



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: Final rule.

SUMMARY: This document contains a final regulation under Title I of the Employee Retirement Income Security Act (ERISA) that establishes additional criteria under ERISA section 3(5) for determining when employers may join together in a group or association of employers that will be 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 establishing 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), and otherwise removing undue restrictions on the establishment and maintenance of Association Health Plans (AHPs) under ERISA, the regulation facilitates the adoption and administration of AHPs and expands access to affordable health coverage, especially for employees of small employers and certain self-employed individuals. At the same time, the regulation continues to distinguish employment-based plans, the focal point of Title I of ERISA, from commercial insurance programs and other service provider arrangements. The final rule also sets out the criteria that would permit, solely for purposes of Title I of ERISA, certain working owners of an incorporated or unincorporated trade or business, including partners in a partnership, without any common law employees, to qualify as employers

for purposes of participating in a bona fide group or association of employers sponsoring an AHP and also to be treated as employees with respect to a trade, business or partnership for purposes of being covered by the AHP. The regulation would affect AHPs, bona fide groups or associations of employers sponsoring such plans, participants and beneficiaries with health coverage under an AHP, health insurance issuers, and purchasers of health insurance not purchased through AHPs.

DATES: *Effective date.* This final regulation is effective on [INSERT 60 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER]

Applicability dates. See Section D of the **SUPPLEMENTARY INFORMATION** section for applicability dates for the final rule for fully-insured AHPs and self-insured AHPs. As discussed more fully below, the Department has established an applicability date of September 1, 2018, for fully-insured AHPs, an applicability date of January 1, 2019, for existing self-insured AHPs complying with the Department's pre-rule test, and an applicability date of April 1, 2019, for new self-insured AHPs formed pursuant to this final rule. The Department has concluded that a staggered approach to implementation of this final rule is consistent with the objective of allowing stakeholders, including States and State insurance regulators, an appropriate amount of time to tailor their groups, associations, plans, and regulations to the final rule and to address a range of oversight and compliance assistance issues, especially with respect to self-insured AHPs.

FOR FURTHER INFORMATION CONTACT: Amber Rivers or Suzanne Adelman, 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. Background

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.”¹ To advance this policy, the Executive Order directed the Secretary to consider issuing regulations or revising guidance, consistent with law, that would expand access to more affordable health coverage by permitting more employers to form AHPs. The Executive Order specifically directed the Secretary to consider expanding the conditions that satisfy the commonality of interest requirements under existing DOL advisory opinions interpreting the definition of an “employer” under ERISA section 3(5) and also 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). Through AHPs, employers band together to purchase health coverage. By participating in AHPs, employees of small employers and working owners are able to obtain coverage that is not subject to the regulatory complexity and burden that currently characterizes the market for individual and small group health coverage and, therefore, can enjoy flexibility with respect to benefit package design comparable to that enjoyed by large employers. AHPs may also help reduce the cost of health coverage to participating employer members by

¹ See Executive Order 13813 at 82 FR 48385 (Oct. 17, 2017).

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 day-to-day administration of the benefit program is transferred from participating employers, who may have little expertise in these matters, to the AHP sponsor).

The Department expects that a substantial number of uninsured people will enroll in AHPs because the Department expects the coverage will be more affordable than what would otherwise be available to them, and other people who currently have coverage will replace it with AHP coverage because the AHP coverage will be more affordable or better meet their needs. The Department also notes the U.S. Congressional Budget Office (CBO) predicted that 400,000 people who would have been uninsured will enroll in AHPs and 3.6 million people will enroll in AHPs who would have had other coverage, resulting in 4 million additional people enrolling in AHPs.²

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 issuers³ directly to these individuals and

² U.S. Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028.” <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf>. The Department did not rely on the information contained in the CBO report to reach its conclusions regarding the effects of the final rule, but notes that the CBO’s findings are consistent with the Department’s own findings.

³ A “health insurance issuer” or “issuer” means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not

small employers, unless the coverage sponsored by the group or association constitutes a single ERISA-covered plan. Whether, and the extent to which, various regulatory requirements apply to association health coverage depends on whether the coverage is individual or group coverage and, in turn, whether the group coverage is small or large group coverage. Generally, unless the arrangement sponsored by the group or association constitutes a single ERISA-covered plan, the current regulatory framework disregards the group or association in determining whether the coverage obtained by any particular participating individual or employer is individual, small group, or large group market coverage (the “look through” doctrine). 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 employees of the particular employer obtaining the coverage. Thus, unless the association plan is treated as a single ERISA-covered employee welfare benefit plan, the size of each individual employer participating in the group or 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). Accordingly, different group or association members will have coverage that is subject to the individual market, small group market, and/or large group market rules concurrently, as determined by each member’s circumstances, making the arrangement very difficult to administer and discouraging employers from banding together to sponsor association health coverage.

include a group health plan. 29 CFR 2590.701-2. The terms “health insurance issuer” and “issuer” are used interchangeably in this preamble.

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, to be an employee welfare benefit plan, the plan, fund or program must, among other criteria, be established or maintained by an employer, an employee organization, or both an employer and an employee organization. With respect to groups or associations of employers, only a group or association acting as an “employer” under ERISA section 3(5) is capable of establishing an employee welfare benefit plan.

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. Based on definitions in Title I of ERISA, and because Title I’s overall structure contemplates employment-based benefit arrangements, DOL historically has recognized that, in the absence of the involvement of an employee organization, a group or association of employers may sponsor a single “multiple employer” plan, if certain factors are

present.⁴ The key factors have been commonality of interests of employer members and control of the benefit arrangement by the employer members. These factors are present when an organized group or association of employers with common interests unrelated to the provision of benefits, 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).⁵

In defining the type of employer group or association that can act as an ERISA section 3(5) employer in sponsoring a single “multiple employer” plan, DOL has long considered whether the group or association has a sufficiently close economic or representational nexus to

⁴ Congress did not intend to treat commercial insurance products marketed by private entrepreneurs as ERISA-covered welfare benefit plans. Shortly after ERISA’s passage, Congress expressly noted these concerns in The Report of the Committee on Education and Labor, HR. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977):

Certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that [its] enterprise is an ERISA benefit plan which is protected, under ERISA’s preemption provision, from state regulation... [W]e are of the opinion that these programs are not ‘employee benefit plans’... [T]hese plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. ... They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan.

⁵ See AO 2008-07 at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2008-07a; AO 2003-17A at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2003-17a; AO 2001-04A at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2001-04a; AO 96-25A at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/1996-25a.

the employers and employees that participate in the plan. This “commonality of interest” standard is intended to distinguish bona fide groups or associations of employers that 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.⁶

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, 1063-1064 (8th Cir. 1986); see also MD Physicians & Associates, Inc. v. State Bd. of Ins., 957 F.2d 178, 183-186 (5th Cir. 1992); National Business Assn. Trust v. Morgan, 770 F. Supp. 1169 (W.D. Ky. 1991).⁷

DOL advisory opinions and court decisions have applied a facts-and-circumstances approach to determining whether a group or association of employers is 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 commonality and genuine organizational relationship unrelated to the provision of benefits; and (3) whether the

⁶ See AO 94-07A at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/1994-07a and AO 2001-07A at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2001-07a.

⁷ Brief of the Secretary of Labor as amicus curiae, MD Physicians & Associates, Inc. v. State Bd. of Ins., 957 F.2d 178 (5th Cir. 1992) (No. CA-2-90-0054), 1991 WL 11248117.

employers that participate in a benefit program, either directly or indirectly, exercise control over the program, both in form and substance.

The Department’s historical approach to these issues was designed to ensure that the Department’s regulation of employee benefit plans is focused on employment-based arrangements, as contemplated by ERISA, rather than merely commercial insurance-type arrangements that lack the requisite connection to the employment relationship. But neither the Department’s previous advisory opinions, nor relevant court cases, foreclose DOL from adopting a more flexible test in a regulation, or from departing from particular factors previously used 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. Rather, the terms “employer” and “indirectly in the interest of an employer” 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 “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).

In addition to the text and structure of Title I of ERISA, a regulation under ERISA section 3(5) should be guided by ERISA’s purposes and appropriate policy considerations, including the need to expand access to healthcare and to respond to changes in law, market dynamics, and employment trends. Thus, Executive Order 13813 directed the Department to address the problem that too many legitimate employer associations cannot sponsor ERISA-covered plans because they do not satisfy the requirements for being treated as an “employer” or as “acting in the interest of” an employer under the Department’s previous sub-regulatory guidance (“pre-rule guidance”). Instead, too many association arrangements for health coverage

are treated as a mere collection of distinct plans, each separately sponsored by individual employers. Under the Department’s pre-rule guidance, the association in most cases is treated as the mechanism by which each individual employer obtains benefits and administrative services for its own separate plan. To the extent the separate employers are small employers, their insurance is subject to regulation as small group coverage for purposes of the Patient Protection and Affordable Care Act (ACA). Similarly, in the case of sole proprietors and other business owners that do not also employ other individuals, the insurance coverage they obtain for themselves through an association is treated as individual coverage. As a result, associations that want to form AHPs and existing AHPs currently face a complex and costly compliance environment insofar as the various employer members of the association and the association’s health insurance coverage arrangement may simultaneously be subject to large group, small group, and individual market regulation, which undermines one of the core purposes and advantages of an association forming and its employer members joining an AHP (i.e., to help small employers obtain better terms on health coverage by allowing them to group together to spread risk and administrative costs in a large group environment).

After Executive Order 13813 was issued, on January 5, 2018, the Department published a proposed regulation (“Proposed Rule”) on the definition of “employer” in ERISA section 3(5) that would broaden the types of employer groups or associations that may sponsor a single group health plan under ERISA for the benefit of the employees of the group or association’s member employers. The Proposed Rule would broaden the criteria for a group or association to satisfy the “commonality of interest” requirement, and provide additional flexibility for employer groups or associations to offer health coverage in a manner that would be considered a single group health plan. Specifically, under the Proposed Rule, employer groups or associations

would meet the commonality of interest criteria if their members were in the same trade, industry, line of business, or profession, or maintained their principal places of business in a region that does not exceed the boundaries of the same State, or in the same metropolitan area (even if the metropolitan area includes more than one State).

The Proposed Rule also included a provision that would establish clear criteria under which working owners, such as sole proprietors and other self-employed individuals, could participate in AHPs. Furthermore, while the Department's regulation at 29 CFR 2510.3-3(b) (which excludes "plans without employees" from the definition of employee benefit plans covered by Title I of ERISA) does not prevent sole proprietors or other working owners from being participants in broader plan arrangements, such as AHPs, the Proposed Rule also included an amendment to that regulation that would expressly permit participation of working owners without any common law employees in AHPs. Under the Proposed Rule, the participants in an AHP thus could consist of common law employees, common law employees and working owners, or solely of 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 bona fide group or association and an employee participant in the AHP.

The Department received over 900 comments in response to the Proposed Rule from a wide range of stakeholders, including group health plan participants, consumer groups, employer groups, individual employers (including sole-proprietors), employer associations and other business groups, individual health insurance issuers, trade groups representing health insurance issuers, State regulators, and existing AHPs. The public comments submitted in response to the Proposed Rule were posted on the Department's Web site at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public->

comments/1210-AB85. A significant number of commenters, including small business owners and self-employed individuals, expressed serious concerns regarding the rising cost of healthcare. Many of these small business owners currently do not offer health coverage to their employees, citing ever-increasing costs as the primary reason they cannot offer affordable health coverage to their employees and their families. Similarly, small business owners that provide health coverage stressed that the premiums are exceedingly costly, and the increases in premiums are frequent and unsustainable. Many self-employed individuals, for example real estate agents, stated that they are forced to purchase insurance in a volatile individual insurance market, which tends to offer fewer choices at much higher costs. The small business owners who submitted these comments said that they were very supportive of the Proposed Rule as a way to expand the options they have to obtain more affordable healthcare coverage for themselves and their employees.

After careful consideration of the issues raised by the written public comments, the Department decided to adopt the Proposed Rule as a final rule, with certain modifications made in response to public comments. Small businesses are crucial to the U.S. economy. Small business owners are often anxious about their ability to obtain healthcare coverage for their employees through employee benefit plans. Similarly, sole proprietors and other self-employed individuals who do not have employees also find it difficult to obtain affordable coverage for themselves and their families through employee benefit plans, or through individual coverage. The Department believes that this final rule will promote broader availability of group health coverage for these small business owners and self-employed people, and help alleviate their problems of limited or non-existent affordable healthcare options for these small businesses and self-employed people. The Department believes it is important to provide an alternative to the

restrictions present in the Department’s pre-rule guidance that have hampered the ability of small businesses to join together to purchase and provide affordable, quality health coverage for themselves, their employees and their families. The Department continues to believe that providing additional opportunities for employer groups or associations to offer health coverage to their members’ employees under a single plan may, under the final rule, provide many more small businesses and self-employed individuals affordable alternatives not currently available in the individual or small group markets. The provisions in the final rule are designed to achieve the same goals that the Department’s guidance regarding AHPs has always pursued—i.e., making AHPs available while helping to prevent fraud and distinguishing AHPs from commercial health insurance issuers—in light of compelling policy objectives, including especially the need to provide more, and more affordable, healthcare coverage for employees of small businesses and self-employed individuals.

The Department also continues to believe that the final rule will prompt some working owners who were previously uninsured and some small businesses that did not previously offer health coverage 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. As under the Proposed Rule, AHPs that buy insurance would not be subject to the insurance look-through doctrine as set forth in 2011 guidance from the Centers for Medicare & Medicaid Services (CMS);⁸ instead, because an AHP would constitute a single group health

⁸ 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. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf. Hereinafter referred to as “2011 CMS guidance.”

plan, whether the AHP would be buying insurance in the large or small group market would be determined by reference to the total number of employees of all the member employers participating in the AHP.

B. Overview of the Final Rule and Discussion of Public Comments

The final rule adopts a new regulation at 29 CFR 2510.3-5. Subsection (a) of the final rule describes the general purpose of the regulation as clarifying which persons may act as an “employer” within the meaning of ERISA section 3(5) in sponsoring a multiple employer group health plan. Subsection (b) sets forth criteria for a bona fide group or association of employers capable of establishing a group health plan that is an employee welfare benefit plan. Subsection (c) sets forth criteria for the requisite commonality of interest that employer members of a group or association must have to constitute a bona fide group or association of employers. Subsection (d) establishes nondiscrimination requirements for any health coverage offered by the bona fide group or association, including examples that illustrate the application of those requirements. Subsection (e) describes the types of working owners without common law employees who can qualify as employer members and also be treated as employees for purposes of being covered by the bona fide employer group or association’s health plan. Subsection (f) describes the effective date and applicability dates for the final rule. Subsection (g) is a severability provision making it clear that individual provisions in the final rule are independent of, and severable from, other provisions of the final rule.

The final rule establishes alternative criteria from those 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 final rule has been developed in consultation with

the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), the Department of the Treasury (Treasury), and the Internal Revenue Service (IRS), with which the Department is working to implement the ACA, Executive Order 13813, and Executive Order 13765.⁹ However, the final rule will apply solely for purposes of Title I of ERISA and for determining whether health insurance coverage of the AHP is regulated by Public Health Service Act (PHS Act) provisions that apply to the individual, small group, or large group market, and not, for example, for purposes of taxation under the Internal Revenue Code (Code).¹⁰

1. Continued Availability of “Bona Fide Group or Association of Employers”

Definition Under the Department’s Pre-Rule Guidance.

The principal objective of the final rule is to expand employer and employee access to more affordable, high-quality coverage. Some commenters expressed concern, however, that application of the final rule’s requirements to existing AHPs could reduce coverage. They argued that existing AHPs that relied on the Department’s pre-rule guidance on “bona fide group or association of employers” did not design their operations with the new requirements in mind.

⁹ 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).

¹⁰ Both the Proposed Rule and this final rule under ERISA section 3(5) are limited to health benefits and AHPs. Accordingly, for simplicity, the preamble to this final rule often refers only to health benefits, including when discussing the application of prior Departmental guidance. Thus, neither this preamble nor the final rule address the application of the ERISA section 3(5) statutory phrases, “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. Several commenters asked that the final rule include provisions to expand the circumstances under which employers and self-employed individuals can sponsor and participate in ERISA-covered multiple employer plans (MEPs) that provide retirement benefits within the meaning of ERISA section 3(2) or other welfare benefits listed in ERISA section 3(1). The Department notes that as more Americans engage in part-time, contract, self-employment, or other alternative work arrangements, it is increasingly important that retirement plans and employee benefit regulation in general allow for more flexible, portable benefit programs. Although those issues are beyond the scope of this rulemaking, the Department will consider comments submitted in connection with this rule as part of its evaluation of MEP issues in the retirement plan and other welfare benefit plan contexts.

As a consequence, existing AHPs may not be able to comply with the new conditions without reducing existing options for affordable healthcare. The Department agrees that would be an undesirable result. Accordingly, the Department notes that AHPs may continue to rely upon the Department's previous guidance.¹¹ This final rule provides an additional mechanism for groups or associations to meet the definition of an "employer" and sponsor a single ERISA-covered group health plan; it is not the sole mechanism.¹²

A central aim of the new regulation is to provide an additional opportunity beyond those available under pre-rule guidance for employer groups or associations to offer health coverage to their members' employees under a single plan. While the Department believes that it is appropriate to expand the availability of AHPs to the new arrangements permitted under the final rule, it does not suggest that arrangements that comply with its pre-rule guidance fail to meet the statutory definition of employer. An employer group or association that complies with either the requirements under the new rule or the pre-rule guidance is considered to be acting in the interest of participating employers. In either case, the group or association acts as an "employer" within the meaning of ERISA section 3(5), and has a sufficient nexus to employers and employees in

¹¹ See, e.g., Advisory Opinion Nos. 94-07A, 2003-13A, and 2007-06A.

¹² Also, some commenters indicated that some existing multiple employer welfare arrangements (MEWAs) are not interested in obtaining single-employer AHP status under ERISA. These commenters requested clarification of whether a group or association that provides health coverage to more than one employer member must sponsor an AHP to provide those benefits. While the final rule describes when a group or association of employers is permitted to act as an "employer" under section 3(5) of ERISA, the final rule does not compel the group or association to sponsor an AHP on behalf of the group or association's participating employer members. The Department believes that a group or association operating a MEWA can structure its operations to avoid being deemed an employer sponsoring a single ERISA-covered health plan for the employees of the participating members. Such a group or association is permitted to operate a MEWA under which each employer that gets its health coverage through the group or association is considered to have established a separate, single-employer health benefit plan covering its own employees. As under pre-rule guidance, the Department would look to the intent of all parties, as reflected in the plan documents, to determine whether there is a single multiple-employer plan or there are multiple single-employer plans. MEWAs are discussed further below.

the AHP to distinguish it from a mere commercial health insurance issuer that lacks the requisite connection to the employment-based relationships that ERISA regulates.¹³

Accordingly, the final rule includes additional regulatory text to make it clear that this final rule does not supplant the Department's previously issued guidance under ERISA section 3(5), but rather provides an additional basis for meeting the definition of an "employer" under ERISA section 3(5). The Department emphasizes that both existing and new employer groups or associations that conform to the Department's pre-rule guidance can sponsor an AHP.

