UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, et al., Plaintiffs, v. U.S. DEPARTMENT OF LABOR, et al., Defendants.	Civ. Action No. 18-1747-JDB

NOTICE OF FILING OF ADMINISTRATIVE RECORD APPENDIX

Pursuant to Local Rule 7(n), Plaintiffs hereby file the attached Appendix, Volumes 1-8, containing those portions of the administrative record that are cited in the parties' memoranda of points and authorities in support of, in opposition to, or in reply to the pending cross-motions for summary judgment and motion to dismiss (ECF Nos. 31, 49-1 and 54-1). All parties have agreed to the contents of the Appendix.

Dated: January 9, 2019

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 9, 2019, I electronically filed the foregoing Notice of Filing of Administrative Record Appendix and attached Appendix, Volumes 1-8, using the Court's CM / ECF system, causing a notice of filing to be served upon all counsel of record.

Dated: January 9, 2019

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ADMINISTRATIVE RECORD APPENDIX

VOLUME 8

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AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and
CEO

March 6, 2018

The Honorable Alexander Acosta
Secretary
U.S. Department of Labor
200 Independence Avenue, NW
Washington, DC 20210

Re: RIN 1210-AB85; Definition of "Employer" Under Section 3(5) of ERISA–Association Health Plans

Dear Secretary Acosta:

The American Lung Association appreciates the opportunity to submit comments on the proposed rule Association Health Plans (AHPs).

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD. And as such, the Lung Association is committed to ensure all patients have access to quality and affordable healthcare and are treated with guidelines-based care.

In March of 2017 the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, the proposed rule on AHPs would jeopardize access to healthcare that is affordable, accessible and adequate for lung disease patients. AHPs have a history of providing inadequate care to patients. If the Department of Labor (DOL) wishes to change the rules governing AHPs, additional patient protections, including coverage of the Essential Health Benefits, should be required. However, the proposed rule as currently written does not protect patients, and the American Lung Association requests that the Department rescind the proposed rule.

The Lung Association along with 14 patients organizations have outlined major concerns with the proposed rule in the attached comments (see Appendix B), however the Lung Association is a unique position to comment in more detail the issues described below.

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Preventive Services

The Lung Association appreciates that AHPs would be required to cover preventive services with no cost-sharing. Current law requires most private health plans to cover preventive services without cost-sharing, including co-pay, co-insurance and deductible. The defined preventive services are any treatment receiving an "A" or "B" from the United States Preventive Services Task Force (USPSTF) and any immunization having a recommendation from the Advisory Committee on Immunization Practices.

These preventive services save both money and lives and are particularly important for lung disease patients. Current preventive services include lung cancer screenings for people at high-risk for lung cancer, which allow lung cancer to be discovered earlier, at a more treatable stage. Lung cancer is currently the leading cancer killer for both men and women in the United States, and the expansion of access to this important screening can save lives. Additionally, up to 50,000 adults die each year from vaccine-preventable diseases.[1] Coverage of preventive services removes the barrier of cost-sharing to getting the influenza, pneumococcal and other vaccines, saving both lives and money. However, while coverage of preventive services at no cost-sharing is critical for lung disease patients, these alone are not adequate coverage, and we again urge DOL to include coverage of all 10 essential health benefits in this rule to ensure that patients have access to all of the services, medications and treatment that they need.

Tobacco Surcharges

The American Lung Association opposed section 2701 of the Affordable Care Act, which allows insurance plans in the individual and small group markets to charge tobacco users up to 50 percent more in premiums than non-tobacco users. This policy will herein be referred to as the "tobacco surcharge."

A health insurance surcharge for tobacco use and what is for many, a chronic disease of tobacco addiction, is likely to produce adverse consequences. There is little evidence that financial incentives or disincentives through insurance premiums change individual behavior. In fact, recent studies from Health Affairs[2] and the Center for Health and Economics Policy at the Institute for Public Health at Washington University[3] have suggested that tobacco surcharges do not increase tobacco cessation. The studies also have data suggesting tobacco users eligible for Marketplace or exchange health plans forgo health insurance rather than paying the surcharge. Tobacco users often have expensive comorbidities. Charging a tobacco surcharge could cause those enrollees to go without coverage and access to preventive care (including tobacco cessation treatments), allowing comorbid health conditions to worsen. This could result in more expensive healthcare being required later on.

Tobacco surcharges are an unproven theory to improve public health – in contrast to several thoroughly tested, evidence-based interventions and policies that are proven to reduce smoking consumption and prevalence. These tools include offering a well-promoted comprehensive tobacco cessation benefit without barriers.

While the Lung Association recognizes tobacco surcharges are legally allowed, currently states are also able to limit or prohibit the surcharge in their state. The AHP rule, if enacted, will take enrollees out of marketplace coverage – coverage that is regulated by the state – and put them in ERISA regulated plans. This will take away the important role of state in regulating health insurance.

The Lung Association also requests DOL hold public hearings on this rule prior to any promulgation of a final rule. This proposed rule on AHPs, if implemented, would impact patients and the public at large with regards to the range of health benefits offered. It is important DOL has ample opportunity to hear from patient voices on access to quality and affordable healthcare. A public hearing, while not required, would provide an additional avenue to hear from patients on how they could be impacted by the proposed rule.

The American Lung Association appreciates the opportunity to submit comments on this important rule and urges the Department of Labor to rescind this proposed rule. As outlined in the attached coalition comments, if proposed, the rule would undermine marketplace stability, jeopardizing access to quality, affordable healthcare for lung disease patients.

Sincerely,

Harold P. Wimmer
National President and CEO

CC: Ms. Jeanne Klinefelter Wilson
Deputy Assistant Secretary for Policy
Employee Benefits Security Administration

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[1] Weinberger B, Herndler-Brandstetter D, Schwanninger A, et al. Biology of immune responses to vaccines in elderly persons. Clin Infect Dis. 2008;46:1078-1084.
[2] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract
[3]Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

Appendix A

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

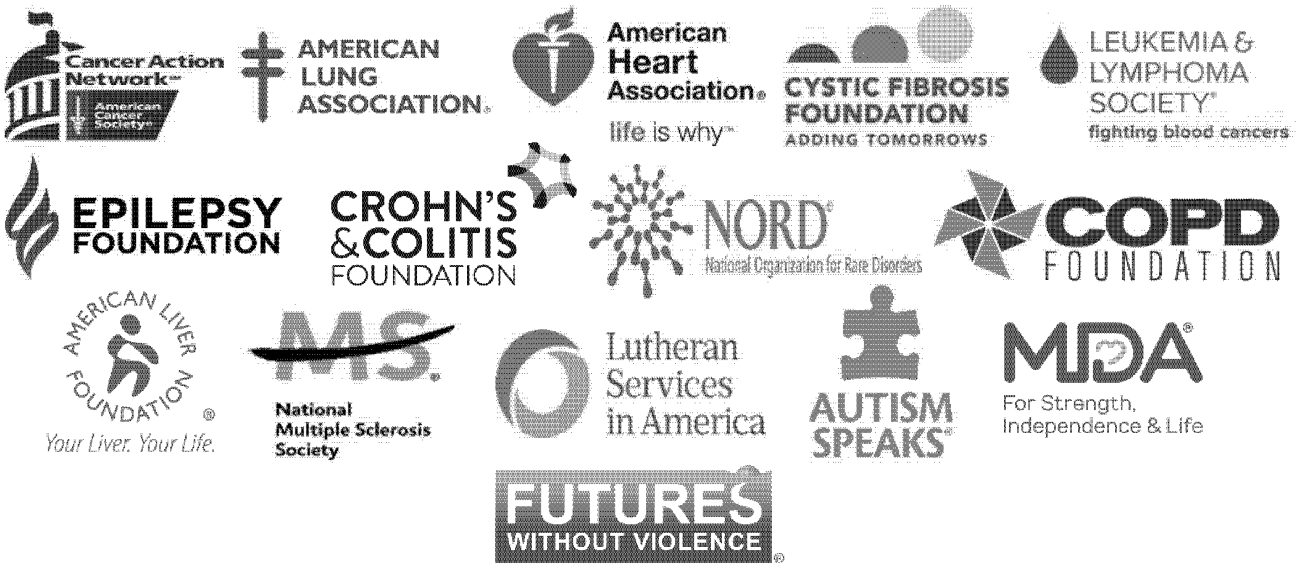
Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance

must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

Appendix B



March 6, 2018

The Honorable Alexander Acosta
Secretary
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Employee Benefits Security Administration
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Re: **RIN 1210-AB85; Definition of "Employer" Under Section 3(5) of ERISA– Association Health Plans**

Dear Secretary Acosta and Deputy Assistant Secretary Wilson:

Thank you for the opportunity to submit comments on the Department of Labor's (the Department) proposed rule on Association Health Plans (AHPs). The 15 undersigned organizations urge the Department not to finalize this proposed rule and instead focus its efforts on protecting patients and consumers in order to ensure they will continue to have access to affordable, adequate, and understandable health care coverage.

Our organizations represent millions of patients and consumers facing serious, acute, and chronic health conditions across the country. We have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge

the Department to make the best use of the collective insight and experience our patients and organizations offer in response to this proposed rule.

In March 2017, our organizations agreed upon three overarching principles to guide any work to reform and improve the nation's healthcare system.[1] These principles state that: (1) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need including all the services in the essential health benefit package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. Enrollment should be easy to understand, and benefits should be clearly defined.

Our organizations are deeply concerned about the impact the Department's proposed rule on AHPs will have on the individuals and families we represent. While AHPs can offer cheaper coverage, they frequently do not adhere to important standards, including financial protections and coverage for essential health benefits. AHPs also have a long history of fraud and insolvency and have historically affected small employers and individuals. Many of these plans collected premiums for health insurance coverage that did not exist and did not pay medical claims --leaving businesses, individuals, and providers with millions of dollars in unpaid bills. For consumers and patients, the results were disastrous. Our organizations are extremely concerned that the proposed rule will once again leave consumers in the lurch with insufficient coverage, unpaid medical bills, and lifelong health implications – just as many of these plans did before the Affordable Care Act (ACA) was passed.

In the proposed rule, the Department recommends eliminating and/or altering several standards and regulatory structures that have served to protect patients and consumers, including those related to benefit structure, cost, and oversight. We are deeply concerned about these proposed policies and the potential negative impact on the communities we represent. Therefore, we strongly encourage the Department not to finalize this proposed rule until the needs of our communities have been met. Should you decide to proceed, then any modifications should, at a minimum:

- Require AHPs to comply with the Essential Health Benefits (EHBs) coverage requirements to ensure coverage adequacy, as well as protections from lifetime and annual caps, and annual out-of-pocket maximums;
- Allow the employees of businesses that choose to enroll AHPs to remain eligible for premium tax credits to encourage market choice;
- Require AHPs to provide clear consumer information, including details about coverage, costs, and plan policies, prior to enrollment; and
- Clarify and bolster state regulation of AHPs.

Adequacy

Healthcare coverage for the populations we serve must be adequate, covering the services and treatments patients need, including patients with unique and complex health needs. It is paramount that protections including EHB packages, the ban on annual and lifetime caps, and restrictions on premium rating all be preserved. We are deeply concerned that the AHPs created by this proposed rule

[1] Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

could offer entirely inadequate, even discriminatory, coverage to the communities we represent. Additionally, we are also concerned that some of the proposals included in the proposed rule would make it difficult for consumers to understand their options and make informed choices about the coverage they select. Our organizations emphatically urge the Department to not to finalize the rule or, if unwilling to do so, modify the proposed rule to fully protect consumers and patients against harm.

Essential Health Benefits (EHBs)

One of the most troubling aspects of Association Health Plans is that they are not required to comply with EHB coverage requirements created under the ACA. This proposed rule would regulate AHPs as if they were *Employee Retirement Income Security Act* (ERISA)-governed large-group health plans (sometimes referred to as single multi-employer plans) that do not have to comply with many of the ACA's coverage and adequacy requirements.

This is deeply concerning to our organizations because the individuals we represent rely on the current law's coverage requirements for access to medically necessary care. Prior to the passage of the ACA and creation of the ten EHB categories, patients and consumers often found themselves enrolled in plans that failed to provide coverage for medically necessary care. Patients with serious illnesses would discover they were not covered for new and innovative treatments, some could not get coverage for emergency room services, and patients with chronic illnesses were often denied coverage for life-improving, sometimes even life-saving, medication.

Discriminatory Plan Design

Under the proposed rule, the Department would maintain one of most important patient protections for individuals with pre-existing conditions: guaranteed issue. AHPs would not be allowed to turn away individuals seeking to purchase their plan. They would also be required to treat all enrollees within their plan the same way, and could not deny certain coverage or benefits to one enrollee while offering it to another. These are the same standards under which ERISA-covered employer plans must operate. Our organizations strongly support guaranteed issue and thank the Department for including it in the proposed rule.

However, while this proposed rule would not allow AHPs to offer varying benefit designs to enrollees based upon health factors, it would allow AHPs to offer differing coverage to groups of enrollees based upon non-health related factors. These factors could include gender, age, employee classifications, locations, or any other non-health criteria that could stratify the plan beneficiary population. Therefore, AHPs could structure their coverage and benefit designs using "non-health related factors" to effectively exclude entirely classes of beneficiaries with higher rates of illness and disease.

Furthermore, even if AHPs chose to offer uniform coverage to all beneficiaries regardless of any non-health related factor, they are still allowed to freely structure their benefit design in any way they see fit. This allowance would once again allow discriminatory plan design that excludes benefits for patients with certain health and preexisting conditions.

Consequently, under this proposal, AHPs could design a plan that excludes coverage for medically-necessary prescription drugs, certain specialists who treat particularly expensive conditions, or other medically necessary care for individuals with chronic conditions. According to the Kaiser Family Foundation, approximately 27 percent of American adults currently have a condition that would result in

being denied health coverage.[2] Of Crohn's & colitis patients surveyed before the implementation of the ACA, 42.5 percent of those who sought insurance coverage had specific health conditions excluded from their coverage.[3] Our patients could once again face these same coverage denials within AHPs under this proposed rule, resulting in entirely inadequate coverage.

This allowance for discriminatory benefit design completely undermines the guaranteed issue requirement by enabling AHPs to de facto deny coverage to individuals with pre-existing conditions by creating "non-health" classifications with substantially weaker coverage, or by refusing to offer coverage for the specific care they need.

Network Adequacy

AHPs would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant Qualified Health Plans (QHPs) must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, oncology, maternity and newborn care, mental health, and emergency services, AHPs are not required to comply with these standards.

This is particularly concerning for our organizations as we represent the individuals who are most in need of access to emergency services, outpatient care, and specialty physicians. These physicians and health services are also often the most expensive. Without regulation and oversight of network adequacy within AHPs, as this proposal would allow, the physicians and services patients rely on could be excluded from AHP provider networks altogether. For example, AHPs may choose to exclude all cardiologists, oncologists, or specialty clinics from their provider networks. They may also include facilities or specialists in the network that are far too distant from beneficiaries to be accessible.

ACA Section 1557 Nondiscrimination Protections

Under our interpretation of the proposed rule, AHPs would only be required to comply with ACA section 1557 nondiscrimination requirements if the entity offering the plan receives Federal financial assistance.[4] Understanding that AHPs may be operated by a variety of entities, we envision many AHPs would be exempt from ACA section 1557 requirements, potentially subjecting our patients to harmful discriminatory policies.

Consumer Education and Transparency

As advocates for health care consumers, many of whom live with serious, acute, and chronic health conditions, our organizations are concerned that employers and prospective enrollees of AHPs will not be sufficiently informed about these products prior to enrollment. Our experience prior to passage of the ACA suggests that many patients were confused about what a policy did and did not cover due to a lack of required transparency, resulting in cases of medical debt and bankruptcy[5]. Patients were also forced in some cases to delay or forgo treatment. We are concerned that we will see a dramatic

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[2]Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, and Karen Pollitz, "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Found. Issue Brief, Dec. 12, 2016, available at https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

[3] Rubin DT, Feld LD, et. al. Crohn's & Colitis Foundation of American Survey of Inflammatory Bowel Disease Patient Health Care Access. *23*(2), 224-232.

[4] Department of Health and Human Services, "Section 1557: Frequently Asked Questions", available at https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html#_ftnt32.

increase in these outcomes if AHPs are made easily available to consumers without clear transparency about what they do, and do not cover.

Survey data, focus group testing and academic research on Americans' understanding of health insurance reveals serious deficiencies in comprehension of the common language and concepts of health plans. Research has highlighted evidence of Americans' health and health insurance literacy including: nearly nine out of ten adults had difficulty using health information to make informed decisions about their health[6]; 51 percent of respondents did not understand the basic health insurance terms premium, deductible and copay; and only 16 percent could calculate the cost of an out-of-network lab test.[7] Consumers Union has cautioned that it is not enough to know the difference between premiums, deductibles, and copays, one must also understand how these costs must be sequenced to understand how health insurance must be viewed in the context of real world health care needs.[8]

We note that the ACA sought to address many of these concerns by implementing new and evolving measures to help inform and educate consumers about health insurance, including the online Marketplaces, the Summary of Benefits & Coverage, Glossary of Health Care Terms and Actuarial Value, and for some, access to new professional insurance counselors with no vested interest in consumers' choice of health plan. These resources are helping consumers make more informed choices by presenting and explaining details about coverage, costs, and plan policies. Yet because most of these helpful tools would not be required resources of AHPs, prospective enrollees of AHPs would not benefit from them, improvements in health care and health insurance literacy could be reversed, and more Americans would be at risk of being under-insured once more. This lack of transparency is particularly concerning as it relates to AHPs because of the history of fraud and insolvency. Consumers have grown accustomed to being able to purchase a high-quality plan on the marketplace and may not even realize these plans to not meet those same standards.

Affordability

Our organizations recognize that illness impacts individuals across the economic spectrum. We believe that everyone – regardless of their economic situation – should be able to obtain the treatment they require. Having access to treatments also means that treatments should be affordable to the individual, including reasonable premiums and cost-sharing, as well as protecting individuals with pre-existing conditions from being charged more for their coverage. We are concerned that the proposed policy fails to achieve this aim.

<u>Solvency protections from AHPs</u>

Unfortunately, in the past there have been numerous examples of AHPs that have become insolvent either because the AHP was formed with fraudulent intent or failed to be adequately capitalized. In such instances, consumers – many of whom had serious and chronic diseases – experienced great harm when they were left with significant medical bills after their AHP folded and were unable to pay their claims.[9]

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[9] *ibid.*

These consumers would have received little to no advance notice that their plan would fail to provide adequate coverage until it was too late.

We are pleased that the proposed rule allows states to impose requirements such as reserve standards and other financial requirements on AHPs. However, this proposal assumes that the states are adequately resourced to enforce these requirements. In addition, some states may be hesitant to regulate these plans given that questions remain about the extent to which states have the authority to do so.[10]

AHPs are substandard coverage

as discussed in detail above, we are concerned that the proposed rule would allow an AHP to offer non-comprehensive coverage. This coverage could fall far short of the needs of individuals – particularly those with serious and chronic conditions. We are concerned that some employers may offer AHPs to their employees, despite the fact that the overall benefit package may not provide adequate coverage, but would meet the actuarial value for minimum essential coverage (MEC) requirements.[11] Under current law, if an employer offers MEC-compliant coverage, the individual is permitted to enroll in a plan on the marketplace, but would be precluded from eligibility for advance premium tax credits (APTCs). As a result, individuals – such as those with serious or chronic illnesses – who are offered an AHP through their employer and need comprehensive coverage would be unable to obtain adequate coverage through the marketplace with the help of APTCs. To correct this, we urge the Department to amend current regulations to permit an individual who declines an employer-sponsored AHP to be deemed eligible for APTCs based on income.

Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only apply to EHB-covered services. In this proposal, the Department would facilitate the proliferation of health insurance options that do not have to comply with EHB coverage requirements. Therefore, this proposal would once again subject patients to significant financial insecurity due to medical needs. In 2007 alone, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.[12] Patients who faced heart transplants, used specialty medications, had complicated pregnancies, a cancer diagnosis, or other rare and complex conditions could easily meet or exceed lifetime and annual caps. For example, prior to the ACA, many children with hemophilia would hit the lifetime limit on coverage under both parents' insurance plans before turning 18, leaving them without coverage options. For these reasons, we strongly urge the Department to consider the financial implications to our patients of removing this critical protection.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for QHPs to include an annual out-of-pocket maximum set each year by the Department of Health and Human Services (HHS). For 2017, the annual out-of-pocket limit for an individual is $7,350, and for a family plan is $14,700.[13] Similar to the ban on annual and

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[10] See, K. Lucia and S. Corlette, "Association Health Plans: Maintaining State Authority is Critical to Avoid Frau, Insolvency, and Market Instability." *To the Point*, The Commonwealth Fund, Jan. 24, 2018, available at http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority.

[11] 45 C.F.R. § 156.604.

[12] Himmelstein DU, Throne D, Warren E, Woolhander S, Medical bankruptcy in the United States, 2007: results of a national study. Am J Med 2009 Aug; 122(8): 741-6. Doi.

[13] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Final Rule, 81 Fed. Reg. 94058 (Dec. 22, 2016).

lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. If the Department moves forward with this proposed dramatic expansion of non-EHB compliant AHPs, it will also be subjecting patients with complex and chronic conditions to unaffordable cost-sharing for medically-necessary services on which they rely.

Accessibility

The third key principle agreed to by our organizations is that healthcare must be accessible. Everyone needs access to quality and affordable healthcare to manage chronic diseases and be able to access medical care during a health emergency. The connection between access to health insurance and health outcomes is clear and well documented.[14,15]

Market Segmentation

We are concerned about the impact of the proliferation of AHPs on the overall individual market. We expect that individuals with serious and chronic conditions will continue to enroll in coverage offered through state marketplaces. Conversely, younger and healthier individuals may be more likely to shop for coverage on the basis of premiums and thus may be more drawn to lower cost AHPs, despite the fact that these products will likely have less comprehensive coverage.

Over time, as younger and healthier individuals leave the marketplace, premiums will likely increase and fewer issuers may participate in a state's marketplace. This could lead to market segmentation that "could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage."[16]

Other Concerns

As detailed above, our organizations are very concerned about the impact of this specific regulation. However, when combined with other actions, regulations, and policies pursued by the Administration it is clear that their compounded impact will destabilize the individual insurance market and increase access to substandard insurance and its alternatives.

Shortening the open enrollment period by half, reducing funds for outreach and advertising, restricting eligibility for Medicaid through waiver approvals, and the repeal of the individual mandate are all affecting the coverage landscape. In addition, the policies in the short term limited-duration insurance proposed rule and policies within the Notice of Benefit and Payment Parameters proposed rule would allow states to diminish the value of some essential health benefit categories, change the annual out-of-pocket costs maximums and open the door to lifetime and annual caps, which will negatively impact individuals and families struggling with chronic, serious, or acute disease. We urge the Administration to work with Congress and organizations like ours to ensure that consumers everywhere have access to affordable *and* high-quality insurance plans while maintaining a strong marketplace.

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[14] Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

[15] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

[16] American Academy of Actuaries, "Issue Brief: Association Health Plans", Feb. 2017, available at http://www.actuary.org/content/association-health-plans-0.

Protect State Regulatory Authority

The proposed rule raises questions about preemption of state law and future regulatory authority. While the Department states that the proposed rule would not alter existing ERISA statutory provisions governing multiple employer welfare arrangements, we are concerned that the proposed rules will have the result of preempting existing and future efforts by states to regulate them. The proposed rule's new framework allowing AHPs to be treated as single multiple-employer plans creates confusion about states' enforcement authority. In the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut down scam operations.[17]

States must maintain the ability to protect patients and manage their insurance markets. We urge the Department to clarify that ERISA single employer AHPs, including those that cover more than one state, would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

Finally, we strongly oppose any proposal that would exempt AHPs from state regulation. States have long taken the lead in protecting patients by addressing AHP insolvencies and fraud and maintaining competitive markets. States have the history, resources, and local expertise to serve in this role and we urge the Department not to take action that would prevent that.

Conclusion

Our organizations represent millions of patients, individuals, caregivers, and families who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide our recommendations on the proposed rule. However, given the history of AHPs, we are deeply concerned that the rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law – and put those we represent at risk.

We urge the Department not to finalize the AHP proposed rule until the needs of our populations are met and instead to focus on lowering premiums for QHPs. Short of this, in order to protect vulnerable populations, the Department must modify the AHP proposed rule with the following:

- Require AHPs to comply with the Essential Health Benefits (EHBs) coverage requirements to ensure coverage adequacy, as well as protections from lifetime and annual caps, and annual out-of-pocket maximums;
- Allow the employees of businesses that choose to enroll AHPs to remain eligible for premium tax credits to encourage market choice;
- Require AHPs to provide clear consumer information, including details about coverage, costs, and plan policies, prior to enrollment; and
- Clarify and bolster state regulation of AHPs.

As leaders in the healthcare and research communities and staunch patient and consumer advocates, we look forward to working with Department of Labor leadership and staff on the direction of such important public policy. Thank you for the opportunity to submit comments on this rule. If you have any

[17] Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority.

questions or would like to discuss these comments further, please contact Katie Berge, American Heart Association Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Autism Speaks
COPD Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Futures without Violence
Leukemia & Lymphoma Society
Lutheran Services in America
Muscular Dystrophy Association
National Multiple Sclerosis Society
National Organization for Rare Disorders

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March 6, 2018

Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

Attention: Definition of Employer – Small Business Health Plans
RIN 1210-AB85
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

RE: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans

The Louisiana Association of Business and Industry (LABI) and their consultant, Associated Benefits Consulting (ABC) appreciate the opportunity to comment on the Department of Labor notice of proposed rulemaking titled "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," RIN 1210-AB85, 83 *Fed. Reg.* 614 (January 5, 2018). While LABI has several comments to express, **LABI supports the Department's proposed rule on Association Health Plans (AHPs).**

The Louisiana Association of Business and Industry (LABI) was founded in 1974 and serves as the Louisiana State Chamber of Commerce and the Louisiana Manufacturing Association. LABI has over 2,000 business members who employ 320,000 workers with small business representing 70% of the membership.

Over 30 years ago, LABI saw the need to offer their members a group comprehensive major medical plan that was not available in the market at that time. Since its inception, the LABI health offering has been with only 2 different carriers—Travelers Insurance and Blue Cross Blue Shield of Louisiana (BCBSLA). In 1994, Travelers Insurance decided to no longer underwrite group health insurance in Louisiana. LABI and ABC went to BCBSLA and created the LABI Blue Chip Health plan, a comprehensive major medical group health offering. At the time, BCBSLA offered only limited group health coverage - a hospital surgical plan with a supplemental major medical plan offering far less coverage, double the burden of filing claims and indemnity coverage for surgeries/hospital stays.

Through its 24-year course, the LABI Blue Chip plan has evolved. At one time, the insurance contract for LABI members was filed separately with the Dept. of Insurance in LA and had numerous exclusive contractual plan differentials such as:

- no maximum on durable medical equipment
- 2 wellness exams a year, no organ transplant maximums
- $2-million-dollar lifetime maximum
- higher Accidental Injury Endorsement
- dependent maternity coverage
- coverage of TB tests
- 100% coverage of skilled nursing, hospice and home health after the deductible was met
- preferred rating for 3+ employees with medical conditions
- higher commissions for brokers

The trusted LABI Blue Chip Health plan, at the highest point, assisted over 1,800 businesses providing health coverage to over 45,000 individuals. Through the course of time, the LABI Blue Chip Health plan experienced some loss of exclusive membership features (plan differentials), due to market place changes, as well as changes made by the carrier. However, with the passage of the Affordable Care Act (ACA), the benefits of association exceptions were essentially outlawed under the community rating rules, mandates and standards set forth in the new act, eliminating all remaining features exclusive to the LABI Blue Chip Health plan. Choices were limited, rates were set, and group size determined the mandated benefits. Our membership was directly affected by these changes and we have seen a significant reduction in the number of employer groups who participate in our plan.

Despite the removal of customization and flexibility, LABI continues to offer a plan to our members. Louisiana allowed the grandfathering of plans in effect prior to March 23, 2010. Today, half of the employer groups in the LABI Blue Chip Health plan have maintained grandfathered status. This high grandfathered number demonstrates the mindset of many employers who prefer offerings specifically designed to their needs and those of their employees.

LABI would like to make the following specific comments on the proposed rule:

Definition of Bona Fide Association. It is our belief that many credible associations already exist that meet the sub-regulatory guidance on ERISA section 3(5). LABI has been in existence for 43 years and has had a reputable form of an AHP since 1983 and adheres to a governing body and by-laws, as do other long-standing associations. The primary mission of the organization is paramount and further demonstrates "acting in the interest of" employers. Newly formed associations may lack cohesiveness, insurance knowledge, sufficient bylaws and governing bodies. A new organization with insurance as the primary mission could be more at risk for mismanagement, leaving employers and individuals without insurance, like the Multiple Employer Welfare Arrangements (MEWAs) that are now defunct. For these reasons, LABI suggests a standard definition for an association be determined, whether that means qualifying factors such as years in existence, financial reserves and/or insurance expertise.

Working Owners. All size employers can benefit from AHPs as described in this proposed rule. As seen in the LABI Blue Chip plan, both small and large employers benefit from creative plans that meet their employees' needs. LABI's membership includes many sole proprietors, or working owners, who are looking for affordable coverage, but are currently not considered eligible for the group market. The view of working owners set forth in the proposed rule is extremely beneficial and important to such employers/employees. These workers are perhaps the group with the most need for choices.

Therefore, LABI supports the proposed requirement of an owner/employee to submit written representation to the sponsoring organization as being reasonable.

The one area of concern is the requirement in the proposed rule precluding eligibility of an owner/employee if she or he is eligible for "other subsidized group health plan coverage ... of the individual or by a spouse's employer." While the proposed rule opens AHPs to this category of working owners, the subsidized coverage eligibility requirement negates the value of this potential offering.

To demonstrate how working owners can be penalized if the spouse's employer subsidizes coverage disqualifying them from participating in an AHP, consider the following example: Jim (a working owner) seeks to cover himself and his two children and has only the individual market to purchase coverage. In 2017, his individual market premium went from $1,600 a month to $2,700 a month in 2018. Currently, Jim is not eligible for a group health plan.

To expand on this example, assume Jim is married to Suzy, who has health insurance coverage through work, in which her employer subsidizes ANY portion of Jim's coverage. According to the proposed rule as currently written, Jim would not be eligible for coverage through an AHP. Even though Jim has access to subsidized coverage through Suzy's employment, if the cost is prohibitive and the specific coverage does not meet his needs, his choices are limited to his wife's plan or the individual market. This appears to contradict the expressed goals of this proposed rule to increase choices and affordability of group health coverage.

If this requirement remains in the final rule, the term "subsidized" should be further defined to mean an employer's payment of a "significant" percentage of the premium.

Health Nondiscrimination Rules. The HIPAA/ACA health nondiscrimination rules for membership and access to an AHP are necessary and should be easy to follow/implement. The area requiring further review, discussion and concern is the prohibition of non-discrimination *within* groups of similarly situated individuals, and the applicability of discrimination *across* different groups of similarly situated groups. In looking at the rules of classifications that may be bona fide, "different geographic location" is one to address. An association that meets all necessary requirements, may see fluctuations in costs based on geographic locations within one state or area of the country. It seems these premium fluctuations should be allowed if done so for all offerings and employers in that geographic area. Using example 6, on page 636 of the proposed rule, if the premium for any members in City *O* were set before this one member was rated, that should be allowable.

This example is consistent with principles of insurance which are necessary to create and maintain a successful, long term association health plan, like the LABI Blue Chip Health plan. Rating based on risk must be allowed in some form or fashion. The many defunct co-ops are examples of what happens when the principles of insurance are ignored. These principles are seen in all types of insurance (i.e. adolescent males pay higher auto insurance rates and why life insurance is less expensive for a 35-year-old than a 65-year-old).

The ability to pool all size employers under one long-standing, reputable, well organized association, creates a sustainable pool to absorb multiple types of health risks. The removal of mandated coverages and the ACA's health insurance premium rating rules, which today only apply to individual and small

group markets, allow for all size groups to benefit from plan creativity, customization, wellness incentives and premium reductions.

To further demonstrate how the removal of mandated coverages can benefit individuals participating in an AHP, consider, a 61-year-old female who is relegated to the individual market where she must purchase coverage that includes maternity. This proposed rule could potentially allow maternity to once again be a choice rather than a mandate.

