as described at the following webpage: https://www.state.nj.us/dobi/consumer.htm.

10/29/18
Date

Marlene Caride
Commissioner

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not qualify as minimum essential coverage unless the plan complies with the requirements of one or more of the following New Jersey statutes, as applicable to a carrier and health benefits plans offered in the relevant individual, small employer, or large employer markets:
(1) P.L.1938, c.366 (C.17:48-1 et seq.);
(2) P.L.1940, c.74 (C.17:48A-1 et seq.);
(3) P.L.1985, c.236 (C.17:48E-1 et seq.);
(4) N.J.S.17B:26-1 et seq.;
(5) N.J.S.17B:27-26 et seq.;
(6) P.L.1973, c.337 (C.26:2J-1 et seq.);
(7) P.L.1992, c.161 (C.17B:27A-2 et seq.);
(8) P.L.2001, c.352 (17B:27C-1 et seq.);
(9) P.L.1997, c.1972 (C.26:2S-1 et seq.); or
(10) P.L.1992, c.162 (C.17B:27A-17 et seq.).

N.J.S.A. 54A:11-4(h).