2. Bona Fide Groups or Associations of Employers under the Final Rule

Paragraph (b) of the Proposed Rule defines certain criteria for a "bona fide group or association of employers" that may establish a group health plan that is an employee welfare benefit plan as those terms are defined in ERISA.¹⁴ Some commenters suggested broadening the definition of "bona fide groups or associations" to include a variety of tax-exempt organizations under Code section 501(c), such as scientific, literary, and educational organizations whose

¹³ The Department's previously issued guidance established criteria for determining that an employer group or association is an employer within the meaning of ERISA section 3(5) for purposes of establishing an AHP (or other employee welfare benefit plan). Among the factors considered are the following: how members are solicited; who is entitled to participate and who actually participates in the group or association; the process by which the group or association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; and who actually controls and directs the activities and operations of the benefit program. The employer members must also have a sufficient employment-based common nexus or other genuine organizational relationship unrelated to the provision of benefits. That determination is made on the basis of all the facts and circumstances involved. The employers that participate in a benefit program must also exercise control over the group or association's group health plan, both in form and in substance, in order to act as a bona fide employer group or association with respect to the plan.

¹⁴ One commenter also suggested that the term "bona fide" should be deleted from the rule because ERISA section 3(5) does not use that term but merely refers to "group or association of employers." The Department has chosen not to adopt this change in nomenclature. The term "bona fide" properly indicates that the group or association of employers must meet certain criteria to be eligible to act as an employer sponsor of a single AHP, within the meaning of ERISA section 3(5). The Department could have used "qualified" or "qualifying" but chose to use "bona fide" because that is the term used in the Department's previously-issued sub-regulatory guidance under ERISA section 3(5).

members are not necessarily employers. These commenters urged the Department to expand the regulation to allow groups or associations of individuals to sponsor an AHP, without regard to whether such individual's employer is a participating member or whether the individual is a "working owner." They explained that many well established professional associations include individuals in a common trade or business, but who are not self-employed and whose employers may not be participating members. Accordingly, they argued that the Department's Proposed Rule unduly limits these associations' ability to offer AHPs to their members, including members who are independent contractors or sole proprietors who could otherwise benefit from the new rule's extended coverage of "working owners." Whatever the policy merits of these arguments, however, the Department's authority to define "employer" and "group or association of employers" under ERISA section 3(5) does not broadly extend to arrangements established to provide benefits outside the employment context and without regard to the members' status as employers. The final rule, like ERISA section 3(5), is limited to employers, including working owners, as discussed below. The Department cannot expand its definition beyond the statute's scope.

Some commenters additionally argued that the Department should remove the Proposed Rule's "commonality of interest" and "control" requirements altogether because, in the commenters' view, these requirements are not supported by the statutory text of ERISA. These commenters argued that ERISA section 3(5) does not expressly require either commonality or control but rather, requires only that the group or association of employers act indirectly in the interest of the group or association's employer members. They further argued that the Department should apply in this situation its regulation at 29 CFR 2530.210(c)(3), which provides that, for employee pension plans subject to ERISA's participation and vesting

requirements, “multiple employer plan” means a multiple employer plan as defined in Code section 413(b) and (c). The commenters maintained that neither Code section 413(c) nor Treasury Regulation section 1.413-2 requires a “unique nexus” between the employers that maintain a multiple employer plan. The commenters claimed that, for purposes of the Code and, therefore, ERISA, a multiple employer plan is simply a plan maintained by more than one employer with no “nexus” required. As discussed more fully below, with regard to ERISA section 3(5), the Department does not agree. Commonality and control requirements are retained in the final rule as elements that distinguish employment-based benefit arrangements from commercial insurance marketing programs.

Other commenters argued that the Department’s proposal to redefine the criteria for a bona fide group or association such that the group or association of employers and the individuals that benefit from the plan are no longer required to be tied by a common economic or representation interest, unrelated to the provision of benefits, is inconsistent with allegedly unambiguous statutory language in ERISA and several decades of case law applying ERISA, is in excess of statutory authority, and is arbitrary and capricious under the Administrative Procedure Act (“APA”). As discussed more fully below, although the Department does not believe that the proposal was inconsistent with unambiguous statutory language or lacked reasoned analysis, the Department has decided that the final rule should require that a bona fide group or association of employers have at least one substantial business purpose unrelated to the provision of benefits to be eligible to sponsor an ERISA-covered group health plan, although the final rule makes clear that a group or organization’s principal purpose may be the provision of benefits.

Several commenters also argued that the PHS Act, the ACA, and ERISA manifest a clear intent to treat the group markets and individual market as distinct, and that the Proposed Rule conflicts with the text of the ACA by allowing small employers and individuals, who are not subject to the employer shared responsibility provisions under section 4980H of the Code and who were supposed to be purchasing insurance coverage that is subject to the essential health benefits (“EHB”) requirements, to band together to obtain health insurance that does not comply with all the ACA insurance rules applicable to small group market insurance. The Department disagrees that the Proposed Rule is unlawful under the ACA. As explained in the 2011 CMS guidance, although the ACA revised and added to Title XXVII of the PHS Act, it did not modify the underlying PHS Act framework for determining whether health insurance coverage issued through associations was individual or group health insurance coverage. The PHS Act derives its definitions of group health plan and employer from the ERISA definitions and where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the “employer,” the association itself is considered a group health plan for purposes of the ACA provisions in Title XXVII of the PHS Act. Single plan MEWAs pre-date the ACA and continue to play an important role in the existing regulatory environment under the PHS Act, the ACA, and ERISA. Thus, employer groups already can group together to collectively sponsor ERISA plans, and those plans have to comply with applicable group market rules. In line with that recognized practice, here the DOL has simply used its rulemaking authority to define a statutory term in a way that allows employers to join together more broadly to promote the adoption and administration of AHPs and expand access to affordable health coverage, especially among small employers and self-employed individuals.

a. Purpose of the Association

Paragraph (b)(1) of the Proposed Rule stated that a group or association may act as an employer within the meaning of ERISA section 3(5) for purposes of sponsoring a group health plan if 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. This represented a departure from previously issued sub-regulatory guidance, which required a group or association acting as an employer to exist for purposes other than providing health benefits.

Many commenters, including some who were otherwise supportive of the Proposed Rule, objected to this provision. Several commenters believed that, because most small businesses already have the opportunity to belong to a chamber of commerce or other professional association, allowing a group or association to be formed solely for the purpose of sponsoring a group health plan is unnecessary to achieve the Department's goals. Commenters believed that a proliferation of groups or associations established for the exclusive purpose of sponsoring an AHP could oversaturate the market, diminishing the value of existing trade and professional groups or associations which, for decades, have focused on building and maintaining relationships with their members and serving their members' needs on a multitude of issues well beyond health benefits. Similarly, it could also diminish the market power of existing AHPs and those that may be formed by groups and associations that exist for other purposes, which could limit their opportunities to achieve the economies of scale that make AHPs an attractive vehicle for providing affordable coverage in the first place. Commenters also expressed the view that established industry and trade groups and associations have strong incentives to maintain their good reputation and favorable historical record of responsibly acting in the interests of their employer members. These reputational incentives mitigate the risk that they would set up poorly managed AHPs or provide inadequate coverage. In contrast, these commenters argued, allowing

groups and associations formed for the sole purpose of offering an AHP to be considered bona fide groups or associations of employers could invite unscrupulous promoters to enter the market with mismanaged and thinly funded AHPs and could increase the prevalence of fraudulent and abusive practices. Additionally, according to such commenters, newly-formed groups and associations are likely to lack the knowledge and expertise necessary to prudently operate an AHP, subject to all of the complexities of modern health markets and regulatory structures. Commenters noted that individuals and small businesses are not typically sophisticated purchasers of group health coverage and may confront challenges in evaluating AHP options. As a result, these persons may be more likely to make imprudent decisions that would drive them to select plans with the lowest premiums without understanding the impact on access to care, the rights of their employees, and risks associated with fraud and insolvency. Several commenters stated that self-insured AHPs in particular were ripe for abuse and recommended that groups and associations that do not exist for purposes other than sponsoring an AHP should be limited to offering fully-insured AHPs.

Commenters offered numerous suggestions for alternative criteria for determining a bona fide group or association of employers for purposes of the new rule with the aim that those eligible be limited to legitimate, well-managed, and well-intended organizations with the ability to properly operate an AHP. Some commenters supported retaining the requirement in the Department's pre-rule guidance that the group or association exist for other purposes unrelated to the provision of benefits in order for the group or association to qualify as bona fide. Some suggested requiring a group or association to exist for a specified minimum length of time before it could sponsor an AHP. Others suggested requiring that the group or association meet certain criteria for tax-exempt organizations, have minimum revenues unrelated to AHP operations, or

demonstrate by other means the capacity to oversee the administrative requirements associated with managing the complexities of an AHP in order to be considered a bona fide group or association.

After consideration of the public comments, the Department agrees that some modification of this provision is appropriate. The intent of this final rule is to expand access to AHP coverage options, while protecting plan participants and beneficiaries from imprudent, abusive, or fraudulent arrangements. Removing undue restrictions for existing groups and associations as well as for newly-formed groups and associations of employers and working owners is critical to achieving the Department’s goal of expanding choice in health coverage options. But the Department understands the concerns regarding operational risks such as fraud and insolvency that commenters believed might be more likely with respect to AHPs offered by newly-formed groups and associations that exist solely for the purpose of sponsoring an AHP.¹⁵

Accordingly, the Department is modifying this provision in the final rule to establish a general legal standard that requires that a group or association of employers have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees, even if the primary purpose of the group or association is to offer such coverage to its members. Although the final rule does not define the term “substantial business purpose,” the rule contains an explicit safe harbor under which a substantial business purpose is considered to exist in cases where the group or

¹⁵ In addition, the Department’s revisions of the final rule are responsive to concerns that, in the absence of some purpose other than providing health benefits, there may be insufficient basis for treating the group or association as the sort of bona fide group or association of employers contemplated by ERISA section 3(5), as opposed to a commercial insurance operation or issuer that should be regulated in the same manner as other insurance companies or issuers.

association would be a viable entity even in the absence of sponsoring an employee benefit plan. The final rule also states that a business purposes is not required to be a for-profit purpose.¹⁶ Thus, for example, a bona fide group or association could offer other services to its members, such as convening conferences or offering classes or educational materials on business issues of interest to the association members. Depending on facts and circumstances, a bona fide group or association might be tax-exempt under Code section 501(a) as an organization described in Code section 501(c), with a purpose unrelated to the sponsorship of the AHP, if it meets all the requirements for exempt status, including furthering an exempt purpose. A bona fide group or association could also act as a standard-setting organization that establishes business standards or practices. A bona fide group or association could also engage in public relations activities such as advertising, education, and publishing on business issues of interest to association members unrelated to sponsorship of an AHP. A bona fide group or association's purpose could simply be to advance the well-being of the industry in which its members operate, although in that case the group or association would need to advance that well-being through substantial other activity in addition to providing health coverage. In each instance, the other business purpose(s) or activity should be substantial enough that the association could be a viable entity even in the absence of acting as a sponsor of an AHP. If, for example, the group or association had operated with an active membership before sponsoring an AHP, that would be compelling evidence of such a substantial business purpose. Nor would it be inconsistent with this provision if such a pre-

¹⁶ This responds to commenters concerns that engaging in substantial "for profit" activity could have unintended consequences with respect to an organization's status under section 501(c) of the Code. An association that is, or intends to be, tax-exempt under section 501(a) of the Code should keep in mind that engaging in a business ordinarily carried on for profit might affect its qualification for, or maintenance of, any recognition as a tax-exempt organization under federal law if the business activity is substantial.

existing group or association created a wholly owned subsidiary to administer an AHP, even if the subsidiary exists solely to administer the group health plan. In this circumstance, the group or association's substantial business purpose unrelated to the provision of healthcare benefits is not eliminated by its decision to create a subsidiary under its control to administer the AHP.

These modifications emphasize that nothing in the final rule should be read as prohibiting a bona fide group or association — formed either before or after the issuance of this final rule — from sponsoring an AHP as its primary purpose, provided that it also has a substantial business purpose unrelated to sponsorship of the AHP. Thus, for instance, a group or association formed after this final rule is issued and that has a primary purpose of providing health coverage, but that also convenes conferences and provides educational materials and opportunities to its members, would satisfy this rule's requirements, if the convening and educational activities are sufficiently substantial. The Department believes these modifications assist substantially in drawing the line between traditional health insurance issuers (which typically exist only to underwrite and sell insurance) on the one hand, and those that qualify as an “employer” under section 3(5) of ERISA, on the other (because of their other substantial business purpose).

b. The Group or Association Must Have an Organizational Structure.

Paragraph (b)(3) of the Proposed Rule required that a group or association have “a formal organizational structure with a governing body” as well as “by-laws or other similar indications of formality” appropriate for the legal form in which the group or association operates in order to qualify as bona fide. Commenters generally supported these provisions on the basis that having such formalities will not only serve to clarify the rights and obligations of members of the association or group, but to promote accountability by enabling regulators and others to readily identify those parties who are responsible for operations, including the establishment and

maintenance of the group health plan. These commenters suggested that the existence of formalized and robust organizational structures could be an important form of protection against fraud and insolvency. For these reasons, the final rule adopts these provisions without modification. There were requests for minor wording changes to paragraph (b)(3) to ensure that certain ongoing entities clearly fit within the final rule, and similarly, there were requests to clarify the meaning of certain words or phrases in paragraph (b)(3) as applied to specific fact patterns. The Department declines in this preamble to address the application of the final rule to specific fact patterns. The Department has procedures to answer inquiries of individuals or organizations affected, directly or indirectly, by ERISA as to their status under ERISA and as to the effect of certain acts and transactions.¹⁷

c. Participating Employer Control Over the Group or Association and the AHP.

Paragraph (b)(4) of the Proposed Rule required that member employers control the functions and activities of the group or association, including its establishment and maintenance of the group health plan, in order for it to qualify as a bona fide group or association. Such control under the Proposed Rule could be direct or it could be indirect through the regular election of directors, officers, or other similar representatives that control the group or association and the establishment and maintenance of the plan. The Department noted in the preamble to the Proposed Rule that this “control test” was intended to largely duplicate the conditions in the Department’s pre-rule guidance under ERISA section 3(5).

Some commenters who supported the Proposed Rule acknowledged that a control test is necessary to ensure that bona fide groups or associations act as an “employer” in relation to the

¹⁷ ERISA Advisory Opinion Procedure 76-1 (FR Doc. 76-25168).

group health plan and “in the interest” of participating employers, as required by ERISA section 3(5). Indeed, some of these commenters believe that this provision would assume heightened importance in light of other provisions in the Proposed Rule, notably the special rule on the dual treatment of working owners as employers and employees.

Some commenters who generally opposed the Proposed Rule were skeptical that the proposed control test could adequately protect against fraudulent MEWAs¹⁸ and other entities that may not act in the best interest of the employer members. These commenters suggested that many small employers that join a group or association for the purpose of participating in a group health plan (and especially those employers that have little or no connection to each other beyond doing business in the same State or metropolitan area) are unlikely to have sufficient motivation or capacity to evaluate the integrity and expertise of those governing the group or association or administering the plan. For these reasons, these commenters consider the proposed control test to be a largely illusory safeguard, at least in the limited context they described. Some of these commenters urged the Department to bolster the proposed control test with additional or alternative requirements. In particular, commenters proposed that the Department clarify that employer members must not only control the group or association in form, but also in substance, in order for it to qualify as bona fide, because otherwise the protections contemplated by the control test could be evaded systematically. The commenters advancing this suggestion made reference to a strong historical correlation between fraudulent

¹⁸ A “MEWA” is a “multiple employer welfare arrangement” as defined in ERISA section 3(40). A MEWA can be a single ERISA-covered plan, or an arrangement comprised of multiple ERISA-covered plans, each sponsored by unrelated employer members that participate in the arrangement. AHPs are one type of MEWA, and they are single ERISA-covered plans.

MEWAs and situations where participating employers had only nominal control of the entity sponsoring the MEWA.

A few commenters opposed the proposed control test entirely. These commenters generally expressed apprehension about the logistics of requiring participating employer members to control the functions and activities of a large group or association in order for it to qualify as bona fide. These commenters argued that at least for well-established groups or associations, which may have hundreds or even thousands of member employers and working owners and already act in the interest of their members, the requirement is impractical and unnecessary. One commenter argued that the control test set forth in the Proposed Rule should be recast as a safe harbor and that, if a group or association cannot meet the safe harbor's specific control criteria, it should be permitted to demonstrate in other ways that it is looking out for and acting in the interest of its members and their employees.

After careful consideration of these comments, the Department disagrees with the commenters who believe the proposed control test is unnecessary or that it will be ineffective, and the final rule adopts the proposed control test, with certain revisions as described below. The Department is of the view that the control test is necessary to satisfy the statutory requirement in ERISA section 3(5) that the group or association must act "in the interest of" the employer members in relation to the employee benefit plan. It will also help prevent formation of commercial enterprises that claim to be AHPs but, in reality, merely operate as traditional health insurance issuers, in all but name.

The regulatory text in the final rule is slightly different than in the Proposed Rule. Although the Department's intent in the Proposed Rule was to replicate the control test as it exists in the Department's previously-issued sub-regulatory guidance under ERISA section 3(5),

a number of commenters questioned whether the language in the Proposed Rule would effectively accomplish that objective. The regulatory text in the final rule is intended to better align the control test in paragraph (b)(4) with the Department's pre-rule guidance under ERISA section 3(5), including the requirement that control exist in form and substance. As revised, the control test provides that the functions and activities of the group or association must be controlled by its employer members, and the group or association's employer members that participate in the group health plan must control the plan. Control must be present both in form and in substance. Whether the requisite control exists is determined under a facts and circumstances test.

Several commenters requested guidance and clarification, including specific examples if possible, on what it would mean for participating employers (particularly very small employers and working owners) to control the functions and activities of the group or association or the establishment and maintenance of the plan, especially in cases where the group or association and plan are extremely large and the primary purpose of the group or association is to sponsor the plan. These commenters expressed concern that the control test, as proposed, could be construed as requiring that participating employers be responsible for management and day-to-day operations of the group or association and AHP in order for the group or association to qualify as bona fide. Thus, the commenters specifically asked that the final rule clarify the type and degree of control that employer members must exercise over the group or association in order for it to qualify as bona fide, and suggested that the Department identify specific activities or other criteria that would be sufficient to demonstrate the necessary degree of control. For instance, these commenters requested clarification on whether the Department intended that the proposed control test would require participating employers to actively manage administrative

and operational functions of the AHP, such as network composition, benefit and funding levels, marketing, and distribution.