AHPs can customize plans based upon the needs of their members. An association with members of a certain profession may elect to increase benefits that are widely utilized (i.e. knee replacement surgery for tile workers).

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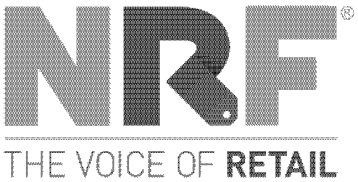
LABI believes this proposed rule can achieve the primary goal of expanding access to affordable and meaningful health coverage by allowing more employers to participate in AHPs. We appreciate the Department of Labor's diligence in considering the importance of reputable, long standing associations as a preferred vehicle for AHPs.

If you have any further questions regarding our comments or the LABI Blue Chip Health plan, please feel free to contact our consultant, Mrs. Susan Ellender at susane@abenefitsconsulting.com or (225) 928-2225.

Sincerely,

Stephen Waguespack
President



March 6, 2018

The Honorable R. Alexander Acosta
Secretary of Labor
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: RIN 1210-AB85

Submitted electronically via www.regulations.gov

Dear Secretary Acosta:

The National Retail Federation appreciates the opportunity to submit comments on the proposed regulation, "Definition of 'Employer' under Section 3(5) of ERISA – Association Health Plans." The regulation was issued by the Department of Labor (DOL) on January 5, 2018.

NRF is the world's largest retail trade association, representing discount and department stores, home goods and specialty stores, Main Street merchants, grocers, wholesalers, chain restaurants and Internet retailers from the United States and more than 45 countries. Retail is the nation's largest private-sector employer, supporting one in four U.S. jobs – 42 million working Americans. Contributing $2.6 trillion to annual GDP, retail is a daily barometer for the nation's economy. NRF.com

NRF has long advocated for association-based coverage and has supported many previous legislative efforts to expand Association Health Plans (AHPs). NRF strongly endorsed the House-passed Small Business Health Fairness Act (HR 1101) in the current Congress. Jon Hurst, president of the Retailers Association of Massachusetts, testified in support on NRF's behalf in the House Education and Workforce Committee on March 1, 2017.

We commend the Trump Administration and DOL in particular for advancing the ability of small businesses to join together through association health plans to provide greater access to affordable health care for their employees. In doing so, this regulation would offer small businesses access to many of the same cost savings available to larger employers under ERISA.

NATIONAL **RETAIL** FEDERATION
1101 New York Avenue, NW, Suite 1200
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www.nrf.com

Group health benefits are the key to coverage for more than 170 million Americans. But, not all groups are created equally. NRF has long noted the discrepancy between health coverage options available to smaller and larger companies and thus has supported legislation to help bring more favorable coverage options to smaller employers.

Group health coverage balances the risk of health care utilization between younger and older employees, healthy or less so. Employment-based group coverage can be distinguished from public pools because employees come to the business to work rather than to seek coverage, as opposed to a public pool where the sole objective is to obtain coverage. The difference in presentation of risk, though subtle, is important. Private, employment-based group plans work better than public pools and provide more affordable coverage options.

Smaller employers have fewer employees to balance their employees' various risk profiles. Strategies taken by the Affordable Care Act – the SHOP plans and the rather byzantine small business tax credit – have not helped smaller employees. Steps must be taken to better support these smaller businesses in providing coverage.

Association Health Plans are an important answer in our view. Not only do they offer the potential to band with additional small employers in their local state through bona fide trade or professional associations, but it also offers potential to band together with other employer groups in other states utilizing the federal ERISA law to maintain common benefits across state lines.

These benefits will necessarily have to be robust to compete with other market participants. Employers do care about the cost of coverage, but more importantly, employers care about the quality of coverage offered to our employees and their dependents. We specifically reject the proposition that AHPs will lead a race to the bottom of coverage.

Our reputation as a long-established and well-respected trade association is at stake as would be our continued membership were we to offer less than quality coverage. We are a trade association first and foremost, not an insurance company. Still, we will have the opportunity under the regulation to sponsor a properly constructed AHP in order to help more small retailers find affordable coverage option. We may also be able to sponsor regional coverage with multiple state retail associations in geographically contiguous areas.

NRF strongly favors the present regulatory emphasis on bona fide trade associations. Trade associations – especially long-established trade associations like NRF – have built-in advantages over AHPs formed solely for the purpose of offering health coverage. Our focus is necessarily first and foremost on our members' needs and interests. Our advocacy and educational programs provide a solid foundation to which AHP sponsorship would be an addition. A decision to sponsor an AHP necessarily would be taken with concern for our larger membership focus.

A. Employers Could Band Together for the Single Purpose of Obtaining Health Coverage

The proposed regulation would go beyond the traditional role of bona fide trade associations in forming AHPs to allow employers to join together in organizations that offer group health coverage to member employers and their employees in one large group plan. The proposed regulation would allow these groups to form around (1) the same trade, industry, line of business or profession, or (2) around geographical terms, either up to the boundaries of their same state or the same metropolitan area, even if that exceeds state boundaries. We urge DOL to move cautiously in expanding the definition of employers under ERISA to include single purpose AHPs.

NRF believes that bona fide trade association AHPs are superior to single purpose AHPs because a bona fide trade association has dominant interests beyond health coverage, including advocacy focus, membership and reputation. We also fear that, absent higher barriers to entry, single purpose AHPs could prove unstable or more fraud prone, like many past Multiple Employer Welfare Arrangements (MEWAs). The failure of one AHP to pay medical claims will tar all AHPs, more-or-less equally. Opponents of AHPs will only be too willing to trot out well-worn arguments against all AHPs, given practically any pretext.

We do think that franchised operations might offer a stronger case for single purpose AHPs. A franchisor could offer franchised stores or restaurants membership in a single purpose AHP or sponsor a separate single purpose AHP for its franchisees. In this case, the single purpose AHP would be more like a bona fide trade association with resources, reputation and regard for franchisees. NRF represents many chain restaurants through our division, the National Council of Chain Restaurants.

We do share a concern raised by others regarding whether a plan offered by a franchisor to franchised stores or restaurants might support a finding that employees of franchised stores or restaurants are jointly employed by the franchisor. We urge DOL and Congress to consider structuring a safe harbor for AHPs offered in a franchised structure from potential joint employer liability.

We are also concerned by geographic criteria supporting single purpose AHPs. We urge DOL and states to monitor definition of geographic areas for potential discrimination. Redlining of geographic areas for insurance purposes is not unknown or a facet of the remote past. AHP boundaries should not be gerrymandered or quartered by risk.

B. The Group or Association Must Have an Organizational Structure and Be Functionally Controlled by its Employer Members.

NRF supports the proposed regulation's requirements for a clearly-defined organizational structure functionally controlled by its employer members. But, such a structure will require a detailed review and ongoing oversight to determine control. In addition, financial, fiduciary and regulatory obligations will need to be clearly spelled out. Federal requirements alone pertaining to a large group plan are quite complex and time consuming. AHPs will not function in a Hobbesian state of regulatory nature but rather will need to be able to navigate a complex society of rules and requirements. Outside agencies such as third-party administrators and large brokerages may be able to help. But, ERISA's fiduciary obligations will remain.

C. Group or Association Plan Coverage Must be Limited to Employees of Employer Members and Treatment of Working Owners

NRF appreciates the distinction DOL draws between employers, employees and others. The essence of association plans is commonality of interest beyond obtaining coverage. We agree that to do otherwise would essentially promote unlicensed group health coverage inconsistent with ERISA and state requirements. The potential presence of former employees (absent COBRA coverage) is more troubling. We urge DOL to provide greater clarity here.

The proposed definition of sole proprietors as "working owners" for coverage purposes also is a little more troubling. We recognize the dysfunction of many exchange markets with perhaps a single health plan available to individuals, including sole proprietors. But, sole proprietors are uniquely subject to financial pressures and may not be able to maintain payments to an AHP on a regular basis. Restoration of a strong individual and small group market might provide better options for working owners than an AHP.

Perhaps only permitting entry into plans on a very limited open season basis might help promote greater stability. In addition, allowing self-attestation by business owners might be too difficult for an AHP to verify. Other documentation – such as a current Schedule C, a business license or a history of paid invoices could provide greater assurance that a working owner is exactly that.

D. Health Nondiscrimination Protections

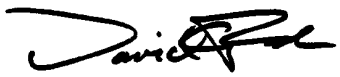
NRF supports extension of HIPAA and ACA nondiscrimination provisions to AHPs, but urges caution in application against existing association health plans. This is less an issue for bona fide trade associations: our overriding interest in obtaining new members and retaining existing members outweighs any potential benefit of selecting between potential members based on industry or health status of a member employer's employees. Our reputation and strength in advocacy is at stake.

We believe that competition will help guard against any desire to tailor benefits, e.g. to attract healthier employer groups. The association business is highly competitive on membership. An association that offers substandard or gimmick-ridden coverage will quickly find membership difficult to maintain. But, nondiscrimination protections will be a welcome addition.

E. Conclusion

NRF sincerely appreciates the opportunity to provide comments on the proposed rule. We look forward to working with you in the year ahead. If you have any questions or need additional information, please do not hesitate to contact Neil Trautwein, NRF Vice President for Health Care Policy at either (202) 626-8170 or trautweinn@nrf.com.

Sincerely,



David French
Senior Vice President, Government Relations
National Retail Federation

American Academy of Pediatrics
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March 6, 2018

R. Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85

Dear Secretary Acosta:

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents, and young adults, I submit comments on the Proposed Rule by Department of Labor (DOL) to amend the definition of "employer" under Title I of the Employee Retirement Income Security Act (ERISA) section 3(5). We read the Proposed Rule with great interest, as it will affect child beneficiaries of employees enrolled in Association Health Plans (AHPs). We believe that commercial coverage for children, whether through a large employer, a qualified health plan or an AHP, must ensure access to timely, affordable, high-quality and age-appropriate health care that meets their unique needs.

We share the Department's goal of increasing access to affordable health care coverage and offering greater choice to individuals and small businesses so long as coverage, benefits, and patient protections for children are not undermined. While we applaud provisions that seek to protect against discrimination based on health status, we believe the Proposed Rule could leave children, particularly children with serious, chronic, or complex medical needs, with less comprehensive coverage and higher out-of-pocket costs. Therefore, we respectfully urge DOL to consider the implications of the rule for the health and wellbeing of our nation's children and pregnant women before finalizing the proposed regulatory changes.

We look forward to working with you to find mutually agreeable solutions that strike the correct balance between affordability and comprehensiveness of coverage for children. Our specific comments are below.

Employer definition, Bona fide group or association of employers, and Commonality of Interest (§ 2510.3-5(a)-(c))

Sections 2510.3-5(a) to (c) of the Proposed Rule will increase the availability of AHPs accessible to individuals and businesses by broadening commonality of interest requirements, permitting employers to come together for the sole purpose of obtaining health coverage, and allowing working owners to join associations. These changes could significantly increase the number of children enrolled in AHPs as dependent beneficiaries.

Under current DOL guidance, many existing AHPs are treated as individual or small group coverage and therefore subject to important regulations under the Affordable Care Act (ACA) that protect the unique needs of children and families, including essential health benefit and actuarial value requirements. As articulated in the preamble, the Proposed Rule would treat many more AHPs as single large multiple employer plans, exempting them from many of these vital protections.

Children are not little adults; they require services and care specific to their unique development and medical needs. Children need a benefit package that ensures timely and affordable access to a comprehensive set of pediatric services, whether they are relatively healthy or have special health care needs. The expansion of AHPs has the potential to move children to cheaper, less comprehensive coverage. We fear this could erode access to important essential health benefits like vaccines, prescription drugs, mental health services, dental and vision services, and habilitative services. A gap in benefits can result in life-long health consequences that are both avoidable and costly. Pediatricians have reported that their experiences with AHPs include poor reimbursement and inadequate benefit packages that have harmed the ability of their patients to access affordable and comprehensive health coverage. The proposed rule contains insufficient protections against these patient harms and we urge that the rule be strengthened to address these concerns.

Additionally, we are concerned that increased enrollment in AHPs could lead to higher cost sharing for families of children with severe, chronic, or complex medical needs. Further, the changes proposed in this regulation could allow these plans to implement annual and lifetime caps on benefits that are no longer included as essential benefits. Increased cost sharing or benefit caps could put families of vulnerable children at serious financial risk.

Also included in the proposed regulation are new criteria to define the "commonality of interest", which would allow employers to come together to form an AHP if they share a common city, county, or metropolitan area. We urge the Department to work with state regulators to ensure that states have both the tools and the authority to conduct stringent oversight of AHP network design. Provider network design and oversight is critically important for children, especially those in need of pediatric specialty and subspecialty services, so that children are receiving timely, appropriate services for their unique health care needs. Inadequate and limited networks that do not include a range of appropriately trained pediatric specialists and subspecialists may result in care delays with poor medical outcomes that ultimately cost insurers and consumers more.

In addition, it is not uncommon for children to travel across state lines to get needed care from a pediatric provider with the requisite training and expertise due to the regional nature of pediatric specialty care. However, as proposed, AHPs could be formed by employers within a common city, county, or metropolitan area, which could result in provider networks with varying geographic boundaries. Absent specific standards that ensure a full range of in-network pediatric providers, families may not have access to an appropriately trained in-network specialist due to those geographic limits.

Children with severe, chronic, or complex medical needs could be subject to high out-of-pocket expenses if they are required to seek out-of-network care to meet their health needs. In the absence of federal standards for provider networks, some children and families could find themselves unable to access the care they need despite having health coverage.

Nondiscrimination (§ 2510.3-5(d))

We applaud the Department's inclusion of nondiscrimination provisions in the proposed rule. However, we believe the nondiscrimination provisions in the rule must be strengthened to ensure that children and their families are protected against adverse risk selection and cherry-picking. In particular, we believe it is

necessary to prohibit AHPs from discrimination that can occur due to limited benefit designs, limited drug formularies and narrow provider networks. We believe that the proposed rule opens the door to health plan benefit and provider network design that can serve as disincentives for individuals with significant health conditions to enroll in those health plans. For example, issuers could exclude certain pediatric specialty providers from their networks and, in so doing, steer parents of a child with special health care needs away from their plan. As a result of this discriminatory network design, the issuer can avoid risk and lower premium costs because it does not enroll individuals with significant health care needs.

We also are concerned about the impact of AHPs with limited benefit packages and networks on children and families that seek coverage through ACA-compliant plans inside or outside of the Marketplaces. As the Department notes in the rule's regulatory impact analysis, the expansion of AHPs that offer lower-cost, less-comprehensive coverage would be most attractive to healthier individuals, thereby drawing them out of the traditional market. The segmented market will result in increased premiums for the more comprehensive non-AHP, ACA-compliant plans that more appropriately cover the services and include the providers that children need. Unfortunately, the nondiscrimination provisions of the proposed rule would not protect children and families from these discriminatory practices.

Oversight of AHPs

In the past, AHPs have at times been associated with fraud, abuse, and insolvency, leaving children and their families with unpaid benefits and bills.[1] While the Proposed Rule offers criteria intended to prevent abuse by ensuring bona fide employment-based associations, the relaxed restrictions afforded to AHPs open the door for potential abuse.

As noted in the regulatory impact analysis, self-insured AHPs have been particularly vulnerable to mismanagement, abuse, and evasion of state regulation and require specific attention. Therefore, we also seek clarification that state requirements for AHPs, including laws and regulations that prohibit their establishment in the state, will not be superseded in any way by federal regulations or guidance. We respectfully remind DOL that several states currently have laws and regulations in place that either prohibit the establishment of AHPs outright or place strict limits on them.

In conclusion, the AAP appreciates this opportunity to submit a comment on this Proposed Rule. We look forward to working with you to ensure that the unique health care needs of children are met in any health insurance product or program. If you have any questions, please do not hesitate to contact Marielle Kress in our Washington, D.C. office at 202/347-8600 or mkress@aap.org.

Sincerely,

Colleen A. Kraft

Colleen A. Kraft, FAAP
President

[1] Kofman, M. Association Health Plan: Loss of State Oversight means Regulatory Vacuum and More Fraud. Georgetown University Health Policy Institute. 2015. Available at: https://hpi.georgetown.edu/ahp.html

March 6, 2018

Submitted electronically via http://www.regulations.gov

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: Definition of Employer – Small Business Health Plans RIN 1210-AB85

Re: Proposed Rule on Association Health Plans

Dear Sir or Madam:

I write on behalf of the American Benefits Council ("Council") to provide comment in connection with the proposed rule published in the Federal Register on January 5, 2018, by the Department of Labor ("Department") entitled "Definition of 'Employer' under Section 3(5) of ERISA – Association Health Plans" ("Proposed Rule").

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

The Council appreciates the opportunity to provide comment with respect to the Proposed Rule.

The Department notes in the preamble to the Proposed Rule that "many consumers have continued to face rising costs of coverage," as well as "a lack of quality and affordable health care options." 83 Fed. Reg. 614, 620 (January 5, 2018). One area where

Americans have generally been able to access comprehensive, high-quality and affordable coverage options is through the employer-based system whereby employers sponsor group health coverage for use by their employees as well as their employees' spouses and dependents.

The success of the employer-based model is due, in part, because employers take very seriously their role in sponsoring health care coverage and seek to provide comprehensive coverage that meets the needs of their employees and their employees' families. Additionally, a great many of our members, as well as employers generally, provide material premium assistance to employees to bring down their employees' cost of coverage and help ensure access as needed to coverage.

The Council is generally supportive of the Proposed Rule's goal to expand access to affordable health coverage by facilitating the establishment and maintenance of association health plans or "AHPs". Under the existing "employer" definition of ERISA section 3(5) – and specifically the Department's existing "commonality of interest" standard as set forth in administrative guidance – companies (both large and small) have found, or otherwise may find it, challenging to come together to facilitate multiple employer welfare arrangements ("MEWAs") that can qualify as a single large group health plan.

We note that the Proposed Rule, if made final, would not only help small employers (including qualifying sole proprietors) access large group plan coverage, but it could also be helpful for employers more generally in certain common scenarios.

For example, the Proposed Rule would allow employers that share certain organizational or corporate goals – such as franchises in a franchisor-franchisee arrangement – to come together through the establishment of an association and qualifying AHP to secure coverage for the employees of the various franchises. Effectively, the Proposed Rule would allow these employers to pool their resources and purchase insurance as a large group under ERISA, which, in turn, could result in lower cost, higher-quality coverage for the employees of the participating franchises.

Additionally, the Proposed Rule could make it easier for employees of a joint venture to access affordable group coverage via the use of an AHP. In the Council's experience, it is not uncommon for two or more employers to come together to establish certain joint venture arrangements whereby no single entity (including affiliates) owns 80% or more of the venture. As a result, if one of the owner entities allowed the employees of the joint venture to participate in its corporate-level plans for its own employees, its plans would risk becoming MEWAS, and if the plans are insured, this could raise material state law compliance issues (since many states prohibit or strictly regulate the offering of self-funded MEWAs). The Proposed Rule, by facilitating the establishment of AHPs, could open up new, more cost-effective coverage options for these sorts of joint ventures.

Lastly, we note that the Proposed Rule, if made final, could be helpful for state and federal government contractors. While outside of the scope of this comment, some state laws, as well as federal law, require that prime contractors provide certain minimum benefits to employees working on a specific contract. *See e.g.*, Davis Bacon Act and Service Contract Act. Relatedly, contracting rules may also require or otherwise encourage a prime contractor's use of certain smaller or local subcontractors in connection with performance of the contract – however, it is not uncommon for certain of these subcontractors to lack the extent and/or quality of benefits that may be offered by the prime or other of the subcontractors. The Proposed Rule could be helpful in the contracting setting by allowing the prime contractor to establish a contract- (or contracts) specific AHP that would facilitate coverage for the employees across the participating prime and/or subcontractors.

ANY FINAL RULE SHOULD PERMIT EMPLOYERS OF ALL SIZES TO PARTICIPATE IN AHPS

The Council appreciates the Department's recognition that both small and large employers could benefit from expanded access to AHPs:

> One of the primary aims of this proposal is to give small employers (as well as sole proprietors and other working-owners) the opportunity to join together to provide more affordable healthcare to their employees; however, the proposed regulation would not restrict the size of the employers that are able to participate in a bona fide group or association of employers. The Department expects minimal interest among large employers in establishing or joining an AHP as envisioned in this proposal because large employers already enjoy many of the large group market advantages that this proposal would afford small employers. However, the Department anticipates that there may be some large employers that may see cost savings and/or administrative efficiencies in using an AHP as the vehicle for providing health coverage to their employees.

83 Fed. Reg. at 620.

For the reasons noted by the Department itself, and those discussed above, the Council urges the Department to make clear in any final rule that employers of all sizes will be permitted to utilize AHPs.

CLARIFY "WORKING OWNER" ELIGIBILITY

The Department proposes to expand the definition of an ERISA section 3(5) "employer" to include a "working owner," the latter of which would be defined in proposed regulation section 2510.3-5(e)(2).

Sub clause (iii) of the definition of "working owner" provides that a working owner cannot be "eligible to participate in **any subsidized group health plan** maintained by any other employer of the individual or of the spouse of the individual."

The reference to "any subsidized group health plan" would appear to include not only group major medical coverage, but also ancillary or supplemental group health coverages, such as dental-only or vision-only coverage. We are concerned that this requirement, as drafted, confuses group major medical coverage with supplemental or ancillary group health coverage.

It is possible that some working owners may be performing services as a common law, i.e., "W-2", employee for another business, with this other business offering some degree of health coverage, but not group major medical coverage. To help ensure that individuals are not inadvertently restricted from accessing AHP coverage by reason of having access to only ancillary group health coverage, we recommend that sub clause (iii) of the definition of "working owner" be revised to reference "group health plan coverage that is minimum essential coverage (as defined in Internal Revenue Code section 5000A)."

FINAL REGULATIONS SHOULD PROVIDE SUFFICIENT SAFEGUARDS TO PROTECT THE STABILITY OF THE INDIVIDUAL HEALTH INSURANCE MARKET

In the preamble to the Proposed Rule, the Department recognizes the potential adverse effect to the individual and small group insurance markets as a result of the proposed expansion of a section 3(5) "employer." Specifically, the Department states:

> The Department considered the potential susceptibilities of individual and small group markets to adverse selection under this proposal. All else equal, individual markets may be more susceptible to risk selection than small group markets, as individuals' costs generally vary more widely than small groups'. The Department believes that under this proposal AHPs' adherence to applicable nondiscrimination rules and potential for administrative savings would mitigate any risk of adverse selection against individual and small group markets.

83 Fed. Reg. at 620.

The Council supports policies intended to result in a robust and healthy insurance marketplace. This is, in part, because the individual market is relied upon by millions of American workers, including those who may not be eligible for employer-sponsored coverage, such as contingent and part-time workers, as well as those participating in what is often referred to as the "gig economy."

Individual insurance is also a meaningful alternative to employer-sponsored

continuation coverage (i.e., COBRA coverage) for use by an employee when he or she terminates employment or leaves the workforce. For many employees who terminate employment or otherwise leave the workforce, individual insurance coverage may be the more affordable option due to the potential eligibility for federal subsidies (especially in the absence of any premium assistance from the employer as may have been provided during active employment).

Individual insurance is also a very important source of health coverage for pre-65 retirees who are not eligible for Medicare. Access to comprehensive, affordable coverage is particularly valued by these individuals as they may experience chronic health issues generally associated with advancing age.

Finally, a robust and stable individual market that reduces the number of uninsured will decrease instances of uncompensated care. Uncompensated care for providers results in cost-shifting by providers to other payers, including large plan sponsors and participants in the health benefits plans they sponsor.

For these reasons and the overall importance of the individual insurance markets to Americans as a whole, the Council urges the Department to take steps to ensure that any final rule with respect to AHPs not result in further adverse risk selection or segmentation to the individual insurance market. This will ensure that the individual insurance market remains a viable coverage option for the tens of millions of Americans that rely on it for health insurance coverage.

* * *

Thank you for considering these comments submitted in response to the Proposed Rule. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

Kathryn Wilber
Senior Counsel, Health Policy

State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
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PHIL MURPHY
Governor

SHEILA OLIVER
Lt. Governor

MARLENE CARIDE
Acting Commissioner

March 6, 2018

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed regulation, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans" (83 Fed. Reg. 614 (Jan. 5, 2018)) (AHP Proposed Rule). This proposed regulation expands the criteria under ERISA for determining when employers may join together in an association that is treated as the ERISA "employer" of a single, multiple employer group health plan. I submit this comment letter on behalf of the New Jersey Department of Banking and Insurance.

Before turning to New Jersey's state-specific comments on the proposed regulation, please note that New Jersey endorses the general comments submitted by the National Association of Insurance Commissioners (NAIC) with regard to state insurance commissioners' long history of regulating insurance in general and Multiple Employer Welfare Arrangements (MEWAs) in particular, and the importance of that state-based regulation for consumer protection. The history of insolvencies of MEWAs has demonstrated the need for state regulation, and Congress enacted amendments to federal law in 1983 to give state regulators such powers. Since that time, solvency regulation by state insurance commissioners has been key in ensuring MEWAs members, and the providers rendering care to those members, receive the benefits promised.

New Jersey also agrees that it is particularly important that the federal rule, if implemented, not threaten the states' abilities to enforce existing laws or enact laws in the future that regulate insurance. States – like New Jersey – remain in the best position to monitor closely what is happening in their insurance markets and have the tools in place to respond quickly as issues arise. This has long been considered of particular importance in New Jersey.

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 our Small Employers Health Benefits Program Board. N.J.S.A. 17B:27A-48; N.J.S.A. 17B:27C-8 (New Jersey small employer market is an employer with 50 or less employees).

The rule proposal states that it does not intend to impact the ability of states to regulate MEWAs; however, with a plain language reading of the amendment, the intent of the rule and the impact on New Jersey is unclear. We urge the Department of Labor (DOL) to clearly state that the rule in no way limits the ability of states to continue their existing regulation of multiple employer associations/MEWAs, especially with respect to members that are defined as small employers under State law. Despite the clear language in N.J.S.A. 17B:27A-48 and N.J.S.A. 17B:27C-8, entities in the past have unlawfully sold non-compliant coverage in New Jersey and extensive state administrative enforcement actions were needed to protect our small employers, their employees and medical providers, ensuring that they had the protections required under New Jersey law. Since those enforcement actions took time, and until those instances of noncompliance were addressed, many citizens failed to enjoy all of the protections to which they were entitled under New Jersey law. In addition, there were financial expenditures for the State associated with these investigations and subsequent cessation of the plans. On these grounds, we urge the DOL to affirm the states' continued ability to enforce their laws applicable to association plans/MEWAs and not inadvertently encourage the formation of new non-compliant plans.

New Jersey enacted significant reforms for our small employer market that were first effective in 1994. While enrollment in small employer plans steadily and significantly increased as a result of the reforms, enrollment began to decrease with the economic recession in 2008. Even after recovery from the recession, enrollment continues to decline. While small employers are not able to join associations to be treated as large employers, small employers, particularly those with younger, healthy lives, are becoming increasingly attracted to self-funded programs. Many small employers are unwilling or unable to participate in self-funded programs which means the small employer plans continue to be purchased. However, if the association health plan proposal were to be adopted, and if the DOL were to take the position that the regulation pre-empts state law, employers currently securing coverage in the small employer market may find the rates for a large group association plan more attractive and exit the small employer market. The resulting loss of participation in the small employer market would increase adverse selection and further increase costs.

New Jersey appreciates the desire to enable small employers to have more plan choices at what may be lower premium rates. However, if the rule requires New Jersey to ignore the nature of employer members in the association/MEWA, then the rule will deprive New Jersey small employers of the comprehensive benefits they are promised under State law. Simply put, the associations/MEWAs would be free to offer plans that are not as comprehensive as those required to be sold to small employers. Furthermore, standard small employer plans in our State contain benefits far richer than those that are mandated by New Jersey law for large groups. To the extent the association plan is issued outside of New Jersey, the benefits would not even include New Jersey mandated benefits. The more affordable premium comes with a cost – less coverage for small employers.

Despite the DOL's efforts in the rule proposal to prohibit discrimination, we are concerned that monitoring and enforcement of the association/MEWA plans will be problematic if the definition of employer is expanded to eliminate the long-standing requirements for "bona fide" employer groups/associations. The Department is concerned that these associations/groups will be subject to increased levels of impermissible medical underwriting. The concern is even more acute as the proposed definition of eligible employers includes employer types that are required to seek coverage in the individual market under the Affordable Care Act. Medical underwriting increases adverse selection and the premiums in the individual and small employer markets. The result leads carriers to withdraw from the market or at least reduce plan offerings; this is commonly called the adverse selection "death spiral". Overall, the expanded availability of association plans would lead to fewer carrier and plan choices that provide comprehensive coverage. The reduction in plan offerings will leave the population that needs comprehensive coverage with few or no options, and any available options will have very high premiums. For these reasons, any expansion of the definition and implementation of the proposed regulation should continue to permit states – like New Jersey – to enforce long-standing laws aimed at preventing such a death spiral and ensuring our consumers have comprehensive coverage.

Thank you for this opportunity to comment.

Sincerely,

Marlene Caride
Acting Commissioner

Attorneys General of New York, Massachusetts, California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Maine, Maryland, New Jersey, New Mexico, Oregon, Pennsylvania, Vermont, Virginia

March 6, 2018

Via Federal eRulemaking Portal
Director Joe Canary
Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW, Ste. N-5655
Washington, DC 20210

Re: Comments on Proposed Rule: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 614 (Jan. 5, 2018), RIN 1210-AB85; Request for a Public Hearing

Dear Mr. Canary:

The undersigned State Attorneys General submit these comments to oppose the Department of Labor's Proposed Rule: *Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans*, 83 Fed. Reg. 614 (proposed Jan. 5, 2018) (to be codified at 29 C.F.R. pt. 2510) ("Proposed Rule"). The Department of Labor ("Department" or "DOL") proposes to expand the criteria for determining when employers may join together in an association to purchase health coverage, allowing individuals and small employers unprecedented ability to group together as an association in order to exempt them from many of the Affordable Care Act ("ACA") protections that currently apply to individual and small group plans (including essential health benefit coverage and premium restrictions based on race and sex). These changes would increase the risk of fraud and harm to consumers; would undermine the current small group and individual health insurance markets; and are inconsistent with the text of the Employee Retirement Income Security Act ("ERISA") and the ACA.

Association Health Plans ("AHPs") have a long and notorious history of fraud, mismanagement, and deception. Over decades, Congress has legislated – including through ERISA and the ACA – to protect health care consumers from this fraudulent conduct. The Proposed Rule would reverse many of these critical consumer protections and unduly expand access to AHPs without sufficient justification or consideration of the consequences. Because the Proposed Rule is an unlawful attempt to accomplish by executive rulemaking changes in law and policy that lie within the power of Congress – and that Congress has refused or failed to adopt – we urge that the Proposed Rule be withdrawn. In addition, in light of the significant impacts this proposal would have on the States' consumers, health care markets, and

enforcement resources, we request that the Department hold a public hearing to receive input from affected stakeholders before any regulatory changes are finalized.[1]

I. Background

Section 3(5) of ERISA defines "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." 29 U.S.C. § 1002(5). ERISA allows an "association of employers" to manage employee benefit plans offering health insurance. To protect these associations from becoming mere commercial insurance arrangements that serve only a profit motive – instead of operating as legitimate employer/employee health benefit plan arrangements as ERISA intended – the Department has consistently required that members of such associations consist of a "bona fide" group of employers with a high degree of common interest, or *"commonality of interest,"* beyond solely purchasing or offering health insurance. The association's employer members must also themselves exercise "control," both in form and substance, over the activities and operations of the employee welfare benefit plan.

The Proposed Rule largely eliminates these current requirements, and instead would allow *any* group of employers in the same industry or the same geographic area to form employer associations under ERISA, even if their sole purpose is simply to purchase health insurance. In short, the Proposed Rule would make three substantial changes:

1. Eradicate longstanding ERISA definitions such that associations may form solely for the purpose of purchasing or providing health plans if the employers are in the same industry or the same geographic region;
2. Deem self-employed individuals to be both employers and employees such that they can participate in employer associations; and
3. Allow most associations to be single, large employers such that they may evade many ACA requirements (now imposed on small group and individual plans).

These changes would vastly expand the ability of AHPs to form in ways that would result in fewer protections for our citizens, increased fraud within our borders, and destabilization of our individual and group markets.