The final rule does not require group or association members to manage the day-to-day affairs of the group or association or the plan in order for the group or association to qualify as bona fide. As has long been the case, the Department will consider all relevant facts and circumstances in determining whether the functions and activities of the group or association are sufficiently controlled by its employer members, and whether the employer members who participate in the group or association's group health plan sufficiently control the group health plan. In the Department's view, the following factors, although not exclusive, are particularly relevant for this analysis: 1) whether employer members regularly nominate and elect directors, officers, trustees, or other similar persons that constitute the governing body or authority of the employer group or association and plan; 2) whether employer members have authority to remove any such director, officer, trustees, or other similar person with or without cause; and 3) whether employer members that participate in the plan have the authority and opportunity to approve or veto decisions or activities which relate to the formation, design, amendment, and termination of the plan, for example, material amendments to the plan, including changes in coverage, benefits, and premiums. The Department ordinarily will consider sufficient control to be established if these three conditions are met.¹⁹

¹⁹ A number of commenters requested clarification or confirmation that the control test would be satisfied in an array of fact patterns involving different control structures, membership classifications, and participation privileges, including subgroup structures and associations of groups or associations. As stated elsewhere in this preamble, control must be present both in form and in substance, and whether control exists is determined under a facts and circumstances test. The Department declines in this preamble to address the application of the final rule to specific fact patterns. As noted above, the Department has procedures to answer inquiries of individuals or organizations

A number of commenters raised issues regarding the interrelationship between the control test and the status of a group or association's board members under the definition of "fiduciary" under section 3(21) of ERISA. Whether, and the extent to which, any particular board members are fiduciaries under ERISA turns on whether they engage in activity described in section 3(21) of ERISA with respect to the AHP. Thus, although in many circumstances board members in fact will be fiduciaries under ERISA, the relevant facts and circumstances of the particular situation will dictate the outcome. Some commenters suggested that the final rule should require board members to acknowledge in writing their status as fiduciaries under ERISA. Section 402 of ERISA already provides that every employee benefit plan shall be established and maintained pursuant to a written instrument, and that such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan. Some commenters suggested that the final rule could contain a deeming provision under which the control test would be considered satisfied if a group or association's board members (along with other officers) acknowledged in writing their fiduciary status. Whether group or association members in fact have sufficient control of the functions and activities of the group or association for it to be considered bona fide, however, is entirely independent of and unrelated to whether the group or association's key officials or board members are fiduciaries of the AHP. For these reasons, the Department declines to adopt the suggestions of these commenters.

Other commenters suggested revisions that the Department considers to be unnecessary,

affected, directly or indirectly, by ERISA as to their status under ERISA and as to the effect of certain acts and transactions. See ERISA Advisory Opinion Procedure 76-1 (FR Doc. 76-25168).

unduly burdensome, or beyond the scope of this rulemaking. For example, one suggestion was that the Department should require that a majority of the group or association's board members be participating employer members in order for it to be considered bona fide. Another suggestion was that the Department should dictate that groups or associations grant each employer member voting rights with respect to affairs of the group or association, health plan, or both, or require that groups or associations confer officer or director rights or status to some subset of participating employer members in order for the group or association to be considered bona fide. While these factors could be relevant to whether the members had the requisite degree of control, the Department is reluctant, and accordingly declines, to dictate specific governance structures (e.g., by requiring a board structure and specifying the board's powers, selection process, and membership criteria). The test is whether the employer members exercise control in form and substance, not whether they adopted a specific organizational structure.

d. Definition of Eligible Participant.

The Proposed Rule provides that only employees and former employees of employer members and their families or other beneficiaries (for example, spouses and dependent children) would be able to participate in a group health plan sponsored by the group or association. Commenters asked the Department to clarify or modify the definition of the individuals who are eligible to participate in an AHP. Some commenters said the rule should expressly state that retirees and COBRA-eligible persons²⁰ do not lose their status as eligible participants if their

²⁰ COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. COBRA added ERISA sections 601-609, which require, among other things, group health plans to offer temporary continuation health coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events.

employer decides to no longer continue as a member of the bona fide group or association or ceases to be an employer member for other reasons (e.g., the employer goes out of business). Others said that the term “former employees” is too broad to the extent individuals would be able to join an AHP merely because at some time in the past they worked for an employer that currently is a member of the bona fide group or association. The commenters expressed concern that such an expansive approach would introduce adverse selection issues. Another commenter stated that the term “family member” is too broad and that the term “beneficiary” alone would suffice. Some commenters suggested defining eligible participants under paragraph (b)(6) as including only employees, spouses, and dependent children. One commenter requested clarification regarding whether employees of the bona fide group or association (as opposed to employees of employer members) can participate in the AHP.

The Department agrees that some clarification of the definition of eligible participant is appropriate. Thus, the final rule provides that an eligible participant includes employees of a current employer member of the group or association, former employees of a current employer member of the group or association who became entitled to coverage under the group’s or association’s group health plan when the former employee was an employee of the employer, and beneficiaries of such individuals (e.g., spouses and dependent children). The Department’s objective with this final rule provision is to provide participating employers and their employees with the same basic rule for defining participants as would apply if the employer member of the association established its own separate group health plan. To achieve this objective in the case of working owner coverage, the final rule includes a special provision that states that, except as may be required for purposes of COBRA continuation coverage, an individual eligible for coverage under the group health plan as a working owner (and the individual’s beneficiaries)

cannot continue to be eligible for coverage under the group health plan for any plan year after it is determined that the individual does not meet the conditions for being treated as a working owner under paragraph (e)(2). In the Department's view, these provisions make it clear that, when applicable, an AHP must provide COBRA continuation coverage and certain other post-employment coverage to persons who became eligible for coverage by virtue of an employment relationship to an employer member that has a connection to the bona fide group or association and the AHP. The Department also believes that the provision clarifies that employment with an employer unrelated to the employer's membership in the group or association sponsoring the AHP, in itself, is insufficient for an individual to be eligible for coverage under the AHP. For example, an employment relationship entered into with an employer only after the employer ceased being a member of the bona fide group or association would not be sufficient to allow the individual to be a covered participant in the AHP.

The Department also agrees with the commenters who suggested that it use the existing ERISA-defined term "beneficiary" rather than "spouses," "dependent children," or "family member." Since an AHP may provide coverage to any ERISA beneficiaries (for example, dependents for federal tax purposes) and is not limited to spouses or dependent children, or other family members, the Department agrees that using the term "beneficiary" is more accurate.

The Department also agrees that it is not unusual for employer groups or associations to be established as separate legal entities that have their own employees, and for the group or association to choose to participate in the group or association's arrangement for the provision of health benefits as a way of providing benefits to its own employees. In the case of a geography-based AHP under the final rule, the group or association could be a participating employer by having its principal place of business within the relevant state or metropolitan area. In the case

of an industry-based AHP under the final rule, the Department added a provision to the final rule to explicitly state that the group or association will be treated as being in the same trade or industry as the other employer members of the group or association.²¹

Some commenters asked the Department to hold harmless health insurance issuers and third party administrators who exercise diligence and good faith in relying on the bona fide group or association's representations of participant eligibility in cases where an ineligible individual is enrolled in an AHP. Another commenter asked that issuers and administrators be given access to the documentation necessary to verify employee eligibility. Issues of legal responsibility for operational errors in the establishment or implementation of an AHP would invariably depend on the particular facts and circumstances involved, including contractual provisions establishing the parties' respective rights and obligations. In the Department's view, this definitional rulemaking is not an appropriate vehicle for addressing such issues. Similarly, although the Department would expect a bona fide group or association to furnish its service providers (including issuers and third party administrators) access to documents and information necessary for those service providers to perform their obligations, the establishment of such information-sharing obligations is beyond the scope of this rulemaking under ERISA section 3(5).

Several commenters were concerned that if an AHP made coverage available to eligible participants on a continuous basis, as opposed to limiting enrollment to specified periods, the AHP could be subject to adverse selection as participants switched in and out of AHP coverage

²¹ The Department notes that it would similarly conclude under its pre-rule guidance that employees of the sponsoring association could participate in the association's AHP.

according to their current health needs. This could, in turn, make it difficult for AHPs to achieve stable risk pools and create challenges for issuers when setting rates for the policies they would offer to fully-insured AHPs. These commenters suggested that a final rule should require, or at least permit, AHPs to set temporal restrictions on enrollment such as only making coverage available to eligible participants during set open enrollment periods.

The Department declines to impose any specific requirements for AHPs with respect to the use of open enrollment periods. Although open enrollment periods are common for participant enrollment in group health plans, they are not required under any provision of Federal law and nothing in these final rules affects or restricts an AHP's ability to limit open enrollment periods.²²

e. Health Insurance Issuer Cannot Sponsor an AHP.

The final rule retains the requirement in the Proposed Rule that the group or association sponsoring the AHP cannot be a health insurance issuer or owned or controlled by a health insurance issuer in order for it to qualify as bona fide. Several commenters supported this requirement as important to differentiate bona fide employer groups from commercial entities selling insurance to employers. Others asked the Department to strengthen this prohibition further by including other entities with similar conflicts of interest, such as healthcare systems and network providers. Some commenters also sought clarification that this requirement would

²² Of course, group health plans must provide special enrollment periods under certain circumstances. For example, current employees and their dependents who have experienced a loss of coverage must have an opportunity to enroll in the plan under a special enrollment period if they are otherwise eligible to enroll and the coverage was previously offered at a time when the employee had other health coverage. Additionally, special enrollment periods must be provided for certain dependent beneficiaries who experience a qualifying life event such as marriage, birth, or adoption. See ERISA section 701(f) and 29 CFR 2590.701-6. In addition, a group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days. See PHS Act section 2708 and ERISA section 715. See also 29 CFR 2590.715-2708.

not prohibit insurance issuers from serving as third party administrators or providing certain services to bona fide groups or associations. Those commenters explained that health insurance issuers and insurance agents and brokers often provide significant assistance to groups or associations, such as plan design advice and development, marketing, and administrative services (including claims administration).

Other commenters opposed this requirement and argued that insurance issuers should be allowed to form and operate AHPs because, they argued, issuers are uniquely capable of guarding against fraud and are already subject to measures designed to protect against insolvency. These commenters argued that insurance carriers can leverage their existing knowledge to reduce the risks of insolvency and fraud, run AHPs efficiently, and improve the affordability of coverage for AHPs. One commenter argued that the prohibition was inconsistent with the Proposed Rule's provision that allowed AHP sponsors to be created solely for the purpose of providing health benefits. The same commenter stated that the Department did not provide any rationale for prohibiting health insurance issuers from sponsoring or controlling an AHP.

Other commenters noted that it is not uncommon for an employee of an issuer to sit on the boards of employer groups or associations. Such commenters asked the Department to confirm that an insurance issuer, agent, or broker providing services to an AHP or having members on the governing body of the bona fide group or association or the AHP would not be considered to be "controlling" the bona fide group or association. One commenter also suggested that the final rule should allow AHPs to engage in joint ventures with insurance companies.

The Department believes that it is important to continue to preclude health insurance issuers in their capacity as health insurance issuers from constituting or controlling a bona fide group or association under the final rule. As the Department explained in the preamble to the Proposed Rule, this prohibition was designed to draw a line between the sorts of employer-sponsored arrangements that are regulated by ERISA and commercial insurance arrangements that lack the requisite connection to the employment relationship.²³ Being an insurance company or concern necessarily would require the group or association to serve and advance the exclusive business interests of the company or concern, including its shareholders or other owners, which might stand as an obstacle to acting in the interests of the employer members of the group or association, as is required by section 3(5) of ERISA in order for the group or association to qualify as bona fide. The prohibition also serves to prevent the various conflicts of interest that could arise in a situation where, for example, a health insurance issuer acts as both an AHP plan sponsor and also offers an insurance policy or administrative services in connection with the plan in exchange for compensation. Further, there may be limited circumstances where such a person could be on a governing board, e.g., appointed as a part of a temporary board during an initial period of establishing the group or association or AHP, or serving as a non-voting member. But in general the Department does not believe it would be consistent with the final rule to have insurance issuer representatives on an AHP governing body due to concern that such structures suggest that the participating employers have effectively ceded control to an insurance issuer.

²³ See ERISA section 733(b)(2) and 29 CFR 2590.701-2, which provide that a health insurance issuer is an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is required to be licensed to engage in the business of insurance and that is subject to state law that regulates insurance but does not include a group health plan (emphasis added).

However, this prohibition does not prevent a health insurance issuer from participating as an employer member of a bona fide association of insurers that sponsors an AHP. Nor does it prevent a group or association of health insurance issuers acting as employers from sponsoring an AHP for the benefit of their employees. In such cases, the health insurance issuers would be controlling the AHP in their capacity as employers of covered employees, and not in their capacity as health insurance companies, insurance services, or insurance organizations. The final regulation includes additional language to reflect this.

The Department agrees that, just as in the case of health insurance issuers, a group or association or plan that is controlled by a network provider, a healthcare organization, or some other business entity that is part of the U.S. healthcare delivery system would not be a bona fide group or association or AHP under this rule. The Department does not believe it is necessary or advisable to try to include an exhaustive list of all such entities in this provision of the rule. This is because such a control relationship would result in the employer group or association and plan failing the requirements in the final rule that the group or association must be controlled by its employer members and that the AHP be controlled by the employer members who participate in the plan. The Department acknowledges that the provision prohibiting control by a health insurance issuer could similarly be said to be redundant, however, in light of the fact that a key objective of various conditions in this final rule is to distinguish AHPs as employment-based benefit plans from commercial insurance arrangements, the Department believes that highlighting health insurance issuers in this provision helps reinforce that objective. The Department believes it would be consistent with the Department's purpose in including the health insurance issuer provision in the rule, and would also respond at least in part to the commenters, if the provision in the final rule was revised to expressly include subsidiaries of

affiliates of health insurance issuers. The final rule includes such a revision. This provision of the final rule has been further revised to make clear that it does not preclude health issuers, their subsidiaries, or affiliates from being involved in the control of a bona fide group or association or AHP in such entity's capacity as a participating employer (e.g., an issuer participating in an AHP as an employer member of an industry-based or geography-based bona fide employer group or association).

Moreover, nothing in this rule precludes a health insurance issuer or other business entity that is part of the U.S. healthcare delivery system from providing administrative services to an AHP. For example, a health insurance issuer could provide third party claims administration and payment services to an AHP. Similarly, a health insurance issuer could provide services to an AHP such as medical provider network design, pharmacy network design, formulary design, recordkeeping services, reporting and disclosure services, wellness program administration, 24-hour nurse helpline services, or audits services, as well as assistance in setting up the AHP.

f. Commonality of Interest.

Paragraph (c) of the Proposed Rule addressed the “commonality of interest” required for a group or association of employers to sponsor an AHP. Under the Proposed Rule, commonality could be established by employers that (1) are 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). The final rule adopts the commonality of interest test from the

Proposed Rule without substantive change.²⁴ Comments and clarifications on the main provisions are addressed below.

(i). Trade, industry, line of business, or profession.

Commenters generally supported the provision in the Proposed Rule establishing trade, industry, line of business, or profession, as a basis for finding commonality of interest, noting that groups or associations comprised of these classes of employer groups tend to be more stable, provide more predictable risk pools, allow formation of AHPs that are tailored to healthcare needs in the industry, and are more cost effective. Many commenters, however, requested that the Department clarify the terms “trade,” “industry,” “line of business,” and “profession” so that persons interested in forming AHPs would have more certainty regarding the permissible scope and membership classifications that would satisfy the rule. Some of these commenters suggested that the Department develop specific definitions for these terms, including one suggestion that these definitions dovetail with existing definitions of similar terms for VEBAs under Treasury Regulations.²⁵ Other commenters suggested a number of preexisting industry classification systems that the Department could sanction for this purpose. Among them were the North American Industry Classification System (NAICS) codes developed in part by the Office of Management and Budget (and which the Department incorporates in its Form 5500 series

²⁴ Paragraph (c) of the final rule contains a minor modification in wording. Paragraph (c) of the Proposed Rule contained introductory language stating that the commonality test would be “determined based on relevant facts and circumstances.” That language was intended for those groups and associations that would prefer to rely on the Department’s pre-rule guidance regarding when, and under what circumstances, a group or association of employers is able to act as an employer within the meaning of ERISA section 3(5). Paragraph (a) of this final rule now contains language to more clearly make this point.

²⁵ A VEBA is a “voluntary employees’ beneficiary association” described in Code section 501(c)(9).

returns), the codes for the Standard Industrial Classification, which preceded the NAICS, and the OECD²⁶ International Standard Industrial Classification.

Determinations of what is a “trade,” “industry,” “line of business,” or “profession,” as well as whether an employer fits into one or more these categories, are based on all the relevant facts and circumstances. The Department is not persuaded that embracing proscriptive definitions or sanctioning a specific industry classification list is appropriate because doing so might interfere with the ability of groups or associations to determine the scope of their own membership. In general, the Department intends for these terms to be construed broadly to expand employer and employee access to AHP coverage.²⁷ The Department will consider the use of any generally-accepted classification system of the sort identified by the commenters above, as sufficient to meet the commonality condition in paragraph (c)(1)(i) of the final rule.²⁸ That is because each of these definitions adequately articulates a concept of nexus or commonality that serves to distinguish a bona fide association from a commercial health insurance issuer. Similarly, if an association or group can establish that it would satisfy the “line of business” definition for VEBAs, as applicable in Treasury Regulations, the association or

²⁶ Organization for Economic Cooperation and Development.

²⁷ A few commenters requested clarification whether the “line of business” test is limited to “for profit” businesses or other organizations and excludes non-profit organizations. Paragraph (c)(1)(i) of the final rule is not limited in this manner. Thus, a non-profit employer does not fail to have commonality with for-profit employers in the same trade, industry, line of business, or profession in which it operates merely because of its non-profit status. Accordingly, paragraph (c)(1)(i) of the final rule would permit groups of for-profit employers, non-profit employers, or both.

²⁸ The business code subcategories in the NAICS may be more restrictive than what would constitute an industry, trade, line of business or profession under the final rule. For instance, although each of the twenty subcategories of manufacturing listed by the NAICS, e.g., “Food Manufacturing,” “Beverage and Tobacco Product Manufacturing,” “Paper Manufacturing,” etc. could be a “trade, industry, line of business or profession” within the meaning of paragraph (c)(1)(i) of the final rule, combinations of the listed manufacturing subcategories could also satisfy this provision in the final rule. However, a categorization that is defined or applied so broadly so as to potentially include practically any type of business would not satisfy the final rule.

group is considered to meet the commonality test under the requirements of the final rule.²⁹

Finally, in the case of a bona fide group or association that is sponsoring an AHP and that is itself an employer member of the group or association, the Department will consider any trade, industry, line of business, or professional group or association to be in that same trade, industry, line of business, or profession, as applicable, as the other employer members of the bona fide group or association.