[1] *See, e.g.*, U.S. Dep't of Labor, *Hearing on Definition of the Term "Fiduciary"; Conflict of Interest Rule – Retirement Investment Advice and Related Proposed Prohibited Transaction Exemptions*, 80 Fed. Reg. 34,869 (June 18, 2015) (scheduling a four-day public hearing for August 2015 to consider issues related to the Department's proposed conflict of interest rulemaking under ERISA); U.S. Dep't of Labor, *Hearing on Definition of "Fiduciary"*, 76 Fed. Reg. 2142 (Jan. 12, 2011) (scheduling a two-day public hearing for March 2011 to receive input on the Department's October 2010 fiduciary rulemaking proposal under ERISA, "to ensure that all issues are fully considered and interested persons have sufficient time to share their views on this important regulation").

II. The Proposed Rule Would Facilitate Increased Fraud and Misconduct Relating to AHPs

AHPs and other multiple employer welfare arrangements ("MEWAs") have a lengthy and well-documented history of fraud and abuse. Although AHPs and other MEWAs are not uncommon, very few of these arrangements are covered by ERISA as they commonly fail to meet the requirements of ERISA and longstanding DOL regulations and guidance. By dramatically expanding the use of AHPs under ERISA, while also failing to include any provisions that would decrease the likelihood of future misconduct, the Proposed Rule would substantially weaken the current regulatory structure that safeguards against fraud and abuse.

A. There Has Been an Extensive History of Fraud and Mismanagement Associated with AHPs

By enacting ERISA in 1974, Congress federalized the regulation of employee benefits, including employee benefits plans. Immediately after ERISA's passage, various entities marketing MEWAs entered the health insurance market. The plans offered by these entities were rife with abuse and mismanagement and left behind a trail of unpaid claims.[2] When states sought to enforce their own insurance laws to regulate these plans, the entities argued that ERISA preempted state law, in many cases hindering efforts to stop fraudulent and illegal activity.[3] At the same time, the DOL claimed to lack authority over these insurance arrangements because most were not, in fact, ERISA plans.[4]

In response, Congress amended ERISA in 1982 to eliminate any doubt regarding ERISA preemption of state laws as to MEWAs, firmly declaring that MEWAs are subject to state insurance laws, *see* 29 U.S.C. § 1144(b)(6)(A), and recognizing that the federal government alone could not adequately protect consumers against the fraud and insolvency of MEWAs.[5]

Despite the unambiguous authority granted to the states to regulate MEWAs, entities seeking to market dubious AHPs have sought to exploit any regulatory gaps. These entities have an extensive record of fraud, gross mismanagement, and illegal activity in the marketing and operation of MEWAs and AHPs across the country.[6] In the late 1980s, scammers unleashed a

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[2] Mila Kofman, *Assoc. Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Health Policy Inst., at 2 (Summer 2005), https://hpi.georgetown.edu/ahp.html (providing history of attempts to regulate AHPs by state and federal governments).

[3] *Id.* at 7; *see also* U.S. Government Accountability Office ("GAO"), *Employee Benefits: States Need Labor's Help Regulating MEWAs*, GAO/HRD-92-40, at 8 (Mar. 10, 1992), https://www.gao.gov/assets/220/215647.pdf; U.S. Dep't of Labor, *MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Fed. and State Regulation*, at 3 (Aug. 2013), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

[4] Mila Kofman, *supra* note 2, at 7.

[5] The House of Representatives had earlier clarified the intended scope of ERISA through a resolution stating that plans marketed by entrepreneurs to employers and employees are not covered by ERISA. *See* H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).

[6] *See, e.g.*, GAO, *Private Health Ins.: Employers and Individuals Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312, at 3-5 (Feb. 27, 2004), https://www.gao.gov/assets/250/241559.pdf; GAO,

wave of fraud and misconduct through phony unions, relying on the ERISA exemption for collectively bargained union plans. From 1988 to 1991, failed MEWAs left thousands of people in dozens of states without health insurance and nearly 400,000 patients with medical bills exceeding $123 million.[7] Following a 1991 Senate Report finding that fraudsters attempted to use ERISA to avoid state oversight, Congress eventually required MEWAs to register with the DOL before operating in a state.[8]

A 2004 GAO Report again found that employers and individuals were vulnerable to unlicensed or "bogus" entities selling fraudulent health insurance coverage through, among other things, "associations they created or through established associations of employers or individuals."[9] In total, GAO identified 144 unauthorized entities that covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002.[10] These entities failed to pay at least $252 million in medical claims and state and federal regulators were able to recover only a fraction of this amount.[11] Although state insurance departments sought to stop these entities' activities in their states, nationwide enforcement was hampered because many of the promoters operated across state lines and the DOL was not able to effectively clamp down on these plans.[12]

The ACA, passed in 2010, aimed to provide comprehensive health coverage for all, and its provisions have worked to prevent MEWA fraud in a number of ways. AHP members benefit from the protections of the individual and small group health plan market, including requirements to cover essential health benefits and meet actuarial value requirements. These protections are vitally important in light of the extensive history prior to the ACA of skimpy health plans (of the sort that the DOL now seeks to encourage) causing significant harm to consumers through, for example, medical bankruptcies, failure to cover necessary benefits, and caps on coverage. In addition, the ACA incorporated a series of enforcement tools to prevent MEWA abuses. *See, e.g.*, Sections 4376 (imposing fees on applicable self-insured MEWAs); 6601 (prohibiting false statements in connection with the marketing and sale of MEWAs – subject to up to ten years of imprisonment or fine); 6602 & 10606 (amending definition of "federal health care offense" to include violation of MEWA-related provisions); 6605 (enabling the DOL to issue administrative summary cease and desist orders against plans, including MEWAs, that demonstrate financially hazardous conditions); 6606 (requiring MEWAs to register with the Secretary of Labor before operating in a state). These enforcement tools, which include fines and imprisonment, evidence the serious concerns Congress had with respect to MEWAs – plans that the Proposed Rule now seeks to proliferate.

Employee Benefits: States Need Labor's Help Regulating MEWAs, at 3-7; Mila Kofman, et al., *Proliferation of Phony Health Ins.: States and the Fed. Govt. Respond*, Bureau of Nat'l Affairs, at 13-15 (Fall 2003).

[7] GAO, *Employee Benefits: States Need Labor's Help Regulating MEWAs*, at 2-3.

[8] Mila Kofman, *Ass'n Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, *supra* note 2, at 12.

[9] GAO, *Private Health Ins.: Employers and Individuals Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, at 1-4.

[10] *Id.* at 4.

[11] *Id.*

[12] *Id.*

B. The Proposed Rule Would Dramatically Increase Problematic Use of AHPs by Weakening the Structural Safeguards Against Fraud and Abuse

As States and State Attorneys General, we have extensive experience protecting individuals and small employers within our states from predatory entities that seek to defraud or deceive customers through the use of AHPs. *See infra* Part VI. In light of this experience, we believe that the Proposed Rule would invite fraud and wrongdoing in the health insurance market that will threaten the health and financial security of consumers in our states.

First, by weakening the "bona fide association" requirement to allow unrelated employers to associate solely for health benefit purposes, the Proposed Rule would encourage fly-by-night associations to form, engage in misconduct, and disappear with employees' premiums. The Proposed Rule would transform the "bona fide association" conditions by (a) allowing the provision of health insurance to be the sole reason for an association's existence; (b) not requiring the association sponsoring an AHP to have been in existence for any length of time or to demonstrate its legitimacy its any other way; (c) eliminating the requirement that the association maintain substantive control over the AHP and, instead, require only that it have "formal" control by maintaining an organizational structure with by-laws and a board of directors; and (d) allowing geographic proximity alone to establish "commonality of interest." 83 Fed. Reg. 614, 635.

These changes would expand the treatment of "bona fide associations" to such an extent as to evade the statutory requirement that the association "act[] directly as an employer, or … indirectly in the interest of an employer." 29 U.S.C. § 1002(5). Under ERISA, the employer or an association on its behalf is intended to serve as the guarantor of its employees' interests; but an association that is not truly a bona fide representative of its employer members cannot be counted on to protect them. It is the "representational link between employees and an association of employers in the same industry who establish a trust for the benefit of those employees" that provides the "protective nexus" that differentiates ERISA plans from other health insurance arrangements. *MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 186 (5th Cir. 1992). The Proposed Rule weakens the requirements to be a "bona fide association" so extensively that it would essentially eliminate any requirement of an underlying employer-employee relationship, without which small employers and employees are vulnerable to entities offering health insurance with whom they have no preexisting relationship at all. It is for this reason that Congress specifically did not include "commercial products within the umbrella of the employee benefit plan definition." *See* H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).

Second, the Proposed Rule would further weaken protections against fraud and mismanagement by allowing individuals who purport to own a business to join AHPs as employers even though they have no employees ("working owners"). 83 Fed. Reg. 614, 636. The Proposed Rule would not require the association sponsoring the AHP to obtain any evidence beyond the written representation of the working owner that he or she in fact owns a qualifying business. *Id.* This provision is particularly susceptible to abuse because it opens the door for fraudsters to market to individuals and then enroll them if they "check a box" confirming compliance with the written representation requirement in the Proposed Rule. The AHP could

then collect premiums, and, in the event that a policyholder submits claims, conduct an "audit" that results in the policy being cancelled or rescinded when it turns out that the individual did not, in fact, qualify as a "working owner" as defined in the Proposed Rule. AHP promoters have long marketed fraudulent or deceptive health plans to individuals through associations with whom the individuals have no relationship other than the provision of health insurance; if the Department grants them explicit permission to do so, they will again seize the opportunity to enroll untold numbers of individuals in similar plans.

The potential for fraud is particularly concerning given the characteristics of the "working owners" that AHP promoters are likely to target if the Proposed Rule is promulgated. For example, a business owner may require workers to establish their own LLCs so that the owner can misclassify these individuals as independent contractors even though they might otherwise meet the legal definition of employees. These employers would then very plausibly work with promoters to offer these employees access to AHPs that provide few benefits and little security, while nonetheless creating the impression that their employees are enrolling in comprehensive health care coverage. Workers in these situations, who are already subject to wage theft and other abuses, will be prime targets for unscrupulous AHPs when they should be considered employees eligible for employer-sponsored insurance in the first place. Similarly, "gig economy" workers could be taken advantage of through "employers" who promise health insurance, but arrange for skimpy AHP coverage instead, leaving these workers exposed to unexpected medical bills and without coverage for necessary medical services. Workers such as these are very likely to be harmed given the propensity of AHP promoters to engage in fraud and abuse or, at minimum, to offer skimpy plans with limited coverage.

Third, the Proposed Rule seeks to allow AHPs to provide coverage to a massively expanded universe of "employers" at the "association-level," rather than at the "employer-level." 83 Fed. Reg. 614, 618-19. The ACA's regulation of most AHPs at the "employer-level," generally as small groups, has reigned in much of AHPs' fraud and abuse.[13] By moving so many small employers and individuals out of these markets and into the large group market, the Proposed Rule would undermine the ACA's requirement of providing comprehensive coverage to individuals as well as to employees of small employers.[14] For example, the Proposed Rule would allow small employers and "working owners" who do not share a true commonality of interest and who do not belong to a bona fide association in any meaningful way to be regulated as a single large employer, outside of the individual and small group plan protections of the ACA, opening the door to fraud and abuse. 83 Fed. Reg. 614, 618-19. Moreover, the Proposed

[13] The Centers for Medicare & Medicaid Services in 2011 set forth: "[I]n most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules. In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the 'employer,' the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules." Memorandum from Gary Cohen, Acting Dir., Office of Oversight, Ctrs. for Medicare & Medicaid Servs., (Sept. 1, 2011) ("CMS 2011 Guidance"), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf. This guidance was also codified by New York. N.Y. Ins. Law § 4317(d)–(e).

[14] *Id.*

Rule's application will result in segmentation of the health care market into inexpensive plans with little coverage for the healthy and expensive full coverage for those with preexisting conditions.

III. The Proposed Rule Would Violate the Administrative Procedure Act Because It Is Contrary to ERISA, and Because It Is an Arbitrary and Capricious Change of Longstanding Agency Position

A. The Proposed Rule's Weakening of the "Bona Fide Association" Definition, if Finalized, Would Be Unlawful

The Department's proposal to change the "bona fide association" conditions is inconsistent with ERISA and several decades of case law applying ERISA, and would therefore be contrary to law and in excess of statutory authority. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."). Further, because the Proposed Rule is also inconsistent with the DOL's own longstanding position, this change would be arbitrary and capricious under the Administrative Procedure Act ("APA").

1. The Proposed Rule's New "Commonality of Interest" Requirements Are Contrary to ERISA

Section 3(5) of ERISA defines "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." 29 U.S.C. § 1002(5). When enacting ERISA, Congress's intent was clear: to maintain an employee benefit plan under ERISA, an association must be tied to the employees or the contributing employers by genuine economic or representational interests unrelated to the provision of health insurance benefits, and employer members participating in the plan must exercise actual control over the program.

Relying on a "plain reading of ERISA's language considered against the backdrop of express and implicit congressional intentions," Courts of Appeal have consistently held that the "definition of an employee welfare benefit plan is grounded on the premise that the entity that maintains the plan and the individuals that benefit from the plan are tied *by a common economic or representation interest, unrelated to the provision of benefits*." *Wis. Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1063, 1065 (8th Cir. 1986) (emphasis added) ("decision is premised on ERISA's language and Congress' intent"); *see also Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1998) ("commonality of interest requirement is well-established in the case law"); *MDPhysicians Inc.*, 957 F.2d at 185. This "common economic or representation interest" requires either that there be an "economic relationship between employees and a person acting directly as their employer" or a "representational link between employees and an association of employers in the same industry who establish a trust for the benefit of those employees." *MDPhysicians Inc.*, 957 F.2d at 185-86. Where the "only

relationship between the sponsoring [entity] and . . . recipients stems from the benefit plan itself," the "relationship is similar to the relationship between a private insurance company . . . and the beneficiaries of a group insurance plan," and is simply not covered by ERISA. *Wis. Educ. Ass'n Ins. Tr.*, 804 F.2d at 1063.

Moreover, under the Proposed Rule, AHPs would be allowed to organize for the sole purpose of offering health insurance coverage. Establishing an AHP for this purpose is the definition of a commercial insurance arrangement, rather than in service of an employer-employee relationship as intended by ERISA. This proposed change is inconsistent with Congress's intent of protecting ERISA plans from becoming mere commercial, for-profit insurance arrangements. *See Int'l Ass'n of Entrepreneurs of Am. Benefit Tr. v. Foster*, 883 F. Supp. 1050, 1057 (E.D. Va. 1995) (describing the circumstance of companies that market insurance products and characterize themselves as ERISA benefit plans to avoid state regulation, and noting that these plans "are no more ERISA plans than is any other insurance policy sold to an employee benefit plan") (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)).

Despite this uniform judicial interpretation of ERISA, the Department is proposing to redefine the bona fide association and commonality of interest requirements so that they no longer ensure that the association and the employees have a "common economic or representation interest unrelated to the provision of benefits." The Proposed Rule goes as far as allowing employers connected *only* by geography to satisfy the commonality of interest requirement, and for associations that exist for the sole purpose of providing health insurance to be deemed bona fide. 83 Fed. Reg. 614, 635. The DOL asserts that neither its "previous advisory opinions, nor relevant court cases, have ever held that the Department is foreclosed from adopting a more flexible test in a regulation . . . in determining whether a group or association can be treated as acting as an 'employer' or 'indirectly in the interest of an employer,' for purposes of the statutory definition." 83 Fed. Reg. 614, 617. However, the Department may not seek to issue a new regulatory interpretation that is counter to the unambiguous statutory language and the courts that have interpreted the statute. *See Public Citizen, Inc. v. Mineta*, 340 F.3d 39, 54-62 (D.C. Cir. 2003) (vacating rule because agency interpretation contravened legislative intent and plain reading of statute).

2. The DOL Does Not Offer Reasoned, Evidence-Based Rationales for Reversing Its Longstanding Position

The Proposed Rule would also be arbitrary and capricious because it would reverse several decades of consistent agency interpretation without reasoned support. *See Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015) (explaining that "the APA requires an agency to provide more substantial justification when 'its new policy rests upon factual findings that contradict those which underlay its prior policy'") (quoting *F.C.C. v. Fox Tel. Stations, Inc.*, 556 U.S. 502, 515 (2009)); *see also Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 57 (1983).

First, the Proposed Rule acknowledges but fails to address the long history of fraudulent and abusive conduct by AHPs and other MEWAs. The DOL concedes that "[h]istorically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving

participants and providers with unpaid benefits and bills." 83 Fed. Reg. 614, 631. The Department also acknowledges that "the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse, increasing potential oversight demands on the Department and State regulators." *Id.* at 632. In a footnote, the Department cites reports authored by the GAO and articles detailing the history of financial abuses associated with MEWAs. *Id.* at 614, n. 24. The DOL, however, does nothing else with these sources – whether to explain how the Proposed Rule would safeguard against the historical "financial mismanagement or abuse" it acknowledges, or to discuss any methods for preventing such fraud, or even mitigating the costs associated with a proliferation of abusive MEWAs. This is so despite the extensive records of this conduct maintained by the DOL, which may well show that entities that have engaged in fraud or gross mismanagement have operated in the very same ways that the Proposed Rule now seeks to encourage.[15] The justification provided by the Department – to allow more people to benefit from cheaper, less comprehensive plans – is woefully inadequate in the face of the clear history of fraud and abuse in the marketplace.

Second, the Proposed Rule allows AHPs to form on the basis of a "single industry or trade," *or* a common geographic region within a single state or multi-state metropolitan area, and dilutes the prior commonality of interest requirements to the point of elimination. The Proposed Rule now requires only formal association documents and the right of association members to elect the association's directors or officers that control the group or association. 83 Fed. Reg. 614, 620. Nothing in the Proposed Rule vests employer members with actual control over the directors or officers as is currently required by DOL guidance; instead, it appears to cede authority to govern the association to an elected body and *not* to the employer members. *See* DOL Adv. Op. 94-07A, 1994 ERISA LEXIS 11 (Mar. 14, 1994) (association's governing documents provided "no effective way for members to affect the Board or operations of" AHP and trust operating plan and thus failed the control requirements). There is nothing in the Proposed Rule that explains how employer members of the association can adequately guard against the adverse interests of those who would treat the AHP as a commercial enterprise, the purpose of which is to make money for its promoter, service providers and salesforce. The DOL's failure to provide reasoned and evidenced-based explanations for its departure from longstanding agency policy would be arbitrary and capricious if the Proposed Rule is enacted, and thus, the DOL should withdraw the Proposed Rule and start anew.

3. The Department's Failure to Include Any Quantitative Analysis of the Costs and Benefits of the Proposed Rule Is Unjustifiable

In addition, in proposing these extensive changes to how AHPs are defined and regulated, the Department has declined to include any quantitative analysis of the costs and benefits of the Proposed Rule. The failure to quantify the estimated costs to employees and health care consumers hinders the public's ability to comment on the Department's proposal, and is likely arbitrary and capricious under the APA.

[15] As other commenters have observed, the DOL's failure to make public and to analyze in the Proposed Rule its extensive data concerning AHP fraud and abuse provides a sufficient basis alone to require that the DOL withdraw the Proposed Rule and fundamentally reconsider its approach to this issue.

The Department's Regulatory Impact Analysis acknowledges that this proposal is "economically significant," and that the Department was therefore required to assess – including by quantifying – the costs and benefits of the proposal. 83 Fed. Reg. 614, 625. But despite acknowledging AHPs' history of "financial mismanagement and abuse," the Department makes no effort to assess the economic impact of weakening the requirements for groups seeking to qualify as bona fide associations. *Id.* at 631. Nor does the DOL quantify the likely costs of a proliferation of AHPs in the form of the additional resources to be needed by state and federal agencies to monitor AHPs and enforce state and federal standards. The Department makes only the general assumption that AHPs "are an innovative option" that "can help reduce the cost of health coverage" because AHPs will "help small businesses … to group together to self-insure or purchase large group health insurance." 83 Fed. Reg. 614, 615. In particular, the Department fails to quantify the likely attendant costs of a proliferation of AHPs on the existing individual and small group ACA markets.[16]

Agencies are obligated to provide reasons, not bare conclusions, to support an action. *Amerijet Int'l Inc. v. Pistole*, 753 F.3d 1343, 1350 (D.C. Cir. 2014) ("conclusory statements will not do; an agency's statement must be one of reasoning") (internal quotations omitted). Failing to quantify the costs of a proposal that could have as significant an impact on the health care market as this one would be arbitrary and capricious if absent in a final rule. *See Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin*, 538 F.3d 1172, 1201 (9th Cir. 2008) ("[T]here is no evidence to support [the agency's] conclusion that the appropriate course was not to monetize or quantify the value of carbon emissions reduction at all.").

B. The Proposed Rule's Dual Treatment of Sole Proprietors as Both Employers and Employees Is Unlawful

1. The Proposed Rule's Treatment of Sole Proprietors Is Contrary to ERISA

In a dramatic departure from judicial precedent interpreting ERISA, the Proposed Rule takes the unprecedented step of defining "sole proprietors" – referred to in the Proposed Rule as "working owners" – as both employers *and* employees. 83 Fed. Reg. 614, 621. This dual treatment of sole proprietors as employers and employees conflicts with ERISA and judicial interpretation of the statute's text. *See* 29 U.S.C. § 1002(5). This precise question was squarely before the Second Circuit in *Marcella v. Capital Dist. Physicians' Health Plan, Inc.*, 293 F.3d 42 (2d Cir. 2002). In *Marcella*, the court examined whether plaintiff, an independent contractor, could be a member of an AHP governed by ERISA. Membership in the plan at issue was open to "businesses with employees, but also to sole proprietorships without employees and to

[16] Projections forecast that the Proposed Rule, if finalized, will lead to 3.2 million enrollees shifting out of the ACA's individual and small group markets into AHPs by 2022 and that the Proposed Rule would increase premiums for those remaining in the individual ACA market by 3.5 percent. *See Association Health Plans: Projecting the Impact of the Proposed Rule*, Avalere (Feb. 28, 2018), http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf.

individuals such as plaintiff, *neither of which can logically be considered an 'employer'*…". 293 F.3d at 48 (emphasis added). The Second Circuit held that "[t]he plain language of the statute would, therefore, seem to preclude finding that the group is 'a group or association of employers,' because not all members of the Chamber are employers." *Id.* (quoting Section 3(5) of ERISA).

The Department cites *Yates v. Hendon*, 541 U.S. 1 (2004), to support its argument that self-employed working owners can participate in large group coverage through an association even if they have no employees, but *Yates* asked a different question. In *Yates*, the Court held that a working owner (*i.e.* the employer) can also qualify as a participant of an ERISA plan only "[i]f the plan covers one or more employees other than the business owner and his or her spouse." 541 U.S. at 6. In fact, the Court explicitly noted that "[c]ourts agree that if a benefit plan covers *only* working owners, it is not covered by Title I" of ERISA. *Id.* at 21, n. 6 (citing cases from the Second, Sixth, Ninth, and Eleventh Circuits) (emphasis added).

2. The DOL Does Not Offer Reasoned, Evidence-Based Rationales for Its "Working Owner" Definition as Both Employer and Employee

The Proposed Rule's expanded definition of "employer" to include sole proprietors also conflicts with well-established existing regulations. Most significantly, 29 C.F.R. § 2510.3-3(b) specifically excludes "any plan, fund, [and] program … under which no employees are participants covered under the plan" from the definition of ERISA-covered plans, and uses the specific example of a plan where "only [] sole proprietor[s] are participants" as *not* covered by ERISA. *See id.* at (c)(1) ("[a]n individual and his or her spouse shall *not* be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse.") (emphasis added). The Proposed Rule, which newly defines sole proprietors as employers and employees subject to ERISA, does not provide adequate justification for this significant proposed change.

Indeed, the Department acknowledges the strain of defining "sole proprietors" as both employers and employees, and attempts to minimize this well-established regulation, asserting its application is limited to "narrow circumstance" despite its previously broad application. 83 Fed. Reg. 614, 621. Ultimately, the Department is forced to concede that an amendment of current regulation may be the only way to avoid this irreconcilable conflict:

> [T]o the extent the regulation could result in working owners not being able to participate as employees even in some circumstances, the Department believes the policies and objectives underlying this proposal support an amendment of the 29 CFR 2510.3-3 regulation so that it clearly does not interfere with working owners participating in AHPs as envisioned in this proposal…. Accordingly, and to eliminate any potential ambiguity regarding the interaction of this proposal with the regulation at 29 CFR 2510.3-3, this proposal also includes a technical amendment of paragraph (c) of 2510.3-3 to include an express cross-reference to the working owner provision in this proposal. 83 Fed. Reg. 614, 621-22.

The stated policies and objectives to support such a change do not provide adequate legal support. The Department ultimately invites comment on ways to ensure that working owners who join an AHP are genuinely engaged in a trade or business. 83 Fed. Reg. 614, 622. But similar to the loosening of bona fide association and commonality of interest requirements, the DOL does not support the proposition of working owners as both employers and employees with plausible justification for this significant – and illogical – change. Notwithstanding that this unprecedented dual treatment of working owners as employer and employee will open the door to negative consequences, the DOL has failed to present adequate explanation for its reversal of longstanding agency policy, judicial precedent, and existing regulations.

IV. The Proposed Rule Conflicts with the ACA's Statutory Scheme and Congressional Intent

The intent of the Proposed Rule is not covert: the President himself plainly cited the sabotage of the ACA as the clear purpose of the Proposed Rule. While signing the Executive Order directing this rulemaking, he stated he was "taking crucial steps towards saving the American people from the nightmare of Obamacare,"[17] and tweeted the following day that "ObamaCare is a broken mess. Piece by piece we will now begin the process of giving America the great HealthCare it deserves!".[18] Just days ago, the President reiterated these points, saying at the Conservative Political Action Conference that "piece by piece by piece, Obamacare is just being wiped out."[19] Given the President's goal to destroy – rather than faithfully execute – the ACA, the Proposed Rule unsurprisingly conflicts with the ACA in its attempt to undermine the Act through executive means, as set forth in detail below.

First, the Proposed Rule is contrary to and will undermine the ACA's individual, small group and large group structure. The ACA categorizes health plans as large group, small group or individual, offering the greatest protections to small group and individual plans.[20] In its simplest terms, the Proposed Rule seeks to expand the category of "large groups" so that the many consumers previously protected by the ACA's individual and small group provisions will, through AHPs, become members of large group plans outside of many of the ACA's protections. Specifically, the Proposed Rule provides that unrelated small employers and "working owners" may band together solely for the purchase of insurance to form a single large employer, thereby undermining the market structure set forth by the ACA, which defines these small employers as part of the small group market, and "working owners" as part of the individual market. 42 U.S.C. § 18024(a)(1)-(3). The ACA builds this small group and individual market structure into

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[17] Donald J. Trump, President of the U.S., Remarks at Signing of Executive Order Promoting Healthcare Choice and Competition (Oct. 12, 2017), https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-executive-order-promoting-healthcare-choice-competition/.

[18] Zachary Tracer, *Trump Moving 'Step by Step' to Take Apart Obamacare on His Own*, Bloomberg (Oct. 13, 2017, 2:46 PM), https://www.bloomberg.com/news/articles/2017-10-13/trump-orders-an-end-to-key-obamacare-insurance-subsidies.

[19] Mathew Yglesias, *Donald Trump's CPAC Speech Is a Reminder That He's Not Really in Charge of His White House*, Vox (Feb. 23, 2018, 1:10 PM), https://www.vox.com/2018/2/23/17044770/trump-cpac-2018-speech.

[20] 42 U.S.C. § 18024(a); s*ee, e.g.*, 42 U.S.C. § 300gg–6 (requiring individual and small group health plans to provide coverage for ten essential health benefits); s*ee also* CMS 2011 Guidance, *supra*, note 13.

the ACA itself, as well as the Public Health Services Act ("PHSA") and ERISA.[21] The Proposed Rule, which candidly seeks to expand access to cheaper plans that do not have to abide by the ACA individual and small group rules, anticipates regulating these AHPs as large employers, and is thus in conflict with all three of these statutes. 83 Fed. Reg. 614, 615-16.

The ACA's individual, small group and large group market structure is clearly defined in 42 U.S.C. § 18024 and 42 U.S.C. § 300gg–91(e). Each market receives different ACA protections, with the individual and small group markets afforded the greatest protections. For example, the ACA requires small group plans to utilize adjusted community rating to calculate premiums, which prevents insurers from varying premiums within a geographic area based on age, gender, health status, or other factors.[22] 42 U.S.C. § 300gg(a). The ACA also requires individual and small group plans to cover ten essential health benefits, including pediatric services, maternity care, prescription drugs and coverage for mental health services. 42 U.S.C. § 18022(b). Large group plans, in contrast, are not subject to community rating or essential health benefit mandates, or many other requirements, including premium restrictions based on health status, gender or age.[23] 42 U.S.C. § 300gg(a).

These ACA market designations are also effectuated through amendments to the PHSA, and certain of these reforms are imported directly into ERISA. *See* 29 U.S.C. § 1185d (as amended by § 1536(e) of the ACA) (importing requirements of 42 U.S.C. §§ 300gg through 300gg–28 into ERISA "as if included" in that Act).[24] For example, the essential health benefits and community rating requirements of the ACA, applying only to individual and small group

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[21] *See, e.g.*, 42 U.S.C. §§ 300gg(a)-300gg–28 (applying PHSA requirements to group plans based on market size); 29 U.S.C. § 1185d (provision of ERISA enacted by the ACA importing PHSA provisions into ERISA); 42 U.S.C. § 300gg–91(e) (defining individual and very small group market levels for purposes of imported PHSA provisions).

[22] ACA; Health Insurance Market Rules; Rate Review; Final Rule, 45 C.F.R. §§ 144.101–144.214, 147.100–147.200, 150.101–150.465, 154.101–154.301, 156.10–156.1256 (2013), *available at* https://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf.

[23] Large employers are required to provide their employees with insurance coverage or pay a penalty ("the employer mandate"). Through the employer mandate, the ACA imposes standards on the employer itself, rather than regulating the plan offered by the employer or the insurance issuer selling the plan. These standards include that employers must offer coverage that achieves 60% actuarial value as measured against essential health benefits, or be at risk of paying a penalty of up to $3,000 per employee. 26 U.S.C. §§ 4980H(b), 36B(c)(2)(C)(ii). They must also provide a summary of benefits and coverage, and notice of the right to designate a primary care physician and gynecologist without prior authorization; set limits on out-of-pocket maximums; and comply with various reporting requirements. U.S. Senate, *The Patient Protection and Affordable Care Act as Passed Section-by-Section Analysis with Changes Made by Title X Included within Titles I – IX, Where Appropriate*, 1, 1-2, *available at* http://www.dpc.senate.gov/healthreformbill/healthbill53.pdf (last visited Mar. 5, 2018).

[24] 29 U.S.C. § 1185d (as amended by § 1563(e) of the ACA) inserted this language into ERISA: "[T]he provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart." Part A of Title 27 of the PHSA covers §§ 300gg through 300gg–28 of Title 42. *See* 29 U.S.C. § 1185d(a)(2) (as amended by § 1563(e) of the ACA) ("[T]o the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.").

plans, are incorporated into ERISA. 42 U.S.C. § 300gg–6.[25] Thus, ERISA itself was amended to incorporate the market structure and protections of the ACA.

In addition, in direct conflict with the Proposed Rule, the ACA provides that only in very narrow circumstances can employers join together to be treated as a single employer. This is achieved through the ACA's incorporation of the "aggregation rules" from the Internal Revenue Code ("IRC"). These aggregation rules determine when multiple business entities should be treated as a single employer. The ACA incorporates the IRC's aggregation rules, which state that an employer "treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 [the Internal Revenue Code of 1986]" should be treated as "1 [single] employer" for purposes of the ACA" (the "aggregation rule"). *See, e.g.*, 42 U.S.C. § 18024(b)(4)(A). Pursuant to these rules, businesses may be treated as a single employer when they are in a controlled group of corporations or under common control.[26] The ACA employs these aggregation rules in **eight** provisions.[27] Most significantly, 42 U.S.C. § 18024(b)(4)(A) uses the aggregation rule in order to determine employer size for small group and large group definitions; 26 U.S.C. § 45R(e)(5)(A) (as amended by § 1421 of the ACA) requires entities that meet the aggregation rule be considered a single employer for purposes of determining health insurance credits for small employers; and 26 U.S.C. § 4980H(c)(2)(C)(i) (as amended by § 1513 of the ACA) requires application of the aggregation rule to calculate employer size for the purpose of the employer mandate. Many of the provisions incorporated into ERISA include these narrow aggregation rules as well because they depend on the distinction between large and small group plans.[28]

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[25] *See also* 42 U.S.C. § 300gg(a)(1) (adjusted community rating for individuals and small group employers); § 300gg–1 (guaranteed availability of coverage); § 300gg–2 (guaranteed renewability of coverage); § 300gg–3 (prohibition of preexisting condition exclusions or other discrimination based on health status); § 300gg–5 (non-discrimination in health care); § 300gg–11 (no lifetime or annual limits); § 300gg–13 (coverage of preventive health services).

[26] In defining a "single employer," the IRC looks to whether the employers operate under "common control," perform functions (e.g. management services) for one another, or demonstrate a shareholder or partnership relationship; the IRC limits the "single employer" designation to companies that have a "common owner or . . . are otherwise related." 26 U.S.C. §§ 414(b), (c), (m); *Determining If an Employer Is an Applicable Large Employer*, IRS, https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer (last updated Nov. 22, 2017).

[27] *See, e.g.*, 26 U.S.C. § 4980I(f)(9) (as amended by § 9001 of the ACA) (utilizing the aggregation rule to determine which entities are to be taxed for high cost employer-sponsored coverage); 26 C.F.R. 51.1 (describing regulations issued to "provide guidance on the annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs by section 9008 of the [ACA]", which uses the aggregation rule to identify these branded prescription pharmaceutical manufacturers and importers); 26 U.S.C. § 162(m)(6)(C)(ii) (as amended by § 9014 of the ACA) (requiring "two or more persons" to be treated as "single employers" when identifying the covered health providers to which the ACA's limitation on excessive remuneration applies); 26 U.S.C. § 125(j)(5)(D)(ii) (as amended by § 9022 of the ACA) (using a related aggregation rule for purposes of identifying eligible employers that maintain "simple cafeteria plans"); 26 U.S.C. § 48D(c)(2)(B) (as amended by § 9023 of the ACA) (identifying taxpayers that are eligible to receive the qualifying therapeutic discovery project credit by applying the aggregation rule).

[28] *See* 29 U.S.C. § 1185d (importing requirements of 42 U.S.C. §§ 300gg through 300gg–28 into ERISA "as if included" in that Act); 42 U.S.C. § 300gg–91(e) (defining market levels for purposes of 42 U.S.C. §§ 300gg through 300gg–28 in relation to aggregation rules); *see also* 42 U.S.C. § 300gg(a)(1) (describing community rating); § 300gg–6 (describing group plans that must cover essential health benefits).

Thus, the ACA – as well as the PHSA and ERISA itself – already have aggregation rules for determining when and for what purposes individuals and small employers should be grouped together to be considered a single large employer. The Proposed Rule – which seeks to allow *all* employers in common industry or close geographic location to form a "single large employer" – plainly conflicts with these narrow aggregation rules.[29] Such a vast new definition of "single large employer" far exceeds the ACA's aggregation rules, as applicable under ERISA, the IRC, the PHSA, and the ACA, and therefore clearly conflict with these statutes.

In addition, the Proposed Rule's new classification of "working owners" is directly inconsistent with the ACA. Under the ACA, including under provisions imported into ERISA by the ACA, sole proprietors without employees are treated as individuals – not as employers – protected by the individual market. *See, e.g.*, 42 U.S.C. § 300gg–91(d)(6), (e)(2), (e)(4) (defining "large employer" and "small employer," and then defining "employer" to include "only employers of two or more employees").[30] Moreover, the Proposed Rule offers neither justification nor evidence that the DOL considered the Rule's effect on these various statutory schemes, nor did it suggest ways that the Rule's conflict with law and prior guidance can be resolved (discussed *supra* Part III).

By enabling individual and small groups to be deemed large group plans, the Proposed Rule will allow associations made up of individuals and small employers to evade the ACA's individual and small group protections. This will fulfill the goal of the Proposed Rule to avoid comprehensive coverage and facilitate the sale of cheaper plans "across State lines." Exec. Order No. 13813, 82 Fed. Reg. 48385 (Oct. 17, 2017). In fact, AHPs formed pursuant to the Proposed Rule may be subject to even fewer requirements than large employers currently are, since there may be no *actual* employer – just an association created solely for the purpose of providing health coverage. Congress's intent in enacting the ACA could hardly have been clearer: it established definitions for participation in and protections for large group, small group, and individual plans, and narrow rules for determining when multiple businesses can be treated as a single employer. It then applied those standards under ERISA "as if included" in that Act. This blatant attempt by the DOL to avoid the clear text and purpose of the ACA is contrary to law.

Second, the Proposed Rule will undermine the fundamental ACA provisions that pool risk with the result of destabilizing small group and individual insurance markets. Section 1312(c) of the ACA, "Single Risk Pool," imposes rules on the individual and small group markets to create a diverse risk pool in order to ensure the provision of affordable health care for healthy

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[29] In particular, by crafting specific rules when applying ACA protections to group health plans under ERISA, Congress directly required the DOL to follow the IRC's narrow aggregation rules, barring the Department from applying another standard it prefers under more general ERISA language as a means to undercut the ACA. *See RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012) (Scalia, J., for a unanimous court) (internal citations and quotation marks omitted) ("[I]t is a commonplace of statutory construction that the specific governs the general. That is particularly true where, as [here], Congress has enacted a comprehensive scheme and has deliberately targeted specific problems with specific solutions.").

[30] The ACA also amends the PHSA (42 U.S.C. § 300gg–91) by incorporating: "The term 'employer' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1002(5)], except that such term shall include only *employers of two or more employees*." (emphasis added). Thus, the PHSA also defines employer owners without any employees as individuals, and not as employers.

and sick alike. 42 U.S.C. § 18032(c).[31] The Proposed Rule, again, conflicts with this structure, as AHPs will likely attract healthy individuals out of the existing individual and small group markets, and leave the remaining offerings to turn into "sick" plans whereby premiums will dramatically increase. This will leave those whom the ACA was implemented to help – the sick, elderly, those with preexisting conditions – with unaffordable or inadequate coverage.[32]

For example, since most AHPs will not be required to offer the ACA's essential health benefits, they will opt not to include services that are more expensive or that are required by individuals with greater health care needs. For instance, while complying with the Proposed Rule's non-discrimination provisions, an AHP could opt not to include maternity coverage. This would naturally dissuade potential members who plan to have children from joining the AHP, and they will likely obtain coverage from an ACA-compliant exchange plan. Or an AHP could choose not to cover mental health and substance use disorder treatment, again with the expectation that individuals who need or are likely to need these services for themselves or their families will obtain coverage on the ACA exchanges. The same motivations will cause AHPs to exclude other expensive benefits such as cancer treatment or certain prescription drugs. This market segmentation will lower prices for healthier individuals and groups in the AHPs, but cause premiums to spike (likely out of reach) for people who need these essential health care services – in direct conflict with the ACA's goal of spreading risk, particularly within the small group and individual markets.[33]

The Proposed Rule will also encourage AHPs to form in those industries that attract a younger, healthier, and male workforce (*e.g.,* technology or engineering) or in those geographic areas that have healthier populations (*e.g.,* wealthy communities and/or non-rural areas). The Proposed Rule places no restrictions on this type of risk selection. The Proposed Rule dismisses these risks as speculative and argues that AHPs will also form in industries with older and less healthy workers by delivering sufficient administrative savings to offset the additional costs of insuring this population. 83 Fed. Reg. 614, 628-29. However, the DOL provides no evidence to support the proposition that AHPs can deliver administrative savings that an insurance company cannot. Indeed, all available evidence and analysis is to the contrary.[34]

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[31] The "single risk pool" provision is also referenced in the PHSA provisions imported into ERISA. *See, e.g.*, 29 U.S.C. § 1185d (importing 42 U.S.C. § 300gg, among other protections, into ERISA).

[32] Although the Proposed Rule's non-discrimination provisions are beneficial, they are inadequate to ensure that AHPs are unable to structure themselves to attract healthier individuals and groups while dissuading individuals who may have a greater need for health care services from enrolling in the AHP. Indeed, we have repeatedly seen AHPs that are designed to do precisely this. (*See, e.g.*, *supra* at Part II).

[33] The Proposed Rule speculates that because large employers do not offer skimpy coverage to their employees, AHPs likely will not do so either. 83 Fed. Reg. 614, 628. However, there are fundamental differences between large employers and AHPs that the Proposed Rule simply ignores. Large employer plans typically provide comprehensive benefits because large employers employ a diverse set of individuals with varying health needs and must offer benefit packages to satisfy all current and potential employees. AHPs, on the other hand, allow self-employed individuals and small businesses to pick their insurance plan based on the particular coverage that they need at the time given their current health needs. These individuals and small groups have every reason to enroll in skimpy, cheap coverage that appeals to their own narrow demographic group or health profile.

[34] *See, e.g.*, Mark Hall, et al., *HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed*, HEALTH AFFAIRS 20(1): 142-53 (2001), *available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.20.1.142 (identifying numerous alternative means to save on health care coverage costs); Kaiser Family Foundation et al., *Employer Health Benefits 2017 Annual Survey*, KAISER FAMILY FOUND. (2017), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017 (presenting findings on

These consequences are in clear violation of the language and purpose of the ACA. Also clear is the APA's prohibition against rulemaking in conflict with established law, and as such, the Proposed Rule violates the APA.

V. The Proposed Rule Is Contrary to Longstanding DOL Interpretation of ERISA That Has Been Ratified by Congress

Not only is the Proposed Rule contrary to the ACA in key respects, but it also is contrary to the DOL's longstanding interpretation of "bona fide association." Congress has ratified this longstanding interpretation over decades in a series of statutory schemes, including and most notably in the ACA, which was the capstone of Congress's decades-long efforts to address access to health care through individual and group insurance markets.

As the Supreme Court has explained, "[w]here an agency's statutory construction has been 'fully brought to the attention of the public and the Congress,' and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned." *N. Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 535 (1982) (citation omitted); *see, e.g.*, *Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 846 (1986) ("It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the 'congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress.'") (citation omitted).

As set forth *supra* in Parts I through III, the DOL has long maintained that only a "bona fide association" of employers bound by a "commonality of interest" can meet the definition of "employer" under 29 U.S.C § 1002(5).[35] The Department has consistently held that most MEWAs are not regulated by ERISA as employee welfare benefit plans, and indeed that ERISA itself forecloses such an interpretation, unless such entities qualify as "bona fide associations" under these well-established, narrow principles. *See e.g.*, Brief for Petitioner-Appellant DOL at *7, *Donovan v. Dillingham*, 668 F.2d 1196 (11th Cir. 1982) (No. 80-7879) ("[T]he statutory language of ERISA precludes a finding that a single, umbrella-like ERISA plan has been created in these cases."); *see also Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982) ("An issue in other cases has been whether a multiple employer trust – the enterprise – is itself an

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strategies that private and non-federal public employers have used to shift health care costs to employees and thus reduce employer costs of health care coverage provision).

[35] *See, e.g.*, DOL Adv. Ops., 80-40A, 1980 ERISA LEXIS 38 (July 9, 1980) ("bona fide" association depends on a number of factors, including control by employers over association, but does not cover "several unrelated employers" executing trust agreements as a means to fund benefits); 91-42A, 1991 ERISA LEXIS 49 (Nov. 12, 1991) ("[W]here several unrelated employers merely execute similar documents or otherwise participate in an arrangement as a means to fund benefits, in the absence of any genuine organizational relationship among the employers, no employer association, and consequently no employee welfare benefit plan, can be recognized."); 2008-07 A, 2008 ERISA LEXIS 8 (Sept. 26, 2008) (rejecting local chamber of commerce's request to be an ERISA employee welfare benefit plan); 2017-02 AC, ERISA LEXIS 2 (May 16, 2017) ("The Department has expressed the view that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of ERISA section 3(5).").

employee welfare benefit plan. The courts, congressional committees, and the Secretary uniformly have held they are not.").

The ACA directly included the phrase "bona fide association" in the components of the statute applicable under the PHSA and ERISA. As noted above, Congress imported key protections from Title 27 of the PHSA into ERISA "as if included in" that Act. *See* 29 U.S.C. § 1185d (as amended by § 1563(e) of the ACA). Among the imported provisions is a guaranteed-renewability protection, *see* 42 U.S.C. § 300gg–2, that relies on the phrase "bona fide association," defined with a series of elements, such as five years of active existence and being "formed and maintained in good faith *for purposes other than obtaining insurance*." *See* 42 U.S.C. § 300gg–91(d)(3) (emphasis added). As relevant here, the guaranteed-renewability provision requires a health insurance issuer in the large or small group market to "renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable," except in connection with a series of exceptions, one of which involves when an employer in the small or large group markets ceases to be a member of a "bona fide association." *Id.* § 300gg–2(b)(6). In short, Congress in the ACA imported into ERISA's plain text the phrase "bona fide association," along with its attendant narrow definition, effectively ratifying the DOL's longstanding interpretation of that term.

Even prior to the ACA's enactment, Congress had amended ERISA and the interlocking statutes related to health plans in the IRC and PHSA numerous times based on the DOL's firmly settled interpretation. *See, e.g.,* Consolidated Omnibus Budget Reconciliation Act ("COBRA"), Pub. L. No. 99-272, § 10001, 100 Stat. 82, at 222-23 (1986) (amending, *inter alia*, 26 U.S.C. § 106(b)); *id.* § 10002, 100 Stat. 82, at 227-31 (codified at 29 U.S.C. §§ 1161-69) (whereby Congress applied the narrow aggregation rules from the IRC, suggesting that Congress foreclosed a broad interpretation of "employer" that would group together many unrelated businesses in a single large group); and Health Insurance Portability and Accountability Act ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936, at 1964-66, 1982 (1996) (reflecting continued congressional judgment that unrelated small employers cannot simply be interpreted as one large employer at the DOL's discretion, including through a definition of "bona fide association").

Given these key statutory schemes creating health plan protections for consumers, and these statutes' reliance on DOL definitions, Congress has not left the Department with broad discretion to depart so drastically from a settled understanding of how business entities may be treated as one employer in these interlocking statutes.[36] In short, through a long line of enactments establishing and amending interlocking statutory regimes, Congress long ago ratified the DOL's narrow conception of "bona fide association" and accordingly barred the Department from so fundamentally altering the established edifice of federal regulation of individual and group health insurance.

[36] For example, HIPAA enacted Section 2791 of the PHSA, which defined "large employer" as an employer with an average of at least 51 employees during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. Pub. L. No. 104-191, § 102, 110 Stat. 1936, at 1975-76. That section defined "small employer" as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year." *Id.* at 1976. Like provisions earlier enacted in COBRA, and later enacted in the ACA, this HIPAA provision relied on the IRC's narrow aggregation rules. *Id.*

VI. The DOL Should Not Exempt AHPs from State Regulation

The Proposed Rule also invites comment as to whether the DOL should seek to exercise its never-before-used authority to issue regulations that would exempt AHPs from most state insurance regulation and enforcement. 83 Fed. Reg. 614, 625. The history detailed above (in Part II) shows that this would be a tremendous mistake. Exempting AHPs from state insurance laws would allow fraudulent or improperly managed health plans to operate without fear of detection or punishment until after the damage has been done. The result would be policyholders with unpaid medical bills and health care providers who are not paid for their services. Since exercising this authority would require new regulations, if the DOL decides to explore this misguided idea further, it should issue a separate proposed rulemaking with an opportunity for notice and comment regarding the intended use of this exemption. *See* 29 U.S.C. § 1144(b)(6)(B).

To date, the DOL does not have, and has not sought, the regulatory or enforcement resources to step into the States' shoes and become the primary regulator of AHPs. Furthermore, the Department does not have, and has not proposed, federal financial or other insurance standards to protect beneficiaries from the serious consequences that result when an AHP cannot or does not pay medical claims. Exempting AHPs from state regulation would threaten the health and financial security of individuals and small employers throughout the country.

Indeed, States and State Attorneys General have extensive experience protecting individuals and small employers from predatory entities that seek to defraud or deceive customers through the use of associations. Some examples include:

- In 2007, the operators of an association that deceptively marketed its discount health plan products to Massachusetts residents as "Affordable Healthcare Plans" and "Top Rated Insurance" were ordered to pay restitution to the defrauded consumers, a substantial civil penalty and attorney's fees, and were permanently enjoined from engaging in various conduct in Massachusetts.[37]

- In 2009, pursuant to a consent judgment following Massachusetts' consumer protection lawsuit, HealthMarkets, Inc. and its subsidiaries were ordered to pay $17 million, resulting from unfair and deceptive practices through the sale of insurance products packaged with memberships in three different associations.[38]

- In 2011, the United States Life Insurance Company in the City of New York agreed to pay full restitution to consumers whom it required to join associations and to whom it misrepresented the terms, benefits, and (very limited) coverage

[37] Compl. at ¶ 19, Commonwealth of Mass. v. Nat'l Alliance of Assocs. Professional Benefit Consultants, Inc. et al., Compl. No. 09-1404B (Mass Super. Ct. Apr. 6, 2009).
[38] *See* Press Release, Att'y Gen. of Mass., *AG Martha Coakley Reaches $17 Million Settlement with Health Insurers Regarding Unfair and Deceptive Conduct* (Aug. 31, 2009), http://www.mass.gov/ago/news-and-updates/press-releases/2009/ag-reaches-17-million-settlement-with-health.html.

provided by its plans, as well as the fact that the policies had not been approved for sale in Massachusetts.[39]

- In 2015, Unified Life Insurance Co., agreed to pay $2.8 million in restitution and civil penalties as a result of its deceptive and unlawful selling of sold short-term health insurance that was not authorized for sale in Massachusetts, but which it deceptively marketed through a third-party association.[40]

- In 2001, the Maryland Insurance Administration fined and revoked the registration of a MEWA administrator that engaged in "illegal and dishonest practices" such as failing to register as an insurer as required by state law, failing to pay premiums for stop-loss insurance contrary to representations made to employer members (and thereby exposing these employers to unexpected losses), and failing to pay claims for insured employees. *Md. Ins. Admin. v. SAI Med Health Plan, LLC*, No. MIA-6-1/01 (Md. Ins. Admin. Jan. 16, 2001).

- In 2005, the Maryland Insurance Administration fined and revoked the licenses of a MEWA's administrator for failing to register with the state as required by law and making material misrepresentations regarding the relationship of the MEWA to the insured employees and, overall, engaging in conduct that was "dishonest and lacked … trustworthiness and competence." *Md. Ins. Admin. v. Dennis Kelly, et al.*, No. MIA-2005-07-004 (Md. Ins. Admin. Mar. 30, 2007).

- From the 1980s through the early 2000s in California, AHP failures hurt employees across many different industries. For example, thousands of California farm workers suffered when a plan created by Sunkist Growers collapsed, leaving nearly 5,000 medical providers with an estimated $10 million in unpaid claims. Similarly, when Rubell-Helms Insurance Services went out of business, it reportedly left $10 million in legitimate medical claims unpaid. [41]

Over many years, state enforcement efforts and oversight have lessened AHP fraud. Since the ACA, this success combined with the development of our state and federally facilitated health exchanges has resulted in consumers having comprehensive and reliable health coverage. Relatedly, our states have made great strides in decreasing the uninsured rate since the ACA. This is largely due to the confluence of a range of affordable plans together with one single risk pool with the same premiums paid by all members of a plan. For example, in New York, the

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[39] *See* Press Release, Att'y Gen. of Mass., *Health Ins. Co. to Pay $760,000 for Unlawfully Selling Unauthorized Health Ins. in Mass. and Failing to Cover Mandated Benefits* (Apr. 25, 2011), http://www.mass.gov/ago/news-and-updates/press-releases/2011/health-insurance-company-to-pay-760000.html.

[40] *See* Press Release, Att'y Gen. of Mass., *Ins. Co. to Pay $2.8 Million to Resolve Claims of Unlawful, Deceptive Sales of Health Ins. Sold Across State Lines* (Apr. 4, 2017), http://www.mass.gov/ago/news-and-updates/press-releases/2017/2017-04-04-insurance-company-to-pay-2-8-million.html.

[41] *See* Melinda Fulmer & Ronald D. White, *Sunkist's Health Plan Collapses*, L.A. Times, Jan. 4, 2002, *available at* http://articles.latimes.com/2002/jan/04/business/fi-sunkist4; Robert L. Jackson, *Health Insurance 'Pyramid' Scams Examined: Hearing: Authorities Tell a Senate Panel That Irvine-Based Rubell-Helm Insurance Services Is among Firms under Scrutiny for Allegedly Taking Premiums and Not Paying Large, Legitimate Claims*, L.A. Times, May 16, 1990, *available at* http://articles.latimes.com/1990-05-16/business/fi-362_1_health-insurance.

uninsured rate dropped from 10% to 5%; in California, it dropped from 17% to 7%; in Illinois, from 14% to 6.5%; in Maryland, from 10% to 6%; and in Delaware, from 9% to 6%. In Massachusetts, the uninsured rate has dropped from more than 10% before it enacted health reform in 2006 to less than 4% today. The success of our state and federally facilitated exchanges, and our future success in decreasing the rates of uninsureds is likely to be impacted by any exemption from state regulations that govern the types of AHPs that are envisioned in the Proposed Rule.

VII. Conclusion

For the reasons set forth above, the States strongly oppose the Proposed Rule and urge that it be withdrawn.

Sincerely,

Maura Healey
Massachusetts Attorney General

Eric T. Schneiderman
New York Attorney General

Xavier Becerra
California Attorney General

George Jepsen
Connecticut Attorney General

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March 6, 2018

Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Room N-5655
Washington, DC 20210

Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85

Dear Secretary R. Alexander Acosta:

As the largest and broadest-based business organization in Nevada, the Las Vegas Metro Chamber of Commerce (the "Metro Chamber") is focused on helping Nevada businesses succeed and create jobs. Since the Metro Chamber's founding in 1911, its core mission has been to support its members and their employees in achieving these successes. The Metro Chamber is committed to addressing healthcare issues on behalf of its members and their approximately 230,000 employees.

Employers, including those in Nevada, consider various factors when determining whether to sponsor healthcare plans, such as: changes in the delivery and cost of healthcare, coverage of benefits, coordination among the various providers of healthcare, legislative and regulatory mandates, as well as efforts to improve the regional quality of healthcare. As a result, the Metro Chamber fully supports the efforts by the U.S. Department of Labor ("DOL") to promote and expand healthcare choices to Nevada's employers and employees, as proposed by DOL in its expanding the availability of Association Health Plans, RIN 1210-AB85.

The Metro Chamber

For more than 28 years, the Metro Chamber offered quality health insurance plans to more than 2,700-member organizations that covered 21,000 lives from small employers of fewer than fifty employees in Southern Nevada. In the later years of the program, the Metro Chamber created an LLC called Chamber Insurance and Benefits ("CIB") to help members of the Metro Chamber by providing comprehensive benefits for members, their employees and families. There were between 9 and 10 different plan choices available, all of which were provided through one single carrier, namely Health Plan of Nevada (HMO and POS plans) and its sister company, Sierra

Health & Life (PPO, Dental, Vision and Life). The management and the products that were offered by CIB were well regarded by stakeholders, regulators and customers.

However, as a result of changes in federal law associated with the Affordable Care Act ("ACA"), the number of lives covered by CIB dropped to 16,000 in 2013. In an effort to help our members retain their previous coverage as long as possible, CIB offered an "Early Renewal" on December 1, 2013, as did most carriers and plans, so that those groups most adversely affected (the younger and/or small utilization demographic in particular) could remain on their plans for an additional 11 months into 2014. CIB retained approximately 1,600 groups through this early renewal process, but the entire remaining book of business had to be "mapped over" to ACA-compliant plans upon the following renewal on December 1, 2014. The ACA-compliant plan requirement was put into effect, and the Chamber Health Plan ceased to operate by the end of 2014. Some of the contributing factors were both the statutory requirements of the ACAs insurance market reforms applicable in the small group, the agencies' implementation of those requirements, and guidance addressing association health plans issued by the Center for Consumer Information and Insurance Oversight ("CCIIO").

Specifically, in 2011, CCIIO guidance required many of the Chamber Insurance Plan members to be subject to more restrictive "adjusted community rating" guidelines as small group employers versus being included as part of the CIBs overall large employer group arrangement. "Adjusted community rating" along with "rate-band compression" changed the range structure from 5:1 to 3:1; members with younger employees and lower claims experience found themselves facing premium increases of 100-300 percent. Conversely, members with older employees nearing Medicare eligibility age with significant health concerns experienced significant premium decreases, some paying 25 percent less in premiums than prior to the change in guidance.

Another significant change that impacted the Metro Chamber's "mom & pop" members was the determination that working spouses could no longer qualify as a small group, which meant that a W-2 employee could not be the spouse of the business owner. Under the "Chamber Health Plan", CIB was able to provide these members small group coverage, which was important to the Metro Chamber's small business owners. This change alone affected several hundred members, forcing them to seek individual policies that were, in most cases, significantly higher in price. In a recent survey of these former Metro Chamber members who had lost their coverage options with CIB because of the ACA, 90 percent have indicated that they have some level of concern with the costs of healthcare with 80 percent expressing very concerned.

One last factor adversely affecting the Chamber Health Plan and the key item that made it impossible to remain "price advantaged" in the market was that the ACA prescribes that all ACA compliant plans must be sold for the same price to consumers, regardless of where it is bought.

The former "Chamber Health Plan" had an approved 5 percent filed discount off the street rate for Metro Chamber members only. The Metro Chamber had the right to cancel their coverage if they were late on their dues. Without that discount being accessible to the Metro Chamber, the Chamber Health Plan became a commodity.

It should be noted that the Chamber Insurance Plan offered by CIB had been designated as the benchmark plan for essential health benefit ("EHB") coverage that was required in Nevada beginning in 2014 under ACA guidelines, so the ACA's EHB requirement did not pose as significant a burden.

Nevada's Insurance Markets

In Nevada, the State's Division of Insurance ("DOI") has tried to maintain stability in health insurance markets by expediting rate filing for plan year 2018. However, access to high-quality, affordable, small group and individual coverage remains a concern for Nevadans and Nevada small businesses.

For the Metro Chamber, quality and affordable healthcare plans are important to our organization since more than 85 percent of our members are small business employers. Our members seek affordable plans that offer coverage components such as prescription drug coverage, provider choice, hospital care, flexibility in deductible and cost shares, out-of-pocket limits and emergency coverage.

In 2017, Nevada experienced significant challenges that impacted the Nevada Health Link Exchange (the state's health insurance exchange), including a major healthcare payer leaving 14 of Nevada's 17 counties without a choice on the exchange. Since then, "on-exchange" plans in 2018 have had rate increases of more than 40 percent. Nevada's DOI is now looking at various options to bring stability to the individual and small group markets, including establishment of high risk pools and Medicaid buy-in/public health benefit plans. To address increases in premium, Nevada's health insurers are also shrinking provider networks in order to more directly manage the increasing cost of care. Members and former members have expressed their concerns with the Chamber about the current state of healthcare. They have reported that small employers in Nevada have faced the following challenges:

- Experiencing significant rate increases for the different plans made available with less coverage each proceeding year; one of the Metro Chamber's members stated that "the first year of coverage under the ACA Platinum Level PPO coverage averaged $1,000 per month; the second-year rates for Silver Level PPO rose to $1,400 a month; and this year the pricing for a Bronze Level PPO has risen to $1,800";

- Another member stated that they are experiencing "Increasing monthly premiums ranging from 20 to 40 percent per year with fewer benefits being offered as part of their healthcare coverage";

- Increasing costs are untenable and the options are extremely limited in Nevada, resulting in employers seeking secondary employment to access affordable healthcare coverage;

- Our members and previous members are frustrated that they are no longer able to offer group coverage to their employees because of the increasing costs that they have experienced under the ACA;

- We also received feedback that overall insurance costs have dramatically increased in recent years;

The Proposed Rule

The Metro Chamber believes the proposed rule by the DOL is a positive development, as it would create new opportunities for our members to access additional healthcare options through chambers of commerce and trade associations. As proposed, these provisions could significantly help small businesses in addressing the healthcare challenges that they face because it would allow them to join association health plans either by industry or geographic region.

In a recent healthcare survey to Metro Chamber members, 65.64 percent of respondents indicated that they would be interested in participating in association-based group health insurance plan with large-group pricing advantages, if it was offered by the Metro Chamber. In a similar survey sent to former Metro Chamber members, 84 percent of respondents would be interested in participating in a healthcare plan that was offered by the Metro Chamber. This is a strong indication for the need of additional healthcare coverage at competitive pricing for small businesses in Nevada. Costs and the scope of coverage are important factors for small businesses and a growing concern for them under existing ACA rules and guidelines.

Becoming part of the larger group would potentially allow small businesses to benefit from fewer regulatory requirements than they currently experience in the small group market. Small businesses would also benefit from a reduction in administrative cost. Becoming part of the larger group would also strengthen small business' ability to negotiate for more favorable coverage and benefits from providers and give them the ability to self-insure. Over 90 percent

of respondents expressed some level of concern over the costs of healthcare that they provide to their employees through existing group health insurance coverage. In that same survey, 51.61 percent of respondents indicated that their total health insurance costs for their business incurred an increase in the last twelve months, while only 3.23 percent saw a decrease in their costs during the same twelve-month period. Regarding costs, 53.9 percent of members also expressed some level of dissatisfaction with the cost of their business' health insurance coverage.

The Metro Chamber is supportive of the following components of the proposed rule:

- The revisions of the DOLs regulations implementing the Employee Retirement Income Security Act of 1974, as amended ("ERISA") definition of "employer" to include a qualifying group or association of employers such as chambers of commerce;

- The broadening of the rule determining when an employer association can sponsor the new qualifying association health plans and qualify as a single large plan at the federal level;

- Allowing for the ability of association healthcare plans to be offered to employers within a geographically limited area across industries, or to employers in the same industry without geographic restrictions;

- Allowing association healthcare plans to include small or large employers and sole proprietors, which will give all employers and businesses the opportunity to access these plans;

- Allowing eligibility for sole proprietors who are working 30 hours or more per week or more than 120 hours a month;

- Specifying the requirements for sponsorship of association healthcare plans by qualifying groups of employers or associations, including both organizational, control and management, and non-discrimination requirement.

The Metro Chamber would also like to offer several suggestions that we believe will strengthen the efforts to expand healthcare plans offered by trade associations and chambers of commerce:

- Allow for coverage to be purchased by an employer (including by working owners) from an association healthcare plan regardless of whether that employer/employee has coverage offered from another source (*i.e.*, spouse employer, Marketplace, Medicaid or any other plan offered);

- Clarify and strengthen that under the proposed rule, an eligible working owner and his/her spouse under the association health plan would be eligible for coverage, regardless of whether the working owner-spouse met the 30 hours a week or 120 hours a month working requirement,

- Clarify that the association healthcare plans can be structured in any form, including both fully-insured and self-funded Multiple Employer Welfare Arrangements;

- Maintain and preserve the rule of No Management Carve Out from plans, which permits the small employer to offer coverage to their employees and to contribute to the cost of the employee coverage;

- Allow association health plans to offer more than one plan choice in the small employer group.

The Metro Chamber's members have made clear that the concerns of Nevada's business community need to be addressed in a timely manner. The Metro Chamber applauds the DOL on its efforts in addressing these healthcare concerns with the proposed expansion of association health plans. Therefore, it is the hope of the Metro Chamber that the DOL will expedite and adopt these rules as soon as possible because of the growing need for Nevada's small business to access affordable healthcare options, at least in time to ensure that the Metro Chamber can offer coverage for the 2019 calendar year. The Metro Chamber is fully committed to serving Nevada's business community, which includes the employers, employees and residents through the possibility of once again offering them a healthcare plan through CIB.

The Metro Chamber's reputation as Nevada's leading business association is a result of a strong commitment of generations of visionary leadership, partnerships and engagement over its 107-year history. The Metro Chamber is an integral part of our community's history and a solid foundation to our future successes. The Metro Chamber's commitment to providing reliable and affordable healthcare products is evident in the reputation that it has built in its almost 30 years of operation and considered to be a benchmark plan by many stakeholders in Nevada, including the Nevada's DOI.

It is important to note that CIB has maintained its article of incorporation, business licensing requirements, board of managers and remains in good standing. We estimate that 72 percent of former members who were covered by CIB would rejoin the Metro Chamber because of the stellar reputation, coverage options and affordability that they had previously experienced with CIB. It is our belief that CIB would be able to quickly move forward in offering healthcare options to the business community again as CIB has remained active by offering other benefit products to our members in Southern Nevada since the implementation of the ACA. We are ready to move forward and look forward to the release of the final rule later this year.