Several commenters requested clarification on whether subsets of businesses clearly within trades, industries, or professions could further organize themselves around shared principles, values, or beliefs that, alone, would not be sufficient to establish commonality under paragraph (c) of the final rule. According to the commenters, these situations tend to focus on the characteristics of the owners, such as owners who are women, minorities, or veterans, or the structure of the businesses, such as franchises or companies owned by an employee stock ownership plan (ESOP). Commenters suggested that subset-associations organized in this manner may share more in common than those linked by line of business alone, including a shared culture or regulatory scheme. As mentioned above, the commonality test is based on all the relevant facts and circumstances. In the Department's view, therefore, a subset of otherwise eligible employers does not cease to have the requisite level of commonality under the final rule merely because it chooses to further segment itself inside its trade, industry, or profession into smaller groups based on other, reasonable similarities among employers, and thus such

²⁹ 26 CFR 1.501(c)(9)-2(a)(1) says that membership in a VEBA must consist of individuals who become entitled to participate by reason of their being employees and whose eligibility for membership is defined by reference to objective standards that constitute an employment-related common bond among such individuals. That regulation further states that employees of one or more employers engaged in the same line of business in the same geographic locale will be considered to share an employment related bond for purposes of an organization through which their employers provide benefits.

segmentation is permitted, provided that it is not a subterfuge for discriminating based on a health factor as prohibited under paragraph (d) of this final rule.³⁰ Therefore, for example, a subset of information technology firms, such as cloud storage companies, could meet this test, without having to cover the entire information technology industry. Restaurant owners that are military veterans could also meet this test, without having to include all restaurant owners.³¹

(ii).Geography.

The Proposed Rule's definition also permits a bona fide employer group or association to base its membership on a common geographic location, even if the membership is comprised of unrelated employers in multiple unrelated trades, industries, lines of business or professions. To meet the terms of the geographic test, the group or association's employer members each must 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). The preamble to the Proposed Rule cited examples of such metropolitan areas as 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. The preamble also made it clear that AHPs could satisfy the commonality requirement by limiting themselves to a smaller geographic region, such as a city or county.

³⁰ As discussed elsewhere in this preamble, other Federal and State nondiscrimination rules may also apply.

³¹ This flexibility is also consistent with the final rule's nondiscrimination rules, described below, which permit employment-based distinctions to be used within an AHP, provided that such distinctions are not directed at individual participants or beneficiaries based on any health factor.

The Department invited comments specifically on whether more clarification would be helpful regarding the definition of a metropolitan area. The Department asked in particular whether a federal designation by the U.S. Census or the Office of Management and Budget (OMB), which delineates and defines 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 also asked whether there is any reason for concern that groups or associations could manipulate geographic classifications to avoid offering coverage to employers expected to incur more costly health claims. The Department also sought comments on whether there are other examples that would be helpful to clarify the provision and on whether there should be a special process established to obtain a determination from the Department that all of a group or association's members have a principal place of business in the same metropolitan area.

Many commenters supported this provision and said a geography-based ability to satisfy the commonality requirement would provide employer groups and associations with important flexibility and allow more employers to join together to secure lower cost healthcare coverage for themselves and their employees through AHPs. Many commenters supporting an expansion of the commonality of interest test to allow employers with a principal place of business in a single State said that such a provision in the final rule would allow well-established organizations like a State chamber of commerce to take advantage of the new health coverage choice that AHPs represent. Many commenters also sought clarification of what would constitute a metropolitan area for purposes of the final rule. Some commenters suggested that the final rule define a metropolitan area consistent with definitions developed by OMB and used

by the Census Bureau and other federal agencies, such as the Bureau of Labor Statistics (BLS). Some of those commenters noted that although they would prefer the OMB Metropolitan Statistical Areas definition, other federal sources would be acceptable. The commenters noted that OMB, in identifying Metropolitan Statistical Areas, requires that the regions demonstrate high degrees of economic and social ties, and that Metropolitan Statistical Areas could, therefore, serve as appropriate geographic markers for bona fide associations and AHPs. Some of those commenters noted that one of the benefits of using the OMB definition of Metropolitan Statistical Areas is that it is an objective and standard benchmark that would create a level of certainty for groups and associations to use in structuring the scope of their bona fide group and association and their AHP. Others suggested that the rule expressly allow associations and groups sponsoring AHPs to rely on OMB's definitions of Metropolitan and Micropolitan Statistical areas. One commenter urged the Department not to limit the geographic commonality standard to one State or a single Metropolitan Standard Area, claiming it was arbitrary because employers that satisfy the commonality of interest requirement on the basis of trade, industry, line of business, or profession are not subject to geographic constraints and any employer group or association that sponsors an AHP will demonstrate that it acts in the interest of its members by meeting the control requirements. The commenter suggested that if any geographic limitation were to be included in the final rule it should allow employers in three contiguous States to meet the test.

Other commenters generally opposed the geography-based expansion of the commonality of interest test, saying it is so broad that employers with no genuine common interest other than being in the same State will be allowed to join together to offer AHPs, opening the door to fraudulent entities to offer coverage. These commenters expressed concern that the proposed test

was so permissive as to promote the formation of AHPs across State lines with the result that some sponsors of AHPs might attempt to manipulate geographic boundaries with the goal of choosing particular State regulators. They argued that the ability of State insurance regulators to assist consumers would also decrease because State regulatory jurisdiction typically does not extend across State lines. One commenter said that the final rule should allow multi-State metropolitan areas only if, after consultation with the NAIC, the Department finds that such a provision would not diminish the ability of States to have proper oversight. One commenter said that if the final rule envisions AHPs operating in multiple States, then the Department should establish an independent task force to resolve issues of interstate regulation and oversight among impacted States. One commenter suggested that the Department create a process to review and issue a determination that all of the employer members of a bona fide group or association sponsoring an AHP have a principal place of business in the same metropolitan area. The commenter reasoned that verification that the plan service areas align with the employers' principal places of business is essential to determining an accurate quote for the cost of coverage.

Some commenters said the “principal place of business” standard was confusing. They said that health insurance issuers typically declare a “situs” State for large employer plans that is typically the location of the company’s headquarters and/or the State where most of the employees reside. The commenter was concerned that, without more conditions, the principal-place-of-business provision could be used by sponsors of AHPs to pick as a situs one State with perceived regulatory advantages. The commenter suggested that the final rule also require that the situs State be where the principal place of business of most of the employer members of the AHP are or are anticipated to be. Another suggested that if an AHP is formed for members in a certain region, the AHP should be required to cover a minimum number of members to assure

that the group or association is not formed to provide a special benefit for a limited number of individuals. Another suggestion was that the final rule require the situs of the AHP to be a physical location and not merely a post office box.

Other commenters said that if the geography provision was included in the final rule, the group or association and AHP should be required to cover the whole State or metropolitan area or, if sub-areas were permitted, the sub-areas should be required to be contiguous in order for the group or association to qualify as bona fide. The commenters said that, without such requirements, an AHP could “redline” to achieve favorable risk pools by defining a region or a metropolitan area to avoid areas that are less affluent and, therefore, more likely to have chronic health problems. Other commenters similarly argued that the Proposed Rule should be revised to prohibit redlining in geographic or commonality definitions. The commenters expressed concern that geographically-based AHPs, in particular, could cater to upper income, more highly educated zip codes and avoid lower-income, inner-city areas with lower levels of college-educated residents, and effectively exclude individuals in poorer health. The commenters also expressed concern about the ability of AHPs to use geographic restrictions to exclude certain high-cost areas or high-risk profession employees (e.g., defining their region to cover only a high density area while excluding a rural area) and to favor participation of lower risk industries, professions, and geographic areas. One commenter suggested that the Department rely on rating areas that already exist in every State. The commenter said each State already has a set of geographic rating areas that issuers must use to set rates, and that these areas are generally the size of Metropolitan Statistical Areas, or larger to include adjacent rural areas, and are designed to be reasonably economically diverse.

This final rule retains the geography standard as a basis for meeting the commonality test as proposed without substantive revision. The Department acknowledges stakeholders' interest in clear guidelines so that employer groups interested in establishing and maintaining AHPs pursuant to the final rule can have an acceptable level of certainty regarding the group or association's status as an employer under ERISA section 3(5) and the plan's status as an employee welfare benefit plan under ERISA section 3(1). The Department did not intend the commonality of interest provisions to be overly restrictive or to be applied in an overly rigid way. In the Department's view, an area that matches a Metropolitan Statistical Area or a Combined Statistical Area, as defined by OMB (and as used by U.S. government agencies for statistical purposes), would constitute a metropolitan area for purposes of the rule.³² The Department does not intend, however, that the OMB standard be the exclusive definition of metropolitan area for purposes of the final rule. Rather, by adopting the proposed geography provision as the final rule the Department intends to leave open the possibility that other geographic areas may also qualify as metropolitan areas based on the particular facts and circumstances involved. For instance, the area from which a city regularly draws its commuters

³² The Office of Management and Budget is responsible for maintaining and updating statistical area delineations, a task it has performed every decade since the 1950 Census. OMB establishes and maintains these areas solely for statistical purposes. The delineations are intended to provide a nationally consistent set of geographic areas for collecting, tabulating, and publishing federal statistics. More information, including current and historical federal statistical area delineation files, is available on the Census Bureau website at www.census.gov/programs-surveys/metro-micro.html. In periodically reviewing and revising the definitions of these areas, OMB does not take into account or attempt to anticipate any nonstatistical uses that may be made of the definitions, nor will OMB modify the definitions to meet the requirements of any nonstatistical program. Thus, OMB has advised agencies that in cases where there is no statutory requirement and an agency elects to use the Metropolitan, Micropolitan, or Combined Statistical Area definitions in nonstatistical programs, it is the sponsoring agency's responsibility to ensure that the definitions are appropriate for such use.

may qualify as a metropolitan area, regardless of whether it would qualify under OMB's definition.

Further, as noted in the Proposed Rule, the Department did not intend, and nothing in the final rule requires, that a group or association or their AHP cover the entire State or an entire metropolitan area in order for the group or association to qualify as bona fide. Rather, as explained elsewhere in this preamble, in the Department's view, the final rule provides substantial flexibility for groups and associations to cover segments of a geographic area that otherwise meets the commonality of interest definition, provided such segmentation is not gerrymandered or manipulated in such a way as to be a subterfuge for discriminating based on a health factor.³³

The Department does not agree that it would be appropriate to expand the single-State provision to include, as one commenter suggested, three contiguous States. The Department believes that the final rule's provisions allowing nationwide AHPs based on a common trade, industry, line of business or profession and multi-state AHPs based on a common metropolitan area provide sufficient flexibility to groups or associations interested in sponsoring multi-State AHPs. At the same time, the final rule appropriately balances the need for flexibility with the concerns expressed by State regulators and other stakeholders about potential confusion related to compliance with insurance laws and regulations when AHPs, especially self-insured AHPs, operate in multiple States.

³³ See ERISA sections 510 and 702. See also 29 CFR 2590.702. Other federal and State nondiscrimination laws may also apply.

With respect to the comments suggesting that more clarity is needed in defining the “principal place of business” provision, the Department does not agree that further clarification is necessary or would be helpful. First, several commenters raising this issue seemed to believe that the principal place of business provision applied to the group or association and their AHP. However, the requirement in the Proposed Rule, which is adopted in the final rule, applies to the principal place of business of the *employers* that are participating in the group or association, not the principal place of business of the group or association or AHP. To the extent the commenters were intending to raise issues about situs states and state insurance regulation, those issues are not germane here. The application and coordination of state insurance law remains the province of the States and is discussed by the Department elsewhere in this document in connection with other provisions of the final rule.

The Department believes that the inclusion of the subterfuge provision in the final rule, as well as other provisions of federal and State law, sufficiently address the concern about groups or associations and their AHPs being structured to define eligibility for membership in a way that will avoid high cost areas and/or high risk professions.³⁴ The Department agrees with those commenters who suggested that these issues are more appropriately addressed under State authorities. Additionally, the Department explains elsewhere in this preamble that the final rule does not change existing ERISA preemption rules that authorize broad State insurance regulation of AHPs, either through the health insurance issuers through which they purchase coverage or

³⁴ As discussed elsewhere in this preamble, if a group or association organizes or offers health coverage to a segment of an industry or geography as a subterfuge for discriminating against an individual based on a health factor, the association will not meet the commonality of interest requirement. Moreover, the HIPAA health nondiscrimination rules and paragraph (d) of the final rule prohibit AHPs from making distinctions between groups of participants for purposes of eligibility, benefits, or premiums, if such distinctions are directed at individual participants or beneficiaries based on any health factor.

directly in the case of self-insured AHPs. State insurance regulators have a long history of preventing redlining in insurance; the Department is confident that States will continue to use their authority to play that important role successfully in this context.³⁵ Moreover, the Department does not believe that imposing contiguity requirements or similar constraints would effectively address the rating and redlining concerns described above because even with such restrictions an AHP could rate coverage within the AHP based on sub-areas.

(iii). Other factors for commonality of interest.

The Proposed Rule also requested comments on whether the final rule, if adopted, should also recognize other bases for finding a commonality of interest. In response, stakeholders suggested other bases for finding commonality such as ownership characteristics (e.g., an association of owners who are women, minorities or veterans), business models or structures (such as businesses owned by ESOPs, franchises, or not-for-profits), size of business (e.g., small businesses), shared religious and moral convictions, and those without any commonality at all. According to the commenters, employers within these relationships often share unique bonds, interests, needs, and regulatory schemes, and may have significantly more commonality of interest than those in the same industry or region due to these shared traits. Commenters argued that permitting such employers to work together through their groups and associations to establish market power and economies of scale is consistent with the Department's stated goals, and, therefore, should be permitted to benefit from the final rule.

The Department does not agree that these characteristics should be included as additional commonality of interest criteria in the final rule. To the extent these classes of unrelated

³⁵ See, e.g., <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf>.

businesses are not part of a single trade, industry, line of business, or profession, the geography standard for establishing a commonality of interest at paragraph (c)(1)(ii) already provides them with the ability to form State-wide and metropolitan area groups and associations that qualify as an employer for purposes of sponsoring an AHP. Thus, for example, groups or associations of employers with no commonality of interest other than shared moral convictions may sponsor AHPs, provided they satisfy the geography standard and other requirements of the final rule. Similarly, the “same business” standard in paragraph (c)(1)(i) also is available to all of these scenarios to the extent the employers are in the same trade, industry, line of business, or profession. For example, a national affinity group or association of military veteran business owners or franchise operators may, through its constitution and bylaws, establish subgroups of its members along relevant industry or business lines, such as entertainment, construction, security, agriculture, gaming, information technology and so forth. Each subgroup, in turn, could serve as the “employer” for purposes of section 3(5) of ERISA and could establish an AHP without geographic limitations covering the employer members within the subgroup. In these circumstances, the provisions of the rule would apply at the subgroup level, including the control requirement in section (b), and the subgroups could rely on their membership in the national affinity group or association to satisfy the requirement that the subgroup have a substantial business purpose other than providing benefits. However, a test that would treat all nationwide franchises, all nationwide small businesses, or all nationwide minority-owned businesses, as having a common employment-based nexus – no matter the differences in their products, services, regions, or lines of work – would not be sufficient to establish commonality of interest for a national group or association and AHP because it would be impossible to define or limit

(e.g., business owners who support democracy) and, in the Department's view, would effectively eviscerate the genuine commonality of interest required under ERISA.

g. Nondiscrimination.

The Proposed Rule included certain nondiscrimination requirements that built on the existing health nondiscrimination provisions applicable to group health plans under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).³⁶ As explained in the preamble to the Proposed Rule, the HIPAA health nondiscrimination rules generally prohibit health discrimination in eligibility for benefits and premiums³⁷ 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 health nondiscrimination rules at 29 CFR 2590.702, generally provides that plans may, subject to an anti-abuse provision for discrimination directed at individuals, treat groups of 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 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

³⁶ See ERISA section 702 and 29 CFR 2590.702-1. This final rule generally refers to the HIPAA health nondiscrimination provisions in ERISA. Parallel provisions are included in the Code and PHS Act at Code section 9802, PHS Act section 2705, 26 CFR 54.9802-1 and 45 CFR 146.121. The Department notes that HIPAA was amended by the ACA in certain respects not relevant to this final rule.

³⁷ 29 CFR 2590.702(c)(3) provides that, notwithstanding the general nondiscrimination rule, a plan or issuer may vary premium or contribution amounts that it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies 29 CFR 2590.702(f).

for health coverage (e.g., determining eligibility for other employee benefits or determining other terms of employment). Examples in the HIPAA 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 the HIPAA health nondiscrimination rules at 29 CFR 2590.702(d)(3), 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.³⁸

In addition, under the HIPAA 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, with respect to children of a participant, 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 health nondiscrimination rules generally allow group health plans to treat participants and beneficiaries as distinct groups.

³⁸ The term health factor means, in relation to an individual, any of the following health status-related factors: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, or disability. Evidence of insurability includes conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities. ERISA section 702(a)(1); 29 CFR 2590.702(a). In the Department's view, "[t]hese terms are largely overlapping and, in combination, include any factor related to an individual's health." Nondiscrimination in Health Coverage in the Group Market; Interim Final Rules and Proposed Rules, 66 FR 1378, 1379 (Jan. 8, 2001).

The HIPAA nondiscrimination rules apply to group health plans, including AHPs. Therefore, AHPs, like any other group health plan, cannot discriminate in eligibility, benefits, or premiums against an individual within a group of similarly situated individuals based on a health factor. AHPs, like other group health plans, generally may make distinctions between groups of individuals based on bona fide employment-based classifications consistent with the employer's usual business practice, provided such distinction is not directed at individual participants or beneficiaries based on a health factor. Accordingly, as illustrated in examples in the final rule, an agricultural AHP may offer a different coverage package to dairy farmers than to corn growers, and a metropolitan AHP may offer different pricing to retailers than to restaurateurs, provided such distinctions are not directed at individual participants or beneficiaries based on a health factor.

The Proposed Rule proposed that, in applying the HIPAA health nondiscrimination rules for defining similarly-situated individuals, the group or association may not treat member employers as distinct groups of similarly-situated individuals if it wishes to qualify as a bona fide group or association for purposes of sponsoring an AHP. As noted above, the HIPAA health nondiscrimination rules apply within groups of similarly-situated individuals. If a bona fide group or association could treat different employer-members as different bona fide employment classifications, the preamble to the Proposed Rule said that the nondiscrimination protections in paragraphs (d)(1) through (d)(3) could be ineffective, as AHPs could offer membership to all employers meeting the group or association's membership criteria, but then charge specific employer members higher premiums, based on the health status of those employers' employees and dependents. Accordingly, the preamble to the Proposed Rule stated that a group or association that 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. The Department sought 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.