Thank you for allowing the Las Vegas Metro Chamber of Commerce to offer its support for the expansion of healthcare by the proposed revisions to the Association Health Plans. If we can be of any assistance or provide you with additional information, please feel free to contact us at 702.641.5822.

Sincerely,

Mary Beth Sewald
President and CEO

Michael F. Bolognini
Board of Trustees, Chairman

NATIONAL GOVERNORS ASSOCIATION

Brian Sandoval
Governor of Nevada
Chair

Steve Bullock
Governor of Montana
Vice Chair

Scott D. Pattison
Executive Director and CEO

March 6, 2017

The Honorable R. Alexander Acosta
Secretary of Labor
c/o Office of Regulations and Interpretations
Employee Benefits Security
U.S. Department of Labor, Room N-5655,
200 Constitution Avenue, NW, Washington, DC 20210,

Re: NGA Comments on the Proposed Rule on the Definition of "Employer" under Section 3(5) of ERISA—Association Health Plans (RIN 1210-AB85)

Dear Mr. Secretary:

The National Governors Association (NGA) appreciates the opportunity to comment on the Department of Labor's proposed rule. In the proposed rule, the Department seeks comments on the merits of possible state exemption approaches under ERISA section 514(b)(6)(B). The Department is seeking comment regarding how potential exemptions could promote health care consumer choice and competition and the risk such exemptions might present to appropriate regulation and oversight of Association Health Plans (AHPs), including state insurance regulation oversight functions. NGA has long expressed concern over proposals to federalize regulation and oversight of AHPs. NGA strongly urges the Department not to take any action that would preempt state regulation of health insurance markets and to explicitly clarify that the regulation does not preempt state oversight and regulatory authority.

NGA believes that governors and state regulators are best positioned to address the unique dynamics of state insurance markets and that states are already protecting consumers through their regulation of AHPs. Each state insurance market faces different challenges and opportunities. States have long served as the primary regulators of insurance and have the experience and tools to address fraud, abuse and insolvency, while working to ensure that insurance is accessible and affordable for state residents. It is critical that states have the authority to ensure that the health insurance products available to their residents meet appropriate solvency requirements and do not put consumers, providers or health insurance markets at risk.

Preemption of state regulatory authority should be the rare exception rather than the rule. This is especially true in areas of primary state responsibility, like insurance regulation. NGA urges the Department to promote a strong and cooperative state-federal relationship through this rulemaking process.

Sincerely,

Governor Charlie Baker
Chair
Health and Human Services Committee

Governor Kate Brown
Vice Chair
Health and Human Services Committee

Proposed Rules

Federal Register

Vol. 83, No. 4

Friday, January 5, 2018

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2510

RIN 1210–AB85

Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans

AGENCY: Employee Benefits Security Administration, Department of Labor.

ACTION: Proposed rule.

SUMMARY: This document contains a proposed regulation under Title I of the Employee Retirement Income Security Act (ERISA) that would broaden the criteria under ERISA section 3(5) for determining when employers may join together in an employer group or association that is treated as the "employer" sponsor of a single multiple-employer "employee welfare benefit plan" and "group health plan" as those terms are defined in Title I of ERISA. By treating the association itself as the employer sponsor of a single plan, the regulation would facilitate the adoption and administration of such arrangements. The regulation would modify the definition of "employer," in part, by creating a more flexible "commonality of interest" test for the employer members than the Department of Labor (DOL or Department) had adopted in sub-regulatory interpretive rulings under ERISA section 3(5). At the same time, the regulation would continue to distinguish employment-based plans, the focal point of Title I of ERISA, from mere commercial insurance programs and administrative service arrangements marketed to employers. For purposes of Title I of ERISA, the proposal would also permit working owners of an incorporated or unincorporated trade or business, including partners in a partnership, to elect to act as employers for purposes of participating in an employer group or association sponsoring a health plan and also to be treated as employees with respect to a trade, business or partnership for purposes of being covered by the employer group's or association's health plan. The goal of the rulemaking is to expand access to affordable health coverage, especially among small employers and self-employed individuals, by removing undue restrictions on the establishment and maintenance of association health plans under ERISA. The proposed regulation would affect such association health plans, health coverage under these health plans, groups and associations of employers sponsoring such plans, participants and beneficiaries with health coverage under these plans, health insurance issuers, and purchasers of health insurance not purchased through association health plans.

DATES: Comments are due on or before March 6, 2018.

ADDRESSES: You may submit written comments, identified by RIN 1210–AB85, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Office of Regulations and Interpretations, Employee Benefits Security Administration, Room N–5655, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, Attention: Definition of Employer—Small Business Health Plans RIN 1210–AB85.

Instructions: All submissions received must include the agency name and Regulatory Identifier Number (RIN) for this rulemaking. Persons submitting comments electronically are encouraged to submit only by one electronic method and not to submit paper copies. Comments will be available to the public, without charge, online at *http://www.regulations.gov* and *http://www.dol.gov/agencies/ebsa* and at the Public Disclosure Room, Employee Benefits Security Administration, Suite N–1513, 200 Constitution Avenue NW, Washington, DC 20210.

Warning: Do not include any personally identifiable or confidential business information that you do not want publicly disclosed. Comments are public records and are posted on the internet as received, and can be retrieved by most internet search engines.

FOR FURTHER INFORMATION CONTACT: Elizabeth Schumacher, Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, (202) 693–8335 or Janet K. Song, Office of Regulations and Interpretations, Employee Benefits Security Administration, (202) 693–8500. These are not toll free numbers.

SUPPLEMENTARY INFORMATION:

A. Overview

Since the Affordable Care Act [1] (or ACA) was enacted, many consumers have continued to face rising costs of coverage and a lack of quality affordable healthcare options. On October 12, 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," stating that "[i]t shall be the policy of the executive branch, to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people." The Executive Order states that the Administration will prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance, and health reimbursement arrangements (HRAs). With regard to AHPs, the Executive Order directs the Secretary of Labor, within 60 days of the date of the Executive Order, to consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs. The Executive Order further notes that "[l]arge employers often are able to obtain better terms on health insurance for their employees than small employers

[1] The Patient Protection and Affordable Care Act (Pub. L. 111–148), enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), enacted on March 30, 2010, collectively are known as the Affordable Care Act or ACA. The Affordable Care Act reorganizes, amends, and adds to the provisions in part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. In addition, the Affordable Care Act adds section 715(a)(1) to ERISA and section 9815(a)(1) to the Internal Revenue Code (Code) to incorporate the provisions of part A of title XXVII of the PHS Act (PHS Act sections 2701 through 2728) into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans.

because of their larger pools of insurable individuals across which they can spread risk and administrative costs. Expanding access to AHPs can help small businesses overcome this competitive disadvantage by allowing them to group together to self-insure or purchase large group health insurance. Expanding access to AHPs will also allow more small businesses to avoid many of the PPACA's costly requirements. Expanding access to AHPs would provide more affordable health insurance options to many Americans, including hourly wage earners, farmers, and the employees of small businesses and entrepreneurs that fuel economic growth.''

The Executive Order directs the Secretary, to the extent permitted by law and as supported by sound policy, to consider expanding the conditions that satisfy the commonality-of-interest requirements under existing DOL advisory opinions interpreting the definition of an ''employer'' under section 3(5) of ERISA. The Executive Order also directs the Department to consider ways to promote AHP formation on the basis of common geography or industry.

AHPs are an innovative option for expanding access to employer-sponsored coverage (especially for small businesses). AHPs permit employers to band together to purchase health coverage. Supporters contend that AHPs can help reduce the cost of health coverage by giving groups of employers increased bargaining power vis-à-vis hospitals, doctors, and pharmacy benefit providers, and creating new economies of scale, administrative efficiencies, and a more efficient allocation of plan responsibilities (as the AHP effectively transfers the obligation to provide and administer benefit programs from participating employers, who may have little expertise in these matters, to the AHP sponsor).

Under current federal law and regulations, health insurance coverage offered or provided through an employer trade association, chamber of commerce, or similar organization, to individuals and small employers is generally regulated under the same federal standards that apply to insurance coverage sold by health insurance issuers directly to these individuals and small employers, unless the coverage sponsored by the association constitutes a single ERISA-covered plan. As a practical matter, however, under existing sub-regulatory guidance, the Department treats few associations as sponsoring single ERISA-covered plans. Instead the associations' arrangements for health coverage are generally treated as a collection of plans, separately sponsored by each of the individual employers.

Whether, and the extent to which, various regulatory requirements apply to association health coverage, like other coverage, depends on whether the coverage is treated as individual or group coverage and, in turn, whether the group coverage is small or large group coverage. Generally, unless the arrangement sponsored by the association constitutes a single ERISA-covered plan, the current regulatory framework disregards the association in determining whether the coverage obtained by any particular participating individual or employer is treated as individual, small group, or large group market coverage. Instead, the test for determining the type of coverage focuses on whether the coverage is offered to individuals or employers. And, if the coverage is offered to employers, whether the group coverage is large group or small group coverage depends on the number of people employed by the particular employer obtaining the coverage. Thus, unless the association plan is treated as a single ERISA-covered plan, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group or large group market rules (or the individual market rules, if the participant is an individual and not an employer that can establish and maintain a group health plan), and it is possible that different association members will have coverage that is subject to the individual market, small group market, and/or large group market rules, as determined by each member's circumstances.

There are circumstances, however, even under the Department's existing sub-regulatory guidance, when employer association health coverage is treated as being provided through a plan, fund, or program that is a single ERISA-covered employee welfare benefit plan. In general, this occurs when the employer association, rather than the individual employer member, is considered the sponsoring ''employer'' that establishes and maintains the plan. In such cases, the health coverage program is, accordingly, treated as a single multiple employer plan for purposes of Title I of ERISA.[2] Since these AHPs tend to cover many employees, the coverage, in such cases, tends to be regulated as large group coverage for ACA purposes.

The current criteria that an employer association must satisfy to sponsor a single multiple employer plan, however, are narrow. Thus, the Department often has found that the association is not the sponsor of a multiple employer plan; instead, each employer that gets its health coverage through the association is considered to have established a separate, single-employer health benefit plan covering its own employees. In such cases, the association, much like an insurance company, is simply the mechanism by which each individual employer obtains benefits and administrative services for its own separate plan. Therefore, to the extent the separate employers are small employers, each of their plans are subject to regulation as small group coverage for ACA purposes. Similarly, in the case of sole proprietors and other business owners that do not employ other individuals, the coverage they obtain for themselves through an association is treated as individual coverage. As a result of this regulatory structure today, AHPs currently face a complex and costly compliance environment that may simultaneously subject the AHP to large group, small group, and individual market regulation, which undermines one of the core purposes and advantages of forming or joining an AHP. Accordingly, the Department is proposing to amend the definition of employer in section 3(5) of ERISA to change this state of affairs.

B. Purpose of Regulatory Action

Executive Order 13813 directs the Secretary to consider issuing regulations that will expand access to more affordable health coverage by permitting more employers to form AHPs, and the Secretary has been specifically directed to consider expanding the conditions that a group of employers must satisfy to act as an ''employer'' under ERISA for purposes of sponsoring a group health plan by reconsidering the ''commonality-of-interest'' requirements under current Departmental guidance. This proposed regulation would define the term ''group or association of employers'' under ERISA section 3(5) more broadly, in a way that would allow more freedom for businesses to join together in organizations that could offer group health coverage regulated under the ACA as large group coverage.

[2] The Department's prior guidance under ERISA section 3(5) addressed health benefits and other benefits under section 3(1) of ERISA. However, these proposed rules are limited to health benefits. Accordingly, for simplicity, these proposed regulations often refer only to health benefits, including when discussing the application of prior Departmental guidance.

A principal objective of the proposed rule is to expand employer and employee access to more affordable, high-quality coverage. The Department proposes changes in its approach to the ERISA section 3(5) definition of employer under ERISA. The ACA has caused individual and small group insurance premiums to increase significantly. In part as a result of this increase, health insurance available in the large group market is now typically less expensive, all else equal, than coverage in the small group or individual market. In addition, treating health coverage sponsored by an employer association as a single group health plan may promote economies of scale, administrative efficiencies, and transfer plan maintenance responsibilities from participating employers to the association. The proposed definition includes conditions, including nondiscrimination provisions, designed to continue to draw a line between the sorts of employer-sponsored arrangements that are regulated by ERISA on the one hand, and commercial insurance-type arrangements that lack the requisite connection to the employment relationship on the other, as well as to prevent potential adverse impacts on the individual and small group markets.

It is important to note that the proposed regulation would not preclude associations that do not meet the conditions of the proposal from offering health coverage in accordance with existing ACA requirements and applicable State insurance regulation. *See, e.g.,* CMS Insurance Standards Bulletin, Application of Individual and Group Market Requirements Under Title XXVII of the Public Health Service Act when Insurance Coverage is Sold to, or through, Associations (September 1, 2011) and Department of Labor Publication, Multiple Employer Welfare Arrangements Under ERISA, A Guide to Federal and State Regulation (available at *www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf*). In particular, health insurance coverage sold to, or through, associations that do not sponsor their own separate ERISA-covered employee benefit plans would not need to alter their operations if the proposed rule becomes final. Rather than constricting the offering of such non-plan multiple employer welfare arrangements (MEWAs), the proposed rule would simply make more widely available another vehicle —the AHP— for the employer associations to provide group health coverage to their employer-members, thus making available advantages distinct from non-plan MEWAs, including, often, access to the large group market.

C. Background

1. Section 3(5) of ERISA and the Current Standards for an Association To Be Treated as the ''Employer'' Sponsor of an Employee Welfare Benefit Plan That Is a Group Health Plan.

The term ''employee welfare benefit plan'' is defined in section 3(1) of ERISA to include, among other arrangements, ''any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .'' Thus, in order to be an employee welfare benefit plan, a plan must, among other criteria, be established or maintained by an employer, an employee organization, or both. The term ''employer'' is defined in section 3(5) of ERISA as ''. . . any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.'' Thus, ERISA defines the term ''employer'' to include the ''direct'' (or common law) employer of the covered employees or ''any other person acting indirectly in the interest of'' the common law employer.[3] Although there are various ways in which groups of employers can participate in a single plan, for example because they share substantial common ownership (*e.g.,* a controlled group of corporations), the Department has taken the view, on the basis of the definitional provisions of ERISA, as well as the overall structure of Title I of ERISA, that, in the absence of the involvement of an employee organization, a single ''multiple employer'' plan may also exist where a cognizable group or association of employers, acting in the interest of its employer members, establishes a benefit program for the employees of member employers and exercises control over the amendment process, plan termination, and other similar functions on behalf of these members with respect to the plan and any trust established under the program. DOL guidance generally refers to these entities as ''bona fide'' employer groups or associations. *See, e.g.,* Advisory Opinions 2008–07A, 2003–17A and 2001–04A. *See also* Advisory Opinion 96–25A (if an employer adopts for its employees a program of benefits sponsored by an employer group or association that does not itself constitute an ''employer,'' such an adopting employer may have established a separate, single-employer benefit plan covered by Title I of ERISA).

In distinguishing employer groups or associations that can act as an ERISA section 3(5) employer in sponsoring a multiple employer plan from those that cannot, the touchstone has long been whether the group or association has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan. This ''commonality of interest'' requirement distinguishes bona fide groups or associations of employers who provide coverage to their employees and the families of their employees from arrangements that more closely resemble State-regulated private insurance offered to the market at large. *See, e.g.,* Advisory Opinion 94–07A; Advisory Opinion 2001–04A. Courts have also held that there must be some cohesive relationship between the provider of benefits and the recipient of benefits under the plan so that the entity that maintains the plan and the individuals who benefit from the plan are tied by a common economic or representational interest. *Wisconsin Educ. Assn. Ins. Trust* v. *Iowa State Bd. of Public Instruction,* 804 F.2d 1059, 1064 (8th Cir. 1986). *See also MD Physicians & Associates, Inc.* v. *State Bd. of Ins.,* 957 F.2d 178 (5th Cir. 1992), *cert. denied,* 506 U.S. 861 (1992); *National Business Assn. Trust* v. *Morgan,* 770 F. Supp. 1169 (W.D. Ky. 1991).

DOL advisory opinions and court decisions have applied a facts-and-circumstances approach to determining whether there is a sufficient common economic or representational interest or genuine organizational relationship for there to be a bona fide employer group or association capable of sponsoring an ERISA plan on behalf of its employer members. This analysis has focused on three broad sets of issues, in particular: (1) Whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits; (2) whether the employers share some

[3] For more information on common law employment relationships, *see Nationwide Mutual Insurance Co.* v. *Darden,* 503 U.S. 318 (1992).

commonality and genuine organizational relationship unrelated to the provision of benefits; and (3) whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program, both in form and substance. The first two issues have tended to merge, depending on the facts of a particular case. When an entity meets each of these requirements, the Department has concluded that it is appropriate to treat the entity as an ''employer'' within the meaning of section 3(5) of ERISA, rather than merely as a commercial insurance-type arrangement that lacks the requisite connection to the employment relationship.

This approach has ensured that the Department's regulation of employee benefit plans is focused on employment-based arrangements, as contemplated by ERISA's text, but neither the Department's previous advisory opinions, nor relevant court cases, have ever held that the Department is foreclosed from adopting a more flexible test in a regulation, or from departing from the three particular factors set forth above in determining whether a group or association can be treated as acting as an ''employer'' or ''indirectly in the interest of an employer,'' for purposes of the statutory definition. These definitional terms are ambiguous as applied to a group or association in the context of ERISA section 3(5), and the statute does not specifically refer to or impose the particular historical elements of the ''commonality'' test on the determination of whether a group or association acts as the ''employer'' sponsor of an ERISA-covered plan within the scope of ERISA section 3(5). Accordingly, that determination may be more broadly guided by ERISA's purposes and appropriate policy considerations, including the need to expand access to healthcare and to respond to statutory changes and changing market dynamics.

2. Federal and State Regulation of Multiple Employer Welfare Arrangements

For many years, promoters of health coverage arrangements and others have established and operated MEWAs, also described as ''multiple employer trusts'' or ''METs,'' as vehicles for marketing health and welfare benefits to employers for their employees.[4] Some MEWAs have provided quality health coverage to their members' employees with less administrative overhead. But others have failed to pay promised health benefits to sick and injured workers while diverting, to the pockets of fraudsters, employer and employee contributions from their intended purpose of funding benefits.

Congress has enacted reforms to curb MEWA abuse. Prior to 1983, a number of States attempted to subject MEWAs to State insurance law requirements but were frustrated in their regulatory and enforcement efforts by MEWA-promoter claims of ERISA-plan status and federal preemption. Recognizing that it was both appropriate and necessary for States to be able to establish, apply, and enforce State insurance laws with respect to MEWAs, Congress amended ERISA in 1983 to provide an exception to ERISA's broad preemption provisions for the regulation of MEWAs under State insurance laws. In general, under the 1983 amendments, if a MEWA that is also an employee welfare benefit plan (an uncommon situation under prior guidance, as explained elsewhere) is not fully insured, then under section 514(b)(6)(A)(ii) of ERISA, any State law that regulates insurance may apply to the MEWA to the extent that such State law is not inconsistent with ERISA. For example, a State law could regulate solvency, benefit levels, or rating. Similarly, States could require registration and claims data reporting of MEWA operators. If, on the other hand, a MEWA is also an employee welfare benefit plan and is fully insured, ERISA section 514(b)(6)(A)(i) of ERISA provides that State laws that regulate the maintenance of specified contribution and reserve levels (and that enforce those standards) may apply to the MEWA, but other State non-insurance laws are preempted. ERISA section 514(b)(6)(D) provides, in turn, that a MEWA will be considered fully insured for purposes of section 514(b)(6) only if all of the benefits offered or provided under the MEWA are guaranteed under a contract or policy of insurance issued by an insurance company that is ''qualified to conduct business in a State.'' With respect to other non-insurance State laws, AHPs under the proposal would be subject to the same general ERISA preemption standards that apply to other ERISA-covered employee benefit plans.

The Affordable Care Act established a multipronged approach to MEWA abuses. Improvements in reporting requirements, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration for MEWAs with the Department prior to operating in a State. The additional information facilitates joint State and Federal efforts to prevent harm and take enforcement action. The Affordable Care Act also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a financially hazardous condition.[5]

3. Impact of ERISA Definition of Employer on Health Insurance Markets

Federal and State healthcare laws, including the Affordable Care Act, include a variety of requirements that sometimes differ based on whether health coverage is insured or self-insured, and if the coverage is insured, whether it is offered in the individual, small group, or large group health insurance market. Whether coverage is offered in the individual or group health insurance market is determined by reference to ERISA. Specifically, ''individual market coverage'' is health insurance coverage that is offered other than in connection with a group health plan. PHS Act section 2791(e)(1)(A). *See also* 26 CFR 54.9801–2; 29 CFR 2590.701–2; 45 CFR 144.103. A ''group health plan'' is generally defined as an employee welfare benefit plan under ERISA section 3(1), to the extent the plan provides medical care. ERISA

[4] The term MEWA or ''multiple employer welfare arrangement'' is defined in ERISA section 3(40). The term includes an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan) which is established or maintained for the purpose of offering or providing any ERISA welfare benefit to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries. Section 3(40) expressly excludes from the MEWA definition any such plan or arrangement that is established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association. The definition of MEWA thus includes both ERISA-covered employee welfare benefit plans and other arrangements which offer or provide medical, surgical, hospital care or benefits, or benefits in the event of sickness, accident, disability, or any other benefit described in ERISA Section 3(1). AHPs as described in this proposal are one type of MEWA.

[5] Section 6605 of the Affordable Care Act added section 521 to ERISA to give the Secretary of Labor additional enforcement authority to protect plan participants, beneficiaries, employees or employee organizations, or other members of the public against fraudulent, abusive, or financially hazardous MEWAs. ERISA section 521(a) authorizes the Secretary of Labor to issue an ex parte cease and desist order if it appears to the Secretary that the alleged conduct of a MEWA under section 3(40) of ERISA is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. Section 521(e) of ERISA authorizes the Secretary to issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition.

section 733(a); PHS Act section 2791. *See also* 26 CFR 54.9831–1(a); 29 CFR 2590.732(a); 45 CFR 146.145(a). ''Group health insurance coverage'' means, in connection with a group health plan, health insurance coverage offered in connection with such plan. ERISA section 733(b)(4); PHS Act section 2791(b)(4). *See also* 26 CFR 54.9801–2; 29 CFR 2590.701–2; 45 CFR 144.103.

The group health insurance market is divided into the small group market and the large group market, depending on the number of employees employed by the employer. PHS Act section 2791(e)(2)–(7). *See also* 45 CFR 144.103. Generally, group health insurance offered by an employer with at least one and not more than 50 employees is in the small group market, while group health insurance offered by an employer with at least 51 employees is in the large group market. *Id.*[6]

With respect to insured coverage, whether coverage is offered in the individual, small group, or large group market affects compliance obligations under the Affordable Care Act and other State and Federal insurance laws. For example, only individual and small group market health insurance coverage is subject to the requirement to cover essential health benefits as defined under section 1302 of the Affordable Care Act.[7] Moreover, the risk adjustment program, which transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees, applies only to health insurance issuers offering coverage in the individual and small group markets, not the large group market.[8] The single risk pool requirement, which requires each health insurance issuer to consider the claims experience of all individuals enrolled in plans offered by the issuer in the individual market to be in a single risk pool, and all its individuals in the small group market to be members of a single risk pool, also applies only in the individual and small group markets, not the large group market.[9] In addition, the health insurance premium rules that prohibit issuers from varying premiums except with respect to location, age (within certain limits), family size, and tobacco-use (within certain limits) apply only in the individual and small group markets.[10] Finally, the Medical Loss Ratio (MLR) provisions, which limit the portion of premium dollars health insurance issuers may spend on administration, marketing, and profits establish different thresholds for the small group market and the large group market.[11] Self-insured group health plans are exempt from each of these obligations regardless of the size of the employer that establishes or maintains the plan. These differences in obligations result in a complex and costly compliance environment for coverages provided through associations, particularly if the coverages are simultaneously subject to individual, small group, and large group market regulation.

Guidance issued by the HHS Centers for Medicare & Medicaid Services (CMS) in 2011 (CMS 2011 guidance) clarifies that the test for determining whether association coverage is individual, small group, or large group market coverage for purposes of Title XXVII of the PHS Act is the same test as that applied to health insurance offered directly to individuals or employers.[12] Association coverage does not exist as a distinct meaningful category of health insurance coverage under Title XXVII of the PHS Act.[13] Instead, when applying the individual and group market requirements of the PHS Act to insurance coverage offered or provided through associations, CMS will ignore the association and look directly to each association member to determine the status of each member's coverage. As a result, association coverage may be treated as comprised of individual market coverage, small group market coverage, large group market coverage, and mixed associations of more than one coverage type.

The CMS 2011 guidance further states that, ''in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules. In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the 'employer,' the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.''

Since the enactment of the Affordable Care Act, DOL and HHS have heard a number of concerns from stakeholders—especially working owners of businesses that do not employ other individuals, and independent contractors—regarding challenges that small businesses face in securing affordable health coverage options.

Some stakeholders have suggested to the Department that allowing businesses, especially small businesses, more flexibility to form AHPs would facilitate more choice and potentially make health coverage more affordable. These stakeholders opined that the AHP structure would give them increased negotiating power to bargain for lower premiums for their employees, as well as the ability to purchase coverage that would be less expensive because it would not be subject to some of the regulatory requirements applicable to the small group market but not the large group market. Proponents also contend that AHPs can help reduce the cost of health coverage because of increased bargaining power, economies of scale,

[6] Under the ACA, the upper bound for the definition of a small employer for purposes of title XXVII of the PHS Act was to change from 50 (as originally enacted) to 100 employees as of 2016. However, the Protecting Affordable Coverage for Employees Act (PACE Act, Pub. L. 114–60) amended the definition so that the upper bound would remain at 50. The PACE Act also permits States to elect an upper bound of 100 employees. CMS guidance indicates that States may elect to extend this upper bound to 100 employees by any means that is legally binding under State law, provided the definition applies to all insurers. States that elect to extend the upper bound were requested to notify CMS. *See https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-on-the-Impact-of-the-PACE-Act-on-State-Small-Group-Expansion.pdf.* CMS has informed DOL that, to date, no States have elected to change the upper bound to 100.

[7] *See* PHS Act section 2707, as added by the Affordable Care Act.

[8] *See* section 1343 of the Affordable Care Act.

[9] *See* section 1312(c) of the Affordable Care Act. States may require issuers to merge their individual and small group risk pools.

[10] *See* PHS Act section 2701, as added by the Affordable Care Act.

[11] The MLR provision of the Affordable Care Act requires most health insurance issuers that cover individuals or small employers to spend at least 80% of their premium dollars on healthcare claims and quality improvement, leaving the remaining 20% for overhead expenses, such as administrative costs, marketing, and profit. The MLR threshold is higher for large group plans, which must spend at least 85% of premium dollars on healthcare claims and quality improvement. 45 CFR part 158.

[12] *See* CMS Insurance Standards Bulletin Series—(September 1, 2011) available at: *https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf. See also* CMS Insurance Standards Bulletin Transmittal No. 02–02 (August 2002) available at: *https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/hipaa_02_02_508.pdf.*

[13] Title XXVII of the PHS Act does recognize coverage offered through ''bona fide associations,'' but only for purposes of providing limited exceptions from its guaranteed issue (in limited cases) and guaranteed renewability requirements. PHS Act secs. 2741(e)(1); 2742(b)(5) and (e); 2703(b)(6), as added by the ACA; and 2791(d)(3). Bona fide groups or associations of employers under the definition proposed in this rulemaking would not necessarily qualify as ''bona fide associations'' under the PHS Act definition for purposes of these PHS Act provisions.

administrative efficiencies, and transfer of plan maintenance responsibilities from participating employers to the AHP sponsor. AHPs may also help contain costs by creating a stable risk pool that may enable AHPs to self-insure rather than purchase insurance from commercial insurers.

Legislative proposals designed to foster the formation of AHPs have repeatedly been introduced in Congress.[14] These legislative efforts generally would make it easier for employers to form AHPs and set a uniform federal framework for regulation. In the absence of legislation, however, Executive Order 13813 directs the Department to consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs by expanding the conditions that satisfy the commonality-of-interest requirements under existing Department advisory opinions interpreting the definition of an ''employer'' under section 3(5) of ERISA in the context of AHPs in a manner that would focus on the association rather than the individual members of the association when evaluating association coverage.

Upon due consideration as directed by the Executive Order, the Department is proposing for public comment a revision to its long-standing interpretation of what constitutes an ''employer'' capable of sponsoring an ''employee benefit plan'' under ERISA in the context of group health coverage. Under the proposal, AHPs that meet the regulation's conditions would have a ready means of offering their employer-members, and their employer members' employees, a single group health plan subject to the same State and Federal regulatory structure as other ERISA-covered employee welfare benefit plans. This proposed rule has been developed in consultation with HHS, CMS, the Department of the Treasury, and the Internal Revenue Service, with which the Department is working to implement the Affordable Care Act, Executive Order 13813, and Executive Order 13765.[15] However, these proposed rules would apply solely for purposes of Title I of ERISA and for determining whether health insurance coverage is regulated by PHS Act provisions that apply in the individual, small group, or large group market, and not, for example, for purposes of taxation under the Code.

4. Overview of Proposed Regulation

The Department believes providing additional opportunities for employer groups or associations to offer health coverage to their members' employees under a single plan may, under the conditions proposed here, offer many small businesses more affordable alternatives than are currently available to them in the individual or small group markets. Consequently, the proposed rule may prompt some working owners who were previously uninsured and some small businesses that did not previously offer insurance to their employees, to enroll in AHPs, and similarly prompt some small businesses with insured health plans to switch from their existing individual or small group policies to AHPs. In addition, the option for small employers to join AHPs could offer better financial protection to employers (and their employees) than if they self-insured and purchased stop-loss insurance[16] that may not adequately protect them from financial risk. Under the proposed rule, AHPs that buy insurance[17] would not be subject to the insurance ''look-through'' doctrine as set forth in the CMS 2011 guidance; instead, because an AHP under the proposed rule would constitute a single plan, whether the plan would be buying insurance as a large or small group plan would be determined by reference to the number of employees in the entire AHP.

The proposed regulation would redefine the criteria in the Department's existing sub-regulatory guidance for a bona fide group or association of employers capable of establishing a multiple employer group health plan that is an employee welfare benefit plan and a group health plan as those terms are defined in ERISA. The Department notes that this preamble and the proposed rule do not address the application of the ERISA section 3(5) statutory phrase, ''acting. . .indirectly in the interest'' or ''group or association of employers,'', in any context other than as applied to an employer group or association sponsoring an AHP.

a. Employers Could Band Together for the Single Purpose of Obtaining Health Coverage

The proposed regulation would remove existing restrictions in the Department's sub-regulatory guidance on ERISA section 3(5) to allow employers to more easily join together in organizations that offer group health coverage to member employers and their employees under one group health plan. Specifically, the regulation would allow employers to band together for the express purpose of offering health coverage if they either are: (1) in the same trade, industry, line of business, or profession; or (2) have a principal place of business within 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). As discussed elsewhere in this document, the restrictions in the Department's existing advisory opinions were intended to help distinguish healthcare arrangements sponsored by an entity acting as an ''employer'' within the meaning of section 3(5) of ERISA from commercial-insurance-type arrangements that lack the requisite connection to the employment relationship. The Department has concluded that other conditions in this proposal can adequately serve that purpose while removing the condition that the employer association must have a purpose other than offering health coverage as a potential undue restriction on the establishment and maintenance of AHPs under ERISA. The proposal also would allow associations to rely on other characteristics upon which they previously relied to satisfy the commonality provision of paragraph (c) of the proposed rules, because the Department's existing sub-regulatory guidance applies the commonality requirement as a facts and circumstances test, and the Department intends that any employer group or association that meets the commonality requirement in the Department's existing sub-regulatory requirement should also be treated as meeting the commonality requirement in the proposed regulation. The Department seeks comment on whether the final rule, if adopted, should also recognize other bases for finding a commonality of interest.

[14] *See, e.g.,* Small Business Health Fairness Act of 2017, H.R. 1101, 115th Cong. sec. 1 (2017); *see also,* the Better Care Reconciliation Act of 2017, discussion draft of an amendment in the form of a substitute to the American Healthcare Act, H.R. 1628, 115th Cong. sec. 1 (2017) (available at *www.budget.senate.gov/imo/media/doc/ERN17500.pdf.*).

[15] The Departments of Labor, HHS, and the Treasury operate under a Memorandum of Understanding that implements section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent amendments, including certain sections of the Affordable Care Act, and provides for coordination and consultation. *See* 64 FR 70164 (December 15, 1999).

[16] Stop-loss insurance (sometimes also known as excess insurance) is generally an insurance product that provides protection for self-insured employers or plans by serving as a reimbursement mechanism for catastrophic claims exceeding pre-determined levels. *See https://www.siia.org/i4a/pages/index.cfm?pageID=4549.*

[17] The CMS 2011 guidance ''Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or Through, Associations'' apples only to insured arrangements, and not to self-insured arrangements.

The latter part of the second prong of this proposal's definition relating to States and metropolitan areas will allow an AHP to satisfy the commonality requirement if its members have a principal place of business within a region that does not exceed the boundaries of the same State or metropolitan area (even if the metropolitan area includes more than one State).

Examples of such metropolitan areas include the Greater New York City Area/Tri-State Region covering portions of New York, New Jersey and Connecticut; the Washington Metropolitan Area of the District of Columbia and portions of Maryland and Virginia; and the Kansas City Metropolitan Area covering portions of Missouri and Kansas. AHPs could also satisfy the commonality requirement by limiting themselves to a smaller geographic region, such as a city or county. The Department invites comments specifically on whether more clarification would be helpful regarding the definition of a metropolitan area. For example, the Department is interested in whether a federal designation by the U.S. Census or the Office of Management and Budget (OMB), which delineates metropolitan and micropolitan statistical areas according to published standards (see *www.census.gov/programs-surveys/metro-micro.html*), or another definition, should be used and, if so, how, for purposes of establishing eligibility for continued or new employer membership (*e.g.,* at the beginning of each plan year). The Department is also interested, for example, in comments on whether there is any reason for concern that associations could manipulate geographic classifications to avoid offering coverage to employers expected to incur more costly health claims. The Department also seeks comments on whether there are other examples that would be helpful to clarify the provision and also on whether there should be a special process established to obtain a determination from the Department that all an association's members have a principal place of business in a metropolitan area.

By expressly allowing the group or association to exist for the purpose, in whole or in part, of offering or providing health coverage to its members, the regulation would depart from previous sub-regulatory guidance providing that the group or association must exist for a bona fide purpose other than offering health coverage to be an employer for purposes of section 3(5) of ERISA. The proposal also would not include any requirement that the group or association be a pre-existing organization. Rather, employers could band together in new organizations whose sole purpose is to provide group health coverage to member employers and their employees. And by allowing formation of such an organization based on either common industry or geography, the Department expects that the regulation could greatly increase association coverage options available to American workers.

One of the primary aims of this proposal is to give small employers (as well as sole proprietors and other working-owners) the opportunity to join together to provide more affordable healthcare to their employees; however, the proposed regulation would not restrict the size of the employers that are able to participate in a bona fide group or association of employers. The Department expects minimal interest among large employers in establishing or joining an AHP as envisioned in this proposal because large employers already enjoy many of the large group market advantages that this proposal would afford small employers. However, the Department anticipates that there may be some large employers that may see cost savings and/or administrative efficiencies in using an AHP as the vehicle for providing health coverage to their employees.

b. The Group or Association Must Have an Organizational Structure and Be Functionally Controlled by Its Employer Members

Paragraph (b) of the proposed regulation defines certain criteria for a bona fide group or association of employers to be capable of establishing a group health plan under ERISA. The proposal would require that the group or association have a formal organizational structure with a governing body and have by-laws or other similar indications of formality appropriate for the legal form in which the group or association operates, and that the group or association's member employers control its functions and activities, including the establishment and maintenance of the group health plan, either directly or through the regular election of directors, officers, or other similar representatives. These requirements largely duplicate conditions in the Department's existing sub-regulatory guidance under ERISA section 3(5), and ensure that the organizations are genuine organizations with the organizational structure necessary to act ''in the interest'' of participating employers with respect to employee benefit plans as the statute requires. The proposed regulation would also retain the requirement in the Department's existing sub-regulatory guidance under section 3(5) of ERISA that an AHP's employer-members control the AHP. This requirement is necessary to satisfy the statutory requirement in ERISA section 3(5) that the group or association must act ''in the interest of'' the direct employers in relation to the employee benefit plan, and to prevent formation of commercial enterprises that claim to be AHPs but, in reality, merely operate similar to traditional insurers selling insurance in the group market. In the latter circumstance, the association lacks the requisite connection to the employment relationship, inasmuch as it neither acts directly as an employer, nor ''in the interest'' of employers, within the meaning of section 3(5) of ERISA. The Department intends that any employer group or association that meets the control requirement in the Department's existing sub-regulatory requirement should also be treated as meeting the control requirement in the proposed regulation.

c. Group or Association Plan Coverage Must Be Limited to Employees of Employer Members and Treatment of Working Owners

In addition, paragraph (b)(6) of the proposed regulations would require that only employees and former employees of employer members (and family/beneficiaries of those employees and former employees) may participate in a group health plan sponsored by the association and that the group or association does not make health coverage offered through the association available to anybody other than to employees and former employees of employer members and their families or other beneficiaries. Together, these criteria are intended to ensure that, for purposes of Title I of ERISA, the groups or associations sponsoring the covered AHPs are bona fide employment-based associations, as clarified by this proposal, and not more general membership organizations essentially operating as unlicensed health insurance providers selling commercial group health coverage to individuals and employers without the type of connection to the employment relationship envisioned by ERISA's section 3(1) definition of employee welfare benefit plan. *See, e.g., Wisconsin Educ. Assn. Ins. Trust* v. *Iowa State Bd. of Public Instruction,* 804 F.2d 1059, 1064 (8th Cir. 1986) (''The only relationship between the sponsoring labor union and these non-member recipients stems from the benefit plan

itself. Such a relationship is similar to the relationship between a private insurance company, which is subject to myriad State insurance regulations, and the beneficiaries of a group insurance plan."). *Accord Mandala* v. *California Law Enforcement Ass'n,* 561 F. Supp.2d 1130, 1135 (C.D. Cal. 2008)).

The text of ERISA relevant here specifies that only employees and former employees of the member employers, and their families or other beneficiaries, may receive coverage through an AHP as an ERISA-covered benefit plan. ERISA is an acronym for the "Employee Retirement Income Security Act of 1974." Consistent with the Act's title and understandings about the workplace, the touchstone of ERISA is the provision of benefits *through the employment relationship.* That understanding appears in the definition of "employee welfare benefit plan," which defines which benefit arrangements are subject to ERISA. An "employee welfare benefit plan" is defined as "any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries [benefits such as health insurance]." ERISA section 3(1). The term "participant" is in turn defined as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit . . . from an employee benefit plan which covers employees *of such employer.*" *Id.* section 3(7) (emphasis added). In other words, a participant is an employee of an employer who may receive benefits from *that employer's own* benefits plan. Individuals who are not "participants" within the meaning of ERISA section 3(7), *e.g.,* individuals who are not employees or former employees of employers sponsoring a particular plan, are ineligible to be covered (or have their families or other beneficiaries covered) by an ERISA plan. *See, e.g., Wisconsin Educ. Assn. Ins. Trust,* 804 F.2d at 1064.

Significantly, in paragraph (e) of the regulation, the proposal would expressly provide that working owners, such as sole proprietors and other self-employed individuals, may elect to act as employers for purposes of participating in an employer group or association and also be treated as employees of their businesses for purposes of being covered by the group or association's health plan. This approach is consistent with advisory opinions in which the Department has concluded that working owners may be "participants" in ERISA plans. For example, Advisory Opinion 99–04A reviews various provisions of ERISA and the Code that specifically address working owner issues in ERISA plans, and concludes that, taken as a whole, they "reveal a clear Congressional design to include 'working owners' within the definition of 'participant' for purposes of Title I of ERISA." [18]

This proposed rule would also serve to confirm that the Department's regulation at 29 CFR 2510.3–3 does not limit the ability of working owners to participate in AHPs alongside other employer members. Section 2510.3–3(b) excludes "plans without employees" from the definition of employee benefit plans covered by Title I of ERISA, thereby ensuring that a health insurance arrangement that covers, for example, only the working owner and his or her spouse, is not generally subject to ERISA's reporting and disclosure, fiduciary, and enforcement provisions. Thus, Section (c) of 29 CFR 2510.3–3 is titled "Employees" and states: "For purposes of this section [*i.e.,* for purposes of the regulation defining a covered plan]: (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership." Accordingly, if the sole participants in a benefit arrangement are the individual owner of a business and his or her spouse or partners in the same partnership and their spouses, the regulation treats the arrangement as a plan without employees and excludes it from the definition of ERISA-covered plans.

However, that same regulation expressly limits this language to 29 CFR 2510.3–3, and sole owners or partners are not excluded from being participants in a plan that also covers one or more common law employees in addition to the sole owner or partners of the same partnership and their spouses. Rather, plans covering working owners *and* their non-owner employees clearly fall within ERISA's scope. Thus, the U.S. Supreme Court in *Yates* v. *Hendon,* 541 U.S. 1 (2004), concluded in a case involving section 2510.3–3, that "[u]nder ERISA, a working owner may have dual status, *i.e.,* he can be an employee entitled to participate in a plan and, at the same time, the employer (or owner or member of the employer) who established the plan." The definition of "plans without employees" in 29 CFR 2510.3–3(b) simply defines a limited circumstance in which the only parties participating in the benefit arrangement are an individual owner/partner and spouse, and declines to deem the individuals, in that limited circumstance, as employees of the trade or business for purposes of the regulation. In that narrow circumstance, the regulation concludes that ERISA's reporting and disclosure, fiduciary, and enforcement provisions are unnecessary.

The regulatory definition does not apply, however, outside that limited context and, accordingly, does not prevent sole proprietors or other working owners from being participants in broader plan arrangements, such as the AHPs that are the subject of this proposal. As proposed here, AHPs are a far cry from such individual arrangements "administered" by a single individual on behalf of himself or herself and a spouse. Instead, the association and the AHP are responsible for the provision of employment-based benefits payable to numerous workers employed by multiple employers. Many or most of the affected employers and employees will not be directly involved in the administration of benefits, and all of the employers and employees should benefit from prudence and loyalty requirements for those running the AHP, as well as such other protections as reporting and disclosure obligations and claims procedure requirements, and enforcement, in the same manner and to the same extent as participants in other ERISA plan arrangements.

Accordingly, this proposal would extend by regulation the availability of the dual status of working owners to AHPs as a type of multiple employer plan, and make it clear that 29 CFR 2510.3–3 does not broadly preclude working owners of trades or businesses and other self-employed individuals without common law employees from joining a group health plan sponsored by an employer group or association. The Department set forth above its view regarding the permissible interpretation of the 29 CFR 2510.3–3 regulation as it relates to working owners participating in AHPs. Notwithstanding those views, to the extent the regulation could result in working owners not being able to participate as employees even in some

[18] The Advisory Opinion cites Code section 401(c), which for purposes of certain provisions relating to qualified retirement plans, and also for certain other Code provisions related to employee benefits that cross-reference section 401(c), generally treats a sole proprietor as both an employer and an employee and treats partners (including owners of entities taxed as partnerships, such as limited liability companies) as employees of the partnership.

circumstances, the Department believes the policies and objectives underlying this proposal support an amendment of the 29 CFR 2510.3–3 regulation so that it clearly does not interfere with working owners participating in AHPs as envisioned in this proposal. Accordingly, and to eliminate any potential ambiguity regarding the interaction of this proposal with the regulation at 29 CFR 2510–3–3, this proposal also includes a technical amendment of paragraph (c) of 2510.3–3 to include an express cross-reference to the working owner provision in this proposal.

Specifically, the proposed regulation includes a provision that expressly states that a working owner of a trade or business without common law employees, regardless of the legal form in which the business is operated (*e.g.,* sole proprietors or other working owners of businesses, whether incorporated or unincorporated), may elect to act as an employer for purposes of participating in an employer group or association and be treated as an employee of the trade or business for purposes of being covered by the employer group's or association's health plan, if the individual is earning income from the trade or business for providing personal services to the trade or business; and either provides on average at least 30 hours of personal services to the trade or business per week or 120 hours of such service per month, or has earned income derived from such trade or business that at least equals the cost of coverage under the group or association's health plan. In addition, the individual must not be eligible for other subsidized group health plan coverage under a group health plan sponsored by any other employer of the individual or by a spouse's employer.[19] The proposal also includes an express provision that would allow the group or association sponsoring the AHP to rely, absent knowledge to the contrary, on written representations from the individual seeking to participate as a working owner as a basis for concluding that these conditions are satisfied. Comments are invited on this provision, including whether an individual must not be eligible for other subsidized group health plan coverage under another employer or a spouse's employer.

The Department included the proposed working owner criteria to ensure that a legitimate trade or business exists. ERISA governs benefits provided in the context of an employment relationship. The Department is concerned, therefore, that without such criteria, the regulation could effectively eliminate the statutory distinction between offering and maintaining employment-based ERISA-covered plans, on the one hand, and the mere marketing of insurance to individuals outside the employment context, on the other. Thus, for example, an association would fall outside the purview of this rule if it offered coverage to persons who are not genuinely engaged in a trade or business (*e.g.,* a vendor marketing AHP coverage could not make eligibility turn on such de minimis ''commercial activities'' as giving a ''customer'' a single on-demand ride for a fee, or knitting a single scarf to be offered for sale on the internet, with no requirement that the individual ever engage in the supposed ''trade or business'' ever again). The rule is intended to cover genuine employment-based relationships, not to provide cover for the marketing of individual insurance masquerading as employment-based coverage.

The Department recognizes that it could be possible to draw the line between employment-based arrangements, as covered by ERISA, and non-ERISA arrangements in other ways. For example, the Department also recognizes that some legitimate start-up trades or businesses may take time to become profitable, and ongoing genuine trades or businesses may experience bad years financially. Alternative approaches could focus on other measures of the trade or business as a source of earnings or other measures of time spent on the work activity. Accordingly, the Department solicits comments on whether the proposed standard is workable and, if so, whether any additional clarifications would be helpful to address issues relating to how working owners could reasonably predict whether they will meet the earned income and hours worked requirements, and whether AHPs should be required to obtain any evidence in support of such a prediction beyond a representation from the working owner. Thus, the Department generally invites comment on whether different criteria would be more appropriate to ensure that so-called ''working owners'' who join an AHP are genuinely engaged in a trade or business and are performing services for the trade or business in a manner that is in the nature of an employment relationship.

Under the proposal, an AHP thus could be comprised of participants who are common law employees, common law employees and working owners, or comprised of only working owners. In all cases, the working owner would be treated as an employee and the business as the individual's employer for purposes of being an employer member of the association and an employee participant in the AHP. In the Department's view, allowing sole proprietors and other working owners without common law employees to participate in AHPs covered by ERISA on an equal basis with other employers and employees furthers ERISA's purposes of promoting employee benefit plans and protecting the interests of plan participants and their beneficiaries. This approach acknowledges that an AHP may include as employer-members working owners with common law employees and also addresses the operational impracticability of having an AHP switch in and out of its status as a single multiple employer plan during periods in which the AHP sometimes has and sometimes does not have employees other than sole proprietors.

Finally, as noted above, AHPs that already meet the Department's current commonality of interest and employer-member control standards will continue to be treated as meeting those requirements under the proposal for sponsoring a single multiple employer plan under ERISA. However, if the proposal is adopted as a final rule, upon effectiveness of the final rule, such an existing AHP would need to meet all the conditions in the final rule to continue to act as an ERISA section 3(5) employer going forward.

To the extent a final rule consistent with this proposal would be inconsistent with any prior sub-regulatory guidance, the final rule would supersede that guidance. For example, the regulation would supersede the statement in Advisory Opinion 2003–13A that ERISA section 3(5) does not cover groups with memberships that include persons who are not employers of common-law employees. In the case of statutory and regulatory provisions like those involved here, the Department has the authority to supersede its previous interpretations, as articulated in non-binding advisory opinions, to address marketplace developments and new policy and regulatory issues, *see generally Perez* v. *Mortgage Bankers*

[19] The earned income standard and other group health plan eligibility provision are informed by Federal tax standards, including section 162(l) of the Code that describe conditions for self-employed individuals to deduct the cost of health insurance. However, federal tax treatment, including tax administration of Code section 162(l) and any potential IRS reporting requirements, of working owners is not affected by the proposed regulation's characterization of a working owner as an employer for purposes of participating in a sponsoring employer group or association and an employee for purposes of being covered by the group health plan.

Assn, 135 S. Ct. 1199 (2015), and the authority to supersede a prior interpretation by a federal court, *see National Cable & Telecommunications Ass'n* v. *Brand X internet Services (Brand X),* 545 U.S. 967, 125 S. Ct. 2688 (2005) ("A court's prior judicial construction of a statute trumps an agency construction otherwise entitled to *Chevron* deference only if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion."). The ERISA statutory definition of the term "employer," which includes direct employers and any other person acting indirectly in the interest of the employer in relation to an employee benefit plan, including a group or association of employers, is not an unambiguous term that leaves no room for agency discretion. Moreover, by proceeding through notice and comment rulemaking, the Department has exercised its authority in a way that ensures all interested stakeholders will have an opportunity to present their views on the implications and significance of the proposal in light of past guidance, judicial decisions, and sound public policy.

d. Health Nondiscrimination Protections

Two distinct potential issues prompt the nondiscrimination protections in the proposed rule. First, some stakeholders and experts have expressed concerns that legislative proposals that would have permitted employer groups or associations to sponsor group health plans for the purpose of promoting and expanding association health coverage could have resulted in risk selection. For example, in a letter to the Chairwoman and Ranking Member of the House Committee on Education & the Workforce, the American Academy of Actuaries argued that AHPs could create adverse selection if legislation [20] being considered by the committee allowed them to operate under different rules than other group health plans. They wrote: "If one set of plans operates under rules that are more advantageous to healthy individuals, then those individuals will migrate to those plans; less healthy individuals will migrate to the plans more advantageous to them." [21] Similarly, the National Association of Insurance Commissioners (NAIC) also wrote a letter to the Chairwoman and Ranking Member stating that the legislation would encourage AHPs to select healthy groups by designing benefit packages and setting rates to the detriment of unhealthy groups.[22]

Alternatively, some have argued that more actuarially appropriate pricing where premiums match risk tends to lead people to buy the efficient amount of coverage, rather than underinsuring or overinsuring, and that such pricing also reduces the likelihood that insurance markets deteriorate into adverse selection spirals. In the case of associations, some stakeholders have argued that the presence of nondiscrimination rules may create instability in the AHP market, as employers with disproportionately unhealthy employees seek to join AHPs to lower their rates while AHPs with disproportionately healthy employees constantly modify their rules of admission to avoid this outcome. And stakeholders have argued that allowing employers to join together voluntarily on their own terms to offer health coverage to their members would reflect those employers' interests and maximize the potential for the market, while the converse would deter AHP formation and lead to fewer insured people.

Second, the nondiscrimination provisions distinguish genuine employment-based plans from commercial enterprises that claim to be AHPs but that are more akin to traditional insurers selling insurance in the employer marketplace. ERISA sections 3(1) and (5) require a bona fide employment nexus and a level of cohesion and commonality among entities acting on behalf of common law employers, the common law employers, and the covered employees, as distinguished from commercial insurance arrangements that sell insurance coverage to unrelated common law employers. The nondiscrimination provisions maintain that nexus and cohesion—embodied in the longstanding ERISA section 3(5) "commonality of interests" requirement—in the new circumstance permitted under the proposal under which an employer group or association sponsoring an ERISA employee benefit plan may exist solely for the purpose of providing group health coverage. In the Department's view, AHPs that discriminate among employer-members in ways that would violate the nondiscrimination provisions in the proposal may not reflect the common employer interests that characterize an employee benefit plan as compared to the sort of commercial insurance enterprise that ERISA intended to leave to state, rather than federal, regulation. The nondiscrimination provisions are also based on the Department's broad rulemaking authority under ERISA section 505 (authorizing "such regulations as [the Secretary] finds necessary or appropriate to carry out the provisions of this title") and ERISA section 734. ERISA section 734 authorizes the Secretary to promulgate such regulations as may be necessary or appropriate to carry out the provisions of Part 7 of ERISA, including ERISA section 715(a)(1), which incorporates the provisions of part A of title XXVII of the PHS Act (generally, sections 2701 through 2728 of the PHS Act) into ERISA and makes those provisions applicable to plans and issuers.

The nondiscrimination provisions in paragraph (d) of the proposed regulation build on the existing health nondiscrimination provisions applicable to group health plans under HIPAA, as amended by the Affordable Care Act (HIPAA/ACA health nondiscrimination rules), with an additional clarification addressing how to apply those rules to association coverage.

Specifically, paragraph (d)(1) of the proposed regulation would ensure the group or association does not restrict membership in the association itself based on any health factor, as defined in the HIPAA/ACA health nondiscrimination rules. The HIPAA/ACA health nondiscrimination rules define a health factor as: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability. Code section 9802(a)(1), ERISA section 702(a)(1), and PHS Act section 2705(a)(1). *See also* 26 CFR 54.9802–1(a), 29 CFR 2590.702(a), and 45 CFR 146.121(a).

Paragraphs (d)(2) and (d)(3) of the proposed rules provide that the group health plan sponsored by the group or association must comply with the HIPAA/ACA health nondiscrimination rules, which govern eligibility for

[20] Small Business Health Fairness Act of 2017, H.R. 1101, 115th Cong. (2017).

[21] Letter from the American Academy of Actuaries to Virginia Foxx, Chairwoman, Committee on Education and the Workforce, U.S. House of Representatives, and Robert C. Scott, Ranking Member, Committee on Education and the Workforce, U.S. House of Representatives (March 8, 2017) (available at *https://www.actuary.org/files/publications/AHPs_HR1101_030817.pdf*).

[22] Letter from the NAIC to Virginia Foxx, Chairwoman, Committee on Education and the Workforce, U.S. House of Representatives, and Robert C. Scott, Ranking Member, Committee on Education and the Workforce, U.S. House of Representatives (Feb. 28, 2017) (available at *http://www.naic.org/documents/health_archive_naic_opposes_small_business_fairness_act.pdf*).

benefits [23] and premiums for group health plan coverage. In determining what is a group of similarly situated individuals for purposes of applying those rules, this proposed regulation provides in paragraph (d)(4) how to apply these HIPAA/ACA health nondiscrimination rules in the context of a group or association of employers sponsoring a single group health plan.

Specifically, the HIPAA/ACA health nondiscrimination rules generally prohibit health discrimination *within* groups of similarly situated individuals, but they do not prohibit discrimination *across* different groups of similarly situated individuals. In determining what counts as a group of similarly situated individuals, for these purposes, paragraph (d) of the HIPAA/ACA health nondiscrimination rules generally provides that plans may, subject to an anti-abuse provision for discrimination directed at individuals, treat participants as distinct groups if the groups are defined by reference to a bona fide employment-based classification consistent with the employer's usual business practice. As stated in the HIPAA/ACA health nondiscrimination rules, whether an employment-based classification is bona fide is determined based on all the relevant facts and circumstances, including whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Examples in the HIPAA/ACA health nondiscrimination rules of classifications that may be bona fide, based on all the relevant facts and circumstances, include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. Under an anti-abuse provision contained in paragraph (d)(3) of the HIPAA/ACA health nondiscrimination rules, however, a distinction between groups of individuals is not permitted if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

In addition, under the HIPAA/ACA health nondiscrimination rules, a plan may, generally, subject to certain anti-abuse provisions for discrimination directed at individuals, treat beneficiaries as distinct groups based on the bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage, the relationship to the participant, marital status, age or student status (subject to PHS Act section 2714, as incorporated in ERISA section 715, as well as ERISA section 714) and other factors if the factor is not a health factor. Finally, the HIPAA/ACA health nondiscrimination rules generally allow group health plans to treat participants and beneficiaries as distinct groups.

The proposed regulations propose that, in applying the HIPAA/ACA health nondiscrimination rules for defining similarly-situated individuals, the group or association may not treat member employers as distinct groups of similarly-situated individuals. As noted above, the HIPAA/ACA health nondiscrimination rules apply within groups of similarly-situated individuals. If an association could treat different employer-members as different bona fide employment classifications, the nondiscrimination protections in paragraphs (d)(1) through (d)(3) could be ineffective, as AHPs could offer membership to all employers meeting the association's membership criteria, but then charge specific employer members higher premiums, based on the health status of those employers' employees and dependents. Accordingly, under the proposed regulation a group or association which seeks treatment as an ''employer'' under ERISA section 3(5) for purposes of sponsoring a single group health plan under ERISA section 3(1) cannot simultaneously undermine that status by treating different employers as different groups based on a health factor of an individual or individuals within an employer member. DOL seeks comment on whether this structure, which could potentially represent an expansion of current regulations, would create involuntary cross-subsidization across firms that would discourage formation and use of AHPs.

Moreover, the Department views such employer-by-employer risk-rating as undermining the statutory aim of limiting plan sponsors to ''employers'' and to entities acting ''in the interest'' of employers, and instead extending ERISA coverage to entities that seek to underwrite risk and are nearly—or entirely—indistinguishable from such commercial-insurance-type entities. The extension of ERISA coverage to such commercial entities would not be consistent with Congress' deliberate decision to limit ERISA's coverage to employment-based relationships. Coupled with the control requirement, also requiring AHPs to accept all employers who fit their geographic, industry, or any other non-health-based selection criteria that each AHP chooses, the nondiscrimination provisions ensure a level of cohesion and commonality among entities acting on behalf of common law employers, the common law employers themselves, and the covered employees, as distinguished from commercial insurance arrangements that sell insurance coverage to unrelated common law employers.

Paragraph (d)(5) contains examples that illustrate the rules of paragraphs (d)(1) through (d)(4).

The Department specifically solicits comments on the above described nondiscrimination requirements, including how they balance risk selection issues with the stability of the AHP market and the ability of employers to innovate and enter voluntary coverage arrangements. The Department also solicits comments on the effect of additional or different nondiscrimination protections, such as further limitations on price flexibility. Specifically, the Department invites comments on whether paragraph (d)(4) is an appropriate or sufficient response to the need to distinguish AHPs from commercial insurance (and on any alternative provisions that might achieve the same goal, as well as on whether paragraph (d)(4) could destabilize the AHP market or hamper employers' ability to create flexible and affordable coverage options for their employees.

5. Request for Public Comments

The Department invites comments on the specific issues identified in the discussion above, as well as on all aspects of the proposed rule as a potential alternative approach to the Department's existing sub-regulatory guidance criteria. Comments are invited on the interaction with and consequences under other State and Federal laws, including the interaction with the Code section 501(c)(9) provisions for voluntary employees' beneficiary associations (VEBAs), should an AHP want to use a VEBA. The Department also invites comments on whether any notice requirements are needed to ensure that employer members of associations, and

[23] A rule for eligibility for benefits is defined by reference to the HIPAA/ACA health nondiscrimination rules and includes rules relating to enrollment, the effective date of coverage, waiting (or affiliation) periods, late or special enrollment, eligibility for benefit packages, benefits (including covered benefits, benefit restrictions, and cost-sharing), continued eligibility, and terminating coverage. 26 CFR 54.9802–1(b)(1)(ii); 29 CFR 2590.702(b)(1)(ii); 45 CFR 146.121(b)(1)(ii).

participants and beneficiaries of group health plans, are adequately informed of their rights or responsibilities with respect to AHP coverage. Comments are also solicited on the impact of these proposals on the risk pools of the individual and small group health insurance markets, and for data, studies or other information that would help estimate the benefits, costs, and transfers of the rule.

6. Request for Information

In addition to the proposal set forth in this document, pursuant to Executive Order 13813, the Department is considering other actions it could take to promote healthcare consumer choice and competition across the United States. The proposed rules would not alter existing ERISA statutory provisions governing MEWAs. The proposed rules also would not modify the States' authority to regulate health insurance issuers or the insurance policies they sell to AHPs. As described above, some MEWAs have historically been unable to pay claims due to fraud, insufficient funding, or inadequate reserves.[24] ERISA section 514(b)(6) gives the Department [25] and State insurance regulators joint authority over MEWAs (including AHPs described in this proposed rule), to ensure appropriate consumer protections for employers and employees relying on an AHP for healthcare coverage.

Some stakeholders have identified the Department's authority under ERISA section 514(b)(6)(B) to exempt self-insured MEWA plans from State insurance regulation as a way of promoting consumer choice across State lines. Specifically, ERISA section 514(b)(6)(B) provides that the Department may prescribe regulations under which non-fully insured MEWAs that are employee benefit plans may be granted exemptions, individually or class by class, from certain State insurance regulation. Section 514(b)(6)(B) does not, however, give the Department unlimited exemption authority. The text limiting the Department's authority is in ERISA section 514(b)(6)(A). That section provides that the Department cannot exempt an employee benefit plan that is a non-fully insured MEWA from state insurance laws that can apply to a fully insured MEWA plan under ERISA section 514(b)(6)(A), *i.e.,* state insurance laws that establish reserves and contribution requirements that must be met in order for the non-fully insured MEWA plan to be considered able to pay benefits in full when due, and provisions to enforce such standards.

Thus, self-insured MEWAs, even if covered by an exemption, would remain subject to State insurance laws that provide standards requiring the maintenance of specified levels of reserves and contributions as means of ensuring the payment of promised benefits. While beyond the scope of this proposed rulemaking, the Department is interested in receiving additional input from the public about the relative merits of possible exemption approaches under ERISA section 514(b)(6)(B). The Department is interested both in the potential for such exemptions to promote healthcare consumer choice and competition across the United States, as well as in the risk such exemptions might present to appropriate regulation and oversight of AHPs, including State insurance regulation oversight functions.

The Department is also interested in comments on how best to ensure compliance with the ERISA and ACA standards that would govern AHPs and on any need for additional guidance on the application of these standards or other needed consumer protections. In this connection, the Department emphasizes that AHPs would be subject to existing generally applicable federal regulatory standards governing ERISA plans and additional requirements governing MEWAs specifically, and sponsors of AHPs would need to exercise care to ensure compliance with those standards.

The Department requests comments on how it can best use the provisions of ERISA Title I to require and promote actuarial soundness, proper maintenance of reserves, adequate underwriting and other standards relating to AHP solvency. The Department also invites comments on whether additional provisions should be added to the final rule to assist existing employer associations—including MEWAs that do not now constitute AHPs—in making adjustments to their business structures, governing documents, or group health coverage to become AHPs under the final rule.

The Department likewise encourages commenters to identify any aspect of the foregoing rules and obligations that would benefit from additional guidance as applied to AHPs, as well as any perceived deficiencies in existing guidance or regulatory safeguards.

Regulatory Impact Analysis

1.1. Executive Orders

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

Under Executive Order 12866 (58 FR 51735), ''significant'' regulatory actions are subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a ''significant regulatory action'' as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. It has been determined that this rule is economically significant within the meaning of section 3(f)(1) of the Executive Order. Therefore, OMB has reviewed these proposed rules pursuant to the Executive Order.

[24] *See* U.S. Gov't Accountability Office, GAO–92–40, States Need Labor's Help Regulating Multiple Employer Welfare Arrangements, (1992) (available at *http://www.gao.gov/products/HRD-92-40*); *See also* U.S. Gov't Accountability Office, GAO–04–312, Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage (2004) (available at *http://www.gao.gov/products/GAO-04-312*).

[25] Because small employer group health plans typically are fully-insured or pay benefits out of the employer's general assets, they are generally exempt under current DOL regulations from most, if not all, of ERISA's annual reporting requirements. *See 29 CFR 2520.104–20.* However, as a MEWA, an AHP MEWA would not be eligible for this filing exemption, even if it covered fewer than 100 participants. Further, ERISA-covered group health plans that have 100 participants or more generally are required to file a Form 5500, whether insured or self-insured. Thus, AHPs established as a result of the proposal would be required to file Forms 5500. *See* ERISA section 101(b). In addition, because, as noted above, these AHPs are also MEWAs, they would be required to file a Form M–1. *See* ERISA section 101(g) and 29 CFR 2520.101–2. Both Form 5500 and Form M–1 information is accessible by DOL, as well as the States, to fulfill traditional oversight functions to help ensure that plans meet their obligations to pay benefits as promised under the plan and the law.