Many commenters strongly supported the proposed nondiscrimination provisions and urged that such provisions be retained in any final rule. Some commenters believed that the nondiscrimination provisions would provide important protection for AHP participants and beneficiaries and that they would reduce, if not eliminate, opportunities for AHPs to engage in risk selection. One commenter felt that prohibiting discrimination based on health factors alone is appropriate for AHPs because AHPs differ from single-employer plans which typically have steady enrollment based on the employer's workforce and do not see variability in the underlying demographics of the eligible versus enrolled population. The commenter speculated that allowing AHPs to make distinctions based on non-health factors would ensure that premiums and contributions will be sufficient to pay incurred claims and attract a mix of risk.

Numerous commenters also expressed support for the proposed restriction on AHPs treating different employers as distinct groups based on a health factor of an individual or individuals within an employer member. These commenters argued that this provision is essential for preventing AHPs from discriminating against at-risk populations and individuals with preexisting conditions. In their view, without this requirement, AHPs would also have an excessively unfair advantage over commercial insurance issuers offering coverage in the community rated small group and individual markets, which would lead to adverse selection and

increased premiums for non-AHP employer sponsored coverage. Many commenters urged DOL to go even further in a final rule because non-health factors such as age, gender, industry, occupation, and geography are closely related to health status and, in their view, rating on these criteria would actually be a pretext for discrimination based on health factors. These commenters stated that AHPs should be limited to the rating factors currently allowed in the small group market.

Other commenters argued that additional requirements are necessary and pointed to the fact that age, gender, occupation, and other characteristics are likely to affect an individual's claims experience but do not meet the definition of a health factor. Thus, the commenters stated, groups and associations that wish to be treated as a bona fide group or association and offer a group health plan may still be able to set criteria for membership and set rates in ways that favor healthier populations, because, for example, younger age correlates with lower healthcare expenditures. Commenters also asserted that the Proposed Rule could create an uneven playing field where AHPs were exempt from rating rules and nondiscrimination requirements applicable to health insurance issuers (especially those in the individual and small group markets) and could therefore exercise competitive advantages by charging more actuarially fair premiums. Such practices could encourage healthy groups to obtain AHP coverage while discouraging less healthy groups from doing so. As a result, premiums would likely rise for individuals and small employers with non-AHP coverage. Many of these commenters further suggested that these effects could be avoided if AHPs were made subject to some or all of the rating rules that apply to issuers in the individual and small group markets.

Other commenters argued that the proposed nondiscrimination provisions were too restrictive. With respect to paragraph (d)(4) of the Proposed Rule, which provides that different

employer members of a group or association offering an AHP may not be treated as distinct groups of similarly-situated individuals if the group or association wishes to qualify as bona fide, many commenters claimed that this provision presented a new regulatory restraint for existing AHPs and would discourage the formation and use of new AHPs. They argued that the provision would effectively prohibit AHPs from setting rates for each employer member based on prior or expected claims experience (“experience-rate”). Such rate-setting, they argued, is critical to AHPs’ ability to offer affordable coverage because a key component of balancing risk and creating a stable and sustainable plan is directly related to the ability to assign appropriate premiums through medical underwriting of each employer-member. The commenters asserted that if AHPs cannot separately experience-rate each employer member based on the health status of its employees, employers with healthier employees will leave the AHP to obtain better rates elsewhere, leaving the AHP with a less stable risk pool. Several commenters noted that it is common for existing AHPs to treat employer members as distinct groups of similarly-situated individuals and experience-rate each employer-member. Some commenters believed that requiring existing AHPs to comply with the proposed nondiscrimination rules could be so burdensome and disruptive that it would cause many AHPs to cease operations.

One commenter stated that omitting a risk adjustment mechanism to address differences in enrollees’ aggregate health conditions would make AHPs unstable and would lead to their failure. Another commenter argued that this would disincentivize large employers, whose plans can be experience-rated, from participating in an AHP unless their risk pool was significantly sicker than that of the AHP. Some commenters also stated that experience rating was necessary due to the fact that AHPs have a smaller risk pool as compared to a commercial insurer and without the ability to manage risk by experience rating, they will be unable to compete with

commercial issuers. Another commenter claimed that without the ability to experience-rate each member employer, AHPs would be left to compete with other coverage options on the basis of benefits, such as by offering less generous benefit packages to achieve lower prices. A few commenters were also concerned that the Proposed Rule could interfere with AHPs' ability to establish wellness programs by preventing AHPs from rewarding those groups that do participate, or by reducing the incentive to offer wellness programs.³⁹

Commenters also claimed that a prohibition against experience-rating was not necessary to distinguish AHPs from commercial insurance arrangements because the Proposed Rule retained the requirements of commonality and control. Also, several commenters pointed out that some States, including Washington and Kentucky, appear to allow such practices pursuant to laws and regulations applicable to MEWAs. Many commenters suggested that the Department should include a type of grandfather rule to accommodate AHPs that already use experience-rating for each employer-member, to prevent market disruption and burdens associated with coming into compliance with new rules that are inconsistent with long-standing business practices.

After considering the comments and feedback received from stakeholders, the Department is finalizing the proposed nondiscrimination provisions in paragraph (d) with one clarification and adding four new examples to illustrate the nondiscrimination provisions.⁴⁰ The

³⁹ The Department is not persuaded that AHPs will fail to offer wellness programs due to paragraph (d)(4). Paragraph (d)(4) does not preclude an AHP established under this final rule from offering a wellness program. Employers will retain many incentives to offer wellness programs, even though an AHP cannot rate the employer based on a health factor (e.g., reduced absenteeism and increased productivity).

⁴⁰ As explained elsewhere in the preamble, bona fide employer groups or associations and AHPs that meet the Department's pre-rule sub-regulatory guidance are not required to satisfy the standards of this final rule, including paragraph (d)(4) of this final rule, in order to be considered an employer under ERISA section 3(5) that can sponsor

final rules include an adaptation of the HIPAA health nondiscrimination rules for AHPs, but the Department declines to adopt additional rating requirements in this final rule. Federal rating rules that some commenters suggested should apply to AHPs are grounded in the PHS Act and apply to health insurance issuers in the individual and small group markets, but not to issuers in the large group market or to group health plans. Thus, these rules do not apply those Federal rating rules to self-insured AHPs, or to insured AHPs that have employer members with a total of more than 50 employees, as insurance coverage sold to the latter would generally be regulated as large group coverage.

Additionally, AHPs' ability to discriminate based on non-health factors is subject to State regulation. As discussed in more detail in section B.7., below (entitled "ERISA Preemption and State Regulation of AHPs"), under ERISA section 514, States maintain significant authority to impose additional rating rules on insured AHPs through regulation of the underlying insurance policies obtained by AHPs to fund the benefits they provide, and may also impose similar requirements for self-insured AHPs.

The Department understands the concerns raised by commenters regarding the importance of allowing AHPs to experience-rate each employer member but has decided to keep paragraph (d)(4), with one clarification and several new examples to illustrate the circumstances

a single group health plan. The pre-rule sub-regulatory guidance had a stronger employer nexus requirement in that geography, alone, was not sufficient to establish commonality, and working owners without common law employees were not permitted to participate in the plan. Accordingly, whether a single plan MEWA that meets the Department's pre-rule sub-regulatory guidance can treat employer members as distinct groups of similarly-situated individuals depends on whether the creation or modification of the classification is directed at individual participants or beneficiaries based on a health factor. For example, if the classification was implemented to single out individual participants and beneficiaries based on a health factor and deny them health coverage, the classification would not be permitted under the HIPAA health nondiscrimination rules. 29 CFR 2590.702(d)(3). See also 29 CFR 2590.702(d)(4) Example 5.

under which an AHP could charge different premiums to different member employers under paragraph (d)(4). As explained in the preamble to the Proposed Rule, paragraph (d)(4) was intended to distinguish bona fide AHPs from commercial arrangements that more closely resemble State-regulated private insurance offered to the market at large, a distinction the Department viewed as especially important with the broadening of the employment nexus requirement. See, e.g., Advisory Opinion 94-07A; Advisory Opinion 2001-04A.⁴¹ As discussed earlier in this document, Congress did not intend to treat commercial insurance products marketed by private entrepreneurs, who lack the close economic or representational ties to participating employers and employees, as ERISA-covered welfare benefit plans.⁴²

Accordingly, as noted above, the touchstone of the Department's analysis 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. Only groups or associations that have such a nexus can be appropriately treated as sponsors of ERISA-covered plans, as opposed to commercial insurance providers. Moreover, when plans are sponsored by employers, or by groups or associations that have the requisite connection or commonality, there is less cause for concern about fraud, because an employer or group or association with the requisite commonality pursues objectives—e.g., maintaining a satisfied workforce or advancing the well-being of a particular industry or economic community—that could be imperiled by fraud. Because the final rule relaxes the Department's pre-rule guidance on the groups or associations that may sponsor a single ERISA-covered group health plan, it is especially important to

⁴¹ See AO 94-07A at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/1994-07a and AO 2001-04A at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2001-04a.

⁴² See *supra* footnote 4.

maintain paragraph (d)(4) as proposed. In the context of these new, broader arrangements, paragraph (d)(4) ensures that the group or association is distinguishable from commercial-insurance-type arrangements, which lack the requisite connection to the employment relationship and whose purpose is, instead, principally to identify and manage risk on a commercial basis. Such an AHP that provides benefits for employer members (including working owners without employees), but classifies each of them as distinct groups of similarly-situated individuals that can be experience-rated or otherwise discriminated against based on a health factor, may be more comparable to a commercial insurance issuer.

An important purpose of the commonality of interest test is to ensure that the members of the group or association are bound by a common interest as employers, as reflected in the uniform treatment of members based on their common nexus. Generally, one of the primary benefits of participation in a group health plan is that required premiums and contributions, as well as benefits, are determined for groups of similarly-situated individuals and individual employees cannot be singled out. Absent paragraph (d)(4), the rating practices of AHPs forming under the broader nexus test could too closely resemble medically-underwritten individual or small employer market commercial-type insurance coverage.

At the same time, the final rule clarifies that AHPs are not precluded from making distinctions between employer members in all circumstances. Several commenters asked the Department to confirm that paragraph (d)(4) of the Proposed Rule would not have prevented an AHP from charging employer members different premiums or contributions based on non-health factors, such as age, case size, industry, and gender. According to these commenters, many AHPs may fail without the ability to make these distinctions. Distinctions based on a factor other than a health factor (such as industry, occupation, or geography) are permitted, provided

they are not directed at individual participants or beneficiaries based on a health factor of one or more of those individuals. This clarification is consistent with the HIPAA health nondiscrimination rules. AHPs could draw distinctions based on non-health attributes of a particular member employer (e.g., the industry or region in which it operates) or based on non-health factors of a member employer's workforce (e.g., adjusting the member employer's rate based on the employees' occupations within the member).⁴³

New examples seven through nine in the final rule illustrate some circumstances under which an AHP could charge different premiums to different member employers while complying with paragraph (d)(4) of the final rules. These examples draw on the bona fide business classification principles set forth in the HIPAA health nondiscrimination rules.⁴⁴ For this reason, AHPs will be permitted to charge different premiums to different member employers in much the same way that a single large employer could charge different premiums to employees in different operating divisions, locations, or occupations within the company, but may not make distinctions in premiums that a single large employer could not make. The final rule thus continues to maintain the important distinction between rating approaches that are appropriate for AHPs and those that are used by commercial insurers.

⁴³ Under HIPAA, employer members could then pass through the different premium charges to their employees based on these same non-health factors.

⁴⁴ As discussed earlier in this preamble, examples in the HIPAA 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 locations, 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 the HIPAA health nondiscrimination rules at 29 CFR 2590.702(d)(3), 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.

New example 10 was also added to make clear that the wellness program provisions of the HIPAA health nondiscrimination rules at 29 CFR 2590.702(f) apply. The wellness program provisions permit plans to vary benefits (including cost-sharing mechanisms, such as a deductible, copayment, or coinsurance), and the amount of premium or contribution they require similarly situated individuals to pay, based on whether an individual has met the standards of a wellness program that satisfies the HIPAA health nondiscrimination rules. The HIPAA health nondiscrimination rules generally permit rewards of up to the 30 percent of the total cost of coverage under the plan, except that the percentage is increased by an additional 20 percentage points (to 50 percent) to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use. Moreover, the total cost of coverage for such purpose is generally determined based on the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the plan may use the total cost of the coverage in which an employee and any dependents are enrolled. In either case, the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

3. Working Owner Provision

a. Treatment of Working Owners as Employers and Employees

A number of commenters, including many associations and working owners (such as farm owners, realtors and court reporters) strongly supported the “working owner” provision of the Proposed Rule. These small business owners noted that while most Americans get their health coverage through an employer, self-employed professionals without common law

employees are forced to purchase insurance in the more volatile individual insurance market, which tends to offer fewer choices at much higher costs. These commenters said that the working owner provision will offer sole proprietors and other self-employed individuals without employees more flexibility in insurance plan design, improved negotiating power, and lower cost health coverage. The Department agrees that allowing working owners such as sole proprietors to participate in AHPs covered by ERISA will give additional coverage options to certain individuals who may not currently have access to affordable health coverage. In the time since the Department first issued sub-regulatory guidance on bona fide groups or associations, increasing numbers of workers fall into these categories.⁴⁵ The final rule is responsive to these changes in the composition of the workforce and to the needs of that workforce.

Other commenters opposed the working owner provision and argued that allowing working owners without employees to participate in AHPs, and even permitting an AHP to consist entirely of such individuals, would harm the small group and individual markets. These commenters expressed concern that such AHPs would be able to design and market plans with the result that a disproportionate number of healthy individuals might shift out of ACA-compliant individual markets and small group markets, resulting in increased rates and decreased choice in those markets. These commenters also argued that allowing working owners without

⁴⁵ The number and proportion of U.S. workers with at least some degree of self-employment or working-ownership has been increasing for some time. See for example: Emilie Jackson, Adam Looney, and Shanthi Ramnath, “The Rise of Alternative Work Arrangements: Evidence and Implications for Tax Filing and Benefit Coverage,” U.S. Department of the Treasury, Office of Tax Analysis Working Paper 114 January 2017, <https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/WP-114.pdf>; Steven F. Hipple and Laurel A. Hammond, “Self-employment In The United States,” U.S. Bureau of Labor Statistics Spotlight on Statistics, March 2016, <https://www.bls.gov/spotlight/2016/self-employment-in-the-united-states/pdf/self-employment-in-the-united-states.pdf>; and Katharine G. Abraham, John C. Haltiwanger, Kristin Sandusky, and James R. Spletzer, “Measuring the Gig Economy: Current Knowledge and Open Issues,” March 2, 2017, <https://aysps.gsu.edu/files/2016/09/Measuring-the-Gig-Economy-Current-Knowledge-and-Open-Issues.pdf>.

employees to be considered “employers” under ERISA section 3(5) would upset existing DOL guidance and court decisions. Specifically, these commenters asserted that the Department has consistently taken the position in sub-regulatory guidance that where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of employer status (such as working owners and self-employed individuals without common law employees), and where control of the group or association is not vested solely in employer members, the group or association is not a group or association of employers within the meaning of ERISA section 3(5).

Some commenters also noted that the Proposed Rule would have permitted an AHP to consist entirely of working owners. They complained that it was an impermissible reading of ERISA for the Department to conclude that a plan with no common law employees was an employment-based plan that Congress intended to be regulated under ERISA. They cited the U.S. Supreme Court decision in Nationwide Mutual Insurance Co. v. Darden, 503 U.S. 318 (1992), as supporting that argument. They asserted that even where a working owner participates in an AHP with unrelated persons who are common law employees, there still is no employment-based nexus sufficient for that working owner to be treated as a plan participant.

Additionally, some commenters argued that the inclusion of “working owners” in the definition of “employer” is in conflict with the ACA. Specifically, they argued that Congress, in adopting the ACA, was aware of the existing case law and the Department’s sub-regulatory guidance, and intended to retain that legal structure, as reflected in the ACA’s inclusion of various protections for individual market participants. In particular, they point to ACA definitions of the individual, small group, and large group markets (42 U.S.C. 18024) that continue to provide that owners of businesses who have no employees cannot qualify for group

coverage (although the ACA permitted small group coverage for groups that included only one employee other than the owner). They claim that adopting the working owner provision as part of the final rule would violate the ACA.

The Department disagrees. As described in the preamble to the Proposed Rule, the working owner provision is consistent with the Department's longtime recognition that working owners should be able to participate in ERISA-covered plans. See Advisory Opinion 99-04A (various ERISA and Code provisions "reveal a clear Congressional design to include 'working owners' within the definition of 'participant' for purposes of Title I of ERISA.'). The Department also explained in the preamble to the Proposed Rule that the policy underlying its regulation at 29 CFR 2510.3-3, which excludes "plans without employees" from the definition of employee benefit plans covered by Title I of ERISA, was not to prevent working owners from participating in ERISA covered plans, but to confirm that ERISA does not mandate that a working owner incur costs to comply with reporting and disclosure, fiduciary, and enforcement provisions that serve no practical purpose in the context of a plan run by and covering only the working owner and spouse. In the case of an AHP, however, many or most of the affected employers and employees will not be directly involved in the administration of the AHP or the provision of benefits, and would benefit from ERISA's prudence and loyalty requirements for those administering 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.

The working owner provision in the rule also is consistent with longstanding conclusions the Department has reached that address the operational impracticalities of having a plan alternate between being ERISA and non-ERISA coverage as a result, for example, of a sole

proprietor sometimes having common law employees and sometimes not based on business cycles, or a person who was a common law employee participating in the plan becoming an independent contractor of the member employer. See, e.g., DOL Advisory Opinion 99-04A (acknowledging that nothing in the definition of Title I of ERISA precluded a working owner who had initially participated in a plan as an employee of a contributing employer from continuing to participate in the plan).

The Department also does not believe that the U.S. Supreme Court decision in Darden precludes it from including the working owner provision in this rule. The Darden Court did not address the validity of an agency rule promulgated after notice and comment defining “employer” or “employee” under ERISA. It also must be read in the context of the specific issue the Court was addressing (an attempt to disqualify an individual from receiving benefits) and the fact that the “expectations” test advocated by the plaintiff would have severely undermined ERISA purposes insofar as it would have “severely compromise[d] the capacity of companies to figure out who their ‘employees’ are and what, by extension, their pension-fund obligations will be.” Id. at 327. In the subsequent case Yates v. Hendon, 541 U.S. 1 (2004), the Court clarified 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.” Id. at 14.

Also, unlike the issue in Darden, there are other provisions of ERISA and related federal laws governing employee benefit plans that address the ability of working owners to act both as employer members of groups or associations and to participate as employee participants in AHPs. The varying treatment of working owners in Title I, Title II, and Title IV of ERISA

establishes that the statute allows the Department, where appropriate, to treat a working owner as having dual status as an “employer” and “employee.”⁴⁶

Moreover, the Department’s treatment of working owners as such does not violate the ACA. The PHS Act definitions (which were added to the PHS Act by HIPAA and later amended by the ACA and the Protecting Affordable Coverage for Employees Act⁴⁷ (PACE Act)) all specifically incorporate the ERISA definitions of employer, employee, and employee welfare benefit plan under ERISA sections 3(5), (3)(6), and 3(1), respectively, by reference. Under all of the ACA provisions, related to whether coverage is in the individual or group market, who is an employer (and who is an employee) is determined under ERISA section 3(5).

Accordingly, although a working owner without common law employees generally would not meet the PHS Act definition of a small employer (and, thus, would generally have to purchase insurance in the individual market, to the extent he desired coverage), such a working owner participating in a group or association that meets the ERISA section 3(5) definition of an employer would be counted as an employee of the single group or association employer, which allows him to obtain group health coverage through the AHP. The final rule makes explicit that working owners without common law employees may qualify as both an employer and as an employee for purposes of participating in an AHP. HHS has reviewed this final rule and has advised the Department that nothing in the PHS Act precludes the Department from amending its

⁴⁶ Congress in HIPAA itself expressly provided for dual status treatment of partners and other working owners in defining group health plans covered by Part 7 of Title I of ERISA, which encompasses plans that cover only sole proprietors and spouses. See ERISA section 732(d) and PHS Act 2721.

⁴⁷ Pub. L. 114-60 (2015).

interpretation of the definition of an employer under ERISA section 3(5), and that it concurs with this interpretation of PHS Act section 2791(d)(6) in light of this final rule.⁴⁸

b. Working Owner Definition and Verification of Working Owner Status

As in the Proposed Rule, the working owner criteria in the final rule are designed to ensure that a legitimate trade or business exists, because ERISA governs benefits provided in the context of a work relationship, as opposed to the mere marketing of insurance to individuals unrelated to their status as employees in a trade or business and any benefits they obtain through that status. Thus, a group or association would fall outside the purview of the final rule if it offered coverage to persons who are not genuinely engaged in a trade or business (e.g., a group or association offering AHP coverage could not make eligibility for “working owners” turn on such de minimis “commercial activities” as merely registering with a ride sharing service or 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 engage in the supposed “trade or business” ever again). The rule is intended to cover genuine work relationships, including self-employment relationships, not to permit individual coverage masquerading as employment-based coverage.

The Department also solicited comments on whether the criteria in the proposed standard were workable, 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

⁴⁸ One commenter stated that the PHS Act definitions supersede ERISA in that ERISA section 715(a)(2) provides that, to the extent any provision of “this part” conflicts with a provision of part A of title XVII of the PHS Act with respect to group health plans or health insurance issuers, then the provisions of the PHS Act shall apply. First, the reference to “this part” is to the provisions of Part 7 of ERISA, which does not include section 3(5) of ERISA. Moreover, the Department does not agree there is a conflict between the PHS Act definitions that cross-reference ERISA in any case.

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.

The Proposed Rule's definition of "working owner" required that the individual either work at least 30 hours per week or 120 hours per month providing services to the trade or business, or have 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 beneficiary in the group health plan. The Proposed Rule also expressly would have allowed the group or association sponsoring the group health plan to rely on written representations from the individual seeking to participate as a working owner as a basis for concluding that these conditions are satisfied.

The Department received comments stating that the final rule should (1) retain requirements for minimum hours worked or income; (2) include a verification or audit process to confirm that participating working owners meet eligibility requirements and confirm that issuers may separately verify that working owners meet eligibility requirements as a condition of providing insurance coverage; and (3) clarify that issuers will be held harmless in the event of fraudulent enrollments of working owners.⁴⁹

With respect to the verification process, some commenters said that the Proposed Rule would allow working owner enrollment in an AHP based on the mere attestation that the

⁴⁹ Some commenters urged that the final rule make clear that the AHPs are not required to include working owners in their plans and, therefore, are permitted to exclude working owners from their AHPs. The Department believes the final rule leaves groups or associations with substantial flexibility to determine their own membership requirements, including whether to include working owners. If groups or associations decide to include working owners they can also set criteria for working owner participants that are more stringent than the minimum criteria in the final rule, provided such criteria are consistent with the applicable nondiscrimination provisions under paragraph (d) of this final rule.

individual is actually a “working owner,” without a requirement that the AHP take steps to confirm this basic element of eligibility. Some commenters argued that such an attestation approach invites abuse and does not ensure an adequate employment nexus as required by ERISA. Those commenters suggested that, if the Department decided to retain the working-owners provision in the final rule, the Department should strengthen the verification requirements to ensure that these individuals 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. Other commenters suggested that the Department should include a requirement in the final rule that the working owners have been in business for a certain number of years before joining the AHP.

The Department notes as a preliminary matter, that the attestation provision was included in the Proposed Rule to reduce compliance burdens and potential liability exposure in the case of errors or failures. Plan fiduciaries have an obligation under ERISA to take steps to ensure that only eligible individuals participate and receive benefits under the plan. In carrying out that responsibility, ERISA section 404(a)(1)(B) requires fiduciaries to make eligibility determinations “with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use” The Department agrees with commenters that a written representation from an individual that he or she meets the working owner conditions, without more, may be insufficient in some cases and even could lead to abuses. The Department revised the final rule to eliminate that provision. In its place, the final rule offers flexibility, but clarifies that plan fiduciaries have a duty to reasonably determine that the conditions of paragraph (e)(2) are satisfied and monitor continued eligibility for coverage under the AHP. The Department recognizes that there are various ways

that fiduciaries could establish prudent processes for making working owner (and other eligibility) determinations, and it would not be appropriate for the Department to establish a one-size-fits-all process under this final rule. For instance, in the Department's view, a reasonable determination could involve the fiduciary relying on the accuracy of the information in written documentation or a sworn statement submitted by a working owner, without independent verification, unless something in the written document or sworn statement, or other knowledge of the fiduciary, would cause a reasonable fiduciary to question the accuracy or completeness of the documentation. Nothing in the final rule precludes groups or associations sponsoring AHPs from establishing their own, separate verification processes and requirements for working owners, or any employer or employee, as a condition of membership in the group or association. Similarly, health insurance issuers doing business with AHPs could establish a verification and monitoring requirement as part of the insurance policy or an administrative service arrangement with the AHP.

Commenters stated that the Proposed Rule's "hours worked" provision should be modified to take into account that many industries include workers that do not have a defined work schedule that results in a steady and predictable 30-hour work week or 120-hour month. One commenter noted that in its industry, over 15% of working owners work fewer than 30 hours per week and make less than \$10,000. The commenter also suggested that the provision should also provide for workers who are reducing their hours, as they make a transition out of their former job. Another commenter suggested that the final rule include a "variable" worker provision allowing flexibility in making an hours-worked determination to address situations in which a working owner's time performing services for his business can often vary due to various industry, seasonal, and other business and market factors, and said it would be particularly useful

to owners of start-up businesses and other newly formed entities. The Department agrees that the “hours-worked” criterion could be made more flexible without impairing the objective of limiting the provision to self-employed individuals who are genuinely engaged in a trade or business. Accordingly the final rule reduces the hours-worked provision to an average of 20 hours per week or 80 hours per month. A working owner could demonstrate this by evidence of a work history or a reasonable projection of expected self-employment hours worked in a trade or business. For this purpose, consistent with the principles of the gig economy, hours worked in a trade or business can be aggregated across individual jobs or contracts. Therefore, for example, an on-demand driver could aggregate hours driven using different ride assignment technology platforms. (Similarly, wages earned could be aggregated so that, for example, a pianist could aggregate money earned teaching piano lessons and money earned while giving performances.)

The Proposed Rule stated that the earned income standard and other group health eligibility provisions 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. (In the final rule, the term “self-employment income” replaces the term “earned income” that was used by the Proposed Rule.)⁵⁰ Accordingly, in applying the working owner provisions of paragraph (e) of the final rule, AHPs may rely on the definitions of “wages” and “self-employment income” in Code sections 3121(a) and 1402(b) (but without regard to the exclusion in section 1402(b)(2)), respectively.

⁵⁰ In paragraph (e)(2)(iii)(B) of the final rule, the words “wages or self-employment income” replace “earned income” to conform this paragraph to language in paragraph (e)(2)(ii) of the final rule. This change is to eliminate the use of inconsistent terminology in these two paragraphs and to avoid confusion.

Concerns about the potential liability of issuers with respect to ineligible individuals wrongly treated as working owners would invariably depend on the particular facts and circumstances involved, including contractual provisions establishing the parties' respective rights and obligations. Accordingly, the final rule does not include any provision on that subject.⁵¹

Section 2510.3-5(e)(2)(iii) of the Proposed Rule would have provided that an individual would not be treated as a "working owner" if the individual was eligible to participate in any subsidized group health plan maintained by any other employer of the individual or the individual's spouse. Many commenters opposed this provision. Some argued that coverage available through a separate employer or through a spouse's employer may not be the most affordable option for a family, the AHP coverage may in fact provide more comprehensive coverage than that made available by a separate employer, and that the provision in the Proposed Rule would result in a "marriage penalty" that is not applied to other employers or their employees. These commenters also noted that this requirement would be very hard to enforce and would require the fiduciary of the AHP to establish a verification process that would add unnecessary complexity and burden to the working-owner provision. For example, commenters said that they did not believe the Department intended that eligibility for "excepted benefits"

⁵¹ Some commenters asked the Department more generally to address the liability of the respective parties to the AHP for violations of the nondiscrimination provisions in the rule, general ERISA reporting and disclosure requirements and fiduciary rules, Code section 4980H and the related Code sections 6055 and 6056 reporting requirements, Form W-2 reporting, COBRA compliance, and "all of the other responsibilities that come with the maintenance of a single large employer plan." With regard to the provisions under the Department's jurisdiction, the Department does not believe this document is the appropriate place to address these questions because they also will invariably depend on the application of the particular law involved and the particular facts and circumstances of each case. The Code provisions listed are under the jurisdiction of Treasury and the IRS and are outside the scope of this rulemaking; stakeholders should refer to the relevant Code sections and guidance thereunder.

would be disqualifying. Excepted benefits generally provide only limited health coverage (e.g., dental-only coverage, vision-only coverage, certain employee assistance plans, or fixed indemnity coverage) or are generally not primarily health insurance coverage (e.g., accidental death and dismemberment or automobile coverage).⁵² Those commenters said that if “excepted benefits” coverage was not disqualifying, administrators of AHPs would not only have to monitor for group health coverage but would also have to make determinations on whether the coverage was limited to excepted benefits. Other commenters pointed out that the Proposed Rule did not include any guidance on how administrators would address situations when a working owner or a working owner’s spouse is offered or loses subsidized coverage during the middle of the year.

After consideration of the public comments, the Department agrees that the condition is not a good indicator of whether a working owner is involved in a legitimate trade or business, as opposed to engaged in de minimis “commercial activities” that cannot fairly be classified as meaningful self-employment. Accordingly, the subsidized health coverage provision in the Proposed Rule is not adopted as part of the final rule.

4. Essential Health Benefits and Comprehensive Coverage Requirements

Many commenters opposed the Proposed Rule on the grounds that because AHPs will generally be insured in the large group market or be self-insured, AHPs would not be subject to the requirement to provide EHBs, which only applies to non-grandfathered individual market

⁵² See ERISA section 733. See also Preamble to Health Insurance Portability for Group Health Plans; Interim Rules, explaining that there are four types of excepted benefits and that “category 1” benefits, for example, automobile insurance, liability insurance, workers compensation and accidental death and dismemberment coverage, are generally not “health insurance coverage” and are excepted in all circumstances. The other three categories are considered health insurance (for example, limited scope dental and vision benefits, employee assistance programs) and are excepted only if certain conditions are met. 62 FR 16894, 16903 (April 8, 1997).

and small group market insurance coverage. Commenters raised the possibility that AHPs would seek to deliver low premiums by providing benefits that are not as comprehensive as other coverage options available to working owners and small employers. They asserted that the Proposed Rule could lead to adverse selection in the individual and small group markets because healthier groups and working owners could be attracted to AHPs providing minimal benefits because of the lower costs, while less healthy groups and working owners would seek out more robust coverage in the individual and small group markets. This could lead to less stable risk pools in the individual and small group markets, rising premiums, and cascading effects that could leave certain markets without any active health insurance issuers. Further, they stated that AHPs offering comprehensive benefits may also be disadvantaged, as healthy members could leave to join lower-cost AHPs (and return when their medical needs increase). Commenters noted that certain populations with specific needs, such as those with disabilities, could be disproportionately affected if their coverage does not include a robust level of benefits. Some of these commenters suggested that in order to mitigate these effects, the Department should require AHPs to provide EHBs or some other minimum level of benefits, or require them to provide “minimum value” within the meaning of Code section 36B(c)(2)(C)(ii) and 26 CFR 1.36B-6.⁵³

Other commenters acknowledged concerns that AHPs may provide inadequate benefits but did not believe that legitimate membership organizations would risk their goodwill and reputation by offering such health plans. Instead, they argued that economies of scale would

⁵³ Unless otherwise specified, the Department interpreted commenters’ use of “minimum value” to refer to the term as used in Code section 36B(c)(2)(C)(ii) and 26 CFR 1.36B-6, which generally means that the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and that the plan also provides substantial coverage for inpatient hospitalization and physician services. See also 45 CFR 156.145.

enable AHPs to offer more comprehensive coverage to their members than they would be able to purchase on their own. Another commenter noted that even though self-insured plans and large group market policies are not required to provide EHBs, most do, in fact, provide comprehensive coverage.

The Department declines to adopt commenters' recommendations to make the provision of EHBs in an AHP a condition for a group or association to qualify as bona fide. Such a mandate would run contrary to the goal of leveling the playing field between small employers in AHPs, on the one hand, and large employers, on the other, who generally are not subject to the EHB requirements. Furthermore, such a mandate could reduce AHPs' flexibility to tailor coverage to the particular needs of the members of the group or association offering the benefits, and thereby reduce access to AHPs by making them less attractive options for providing affordable coverage. For this reason, the Department also declines to require the provision of minimum value coverage as a condition for a group or association to qualify as bona fide. The ability to design AHP benefit packages and set cost-sharing requirements without the burden of certain Federal restrictions is critical to enabling AHPs to provide an additional, more affordable coverage option to small businesses and working owners who may otherwise have been unable or unwilling to obtain higher-priced coverage. Moreover, the Department believes that concerns regarding adverse selection as result of AHPs not providing comprehensive coverage are overstated because we agree with those commenters who asserted that AHPs are not likely to offer relatively low levels and scope of benefits, which could jeopardize their relationship with their members and because other federal and State coverage requirements may apply.

The Department notes that for those AHPs that choose to offer coverage to employers that are applicable large employers subject to the employer shared responsibility provisions of

Code section 4980H, the participating applicable large employers face the possibility of having to make an employer shared responsibility payment if the AHP does not provide minimum value coverage.⁵⁴ AHPs also remain subject to Federal and State laws other than EHB requirements that require the provision of certain benefits. For example, AHPs must provide coverage for certain recommended preventive services without the imposition of cost-sharing.⁵⁵ These services include:

- (1) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved;
- (2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be “in effect” after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention;
- (3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- (4) With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

In addition, Title VII of the Civil Rights Act (as amended by the Pregnancy Discrimination Act and administered by the Equal Employment Opportunity Commission

⁵⁴ See Code sections 36B and 4980H.

⁵⁵ See PHS Act section 2713, which is incorporated in ERISA section 715 and Code section 9815.

(EEOC)) generally provides that pregnancy-related expenses for employees and their spouses must be reimbursed in the same manner as those incurred for other medical conditions.⁵⁶

Many AHPs, or the insurance coverage that insures them, will also be subject to State benefit mandates. The State of Pennsylvania, for example, requires policies issued in the large group market to cover in-patient and out-patient services for severe mental illness, inpatient and outpatient services for substance use disorders, autism services, childhood immunizations, and mammography.⁵⁷ These types of State mandates may apply to fully-insured AHPs through the health insurance policies they purchase. In addition, under ERISA's provisions saving State regulation of MEWAs from preemption, States may also extend benefit mandates to self-insured AHPs.

Some commenters also expressed concern that the maximum out of pocket limit (MOOP) under PHS Act section 2707(b) (incorporated into ERISA section 715) and the prohibition of lifetime and annual dollar limits under PHS Act section 2711 (also incorporated into ERISA section 715) only apply with respect to EHBs. These commenters were generally concerned that in the absence of these protections, AHPs would impose burdensome cost-sharing requirements or annual and lifetime limits for critical benefits, such as mental health care, substance-use

⁵⁶ 29 CFR 1604.110(b); EEOC Enforcement Guidance: Pregnancy and Related Issues, No. 915.003 (June 25, 2015), available at https://www.eeoc.gov/laws/guidance/pregnancy_guidance.cfm. Moreover, the protections of the Newborns' and Mothers' Health Protection Act contained in section 9811 of the Code, 711 of ERISA, and section 2725 of the Public Health Services Act generally provides, if plans cover hospital stays in connection with childbirth, that plans must provide hospital stays of at least 48 hours (or 96 hours in the case of a caesarian section) following delivery.

⁵⁷ See 40 P.S. sections 764g, 908-2, 764h, 3502, 764c. (For a list of state benefit mandates, see generally the Center for Consumer Information & Insurance Oversight Information on Essential Health Benefits (EHB) Benchmark Plans available at <https://www.cms.gov/ccio/resources/data-resources/ehb.html>; or see http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx#State_EHB_2016).

disorder services, prescription drugs, and maternity services, in an effort to drive down costs, as had happened in the pre-ACA insurance market.

While group health plans that are offered in the large group market or are self-insured are exempt from the requirement to offer EHBs, all non-grandfathered group health plans are subject to the MOOP and the prohibition on annual and lifetime dollar limits on EHBs. Accordingly, to the extent a plan covers EHBs, the MOOP and annual and lifetime dollar limits provisions apply.⁵⁸ As such, if an AHP covers a benefit that would be considered an EHB, the AHP must count an individual's out-of-pocket spending for in-network provision of that benefit toward the MOOP; any EHBs in excess of the MOOP must be covered without cost-sharing.⁵⁹ Similarly, if an AHP covers any benefits that would be considered an EHB, all such benefits must be covered without any annual or lifetime dollar limit.

5. Application of ERISA Group Health Plan Requirements to AHPs

An AHP sponsored by a bona fide group or association under this final rule is a group health plan and an employee welfare benefit plan under ERISA. Accordingly, the AHP is subject to all ERISA provisions applicable to group health plans and employee welfare benefit plans, including Title I of ERISA.

⁵⁸ For more information regarding the application of the MOOP and prohibition of lifetime and annual limits for plans not subject to the requirement to provide EHBs, see 29 CFR 2590.715-2711(c); See also Q10 of Frequently Asked Questions on Essential Health Benefits Bulletin, available at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

⁵⁹ See Frequently Asked Questions about Affordable Care Act Implementation, Part XII, Q2 (February, 22, 2014), available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html and Frequently Asked Questions about Affordable Care Act Implementation, Part XVIII Q2, (January 9, 2014), available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xviii.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html.