In accordance with the direction of Executive Order 13813, DOL is proposing a rule to broaden the circumstances under which an AHP will be treated as a single multiple employer-plan under ERISA. The proposal is intended to extend advantages typically enjoyed by large employer-sponsored health benefit plans to more working owners and small employers (collectively hereafter, small businesses) that under the proposal would be eligible to participate in AHPs. AHPs generally can offer these small businesses more health benefit options, and options that are more affordable, than typically are available in today's individual and small group health insurance markets. This document assesses the proposal's potential impacts.

1.2. Introduction and Need for Regulation

U.S. families obtain health benefits from a number of different private and public sources. Essentially all individuals age 65 or older are covered by Medicare. Most individuals under age 65 are covered by employer-sponsored insurance. Nearly all large employers offer health insurance to their employees, but only about one-half of employers with fewer than 50 employees do. Altogether, 61 percent of individuals under age 65 have employer-sponsored coverage. Thirty-eight percent of individuals under age 65 obtain coverage from private employers with 50 or more employees, 9 percent from smaller private employers, and 14 percent from public-sector employers.[26]

Large employers have a long history of providing their employees with affordable health insurance options. This regulation is needed to lower some barriers that can prevent many small businesses from accessing such options.

Today, businesses generally access insurance in one of three market segments, depending on their size. These segments are the individual market, which includes working owners among other individuals and their families, if they do not employ employees and therefore cannot establish a group health plan; the small group market, which generally includes small businesses with at least one and not more than 50 employees; and the large group market, which includes larger employers and some groups of employers. (Many large employers self-insure rather than purchase group insurance in the large group market segment.) Historically, relative to large employers, small businesses accessing health insurance in the individual and small group markets have faced at least two disadvantages. First, owing to their small size, working owners and other small businesses generally lack large employers' potential for administrative efficiencies and negotiating power. Second, unlike large employers, individual small businesses do not constitute naturally cohesive large risk pools. Any single small business's claims can spike abruptly due to one serious illness. Historically, individual and small group issuers often responded to such spikes by sharply increasing premiums, and/or by refusing to issue or renew policies or to cover pre-existing conditions. More recently, State and Federal legal changes including the ACA generally have outlawed these practices. Current rules generally regulate the individual and small group markets in which small businesses obtain insurance more stringently than the large group markets and self-insured employer plans. Unfortunately such rules can themselves limit choice, increase premiums, or even destabilize small group and individual markets. They, in effect, force issuers to raise premiums broadly, particularly for healthier small groups and individuals, which can prompt such groups and individuals to seek more affordable coverage elsewhere if available, or drop insurance altogether. In contrast, large employers' natural ability to provide comprehensive coverage at relatively stable cost is mirrored by the regulatory framework that applies to large group markets and self-insured ERISA plans.

Given the natural advantages enjoyed by large employer groups, it may be advantageous to allow more small businesses to combine into large groups for purposes of obtaining or providing health insurance. While some AHPs exist today, their reach currently is limited by the Department's existing interpretation of the conditions under which an AHP is an employer-sponsored plan under ERISA. Under that interpretation, eligible association members must share a common interest (generally, operate in the same industry), must join together for purposes other than providing health insurance, must exercise control over the AHP, and must have one or more employees in addition to the business owner. Accordingly, this proposed rule aims to encourage the establishment and growth of AHPs comprising otherwise unrelated small businesses, including working owners, and to clarify that nationwide industry organizations such as trade associations can sponsor nationwide AHPs.

This proposal would broaden the conditions under which associations can sponsor AHPs, thereby increasing the number of small businesses potentially eligible to participate in AHPs and providing new, affordable health insurance options for many Americans. It generally would do this in four important ways. First, it would relax the existing requirement that associations sponsoring AHPs must exist for a reason other than offering health insurance. Second, it would relax the requirement that association members share a common interest, as long as they operate in a common geographic area. Third, it would make clear that associations whose members operate in the same industry can sponsor AHPs, regardless of geographic distribution. Fourth, it would clarify that working owners and their dependents are eligible to participate in AHPs. Consequently, for example, the proposal would newly allow a local chamber of commerce that meets the other conditions in the proposal to offer AHP coverage to its small-business members, including working owners.

As large groups, AHPs might offer small businesses some of the scale and efficiency advantages typically enjoyed by large employer plans. They additionally could offer small businesses relief from ACA and State rules that restrict issuers' product offerings and pricing in individual and small group markets.

1.3. AHPs' Potential Impacts

By facilitating the establishment and operation of more AHPs, this proposed rule aims to make more, and more affordable, health insurance options available to more employees of small businesses and the families of such employees. Insuring more American workers, and offering premiums and benefits that faithfully match employees' preferences, are the most important benefits of this rule. The proposed rule contains provisions designed to prevent potentially adverse impacts on individual or small group risk pools that might otherwise carry social costs. AHPs will also affect tax subsidies and revenue and the Medicaid program.While the impacts of this proposed rule, and of AHPs themselves, are intended to be positive on net, the incidence, nature and magnitude of both positive and negative effects are uncertain. Predictions of these impacts are confounded by numerous factors including:

[26] DOL calculations based on the Abstract of Auxiliary Data for the March 2016 Annual Social and Economic Supplement to the Current Population Survey, U.S. Department of Labor.

- The dynamic and in some cases unstable conditions currently prevailing in local individual and small group insurance markets under existing ACA and State rules;
- A lack of data on the risk profiles of existing and potential associations and the individual and small group markets with which they intersect;
- A lack of data on the relative availabilities and sizes of subsidies and tax preferences for prospective AHP enrollees in Exchanges or Small Business Health Options Program (SHOP) Exchanges versus in AHPs;
- Legislative proposals to amend or repeal and replace the ACA;
- States' broad discretion to regulate AHPs, and variations in State practices; and
- Interactions with related initiatives per Executive Order 13813, including HRAs and short-term limited duration insurance policies.

In light of these uncertainties, what follows is a mostly qualitative assessment of this proposal's potential impacts, rather than a quantitative prediction. The Department is seeking comments and data that will allow the impacts of the rule to be quantified, and that will enable it to more fully assess the proposed rule's effects.

1.4. Potential Advantages of Scale

Owing to their potentially large scale, under the right conditions, AHPs result in lower insurance premiums compared to existing small group and individual insurance market arrangements. Consequently, AHPs may offer small businesses comparable coverage at lower prices, thereby delivering economic benefits to many working owners and employees of small businesses.

Large employers often enjoy some advantages of scale in the provision of health benefits for their employees, and AHPs may realize some of these same advantages. Scale may yield savings via one or more of three mechanisms: administrative efficiencies from economies of scale, self-insurance, and market power.

Administrative savings generally can be understood to constitute a social benefit, as resources are freed for other uses without reducing consumption. With respect to administrative efficiency from economies of scale, large employers generally avoid the potentially high cost associated with health insurance issuers' efforts to market to, enroll, and underwrite and set premiums for large numbers of individual families or small employer groups.[27] AHPs may, under favorable circumstances, achieve some savings in the same way. On the other hand, rather than avoiding these costs, some AHPs sometimes may merely internalize them, in the form of employers' cost to form associations and AHPs' own efforts to recruit and enroll association members, and to sign members up for insurance. AHPs sponsored by pre-existing associations that exist for reasons other than offering health insurance might have more potential to deliver administrative savings than those set up to offer health insurance. Organizations that already exist for reasons other than offering health insurance (such as chambers of commerce or trade associations) may already have extensive memberships and thus may have fewer setup, recruitment, and enrollment costs than organizations newly formed to offer insurance. Under this proposal, such existing associations that have been prohibited from offering AHPs to some or all of their existing members by the Department's current interpretations could newly extend AHP eligibility to existing members. Some other AHPs, however, might thrive by delivering savings to members by other means, such as by offering less comprehensive benefits, even if their administrative costs are higher.

Some other efficiency gains might arise from AHPs' scale in purchasing not insurance but healthcare services. Healthcare payers and providers sometimes realize administrative efficiencies in their interactions if a large proportion of each provider's patients are covered by a common payer. For example, streamlining of billing and payment processes and procedures for preauthorization for covered services may facilitate volume discounts. A self-insured AHP with a sufficiently large presence in a local market might capture some such efficiency. On the other hand, in some cases AHPs' entry into markets alongside other payers might erode such efficiency by reducing such issuer's scale in purchasing healthcare services. That is, an increase in the number of payers may sometimes increase the administrative burden associated with the payer-provider interface for some or all payers and providers. Consequently, the net impact of this proposal on efficiency in this interface (and on associated social welfare) could be positive or negative.

As large groups, AHPs also may achieve some savings by offering self-insured coverage. Because large group plans in and of themselves constitute large and potentially stable risk pools, it often is feasible for them to self-insure rather than to purchase fully-insured large group insurance policies from licensed health insurance issuers. Large risk pools' claims experience generally varies only modestly from year to year, so well-run large group plans can set premiums and operate with little risk of financial shortfalls. By self-insuring, some large AHPs may avoid some of the overhead cost otherwise associated with fully-insured large group health insurance policies. However State revenue may also decline in States that tax insurance premiums.

Also, as large groups, in addition to potential administrative and overhead savings, AHPs sometimes may be able to achieve savings through market power, negotiating discounts that come at suppliers' expense. In otherwise competitive markets, the exercise of market power sometimes can result in economic inefficiency. The opposite might be true, however, where an AHP's market power acts to counterbalance market power otherwise exercised by issuers or providers. If large group premiums are not already at competitive levels, sufficiently large AHPs may be able to negotiate with issuers for premium discounts. More frequently, issuers and other large payers, potentially including large, self-insured AHPs, may be able to negotiate discounts and other savings measures with hospitals, providers, and third party administrators (TPAs). Because markets for healthcare services are inherently local, payers' market power generally requires not merely scale, but a large geographic market share. Consequently, self-insured AHPs with geographically concentrated membership are more likely to realize such savings than are AHPs whose membership is spread thinly across States.

On the other hand, AHPs might sometimes dilute other payers' market power to command provider discounts,[28] thereby increasing costs for such payers' enrollees. AHP's net effect on payers' market power with respect to providers and consequent effect on enrollee costs consequently could be positive or negative.

It should be noted that diluting others' market power can increase social

[27] ACA and State rules that limit underwriting and set floors for insurers' loss ratios may make some of these savings available even within the existing individual and small group markets.

[28] For a discussion of insurers' market power *see* Sheffler, Richard M. and Daniel R. Arnold. "Insurer Market Power Lowers Prices in Numerous Concentrated Provider Markets." Health Affairs 36, no. 9 (2017).

welfare if it produces more healthy competition. If local individual and small group market premiums are not already at competitive levels, increasing competitive pressure from AHPs might force some individual and small group issuers to lower their own premiums. There is some evidence that competition among issuers has this effect,[29] although the likelihood of this effect occurring in this case is unclear, as market rules and claims experience may already have eliminated excess profit.

Given all of these variables, the net transfer and social welfare effects related to AHPs' exercise of, or impact on others' exercise of, market power are ambiguous.

In summary, AHPs' potential to reap advantages from scale may vary. Under favorable conditions they may realize some administrative savings, and/or negotiate discounts from insurers, providers, or TPAs. Market forces may favor AHPs that reap such advantages, but may also sustain AHPs that deliver savings to members by other means.

1.5. Increased Choice

Because they would not be subject to individual and small group market rules, AHPs in the large group market (which the Department expects would include all or almost all AHPs) would enjoy greater flexibility with respect to the products and prices they could offer to small businesses. AHPs consequently could offer many small businesses more affordable insurance options than would be available to them in individual and small group markets. Under the ACA and State rules, non-grandfathered individual and small group insurance policies generally must cover certain benefits. These rules limit the policies that issuers can offer to small businesses. Under this proposal, as noted earlier in this section, AHPs would generally be treated as large employers and accordingly granted access to the large group market (or, alternatively, could self-insure). The large group market is not subject to the same restrictions that apply in the individual and small group markets.[30] AHPs consequently could offer many small businesses more options than could individual and small group insurance issuers. For instance, AHPs could offer less comprehensive—and hence more affordable—coverage that some employees may prefer.

Some stakeholders have expressed concern that AHPs, by offering less comprehensive benefits, could attract healthier individuals, leaving less healthy individuals in the individual and small group markets and thus driving up the premiums in those markets and potentially destabilizing them. This risk may be small, however, relative to the benefits realized by small businesses and their employees that gain access to more affordable insurance that more closely matches their preferences. AHPs' benefits to their members can be substantial, as discussed above. For example, a small businesses electing less comprehensive AHP coverage can deliver benefits that are more closely tailored to their employees' actual health needs at a price their employees prefer. In addition, to the extent that AHPs deliver administrative savings or market power they may offer less expensive but equally comprehensive benefit options as compared to plans available in the individual or small group markets. This feature of AHPs would appeal to their less healthy members, prompting less healthy individuals to leave the individual and small group markets and potentially balancing out any exodus of healthy individuals from these markets. Moreover, this proposal addresses the risk of adverse effects on the individual and small group markets by including nondiscrimination provisions under which AHPs could not condition eligibility for membership or benefits or vary members' premiums based on their health status. The Department invites comments as to the benefits of AHPs offering wider choice including less comprehensive policies as well as any risk of adverse effects on individual or small group markets.

1.6. Risk Pooling

The proposal seeks to enable AHPs to assemble large, stable risk pools. The ACA and State rules tightly regulate how individual and small group issuers pool risk, for example by limiting the degree to which premiums can be adjusted based on age. These rules can threaten market stability. The ACA and State rules attempt to address this threat with additional, potentially inefficient rules, including the requirement that all individuals acquire coverage and mandatory transfers of "risk adjustment payments" from some issuers to others. AHPs would not be subject to these ACA and State rules, but will be subject to the nondiscrimination rules that bar all group health plans from conditioning eligibility, benefits, or premiums on health status. Properly designed, these rules should help AHPs to assemble large, stable risk pools, while at the same time limiting the risk that AHPs might tend to enroll healthier small businesses and thereby adversely affect individual and small group markets.

Some stakeholders have raised concerns that AHPs will be more likely to form in industries with younger, healthier employees, as employers and their employees receive greater access to more affordable coverage than is available in the individual and small group markets. The Department believes such concerns at this juncture are speculative. While AHPs may have larger incentives to form in industries with younger, healthier workers, they will also have incentives to form in industries with older or less healthy workers when, for example, they deliver sufficient administrative savings to offset any additional cost of insuring an older or less healthy population. The Department requests comments that would help further address this issue.

Likewise, some stakeholders have raised concerns that, because AHPs will enjoy greater pricing flexibility to set premiums, some might offer lower prices to healthier groups and higher prices to less healthy groups than individual and small group issuers are allowed to offer to those same groups. Of course, the nondiscrimination provisions in this proposal would prohibit any such discrimination based on health factors, but some non-health factors (such as age) correlate to a large degree with healthcare expenditures, and AHPs under this proposal could vary premiums to reflect actuarial risk based on such non-health factors. Some stakeholders argue that pursuit of lower prices based on non-health factors would lead, for example, younger association members to join AHPs but might lead older members to remain in individual and small group markets.

This argument, however, depends on the assumption that pricing flexibility is the principal or only advantage available to AHPs. In fact, as outlined above, AHPs have the potential to create significant efficiencies that could lower premiums across the board. An AHP that realizes sufficient efficiencies may offer attractive prices even to less

[29] Frank, Richard G. and Thomas G. McGuire. "Regulated Medicare Advantage and Marketplace Individual Health Insurance Markets Rely on Insurer Competition." Health Affairs 36 no. 9 (2017).

[30] Some States do set some minimum standards for benefits covered by large group policies, however. Such mandates would apply to fully insured AHPs. Because AHPs are MEWAs under ERISA, States also may have flexibility under ERISA's MEWA provisions to extend benefit standards to self-insured AHPs. ERISA generally precludes States from applying such standards to self-insured ERISA plans that are not MEWAs. For lists of "essential health benefits" that must be covered by non-grandfathered coverage in States' individual and small group markets under the ACA, and for lists of benefit standards that States apply to large group plans, *see https://www.cms.gov/cciio/resources/data-resources/ehb.html.*

healthy groups. In that scenario, less healthy people would also have an incentive to leave the individual and small group markets, potentially balancing out any exodus of healthy people from these markets. The Department requests comments that would help further address this issue.

As noted earlier, the Department intends that this proposal would help AHPs to assemble large, stable risk pools, while at the same time limiting any risk of adverse effects on individual and small group markets. In calibrating the proposal to advance those goals, the Department considered a range of evidence on the dynamics of health insurance markets under various conditions and rules. The Department believes available evidence is consistent with the balanced approach adopted in the proposal, and that the proposal would advance the intended goals, and invites comments responsive to this evidence and viewpoint.

Some of the evidence the Department reviewed appears to suggest this proposal would have little impact on the composition of individual and small group market risk pools. Other potential avenues for segmentation that exist today do not appear to have produced major effects. For example, a small employer currently can segregate itself into a separate risk pool by self-insuring and relying on stop-loss insurance to backstop particularly large losses. Yet the proportion of small-firm establishments reporting that they use self-insurance has increased only modestly, from 12.7 percent in 2010 to 17.4 percent in 2016 and the percent of policy holders in self-insured plans at small-firm establishments has increased from 12.5 percent to 15.7 percent over the same time period.[31] In addition, price inelasticity and inertia in individuals' and small businesses' health insurance purchases [32] may help to limit and/or slow any potential impacts. If, as this evidence suggests, small businesses might not vigorously shop for better prices and products, there may be little potential for risk selection, but also limited demand for AHPs.

Various studies of past State and Federal individual and small group market reforms, cited below in connection with AHPs' potential impact on the uninsured population, mostly find that reforms tightening market rules result in only limited adverse selection. This might suggest that this proposal, by in effect loosening such rules, may produce only limited risk selection effects.

Some other evidence illustrates how under some conditions changes in product and price offerings can affect the composition of risk pools. One employer found that older and less healthy employees sometimes declined to join younger and healthier counterparts in switching to new, less comprehensive options, despite incentives provided to encourage such switches, perhaps due to concerns about reduced coverage.[33] A review of experience with consumer-directed health plans suggests some potential for similar effects.[34] Some prior experiences with different AHP and group purchasing arrangements reportedly did not achieve sufficient efficiencies to fully prevent or offset all potential risk segmentation effects.[35] The Congressional Budget Office once predicted modest risk segmentation from an AHP-like proposal, with small premium increases for small employers retaining traditional insurance, and increased coverage among healthier small groups partly offset by a small loss of coverage among less healthy ones.[36]

The foregoing evidence may be consistent with some key stakeholders' concerns that AHPs, if regulated too loosely relative to issuers, might adversely impact some risk pools.[37] On the other hand, severely restricting AHPs would hinder them from providing additional, affordable coverage options. The Department believes that this proposal, under which AHPs could not condition eligibility, benefits, or premiums on health status, strikes the right balance to enable AHPs to assemble large stable risk pools and offer new affordable options to small businesses without posing substantial risk of adverse effects on other risk pools. AHPs' potential to deliver administrative savings further mitigates any such risk

1.7. Individual and Small Group Markets

The Department separately considered AHPs' potential impacts on both individual and small group markets. In both cases, AHPs could offer many small businesses more, and more affordable, coverage options than otherwise available.

With respect to individual markets, many of those insured there now might become eligible for AHPs. AHPs could enroll both working owners and employees of small business that do not currently offer insurance but might elect to join AHPs. The latter group may be growing as small firms' propensity to offer health insurance for employees has declined substantially from 47 percent of establishments in 2000 to 29 percent in 2016.[38] Of the 25 million U.S. individuals under age 65 who were

[31] Agency for Healthcare Research and Quality (AHRQ), 2016 Medical Expenditure Survey-Insurance Component (MEPS–IC).

[32] *See* M. Kate Bundorf, Joanthan Levin, and Neal Mahoney, "Pricing and Welfare in Health Plan Choice," *American Economic Review* 2012, 107(7), 3214–3248, pointing to price inelasticity; and Benjamin R. Handel, "Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts," *American Economic Review* 2013, 103(7), 2643–2682, finding that inertia restrains adverse selection and associated welfare losses.

[33] Fronstin, Paul, and M. Christopher Roebuck. "Health Plan Switching: A Case Study-Implications for Private- and Public-Health-Insurance Exchanges and Increased Health Plan Choice." EBRI Issue Brief 432, March 23, 2017. *https://www.ebri.org/pdf/briefspdf/EBRI_IB_432_PlnSwtch.23Mar17.pdf.*

[34] Bundorf, M. Kate, "Consumer-Directed Health Plans: A Review of the Evidence." *The Journal of Risk and Insurance*. January 2016.

[35] Historically, some efforts to assemble large purchasing coalitions to negotiate such discounts have met with limited success. In one major example, the California Health Insurance Purchasing Cooperative, or HIPC, established by the State and later operated by a business coalition, was eventually disbanded after failing to deliver its intended savings. *See,* for example, National Conference of State Legislatures, "Health Insurance Purchasing Cooperatives: State and Federal Roles." September 1, 2016. Last accessed September 25, 2017. *http://www.ncsl.org/research/health/purchasing-coops-and-alliances-for-health.aspx#Other_Approaches. See also* Bender, Karen, and Beth Fritchen. "Government-Sponsored Health Insurance Purchasing Arrangements: Do they Reduce Costs or Expand Coverage for Individuals and Small Employers?" 2008. Report finds that purchasing arrangements increase premiums by as much as six percent. *http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/archive/2011/health_ins_purchasing_arrangements(1).pdf.*

[36] CBO Paper, "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts," January 2000. *https://www.cbo.gov/publication/12066;* CBO cost estimate, H.R. 525 Small Business Health Fairness Act of 2005. April 8, 2005. *https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/costestimate/hr52500.pdf.*

[37] *See* for example: (1) NAIC letter to Reps. Foxx and Scott, February 28, 2017, *http://www.naic.org/documents/health_archive_naic_opposes_small_business_fairness_act.pdf; (2)* American Academy of Actuaries. "Issue Brief: Association Health Plans," February 2017; .and (3) America's Health Insurance Plans (AHIP), "Association-Sponsored Health Plans and Reform of the Individual Healthcare Market" February 10, 2017.

[38] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey-Insurance Component, 2012–2016. Medical Expenditure Panel Survey Private Sector Insurance Component, Table II.A.2. In 2016, among employees of firms with fewer than 50 employees, just one in four were enrolled in insurance on the job. Nearly one-half worked at firms that did not offer insurance. Agency for Healthcare Research and Quality (AHRQ), 2016 Medical Expenditure Panel Survey Insurance Component (MEPS–IC) Tables. Nonetheless, just 18 percent of small firm employees were uninsured. Many obtained insurance from a spouse's or parent's employer. DOL calculations based on the Abstract of Auxiliary Data for the March 2016 Annual Social and Economic Supplement to the Current Population Survey, U.S. Department of Labor.

insured in individual markets in 2015, approximately 3 million were working owners or dependents thereof, and an additional 6 million were employees of small businesses that did not offer insurance or dependents thereof. With respect to small group markets, essentially all insured businesses might become eligible for AHPs. In 2015, firms with fewer than 50 employees insured 24 million workers and dependents.[39]

In an effort to facilitate the availability of individual insurance, the ACA established federal and State-based "Exchanges," or centralized, regulated marketplaces. The ACA envisioned that a number of health insurance issuers would offer a set of comparable policies in each Exchange, making it possible for individuals to shop (and necessary for issuers to compete) for the best price and quality, while means-tested subsidies would ensure that coverage was affordable. This vision has not been realized fully in much of the country, however.

In 2016, 11 million individuals were enrolled via Exchanges. A large majority qualified for means-tested assistance with premiums (9 million) and/or cost sharing (6 million).[40] However, for 2018, only one issuer offered coverage in the Exchange in each of approximately one-half of US counties. Just two issuers participated in Exchanges in many additional counties.[41] Moreover, many Exchange enrollees have faced large premium increases.[42] The Administration already has taken some steps to stabilize the Exchanges, but their success is uncertain given that the ACA creates significant incentives for some people to wait to purchase insurance until an enrollment period that occurs after they have experienced a medical need. By expanding AHPs, this proposed rule aims to provide many more individuals access to the potentially more stable and affordable large group market. However, to the extent that AHPs prove particularly attractive to younger or lower cost individuals, they may contribute to some Exchanges' instability.

Issuers may elect to offer individual market policies in Exchanges or outside them, or both. Non-grandfathered individual market policies must satisfy various ACA requirements including minimum benefit packages, minimum actuarial value(s), and minimum loss ratios. They must be offered to any individual who applies, and premiums must not vary depending on enrollees' health status, instead varying only based on location, age, tobacco use, and family size, and within certain limits. Issuers offering individual policies in a given location both through the local Exchange and outside it must treat the two as a single risk pool when setting premiums. The issuers offering individual policies, the policies offered, and the premiums charged can vary from place to place and locally between Exchanges and outside markets.

To facilitate access to health insurance for small employers, the ACA established the Small Business Health Options Program, or "SHOP". Small employers may purchase insurance from an issuer, agent, or broker via the SHOP, or directly from issuers or through agents or brokers not via a SHOP, or they may self-insure. Employers purchasing group policies via a SHOP may qualify for tax credits to help cover premium costs. If available, small employers also may obtain coverage from an AHP, and thereby pool together with other employers and gain access to the large group market. Small employers whose employees are represented by a union may participate in a (usually large) multiemployer health benefit plan, established pursuant to collective bargaining agreements between the union and two or more employers.

Issuers may offer small group policies to small employers via SHOPs, directly through issuers, agents or brokers, or both. Either way, as with non-grandfathered individual market policies, non-grandfathered small group policies must satisfy various ACA requirements including minimum benefit packages, minimum actuarial value(s), and minimum loss ratios. They must be offered to any small employer who applies, and premiums may vary only based on location, age, and tobacco use, and within certain limits; they may not vary based on health. Issuers offering small group policies in a given location both through the local SHOP and directly must treat the two as a single risk pool when setting premiums. However, the issuers offering small group policies, the policies they offer, and the premiums charged can vary from place to place and locally between SHOPs and outside markets. In some locations the availability of policies may be limited, and/or the premiums charged may be rising rapidly, although in most locations small group markets continue to offer some choice of issuers and policies and moderate premium growth.[43]

Few small employers have elected to acquire health insurance via SHOPs. As of January 2017, just 27,205 small employers purchased small group policies via SHOPs, covering 233,000 employees and dependents.[44] (Much larger numbers obtained coverage directly from small group issuers via agents and brokers outside of SHOPs: In 2016, 1.6 million small-firm establishments offered health benefits for employees.)[45] Sixteen States and the District of Columbia operated SHOPs, while federally-facilitated SHOPs operated in 33 States. (Beginning in 2017, a special waiver allowed Hawaii to operate its existing small group market within the relevant ACA framework without establishing a SHOP.) At this point, SHOPs cover far fewer employees than existing plan-MEWAs/AHPs, which reportedly cover 1.8 million participants.

The Department considered the potential susceptibilities of individual and small group markets to adverse selection under this proposal. All else equal, individual markets may be more susceptible to risk selection than small group markets, as individuals' costs generally vary more widely than small groups'. The ACA's requirement that essentially all individuals acquire coverage and the provision of subsidies in Exchanges may reduce that

[39] DOL calculations based on the Abstract of Auxiliary Data for the March 2016 Annual Social and Economic Supplement to the Current Population Survey, U.S. Department of Labor.

[40] Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, Compilation of State Date on the Affordable Care Act, December 2016.

[41] See U.S. Department of Health and Human Services, "County by County Analysis of Plan Year 2018 Insurer Participation in Health Insurance Exchanges," available at *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-10-20-Issuer-County-Map.pdf.*

[42] The places with the largest 2017 increases in the unsubsidized second-lowest silver plan included Phoenix, AZ (up 145% from $207 to $507 per month for a 40-year-old non-smoker). See Cynthia Cox, Michelle Long, Ashley Semanskee, Rabah Kamal, Gary Claxton, and Larry Levitt, "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces," Kaiser Family Foundation, October 24, 2016 (updated November 1, 2016), available at *https://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/.*

[43] Between 1996 and 2016 small (fewer than 50 employees) and large private-sector employer premium increases followed similar trajectories. Both averaged 6 percent annually. Agency for Healthcare Research and Quality. Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics (Table I.C.1). Medical Expenditure Panel Survey Insurance Component Tables.

[44] SHOP numbers reported by SB–SHOPs to CCIIO State Marketplace Insurance Programs Group and FF–SHOP Enrollment Database, May 15, 2017.

[45] Agency for Healthcare Research and Quality (AHRQ), 2016 Medical Expenditure Panel Survey Insurance Component (MEPS–IC). Small firms include those with fewer than 50 employees.

susceptibility, however.[46] The Department believes that under this proposal AHPs' adherence to applicable nondiscrimination rules and potential for administrative savings would mitigate any risk of adverse selection against individual and small group markets.

1.8. Medicaid

Under the ACA, Medicaid eligibility was expanded in many States. Some Medicaid-eligible workers may become eligible to enroll in AHPs under this proposal. Among 42 million individuals under age 65 enrolled in Medicaid or CHIP in 2015, 2 million were working owners or dependents thereof, and 6 million were employees of small businesses that did not offer insurance or dependents thereof.[47]

1.9. The Uninsured

Twenty-eight million individuals in the U.S. lacked health insurance coverage in 2015.[48] Because AHPs often can offer more affordable alternatives to individual and small group insurance policies, it is possible that this proposed rule will extend insurance coverage to some otherwise uninsured individual families and small groups. Of the 28 million uninsured, approximately 3 million are working owners or dependents thereof and an additional 8 million are employees of small businesses that do not offer insurance or dependents thereof.[49] It is likely that some of these uninsured will become eligible for an AHP under this proposed rule.

Past State and Federal reforms that tightened or loosened individual and small group market rules may, according to various studies, have changed the prices paid and policies selected by different businesses, somewhat improved access for targeted groups (potentially at others' expense), and/or prompted some individuals or small businesses to acquire or drop insurance, but had little *net* effect on coverage.[50] AHPs' potential to expand coverage may be greater than this experience suggests, however. Market conditions and the size and composition of the uninsured population are different today, and as noted earlier, small firms' propensity to offer insurance to their employees has fallen, suggesting potential opportunities for AHPs to expand coverage.

1.10. Operational Risks

ERISA generally classifies AHPs as MEWAs. Historically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills.[51] Both DOL and State insurance regulators have devoted substantial resources to detecting and correcting these problems, and in some cases, prosecuting wrongdoers. Some of these entities attempt to evade oversight and enforcement actions by claiming to be something other than MEWAs, such as collectively-bargained multiemployer ERISA plans. To address this continuing risk, the ACA gave DOL expanded authority to monitor MEWAs and intervene when MEWAs are headed for trouble, and both DOL and State enforcement efforts are ongoing.

ERISA requires MEWAs to report certain information annually to the Department, using a form known as Form M1.[52] The Department last examined the universe of these reports in September of 2014.[53] That examination included reports for MEWAs (including AHPs) operating in each year from 2010 through 2013. According to this examination, in 2013, 392 MEWAs covered approximately 1.6 million employees. The vast majority of these MEWAs reported themselves as ERISA plans that covered employees of two or more employers. Nearly all of these covered more than 50 employees and therefore constituted large-group employer plans for purposes of the ACA. A few reported as so-called "non-plan" MEWAs, that provided or purchased health or other welfare benefits for two or more ERISA plans sponsored by individual employers (most of which probably were small-group plans for ACA purposes). Some of these might qualify to begin operating as "plan-MEWAs" (or AHPs) under this proposed rule. This proposed rule is intended to facilitate the establishment of more new plan-MEWAs/AHPs, all of which would be required to report annually to the Department.

Most reporting MEWAs operate in more than one State, and a handful operate in more than 20 States. In 2013, 46 MEWAs reported expanding operations into one or more new States. States with the most plan-MEWAs/AHPs in 2012 included California (147), Texas (106), and New York (100). Only one had fewer than 20 (South Dakota had 18). MEWAs were most likely to be

[46] H.R. 1 of the 115th Congress, enacted December 22, 2017 will eliminate the shared responsibility payment for failure to maintain health insurance coverage effective beginning in 2019. AHPs, by offering eligible individuals more affordable options than are available in individual markets, might reduce somewhat any potential increase in the uninsured population that could result from elimination of the tax payment. At the same time, however, such elimination might prompt some individuals who would have joined AHPs to remain uninsured instead.

[47] DOL calculations based on the Abstract of Auxiliary Data for the March 2016 Annual Social and Economic Supplement to the Current Population Survey, U.S. Department of Labor.