Some commenters expressed concerns about the Proposed Rule on the broad assumption that AHPs would be exempt from various consumer protections included in ERISA and other Federal laws, including changes made by the ACA, and that the rule would lead to a diminution in rights and protections for AHP participants. As the Department explained in the Proposed Rule, the primary purpose of allowing more flexibility for groups or associations to sponsor AHPs is to expand access to affordable health coverage, especially among small employers and working owners – many of whom currently do not provide health benefits to their workers – by removing undue restrictions on the establishment and maintenance of AHPs. However, as noted above, an AHP offered by a bona fide group or association under this final rule remains a group health plan under ERISA and participants in AHPs are entitled to the same protections under ERISA that are available to participants in single employer group health plans.

Some commenters requested that the Department provide clarification with respect to the application of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the COBRA continuation coverage requirements. Specifically, because these requirements include an exemption for employers with a certain number of employees, commenters inquired whether it was the total number of employees of the separate participating member-employers or the number of employees of employers, collectively, participating in the bona fide group or association that matters for purposes of determining whether the requirements apply to an AHP.

Generally, MHPAEA requires that financial requirements and treatment limitations for mental health and substance use disorder benefits must be no more restrictive than those placed

on medical and surgical benefits. MHPAEA provides an exemption for group health plans for “any plan year of a small employer.”⁶⁰ Under ERISA section 712(c)(1)(B), a small employer is defined as an employer who employed between 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) and 50 employees on business days during the preceding calendar year. As one commenter observed, because the ERISA provisions of MHPAEA provides a definition of a “small employer” that makes no reference to the separate definition of an “employer” under ERISA section 3(5), some AHP operators may try to argue that the definition refers to the common law definition of employer, rather than the definition in ERISA section 3(5), and that an AHP is, therefore, exempt if all the participating employer-members meet the definition of “small employers.”

MHPAEA amended ERISA, the Code, and the PHS Act and is subject to joint interpretive jurisdiction by the Departments of Labor, the Treasury, and HHS (collectively, the Departments).⁶¹ For purposes of ERISA, the Department interprets the term “small employer,” as specified in ERISA section 712(c)(1)(B) to mean an “employer” of a certain size, using the ERISA definition of “employer” in section 3(5). The Department has consulted with HHS, which has advised the Department that it uses the same interpretation for purposes of applying the MHPAEA small employer exemption in the PHS Act.⁶² Accordingly, for a bona fide group or association, the determination of whether MHPAEA applies under ERISA and the PHS Act depends on the size of the AHP, which generally would be based on the number of employees

⁶⁰ ERISA section 712(c)(1).

⁶¹ See HIPAA section 104. See also Memorandum of Understanding 64 FR 70164 (Dec. 15, 1999).

⁶² The Code does not reference the ERISA definition of employer. For purposes of determining applicability of, and potential for excise taxes under, the Code, interested parties should contact the Internal Revenue Service.

employed in the aggregate during the preceding calendar year by the employer members of the bona fide group or association. This interpretation is consistent with the approach described earlier in this preamble of treating AHPs like large employers.

COBRA provides for a temporary continuation of group health coverage that would otherwise be lost due to certain life events, but does not apply to a group health plan for any calendar year if “all employers maintaining such plan normally employed fewer than 20 employees” on a typical business day during the preceding calendar year.”⁶³ Commenters asked for clarification on how the law would apply to those employers with fewer than 20 employees that joined a bona fide group or association whose member employers, collectively, employ 20 or more employees. The coverage provisions of the COBRA continuation coverage requirements are within the interpretive jurisdiction of Treasury and the IRS. The Department will consult with Treasury and the IRS and anticipates future guidance on the application of COBRA to such plans.

6. Application of Federal Laws Other than ERISA to AHPs

a. Application of Federal Healthcare Laws

Numerous commenters requested that the Department provide clarifications with respect to the application of a wide variety of Federal laws and regulations that are not grounded in ERISA but may implicate or apply to AHPs. Examples include the employer shared responsibility provisions, premium tax credit eligibility rules, network adequacy standards, the Pregnancy Discrimination Act of 1978, other federal nondiscrimination laws, and Medicare secondary payer rules.

⁶³ ERISA section 601.

The Department considers these comments to be beyond the scope of this rulemaking. In setting out additional criteria for determining whether an employer group or association can act as an employer within the meaning of ERISA section 3(5) for purposes of sponsoring a single group health plan for its employer-members, the intent of this final rule is to expand the number of organizations that are eligible to sponsor an AHP. However, many AHPs currently exist and therefore the interaction between AHPs and the various laws and regulations discussed by these commenters are not a consequence of this rule. Further, these laws and regulations are not within the Department's interpretive jurisdiction and therefore any guidance provided would be outside the scope of its regulatory authority.

b. Use of Voluntary Employees' Beneficiary Associations (VEBAs)

A VEBA is a type of tax-exempt organization that could be used by employee welfare benefit plans, including multiple employer welfare benefit plans, to hold plan assets.⁶⁴ The VEBA rules are administered by the IRS and are outside the interpretive jurisdiction of the Department. Some commenters argued that conditions in the Proposed Rule conflict in several ways with IRS guidance regarding the use of VEBAs, and expressed concern that the differences could limit the expansion of AHPs. The commenters noted in particular that VEBA regulations may require that membership consist of individuals who are employees and who have an employment-related common bond, and the way for a fund covering employees who work for multiple employers to meet this requirement is for the employees participating in a VEBA to work for employers in the same line of business in the same geographic locale. This differs from

⁶⁴ See Code section 501(c)(9). An organization described in Code section 501(c)(9) is exempt from tax under Code section 501(a).

the Proposed Rule, which allowed employer groups to be in the same industry or the same geographic locale. They also noted that an organization including working owners who did not have common law employees may not meet VEBA requirements under which no more than 10% of the VEBA members can be sole proprietors and other working owners. The commenters requested that the Department work with the IRS on harmonizing the VEBA requirements with those of AHPs. Commenters also suggested that IRS issue guidance treating membership in a group or association sponsoring an AHP pursuant to the Department's rule as similar to membership in a labor union by employees, and to regard employer participation in the group or association as having a sufficient employment-related common bond to use a VEBA trust in connection with the AHP.

The Department acknowledges that applicable IRS guidance regarding the use of VEBAs sets out different criteria for employer groups and associations that seek to establish and use those arrangements than this final rule sets out for sponsorship of a group health plan under ERISA. Although VEBAs are often a convenient way for multiple employers to fund certain employee welfare benefits in a tax-advantaged environment, VEBAs are not the sole vehicle for funding of multiple employer plans. To the extent that an employer group or association that offers an AHP chooses to use a VEBA in connection with the AHP, the arrangement must comply with applicable VEBA requirements. For more information on the use of VEBAs and the process for obtaining an IRS determination on VEBA status under Code section 501(c)(9), see 26 CFR 1.501(c)(9)-1 through -8, and Revenue Procedure 2018-5 (or latest update).

c. AHPs and Joint Employer Status under Federal Laws

Commenters requested that the Department should include language to ensure that employers, including franchisors whose franchisees participate in an AHP, are not considered

joint employers under ERISA or the Fair Labor Standards Act (FLSA). Similarly, commenters requested clarification that a person or entity who contracts with individuals as independent contractors does not, by participating in an AHP with independent contractors, facilitating formation or operation of an AHP by independent contractors, or promoting an AHP for those independent contractors, become the employer of the independent contractors. The commenters argued that the question of who is an “employer” or “joint employer” carries significant legal consequences because of the increasing prevalence of independent contractor and other third-party relationships in today’s workplace, such as those between a business and a contractor’s employees, or between a corporate parent and its franchisees’ workers. The commenters said that the legal test for employment or joint employment under the FLSA has become less clear, with many tests for employer or joint employer liability looking to a variety of factors. There may also be increased risk of joint liability under ERISA section 510 for a franchisor. Commenters claimed that the potential increased risk for expanded employer or joint-employer liability could limit the expansion of AHPs. Some commenters requested, on similar grounds, that we clarify that franchisors assisting in the start-up and ongoing administration of an AHP involving their franchisees and entities providing similar assistance in connection with AHPs for independent contractors would not be grounds for finding joint employer status.

The employer group or association provision in ERISA section 3(5) merely authorizes separate employers to maintain a single plan to provide benefits to their separate employees. It does not impose any independent employer obligation upon businesses with respect to the employees of other employers that obtain benefits under the plan. Participation in an AHP does not involve any agreement between employers to share employee services, or any sharing of direct or indirect control of an employee or independent contractor or his or her employment. By

participating in an AHP, the individual participating employers also are not acting directly or indirectly in the interest of the other individual employers in relation to an employee, or in the interest of any independent contractor who may participate in the AHP as a working owner. Although the group itself may be acting in the interest of the participating employers in sponsoring the AHP, that is not analogous to one individual employer acting in the interest of another individual employer with respect to an employee or in the interest of an independent contractor. The individual employers are not, by reason of participating in the AHP, involved in hiring, firing, disciplining, setting rates or methods of pay, maintaining records, controlling, or directing and supervising the work of the other participating employers' employees or of independent contractors. Therefore, nothing in the final rule is intended to indicate that participating in an AHP sponsored by a bona fide group or association of employers gives rise to joint employer status under any federal or State law, rule, or regulation. The final rule also should not be read to indicate that a business that contracts with individuals as independent contractors becomes the employer of the independent contractors merely by participating in an AHP with those independent contractors, who would participate as working owners, if applicable, or promoting participation in an AHP to those independent contractors, as working owners.

7. ERISA Preemption and State Regulation of AHPs

The Department received many comments, including from State insurance regulators, expressing the view that it is very important that the final rule not undermine or impair the current ERISA preemption provisions that broadly permit States to regulate AHPs under State insurance laws and regulation. The commenters expressed concern about a history of abuses involving unlicensed entities that compete with State-licensed health insurance issuers, but are

exempt from many of the solvency standards and consumer protections that apply to traditional issuers in the State-regulated individual and small-group markets. These commenters argued that AHPs operating in multiple States should be required to abide by the regulations of each of the States in which the plan is providing health care coverage, and not just the State in which the group or association or their AHP is deemed to be domiciled.

Commenters expressed concerns about potential abuses that could arise if AHPs were exempt from consumer protections that apply to entities marketing and selling insurance in their States. The commenters cited cases of healthcare arrangements purporting to be AHPs that left State residents with unpaid claims for their healthcare when the purported AHP failed, or the operators of the arrangement left the State. Some commenters stated that the States have a relatively strong oversight record and existing mechanisms to protect against fraud. These commenters noted that State officials and the insurance agents they regulate serve as “eyes on the ground” to detect and report fraudulent schemes in their local markets. Another commenter suggested that the final rule should distinguish self-insured AHPs, which have historically presented problems in the market, from fully-insured AHPs, which are backed by licensed health insurance issuers and subject to oversight by State insurance commissioners and HHS. A few commenters asked that the Department promulgate a rule under ERISA section 520 which authorizes the Department to make persons operating AHPs subject to otherwise preempted State insurance laws to prevent fraud and abuse, before we finalize the AHP regulation, in order to give the Department an additional oversight and enforcement tool.

The main point of these commenters was that the Department should make it clear that the final rule in no way limits the ability of States under State insurance laws to regulate AHPs, health insurance issuers offering coverage through AHPs, and insurance producers marketing

that coverage to employees. In particular, they requested that the Department make a clear and unequivocal statement that States retain full authority to set and enforce solvency standards for all AHPs, and comprehensive licensure requirements and oversight for non-fully-insured AHPs including benefit, rating and consumer protection standards, and laws specifying who is eligible to apply for licensure.

The Department agrees that the final rule does not modify or otherwise limit existing State authority as established under section 514 of ERISA. If an AHP is fully insured, ERISA section 514(b)(6)(A)(i) provides that State laws that regulate the maintenance of specified contribution and reserve levels (and that enforce those standards) may apply, and State insurance laws are generally saved from preemption when applied to health insurance issuers that sell policies to AHPs and when applied to insurance policies that AHPs purchase to provide benefits. In addition, in the case of fully-insured AHPs, it is the view of the Department that ERISA section 514(b)(6) clearly enables States to subject AHPs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of State insurance law necessary to ensure compliance with the State insurance reserves, contributions and funding obligations. Furthermore, under this framework, if an AHP established pursuant to this final rule is not fully insured, then, under section 514(b)(6)(A)(ii) of ERISA, any State law that regulates insurance may apply to the AHP to the extent that such State law is “not inconsistent” with ERISA.

Some commenters oppose continued application of State insurance laws, stating that navigating the varying or contradictory standards of multiple States has made it difficult for AHPs to actually operate across State lines. For example, some expressed concern about State MEWA statutes that prohibit participation across different industries, prohibit self-employed

individuals from being covered by MEWAs, and prohibit MEWAs from operating in the State if established solely for the purpose of obtaining or providing insurance. Some commenters noted that several States currently prohibit AHPs from self-insuring. These commenters say that the varying State laws prevent AHPs from providing uniform insurance and healthcare coverage across State lines. Some of these commenters support broader Federal oversight and regulation of self-insured AHPs rather than joint Federal-State regulation.⁶⁵ Others support applying only the laws of one State, such as the State in which the AHP is domiciled.

Several commenters asserted that the Proposed Rule was unclear or in direct conflict with State law, such as group size calculations used to determine the applicability of pooling, loss ratio, community rating, and essential health benefit requirements. These commenters requested that the Department render an opinion, or opinions, as to whether such laws (such as benefit mandates, rating rules, and licensing and registration requirements, among others) would be superseded by or because of the final rule.

The Department declines the invitation of the commenters to opine on specific State laws. The provisions in ERISA section 514 are clear and well established, and both the Department's interpretations and federal court rulings generally have upheld such State laws when they have been challenged as preempted by ERISA. The final rule is not the appropriate vehicle to issue

⁶⁵ One commenter recommended that the Department establish a federal oversight board to, among other things, review and approve benefit designs for AHPs and to establish caps on annual premium rate increases. According to this commenter, such a federal board also could provide notice to participants if there are material changes in benefit levels or coverage under the AHP. A different commenter recommended that the Department establish a high-risk pool or other reinsurance mechanism to provide support to the individual and small group markets that would be affected by the final rule. The Department lacks the statutory authority to establish an oversight board of the type described by the commenters. It also lacks the statutory authority to establish a high-risk pool or other reinsurance mechanism. Further, even if such steps were within the Department's authority, the suggested actions are beyond the scope of this rulemaking, and at least some of the concerns underlying the comments may be better addressed through application of existing State insurance laws or amendments of State insurance laws.

opinions on whether any specific State law or laws would be superseded because of the final rule.

Several commenters recommended that the final rule establish competency standards for persons offering or operating AHPs, and minimum funding requirements for self-insured AHPs. A few commenters encouraged the Department to require a criminal background check of each fiduciary of any self-insured AHP, and a cap on broker compensation for self-insured AHPs. Other commenters suggested that the final rule require self-insured AHPs to meet risk-based capital requirements to ensure the group or association has the capital necessary to support overall business operations, and to engage an insurance underwriter.

As noted above, some commenters called for an increased federal role in regulating AHPs as an alternative to state insurance regulation. One commenter stated that while the states should be responsible for enforcement of standards provided in the final rule, the Department should have the authority to intervene. Other commenters emphasized the need for increased coordination between the states and DOL to evaluate the financial resources of AHPs and protect consumers against fraud and abusive practices. Other commenters noted that DOL should take enforcement action against AHPs that fail to file timely and complete M-1 forms with the Department, and one commenter suggested that all self-insured AHPs should be required to register with the federal government.

Among the commenters arguing for an increased federal role, some urged the Department to use its authority under section 514(b)(6)(B) of ERISA to exempt AHPs from aspects of State insurance law. Most of these commenters focused on the potential benefits of uniform standards, and the need for interstate AHPs to be free of potentially overlapping, cumbersome, different, or contradictory patchworks of regulations that, they asserted, could be so detrimental to the

operation of multi-state AHPs as to prevent them. Some commenters suggested that the Department could replace state protections by crafting an exemption with additional federal consumer protections that AHPs must comply with as a condition of the exemption.

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 by class, from certain State insurance regulations. ERISA section 514(b)(6)(B) does not, however, give the Department unlimited exemption authority. Significantly, ERISA section 514(b)(6)(B) does not give the Department any authority to exempt any fully-insured AHP from any state insurance laws that can apply to a fully-insured MEWA plan under ERISA section 514(b)(6)(A). Furthermore, section 514(b)(6)(B) does not allow the Department to exempt self-insured AHPs from state insurance laws that can be applied to fully-insured AHPs, i.e., laws related to reserve and contribution requirements that must be met in order for the fully-insured MEWA plan to be considered able to pay benefits in full when due, and provisions to enforce such standards. Notwithstanding these limitations, ERISA section 514(b)(6) provides a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule. But, as noted in the Proposed Rule, doing so at this time lies outside the scope of this proceeding.

While no state is required by Federal law to take legislative action in order to regulate AHPs, many states regulate AHPs and other MEWAs under their general insurance statutes while others have chosen to adopt MEWA-specific insurance laws. For example, under some state insurance laws, a self-insured MEWA is subject to the state's general insurance laws and regulations applicable to licensed health insurance issuers unless the state has adopted a specific

MEWA licensing law. To guard against fraud and abuse, a number of States provide that self-insured MEWAs must be licensed, registered, have a minimum number of participating employers, obtain an actuarial opinion that the MEWA can meet promised benefits and require that the MEWA keep a minimum level of reserves.⁶⁶ DOL anticipates close cooperation with State regulators to guard against fraud and abuse.

8. ERISA Fiduciary Status and Responsibilities of AHP Sponsors

Several commenters asked the Department to provide guidance on fiduciary liabilities and responsibilities of a bona fide group or association that sponsors an AHP and clarify that any individual charged with the operation or management of an AHP is considered a fiduciary under ERISA. They stressed that it is important for groups and associations that sponsor an AHP to understand that they are obligated to protect the interests of the participants of the plan, and may be held individually liable if they fail to do so. Some of the commenters also requested the Department to clarify who will be responsible for ensuring compliance with ERISA and other federal requirements, such as COBRA compliance, ERISA reporting and disclosure requirements, compliance with certain requirements under the Code, compliance with the nondiscrimination requirements under paragraph (d) of this final rule and all of the other responsibilities that come with the maintenance of a single large employer plan.