[48] *Id.*

[49] *Id.*

[50] *See* for example: (1) Thomas Buchmueller and John DiNardo, "Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut, "*American Economic Review* 2002, 92(1), 280–294, finding little net effect."" (2) Mark A. Hall, "HIPPA's Small-Group Access Laws: Win, Loss, or Draw," *Cato Journal* 2002 22(1), 71–83, generally calling the results a "draw." (3) Susan M. Gates, Kanika Kapur, and Pinar Karaca-Mandic, "State Health Insurance Mandates, Consumer Directed Health Plans, and Health Savings Account: Are They a Panacea for Small Businesses," Chapter 3 in *In the Name of Entrepreneurship: The Logic and Effects of Special Treatment for Small Businesses,* Susan M. Gates and Kristin J Leuschner, eds., Rand Corporation, 2007, finding little effect. (4) Sudha Xirasagar, Carleen H. Stoskopf, James R. Hussey, Michael E. Samuels, William R. Shrader, and Ruth P. Saunders, "The Impact of State' Small Group Health Insurance Reforms on Uninsurance Rates," *Journal of Health and Social Policy* 2005, 20(3), finding little effect. (5) James R. Baumgardner and Stuart A Hagen, "Predicting Response to Regulatory Change in the Small Group Health Insurance Market: The Case of Association Health Plans and Healthmarts," *Inquiry* 2001/2002, 38(4), 351–364, predicting small effects.

[51] For discussions of this history, *see:* (1) U.S. Gov't Accountability Office, GAO–92–40, "State Need Labor's Help Regulating Multiple Employer Welfare Arrangements.", March 1992, available at *http://www.gao.gov/assets/220/215647.pdf;* (2) U.S. Gov't Accountability Office, GAO–04–312, "Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage." February 2004, available at *http://www.gao.gov/new.items/d04312.pdf;* and Mila Kofman and Jennifer Libster, "Turbulent Past, Uncertain Future: Is It Time to Re-evaluate Regulation of Self-Insured Multiple Employer Arrangements?", Journal of Insurance Regulation, 2005, Vol. 23, Issue 3, p. 17–33.

[52] ERISA requires any plan MEWA/AHP (a MEWA that is also an ERISA plan) to file an additional report annually with the Department. This is the same annual report filed by all ERISA plans that include 100 or more participants or hold plan assets, filed using Form 5500. However, while more than 90 percent of 2012 Form M1 filers reported that they were plan MEWAs, only a bit more than one-half of these entities also filed Form 5500 for that year. Among those that did, frequently some of the information reported across the two forms was inconsistent. These reporting inconsistencies raise questions about the reliability of MEWAs' compliance with ERISA's reporting requirements and the reliability of the information recounted here.

[53] "Analysis of Form M–1 Data for Filing Years 2010–2013," September 23, 2014. *https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/summit2014.pdf.* A small number of new multiemployer welfare plans that have been in operation for less than three years also are required to submit such reports. Such multiemployer plans, which exist pursuant to collective bargaining agreements between one or more employee organizations and two or more employers, are not subject to ERISA's MEWA provisions (other than the reporting requirement), and are not affected by this regulation. These multiemployer plans made up just 2 percent of all reporting entities in 2013. Because of their inclusion among the reports, the statistics presented here somewhat overstate the size of the true MEWA universe.

self-insured in certain western States including Wyoming (37 percent), Oklahoma (31 percent), Montana (30 percent), and North Dakota (28 percent).

About one-fourth of reporting MEWAs are self-insured in all the States in which they operate, and another 9 percent are self-insured in some States. (The remaining majority does not self-insure and instead purchases insurance from issuers in all States in which they operate.) For MEWAs for which the type of benefits offered could be determined, nearly all offered health insurance, and many offered other, additional welfare benefits, such as dental or vision benefits, or life or disability insurance.

MEWAs' annual reports filed with the Department must indicate whether they are in compliance with a number of ERISA's minimum health plan standards, and with ERISA's general requirement that plans hold assets in trust. Nearly none reported lack of compliance with the former, but 13 percent reported that they did not comply with the trust requirement.

This proposed rule includes provisions intended to protect AHPs against mismanagement and abuse. It requires that the group or association has a formal organizational structure with a governing body and has by-laws or other similar indications of formality appropriate for the legal form in which the group or association is operated, and that the functions and activities of the group or association, including the establishment and maintenance of the group health plan, are controlled by its employer members. These requirements are intended to ensure that the organizations are bona fide organizations with the organizational structure necessary to act ''in the interests'' of participating employers with respect to employee benefit plans as ERISA requires. The proposed rule also requires that the AHP's member companies control the AHP. This requirement is necessary both to satisfy ERISA's requirement that the group or association must act for the direct employers in relation to the employee benefit plan, and to prevent formation of commercial enterprises that claim to be AHPs but that operate like traditional issuers selling insurance in the employer marketplace and may be vulnerable to abuse. In addition, the proposal would require that only employer members may participate in the AHP and health coverage is not made available other than to or in connection with a member of the association. Together, these criteria are intended to ensure that associations sponsoring AHPs are bona fide employment-based associations and likely to be resistant to abuse. Nevertheless, the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse, increasing potential oversight demands on the Department and State regulators.

1.11. Federal Budget Impacts

The proposal is likely to have offsetting effects on the budget, with some increasing the deficit and others reducing the deficit. On balance, deficit-increasing effects are likely to dominate, making the proposal's net impact on the federal budget negative.

Approximately 906,000 individuals who are insured on the Exchanges and eligible for subsidies, and approximately 2 million Medicaid enrollees, are working owners or dependents thereof. An additional 2 million and 6 million, respectively, are employees of small businesses that do not offer insurance or dependents thereof.[54] As of February 2017, 10.3 million individuals were enrolled, and paid their premiums, on a Federal or State-based Exchange. Of these individuals, 8.7 million received tax credits, and 5.9 million were receiving cost-sharing reduction subsidies. The average advanced premium tax credit for these individuals was $371 per month.[55] Forty-two million individuals under age 65 were covered by Medicaid.

In 2005, the Congressional Budget Office (CBO) estimated the potential budget impacts of a 2005 legislative proposal to expand AHPs. Under the 2005 legislation and contemporaneous law, many individuals joining AHPs previously would have been uninsured or purchased individual policies without benefit of any subsidies; by joining AHPs they stood to gain potentially large subsidies in the form of tax exclusions. CBO predicted that the legislation, by increasing spending on employer-provided insurance, would reduce federal tax revenue by $261 million over 10 years, including a $76 million reduction in Social Security payroll taxes. CBO also predicted that AHPs would displace some Medicaid coverage and thereby reduce federal spending by $80 million over 10 years. Finally, according to CBO, the legislation would have required DOL to hire 150 additional employees and spend an additional $136 million over 10 years to properly oversee AHPs.[56] Together these budget impacts would have increased the federal deficit by $317 million over 10 years.

Today, consequent to the ACA, many individuals who in 2005 might have been uninsured instead are enrolled in Medicaid or are insured and receive subsidies on individual Exchanges, and therefore would trade existing subsidies for potential new tax subsidies when joining AHPs. Market forces generally favor individuals capturing the larger available subsidy, so it is likely that AHPs will mostly enroll higher income individuals, whose net subsidies will increase, adding to the federal deficit. Resources allocated to support the Departments' efforts to prevent and correct potential mismanagement and abuse could add more to it. If, however, AHPs do enroll some Medicaid enrollees or individuals receiving large subsidies on individual Exchanges, savings from these impacts might offset a portion of these deficit increases.

1.12. Regulatory Alternatives

In developing this proposal DOL considered various alternative approaches.

- *Retaining existing rules and interpretations.* DOL elected to propose relaxing existing rules and interpretations because they have proven to impede the establishment and growth of potentially beneficial AHPs. Existing interpretations generally block working owners who lack employees from joining AHPs. Instead these individuals and their families are limited to options available in individual markets where premiums may be higher and choice narrower than that which AHPs can sometimes provide. The existing commonality requirement sometimes prevents associations from achieving sufficient scale in local markets to effectively establish and operate efficient AHPs. The existing uncertainty as to the sufficiency of a common industry to permit establishment of an AHP may prevent the formation of more nationwide AHPs. And, the existing requirement that associations exist for purposes other than providing health benefits prevents the establishment of beneficial AHPs in circumstances where no other compelling reason exists to establish and maintain an association. By addressing these requirements, this proposal aims to promote the establishment and growth of AHPs and

[54] DOL calculations based on the Abstract of Auxiliary Data for the March 2016 Annual Social and Economic Supplement to the Current Population Survey, U.S. Department of Labor.

[55] CMS, ''2017 Effectuated Enrollment Snapshot,'' June 12, 2017. *https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf*

[56] CBO cost estimate, H.R. 525 Small Business Health Fairness Act of 2005. April 8, 2005. *https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/costestimate/hr52500.pdf*

optimize small businesses' access to them.

• *Relaxing the control requirement.* The proposal generally requires that association members control the AHP. Relaxing this requirement might encourage more and faster establishment and growth of AHPs, as entrepreneurs identify and seize opportunities to reap and share with enrollees the economic benefits AHPs can deliver. DOL believes, however, that relaxing this requirement would increase the risk that AHPs would be vulnerable to mismanagement or abuse. Additionally, the Department's authority to loosen this requirement is unclear in light of ERISA's text.

• *Including only fully-insured AHPs.* DOL considered prohibiting broadening the circumstances under which an AHP is treated as a single plan under ERISA only for fully insured AHPs. Historically, self-insured MEWAs have been particularly vulnerable to financial mismanagement and abuse. MEWA promoters sometimes have used self-insurance both to evade State oversight and to maximize opportunities for abusive financial self-dealing, often with highly negative consequences for their enrollees. Nonetheless, DOL recognizes that well-managed self-insured AHPs may be able to realize efficiencies that insured AHPs cannot. In light of this potential, and considering the enforcement tools that the ACA added to DOL's arsenal, DOL elected to allow AHPs to continue to self-insure under this proposal. This provision will serve to further promote the establishment and growth of effective AHPs, but it will also compel DOL to commit additional resources to AHPs' oversight.

• *Limiting or increasing AHPs' product and/or price flexibility.* As noted earlier, this proposal allows small businesses to band together to obtain advantages that attend the provision of insurance by a large employer, including access to the large-group market. The large-group market is not subject to certain product and pricing restrictions that govern the individual and small group markets. As noted earlier, some stakeholders expressed their concern that allowing small businesses to escape these restrictions could lead to excessive risk segmentation and might destabilize some local individual and small group markets. The Department considered, but rejected, subjecting AHPs to constraints similar to those applicable to the individual and small group markets. The goal of the proposed rule is to allow AHPs to leverage advantages available to large employers to assemble large, stable risk pools, pursue administrative savings, and offer small businesses more, and more affordable, health insurance options. In light of that objective, imposing the product and pricing restrictions that distinguish the individual and small group markets from the large group market would have been too limiting. The flexibility also may increase AHPs' market reach, making more affordable options available to more small businesses than would be possible without it. This proposal would mitigate AHPs' potential to segment risk and destabilize individual and small group markets by applying nondiscrimination rules that bar them from conditioning eligibility, benefits, or premiums on the health status of small businesses' employees. Some stakeholders argue that nondiscrimination provisions themselves unduly restrict AHPs and could prevent AHP formation (and hence lower the number of insured people). DOL considered, but rejected, omitting the nondiscrimination provisions in part. These provisions, among other functions, serve to distinguish AHPs from commercial insurers as a legal matter.

1.13. Conclusion

This proposed rule broadens the conditions under which AHPs will be treated as large group health benefit plans under ERISA, the ACA and State law. Under the proposal, AHPs generally can offer small businesses more, and more affordable, benefit options than are available to them in the individual and small group markets, in part through the creation of various efficiencies. AHPs' flexibility to tailor products and adjust prices to more closely reflect expected claims will also improve social welfare for AHP participants. Although they may limit AHPs' appeal and thus we are seeking comment on them, rules barring discrimination based on health status will moderate the incentives for relatively healthy people disproportionately to leave the individual and small group markets, which would further destabilize local individual and small group markets. Operational risks may demand increased federal and State oversight. The proposal may increase the federal deficit.

2. Paperwork Reduction Act

The proposed rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3501 *et seq.*), because it does not contain a collection of information as defined in 44 U.S.C. 3502(3).

3. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency determines that a proposal is not likely to have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires the agency to present an initial regulatory flexibility analysis (IRFA) of the proposed rule. The Department has determined that this proposed rule, which would broaden the criteria for determining when employers may join together in a group or association to sponsor a group health plan under ERISA, is likely to have a significant impact on a substantial number of small entities. Therefore, the Department provides its IRFA of the proposed rule, below.

Need for and Objectives of the Rule

This proposed rule is intended and expected to deliver benefits primarily to the employees of small businesses and their families, as well as the small businesses themselves. As detailed earlier, this proposed rule would encourage the establishment and growth of AHPs. AHPs may offer small businesses more, and more affordable, health benefit options than otherwise are available to them in the individual and small group markets, resulting in employer-sponsored coverage for more Americans, and more diverse and affordable insurance options.

Affected Small Entities

Potential beneficiaries of savings and increased choice from AHP coverage under the proposed rule include:

• Some of the 25 million individuals under age 65 who currently are covered in individual markets, including approximately 3 million who are sole proprietors or dependents thereof, and an additional 6 million who are employees of small businesses or dependents thereof.

• The 25 million individuals under age 65 who currently are covered in small group markets.

• Some of the 28 million individuals under age 65 who currently lack insurance, including 2 million who are sole proprietors or dependents thereof, and an additional 5 million who are employees of small businesses or dependents thereof.

• Some of the 1.6 million private, small-firm establishments (those with fewer than 50 employees) that currently offer insurance and the 4 million that do not.

Impact of the Rule

By expanding AHPs, this proposal would provide more, and more affordable, health insurance options for small businesses, thereby yielding economic benefits for participating small businesses. The proposal includes provisions to mitigate any risk of negative spillovers for other small businesses. The proposal may impact individual and small group issuers whose enrollees might switch to AHPs, some of which would likely be small entities.

Duplication, Overlap, and Conflict With Other Rules and Regulations

The proposed actions would not conflict with any relevant federal rules. As discussed above, the proposed rule would merely broaden the conditions under which an association can act as an ''employer'' under ERISA for purposes of offering a group health plan and would not change AHPs' status as large group plans and MEWAs, under ERISA, the ACA, and State law.

4. Congressional Review Act

The proposed rule is subject to the Congressional Review Act (CRA) provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and, if finalized, will be transmitted to Congress and the Comptroller General for review. The proposed rule is a ''major rule'' as that term is defined in 5 U.S.C. 804(2), because it is likely to result in an annual effect on the economy of $100 million or more.

5. Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires each federal agency to prepare a written statement assessing the effects of any federal mandate in a proposed or final agency rule that may result in an expenditure of $100 million or more (adjusted annually for inflation with the base year 1995) in any one year by State, local, and tribal governments, in the aggregate, or by the private sector. For purposes of the Unfunded Mandates Reform Act, as well as Executive Order 12875, this proposal does not include any federal mandate that the Department expects would result in such expenditures by State, local, or tribal governments, or the private sector. This proposed rule would merely broaden the conditions under which AHPs will be treated as large group health benefit plans under ERISA, the ACA and State law. In so doing, it makes available to more small businesses some of the advantages currently enjoyed by large employer-sponsored plans.

6. Federalism Statement

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by federal agencies in the process of their formulation and implementation of policies that have ''substantial direct effects'' on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the final rule.

In the Department's view, these proposed regulations would have federalism implications because they would have direct effects on the States, the relationship between the national government and the States, and on the distribution of power and responsibilities among various levels of government. The Department believes these effects are limited, insofar as the proposal would not change AHPs' status as large group plans and MEWAs, under ERISA, the ACA, and State law. As discussed above in this preamble, because ERISA classifies AHPs as MEWAs, they generally are subject to State insurance regulation. Specifically, if an AHP is not fully insured, then under section 514(b)(6)(A)(ii) of ERISA any State insurance law that regulates insurance may apply to the AHP to the extent that such State law is not inconsistent with ERISA. If, on the other hand, an AHP is fully insured, section 514(b)(6)(A)(i) of ERISA provides that only those State insurance laws that regulate the maintenance of specified contribution and reserve levels may apply to the AHP. The Department notes that State rules vary widely in practice, and many States regulate AHPs less stringently than individual or small group insurance. The Department welcomes input from affected States, including the NAIC and State insurance officials, regarding this assessment.

7. Executive Order 13771 Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. This proposed rule is expected to be an EO 13771 deregulatory action, because it would expand small businesses' access to more lightly regulated and more affordable health insurance options, by removing certain restrictions on the establishment and maintenance of AHPs under ERISA.

List of Subjects in 29 CFR Part 2510

Employee benefit plans, Pensions.

For the reasons stated in the preamble, the Department of Labor proposes to amend 29 CFR part 2510 as follows:

PART 2510—DEFINITIONS OF TERMS USED IN SUBCHAPTERS C, D, E, F, G, AND L OF THIS CHAPTER

■ 1. The authority citation for part 2510 is revised to read as follows:

Authority: 29 U.S.C. 1002(2), 1002(5), 1002(21), 1002(37), 1002(38), 1002(40), 1031, and 1135; Secretary of Labor's Order No. 1–2011, 77 FR 1088 (Jan. 9, 2012); Sec. 2510.3–101 also issued under sec. 102 of Reorganization Plan No. 4 of 1978, 43 FR 47713 (Oct. 17, 1978), E.O. 12108, 44 FR 1065 (Jan. 3, 1979) and 29 U.S.C. 1135 note. Sec. 2510.3–38 is also issued under sec. 1, Pub. L. 105–72, 111 Stat. 1457 (1997).

■ 2. Section 2510.3–3 is amended by revising paragraph (c) introductory text to read as follows:

§ 2510.3–3 Employee benefit plan.

* * * * *

(c) *Employees.* For purposes of this section and except as provided in § 2510.3–5(e):

* * * * *

■ 3. Section 2510.3–5 is added to read as follows:

§ 2510.3–5 Employer.

(a) *In general.* The purpose of this section is to clarify which persons may act as an ''employer'' within the meaning of section 3(5) of the Act in sponsoring a multiple employer group health plan. Section 733(a)(1) defines the term ''group health plan,'' in relevant part, as an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents through insurance, reimbursement, or otherwise. The Act defines an ''employee welfare benefit plan'' in section 3(1), in relevant part, as any plan, fund, or program established or maintained by an employer, employee organization, or by both an

employer and an employee organization, for the purpose of providing certain listed welfare benefits to participants or their beneficiaries. For purposes of being able to establish and maintain a welfare benefit plan, an "employer" under section 3(5) of the Act includes any person acting directly as an employer, or any person acting indirectly in the interest of an employer in relation to an employee benefit plan. A group or association of employers is specifically identified in section 3(5) of the Act as a person able to act directly or indirectly in the interest of an employer, including for purposes of establishing or maintaining an employee welfare benefit plan.

(b) *Bona fide group or association of employers.* For purposes of Title I of the Act and this chapter, a bona fide group or association of employers capable of establishing a group health plan that is an employee welfare benefit plan shall include a group or association of employers that meets the following requirements:

(1) The group or association exists for the purpose, in whole or in part, of sponsoring a group health plan that it offers to its employer members;

(2) Each employer member of the group or association participating in the group health plan 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) The functions and activities of the group or association, including the establishment and maintenance of the group health plan, are controlled by its employer members, either directly or indirectly through the regular nomination and election of directors, officers, or other similar representatives that control the group or association and the establishment and maintenance of the plan;

(5) The employer members have a commonality of interest as described in paragraph (c) of this section;

(6) The group or association does not make health coverage through the association available other than to employees and former employees of employer members and family members or other beneficiaries of those employees and former employees;

(7) The group or association and health coverage offered by the group or association complies with the nondiscrimination provisions of paragraph (d) of this section; and

(8) The group or association is not a health insurance issuer described in section 733(b)(2) of ERISA, or owned or controlled by such a health insurance issuer.

(c) *Commonality of interest.* Commonality of interest of employer members of a group or association will be determined based on relevant facts and circumstances and may be established by:

(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).

(d) *Nondiscrimination.* A bona fide group or association, and any health coverage offered by the bona fide group or association, must comply with the nondiscrimination provisions of this paragraph (d).

(1) The group or association must not condition employer membership in the group or association based on any health factor of an employee or employees or a former employee or former employees of the employer member (or any employee's family members or other beneficiaries), as defined in § 2590.702(a) of this chapter.

(2) The group health plan sponsored by the group or association must comply with the rules of § 2590.702(b) of this chapter with respect to nondiscrimination in rules for eligibility for benefits, subject to paragraph (d)(4) of this section.

(3) The group health plan sponsored by the group or association must comply with the rules of § 2590.702(c) of this chapter with respect to nondiscrimination in premiums or contributions required by any participant or beneficiary for coverage under the plan, 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 different employer members of the group or association as distinct groups of similarly-situated individuals.

(5) The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 1,* Association *A*'s exclusion of Restaurant *B* from Association *A* discriminates on the basis of claims history, which is a health factor under § 2590.702(a)(1) of this chapter. Accordingly, Association *A* violates the requirement in paragraph (d)(1) of this section, and, therefore would not meet the definition of a bona fide group or association of employers under paragraph (b) of this section.

Example 2. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 2,* Association *C*'s exclusion of Individual *D* because *D* has diabetes is a decision that discriminates on the basis of a medical condition, which is a health factor under § 2590.702(a)(1) of this chapter. Accordingly, Association *C* violates the requirement in paragraph (d)(1) of this section and would not meet the definition of a bona fide group or association of employers under paragraph (b) of this section.

Example 3. (i) *Facts.* Association *F* offers group health coverage to all plumbers working for plumbing companies in a State. Plumbers employed by a plumbing company on a full-time basis (which is defined under the terms of the arrangement as regularly working at least 30 hours a week) are eligible for health coverage without a waiting period. Plumbers employed by a plumbing company on a part-time basis (which is defined under the terms of the arrangement as regularly working at least 10 hours per week, but less than 30 hours per week) are eligible for health coverage after a 60-day waiting period.

(ii) *Conclusion.* In this *Example 3,* making a distinction between part-time versus full-time employment status is a permitted distinction between similarly situated individuals under § 2590.702(d) of this chapter, provided the distinction is not directed at individuals under § 2590.702(d)(3) of this chapter. Accordingly, the requirement that plumbers working part time must satisfy a waiting period for coverage is a rule for eligibility that does not violate § 2590.702(b) or, as a consequence, paragraph (d)(2) of this section.

Example 4. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 4,* Business *I* cannot be treated as a separate group of similarly situated individuals from other members under paragraph (d)(4) of this section. Therefore, charging Business *I* more for premiums based on one or more health

factors of the employees of Business *I* violates § 2590.702(c) of this chapter and, consequently, the requirement in paragraph (d)(3) of this section.

Example 5. (i) *Facts.* Association *J* sponsors a group health plan that is available to all members. According to the bylaws of Association *J,* membership is open to any entity whose principal place of business is in State *K,* which has only one major metropolitan area, the capital city of State *K.* Members whose principal place of business is in the capital city of State *K* are charged more for premiums than members whose principal place of business is outside of the capital city.

(ii) *Conclusion.* In this *Example 5,* making a distinction between members whose principal place of business is in the capital city of State *K,* as compared to some other area in State *K,* is a permitted distinction between similarly situated individuals under § 2590.702(d) of this chapter, provided the distinction is not directed at individuals under § 2590.702(d)(3) of this chapter. Accordingly, Association *J*'s rule for charging different premiums based on principal place of business does not violate paragraph (d)(3) of this section.

Example 6. (i) *Facts.* Association *L* sponsors a group health plan, available to all members. According to the bylaws of Association *L,* membership is open to any entity whose principal place of business is in State *M.* Sole Proprietor *N*'s principal place of business is in City *O,* within State *M.* It is the only member whose principal place of business is in City *O,* and it is otherwise similarly situated with respect to all other members of the association. After learning that Sole Proprietor *N* has been diagnosed with cancer, based on the cancer diagnosis, Association *L* changes its premium structure to charge higher premiums for members whose principal place of business is in City *O.*

(ii) *Conclusion.* In this *Example 6,* cancer is a health factor under § 2590.702(a) of this chapter. Making a distinction based on a health factor, between members that are otherwise similarly situated is in this case a distinction directed at an individual under § 2590.702(d)(3) of this chapter and is not a permitted distinction. Accordingly, by charging higher premiums to members whose principal place of business is City *O,* Association *L* violates § 2590.702(c) of this chapter and, consequently, paragraph (d)(4) of this section.

(e) *Dual treatment of working owners as employers and employees*—(1) A working owner of a trade or business may qualify as both an employer and as an employee of the trade or business for purposes of the requirements in paragraph (b) of this section, including paragraph (b)(2) that each employer member of the group or association participating in the group health plan must be a person acting directly as an employer of one or more employees who are participants covered under the plan, and paragraph (b)(6) that the group or association does not make health coverage offered to employer members through the association available other than to employees and former employees of employer members and the family members or other beneficiaries of those employees and former employees.

(2) The term ''working owner'' as used in this paragraph (e) means any individual:

(i) Who has an ownership right of any nature in a trade or business, whether incorporated or unincorporated, including partners and other self-employed individuals;

(ii) Who is earning wages or self-employment income from the trade or business for providing personal services to the trade or business;

(iii) Who is not eligible to participate in any subsidized group health plan maintained by any other employer of the individual or of the spouse of the individual; and

(iv) Who either:

(A) Works at least 30 hours per week or at least 120 hours per month providing personal services to the trade or business, or

(B) Has earned income from such trade or business that at least equals the working owner's cost of coverage for participation by the working owner and any covered beneficiaries in the group health plan sponsored by the group or association in which the individual is participating.

(3) Absent knowledge to the contrary, the group or association sponsoring the group health plan may reasonably rely on written representations from the individual seeking to participate as a working owner as a basis for concluding that the conditions in paragraph (e)(2) are satisfied.

Jeanne Klinefelter Wilson,

Deputy Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

[FR Doc. 2017–28103 Filed 1–4–18; 8:45 am]

BILLING CODE 4510–29–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 81

[EPA–R07–OAR–2017–0734; FRL 9972–64–Region 7]

Air Plan Approval and Air Quality Designation; MO; Redesignation of the Missouri Portion of the St. Louis Missouri-Illinois Area to Attainment of the 1997 Annual Standard for Fine Particulate Matter and Approval of Associated Maintenance Plan

AGENCY: Environmental Protection Agency (EPA).

ACTION: Advanced notice of proposed rulemaking.

SUMMARY: The Environmental Protection Agency (EPA) is issuing this Advanced Notice of Proposed Rulemaking (ANPR) to inform the public of currently available information that will be used by the Administrator to issue a subsequent action to propose redesignation of the Missouri portion of the St. Louis MO-IL nonattainment area for the 1997 $PM_{2.5}$ NAAQS, (hereafter referred to as the ''St. Louis area'' or ''area''). On September 2, 2011, Missouri, through the Missouri Department of Natural Resources (MDNR) submitted a request for EPA to redesignate the Missouri portion of the St. Louis MO-IL nonattainment area to attainment for the 1997 Annual National Ambient Air Quality Standards (NAAQS) for fine particulate matter ($PM_{2.5}$) and approve a state implementation plan (SIP) revision containing a maintenance plan for the Missouri portion of the area. In advance of any potential rulemaking to address the state of Missouri's request, EPA is specifically requesting early input and comments on its interpretation that currently available data support a finding that the area will be attaining the 1997 Annual $PM_{2.5}$ NAAQS based on air quality monitoring data from 2015–2017, and on EPA's advanced notice of its expectation that the state's plan for maintaining the 1997 Annual $PM_{2.5}$ NAAQS for the St. Louis Area (maintenance plan) including the associated motor vehicle emission budgets (MVEBs) for nitrogen oxides (NO_X) and $PM_{2.5}$ for the years 2008–2025 is approvable. EPA will take any information received from this ANPR into consideration when developing a proposed action for redesignating the Missouri portion of the St. Louis Area to attainment for the 1997 Annual $PM_{2.5}$ NAAQS.

DATES: Comments must be received on or before February 5, 2018.

Presidential Documents

Executive Order 13813 of October 12, 2017

Promoting Healthcare Choice and Competition Across the United States

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. *Policy.* (a) It shall be the policy of the executive branch, to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people. The Patient Protection and Affordable Care Act (PPACA), however, has severely limited the choice of healthcare options available to many Americans and has produced large premium increases in many State individual markets for health insurance. The average exchange premium in the 39 States that are using www.healthcare.gov in 2017 is more than double the average overall individual market premium recorded in 2013. The PPACA has also largely failed to provide meaningful choice or competition between insurers, resulting in one-third of America's counties having only one insurer offering coverage on their applicable government-run exchange in 2017.

(b) Among the myriad areas where current regulations limit choice and competition, my Administration will prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs).

(i) Large employers often are able to obtain better terms on health insurance for their employees than small employers because of their larger pools of insurable individuals across which they can spread risk and administrative costs. Expanding access to AHPs can help small businesses overcome this competitive disadvantage by allowing them to group together to self-insure or purchase large group health insurance. Expanding access to AHPs will also allow more small businesses to avoid many of the PPACA's costly requirements. Expanding access to AHPs would provide more affordable health insurance options to many Americans, including hourly wage earners, farmers, and the employees of small businesses and entrepreneurs that fuel economic growth.

(ii) STLDI is exempt from the onerous and expensive insurance mandates and regulations included in title I of the PPACA. This can make it an appealing and affordable alternative to government-run exchanges for many people without coverage available to them through their workplaces. The previous administration took steps to restrict access to this market by reducing the allowable coverage period from less than 12 months to less than 3 months and by preventing any extensions selected by the policyholder beyond 3 months of total coverage.

(iii) HRAs are tax-advantaged, account-based arrangements that employers can establish for employees to give employees more flexibility and choices regarding their healthcare. Expanding the flexibility and use of HRAs would provide many Americans, including employees who work at small businesses, with more options for financing their healthcare.

(c) My Administration will also continue to focus on promoting competition in healthcare markets and limiting excessive consolidation throughout the healthcare system. To the extent consistent with law, government rules and guidelines affecting the United States healthcare system should:

(i) expand the availability of and access to alternatives to expensive, mandate-laden PPACA insurance, including AHPs, STLDI, and HRAs;

(ii) re-inject competition into healthcare markets by lowering barriers to entry, limiting excessive consolidation, and preventing abuses of market power; and

(iii) improve access to and the quality of information that Americans need to make informed healthcare decisions, including data about healthcare prices and outcomes, while minimizing reporting burdens on affected plans, providers, or payers.

Sec. 2. *Expanded Access to Association Health Plans.* Within 60 days of the date of this order, the Secretary of Labor shall consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs. To the extent permitted by law and supported by sound policy, the Secretary should consider expanding the conditions that satisfy the commonality-of-interest requirements under current Department of Labor advisory opinions interpreting the definition of an ''employer'' under section 3(5) of the Employee Retirement Income Security Act of 1974. The Secretary of Labor should also consider ways to promote AHP formation on the basis of common geography or industry.

Sec. 3. *Expanded Availability of Short-Term, Limited-Duration Insurance.* Within 60 days of the date of this order, the Secretaries of the Treasury, Labor, and Health and Human Services shall consider proposing regulations or revising guidance, consistent with law, to expand the availability of STLDI. To the extent permitted by law and supported by sound policy, the Secretaries should consider allowing such insurance to cover longer periods and be renewed by the consumer.

Sec. 4. *Expanded Availability and Permitted Use of Health Reimbursement Arrangements.* Within 120 days of the date of this order, the Secretaries of the Treasury, Labor, and Health and Human Services shall consider proposing regulations or revising guidance, to the extent permitted by law and supported by sound policy, to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.

Sec. 5. *Public Comment.* The Secretaries shall consider and evaluate public comments on any regulations proposed under sections 2 through 4 of this order.

Sec. 6. *Reports.* Within 180 days of the date of this order, and every 2 years thereafter, the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor and the Federal Trade Commission, shall provide a report to the President that:

(a) details the extent to which existing State and Federal laws, regulations, guidance, requirements, and policies fail to conform to the policies set forth in section 1 of this order; and

(b) identifies actions that States or the Federal Government could take in furtherance of the policies set forth in section 1 of this order.

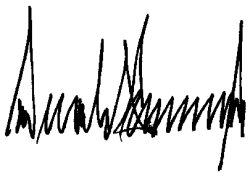
Sec. 7. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.



THE WHITE HOUSE,
October 12, 2017.

[FR Doc. 2017–22677
Filed 10–16–17; 11:15 am]
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