An AHP offered by a bona fide group or association under the final rule is subject to all of the ERISA provisions applicable to group health plans, including the fiduciary responsibility and prohibited transaction provisions in Title I of ERISA. The Department notes that the bona

⁶⁶ See e.g., CA Ins. Code, Art. 4.7; TX Ins. Code sec. 3.95-2; Rev. Code of WA sec 48.125.020.

fide group or association that sponsors the AHP assumes and retains responsibility for operating and administering the AHP, including ensuring compliance with these requirements.⁶⁷

Several commenters requested that the Department clarify that all notice requirements applicable to ERISA group health plans apply to AHPs, including the Summary of Benefits and Coverage (SBCs) and Summary Plan Description (SPDs), as well as notices under FLSA section 18B, which is imposed on the employer, rather than the plan. Commenters also requested that the Department require AHPs to disclose to employer groups and potential beneficiaries if they do not provide specific consumer protections or benefits the covered customers would have otherwise received in the traditional insurance market, including a comparison to EHBs, whether dollar limits apply to any benefit, whether the plan provides minimum value, and the right to receive coverage on the health insurance Exchanges. Other commenters requested that the Department coordinate with State regulators regarding the content of any notices to avoid confusion and excessive administrative costs.

As group health plans, AHPs are subject to the disclosure requirements of Title I of ERISA. This includes the requirement to provide an SPD, Summary of Material Modifications (SMMs) and Summaries of Material Reductions in Covered Services or Benefits (SMRs).⁶⁸ The AHP's SPD must disclose, in a manner calculated to be understood by the average plan participant, the participants' rights and obligations under the plan. The SPD must include, among other requirements, a description of the cost-sharing provisions, limits on benefits, and

⁶⁷ Some commenters suggested that the final rule should set limits on compensation that may be received by plan fiduciaries and brokers. The Department declines this suggestion, and notes that the fiduciary responsibility provisions in Part 4 of ERISA already establish rules and requirements for service provider compensation and other expenses of administering a plan, including a requirement that service providers receive no more than reasonable compensation for their services. See ERISA section 408(b)(2) and 29 CFR 2550.408b-2.

⁶⁸ See 29 CFR 2520.104b-2, 2520.104b-3(a), (d)(3).

the extent to which preventive services, prescription drugs, and medical tests, devices and procedures must be covered under the plan.⁶⁹ The AHP must also furnish a Summary of Benefits and Coverage and Uniform Glossary under PHS Act section 2715, as incorporated into ERISA by section 715. PHS Act section 2715 requires plans and issuers to provide to applicants, enrollees and policyholder or certificate holders a Summary of Benefits and Coverage (SBC) that describes the benefits and coverage under the plan. The current SBC template requires a plan to disclose whether it meets minimum value standards, how it covers benefits, including prescription drugs, maternity care, mental health and substance abuse services, and any limitations, exceptions and other important information (such as dollar limits).

The AHP also must describe services that it does not cover or excludes. The SBC must be provided to participants and beneficiaries as part of any written application materials distributed to participants and beneficiaries, or (if no written application materials are distributed) no later than the first date a participant is eligible to enroll in coverage. This ensures that participants and beneficiaries have the opportunity to familiarize themselves with the terms of their coverage before they enroll. The SBC must also be provided by the first day of coverage if there are changes; upon special enrollment; upon renewal, reissuance or reenrollment (either when application materials are provided or no later than 30 days prior) and within seven business days upon request.⁷⁰ The AHP is subject to a fine if it fails to provide the SBC as required by law. 26 CFR 54.9815–2715(e); 29 CFR 2590.715-2715(e); and 45 CFR 147.200(e). Similarly, those employers who participate in an AHP and are subject to the FLSA must provide a notice at

⁶⁹ 29 CFR 2520.102-3(j)(3).

⁷⁰ Special rules for duplication apply. See 26 CFR 54.9815–2715(a)(1)(iii); 29 CFR 2590.715-2715(a)(1)(iii), and 45 CFR 147.200(a)(1)(iii).

the time of hiring notifying an employee of the existence of an Exchange, the availability of premium tax credits if the employer plan fails to cover 60% of the total allowed costs and that if the employee purchases a qualified health plan through the Exchange, he or she may lose the employer contribution to any health benefit plan, which may be excludable from income. FLSA section 18B. As ERISA-covered group health plans, AHPs are subject to numerous other disclosure requirements.⁷¹

In addition, AHPs are MEWAs and, as such, are subject to existing federal regulatory standards governing MEWAs. Sponsors of AHPs will need to exercise care to ensure compliance with those standards, including those established in the ACA.

The ACA also expanded reporting and required registration for MEWAs with the Department. MEWA registration requirements require plan and non-plan MEWAs to file Form M-1s under ERISA section 101(g) and 29 CFR 2520.101-2. All AHPs under the final rule will be MEWAs and, as MEWAs, required to file the Form M-1 regardless of the plan size or type of funding. Further, all employee welfare benefit plans that are MEWAs subject to the Form M-1 requirements, including AHPs under the final rule, will be required to file the Form 5500, regardless of the plan size or type of funding. In addition, the ACA added new criminal penalties under ERISA section 519 for any person who knowingly submits false statements or makes false representations of fact about the MEWA's financial condition, the benefits it provides, or its regulatory status as a MEWA in the marketing of a MEWA. The ACA also

⁷¹ See, e.g., ERISA sections 104(b), 502(c), 503, 712(a)(4) and 715; PHS Act sections; 2719; 2719A; 29 CFR 2520.104b-1, 2560.503-1, 2590.712(d)(3) and 2590.715-2719. To assist with compliance, a summary of EBSA's reporting and disclosure requirements for employee benefits plans may be found at www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/reporting-and-disclosure-guide-for-employee-benefit-plans.pdf.

amended ERISA section 501(b) to impose criminal penalties on any person who is convicted of violating the prohibition in ERISA section 519.

Thus, as ERISA-covered plans and MEWAs, AHPs will be subject to comprehensive disclosure requirements. In light of these existing requirements, the Department does not believe adding new, and potentially redundant, disclosure requirements on AHPs of the sort suggested by some commentators is necessary or advisable at this time based on the record before the Department. Thus, the final rule does not include any special disclosure requirements on bona fide groups or associations of employers that sponsor AHPs or on AHPs established pursuant to the final rule. As noted elsewhere in this document, the Department intends to work with state insurance regulators on overall implementation of the final rule, including the interaction of any applicable state insurance law disclosure requirements with the disclosure requirements applicable to group health plans, such as AHPs, under Title I of ERISA.⁷²

C. Economic Impact and Paperwork Burden

1. Summary

This final rule is intended to facilitate the creation and maintenance of AHPs to offer more affordable health insurance to small businesses, including working owners. Millions of Americans are working owners of small businesses, employees of small businesses, or are family members of such working owners or employees. Too many have unaffordable options for health insurance or lack health insurance altogether. By revising the Department's rules and promoting

⁷²The Department intends to reexamine existing reporting requirements for AHPs/MEWAs, including the Form M-1 and possibly the Form 5500, and may be asked to propose class or individual prohibited transaction exemptions for AHPs that want to use affiliates to serve as their administrative service providers or act as issuers providing benefits under the AHP.

formation of AHPs for small businesses and working owners, this final rule will make affordable health insurance available to many of these people, including a substantial number who would otherwise be uninsured.

Many employer groups or associations have a thorough knowledge of the economic challenges that their members face. Using this knowledge and the regulatory flexibility provided by this final rule, AHPs may tailor health coverage to better meet the needs of their members at lower and more actuarially fair prices⁷³ than plans currently available in the small group and individual health insurance markets under the ACA and state laws applicable to those markets. Thus, this final rule will increase the choice of affordable health coverage available to many small businesses, including working owners. Small businesses may use some of the economic gains that they will reap from affordable AHP health coverage to raise pay, hire more employees, and invest in new equipment, structures, and intellectual property, all of which contributes to economic growth.

AHPs will pursue economies of scale by encouraging more small businesses and working owners to band together to (1) make health coverage design and purchasing decisions; and (2) provide administrative functions. Like large health insurance issuers, AHPs with large shares in local healthcare markets may exercise bargaining power with local healthcare providers and achieve economies of scale in purchasing healthcare services. AHPs sponsored by geographically-based, multi-industry organizations, which the final rule authorizes, are more likely than AHPs sponsored by industry-based organizations with widely scattered memberships,

⁷³ For purposes of this document, “actuarially fair” generally means that coverage is priced so that the premium paid by an individual or business reflects the risks associated with insuring the particular individual or business covered by that policy.

which the Department’s current pre-rule guidance allows (and this new regulation will continue to permit), to garner sufficient numbers of insured in local healthcare markets to achieve such economies of scale.

There are many well-established, geographically-based organizations, such as local chambers of commerce, that lend themselves to sponsoring AHPs, but generally cannot under the Department’s pre-rule guidance. Such organizations can, and sometimes do, help their members purchase health insurance policies in the individual and small group markets. However, the ACA and state laws and regulations governing individual and small group markets limit both the propensities of such organizations to undertake group purchasing of health insurance and the economies of scale that such organizations can achieve from group purchasing. This final rule will enable such geographically-based organizations to sponsor AHPs that will provide or purchase health insurance for their small business members through the more lightly regulated large group market. Moreover, the final rule will also encourage newly formed employer organizations to sponsor AHPs, and will enable AHPs to extend membership to working owners.

Fully-insured and self-insured AHPs established under this final rule generally will be subject to federal benefit mandates that apply to the large group insurance and self-insured ERISA-covered markets, respectively.⁷⁴ AHPs established under this rule will also be subject to substantial nondiscrimination rules. State laws and regulations may, to a varying degree, impose additional benefit mandates and pricing restrictions. At the same time, however, AHPs formed under this rule will not be subject to federal mandates (e.g., the ACA’s ten categories of EHBs)

⁷⁴ This discussion of “economic impact and paperwork burden” addresses AHPs that enjoy sufficient participation to constitute large groups. Such large AHPs are expected to account for the overwhelming majority of AHP enrollment. Smaller AHPs’ impacts would be different and are not considered here.

and federal pricing rules (e.g., modified community rating rules) that apply exclusively to the individual and small group insurance markets. Placing AHPs in the same regulatory environment as large employers will help small employers to tailor their benefits packages resulting in plan designs that more accurately reflect the coverage and pricing that some small businesses and their employees may value.

Relative to health insurance issuers in the individual and small group markets under ACA and state laws applicable to those markets, AHPs established under this final rule can use their regulatory flexibility to design more tailored, less comprehensive health coverage and set more actuarially fair prices that generally are lower for lower risk groups and higher for higher risk ones, provided the prices comply with applicable nondiscrimination standards. This regulatory flexibility in design and pricing will necessarily lead to some favorable risk selection toward AHPs and adverse selection against individual and small group markets.

To the extent that small businesses that use AHPs avoid paying forced cross subsidies to the ACA-compliant individual and small group markets (and thereby reap economic gains), premiums in those ACA-compliant markets will increase. Individual policy holders with household incomes at or below 400 percent of the federal poverty level generally will be protected from these premium increases (i.e., by premium tax credits), but higher-income individuals and small businesses that lack attractive, affordable AHP options will not. Facing premium increases, small businesses and working owners that remain in the ACA-compliant individual and small group markets may drop insurance or be less able to invest, hire, and grow.

In the past, some AHPs and other MEWAs suffered from mismanagement and abuse, leading to unpaid claims and loss of coverage. Congress, the Department, and states have made progress combatting MEWA abuse and will continue their efforts as AHPs become more

prevalent in response to this rule. AHPs with tighter ties to, and that are more controlled by, employer members are likely to be more insulated from mismanagement and abuse. The final rule requires certain minimum such ties and control in order to reduce operational risks. Nonetheless, risks remain.

The final rule in effect broadens the flexibility of states to tailor their laws and regulations to their local market conditions and policy preferences. The ACA has constrained this flexibility with respect to health insurance in the individual and small group markets. AHPs present an opportunity for states to make affordable health coverage options that the ACA has otherwise foreclosed available to small businesses, including working owners. States' long experience regulating individual and small group markets and close-in knowledge of local market conditions position states to optimize AHPs' role.

Overall, and as discussed more fully below, the Department has concluded that this rule delivers social benefits that justify any attendant social costs.

2. Relevant 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 final rule is economically significant within the meaning of section 3(f)(1) of the Executive Order. Therefore, OMB has reviewed the rule pursuant to the Executive Order.

The background to the rule is discussed earlier in the preamble. This discussion assesses the rule’s expected impacts.

3. Introduction and Need for Regulation

Presently, U.S. households obtain health benefits from a number of different private and public sources. Essentially all individuals age 65 or older are covered by Medicare; many poor individuals under age 65 are covered by Medicaid; and 60 percent of individuals under age 65 have employer-sponsored coverage. Nearly all large employers offer health coverage to their employees, but only about one-third of employers with fewer than 50 employees do. Thirty-seven percent of individuals under age 65 obtain coverage from private employers with 50 or

more employees, nine percent from smaller private employers and 13 percent from governmental employers. Another nine percent purchase individual policies.⁷⁵

Today, businesses generally purchase health insurance in one of three market segments, depending on their size. These segments are: (1) the individual market, which includes working owners if they are not covering employees and therefore cannot establish a group health plan, other individuals, and their families; (2) the small group market, for small employers; and (3) the large group market, which generally includes employers with more than 50 employees. Many large employers self-insure rather than purchase group insurance in the large group market.

Relative to large employers, small businesses purchasing health insurance in the individual and small group markets generally face at least two inherent economic disadvantages. First, owing to their small size, working owners and other small businesses lack very large employers' potential for administrative efficiencies and negotiating power. Second, unlike large businesses, individual small businesses do not constitute large, naturally cohesive risk pools. Any single small business's claims can spike abruptly due to one serious illness. Relative to large employers, small businesses also face more rigorous regulatory requirements. The ACA imposes requirements in the individual and small group health insurance markets that do not apply in the large group market or to self-insured plans. For example, the ACA imposes adjusted community rating rules and mandates coverage of ten categories of EHBs.⁷⁶ These requirements, which aimed to make comprehensive coverage affordable for individuals and

⁷⁵ Population statistics are from 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. Employer statistics are from the Medical Expenditure Panel Survey, Insurance Component, available at https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2016/tia2.pdf.

⁷⁶ See PHS Act sections 2701, 2702, and 2707(a).

small businesses with high expected or actual claims, generally have caused adverse selection by limiting choice and raising premiums for those who do not expect to have high medical needs.

While some AHPs exist today, before the issuance of this final rule, their reach was limited by the Department's prior interpretation of the conditions when an AHP constitutes an employer-sponsored plan under ERISA. Under the prior interpretation, eligible group or association members had to share a common interest (usually, in practice, operate in the same industry) and genuine organizational relationship, join together for purposes other than providing health coverage, exercise control over the AHP, and have one or more employees in addition to the business owner in order for the group or association to qualify as bona fide. Absent any one of these criteria, AHPs were treated not as single, large-group plans, but as issuers or distributors of separate individual, small-group, and/or large-group policies to participating members, based on the status or size of the member. The prior interpretation precluded an AHP's potential advantage of allowing small businesses and working owners to tailor benefit packages under largely the same rules available to large employer plans. Instead, the prior interpretation forced AHPs not meeting the requirements of the prior interpretation to subject their members to different rules, depending on the members' status as an individual working owner, or small or large employer, diminishing any potential for administrative cost savings. Accordingly, after consideration of public comments on the Proposed Rule, the Department is publishing this final rule, which broadens the conditions under which an AHP will be treated as a single large group plan. As a result, the number of small businesses eligible to participate in such AHPs will increase, and many Americans will have new, affordable employment-based health coverage options.

The final rule generally does this in four important ways. First, it relaxes the requirement that group or association members share a common interest, as long as they operate in a common geographic area, in order for the group or association to qualify as bona fide. Second, it confirms that groups or associations whose members operate in the same trade, industry, line of business or profession can sponsor AHPs under the final rule, regardless of geographic distribution. Third, it clarifies the existing requirement that bona fide groups or associations sponsoring AHPs must have at least one substantial business purpose unrelated to the provision of benefits. Fourth, it permits AHPs that meet the final rule's new requirements to enroll working owners without employees. Consequently, for example, the final rule would newly allow a local chamber of commerce that meets the other conditions in the rule to offer AHP coverage to all of its members, including self-employed working owners, based on having their principal places of business within a single state or metropolitan area. This rule does not supplant the Department's previously issued sub-regulatory guidance, which in effect generally permits an AHP to condition each employer member's premiums on its employees' collective health status factors, as long as such rating complies with the HIPAA nondiscrimination requirements, including the requirement that it does not single out one or more individuals based on their health. On the other hand, an AHP providing health coverage under this final rule must not treat the employees of an employer member as a distinct group of similarly-situated individuals based on the employees' health factors. (Such an AHP may, however, treat employees of subsets of employer members as distinct groups of similarly situated individuals based on bona fide employment-based classification based on other, non-health factors, such as its industry or location, or its employees' ages or genders, or occupations.)

4. Increased Choice

Under this final rule, AHPs will be able to offer many small businesses more attractive and affordable health coverage options than are currently available to them in the ACA-compliant individual and small group markets. These options will include tailored plans that omit certain benefits that some small businesses and their employees may prefer to forgo in return for reduced cost. Small businesses taking advantage of these tailored options may accrue economic advantages for themselves and their employees.

Absent this final rule, many small businesses' health coverage choices would be more limited. Under existing ACA federal and state rules, non-grandfathered individual and small group insurance policies generally must provide coverage for ten categories of EHB, and meet certain other benefit standards, for example with respect to actuarial value, and network adequacy. These limits, which are not applicable to large employer plans, hamper the ability of many small employers to offer benefits packages tailored to their needs. Under this final rule, AHPs generally will be subject to the same, more flexible rules to which large employer plans are subject, consistent with leveling the federal regulatory playing field between small and large employers. The Department notes, however, that AHPs and large employers differ with respect to their economic incentives, and the Department does not expect that their behavior will be the same. For instance, AHPs generally will have incentives to tailor benefits to appeal to lower-risk groups – an incentive that large employers generally do not share, as discussed below.

AHPs established under this final rule will be able to match more closely the preferences of many small businesses and often of their employees for the design and price of health coverage than health insurance issuers can in ACA-compliant individual and small group markets. Such closer matches generally will improve the welfare of AHP members. For example, a working owner opting for less comprehensive coverage can devote the attendant

savings to uses he or she values more, and will be less apt to overuse medical care (although possibly at more risk of forgoing beneficial care). The same can be said of small business employees whose employer switches from an ACA-compliant small group policy to more affordable AHP coverage that better matches employer and employee preferences on the optimal mix of wages and health benefits and the composition of health benefits.

Some comments expressed concern that AHPs, by offering more tailored, less comprehensive coverage that appeals mostly to less costly groups, will raise the price of comprehensive policies for some small businesses that prefer them, and generally erode choice and affordability for consumers limited to the ACA-compliant individual and small group markets.⁷⁷ Some comments additionally expressed concern that AHPs, by offering less comprehensive coverage and increasing the cost of more comprehensive coverage offered by

⁷⁷ The American Academy of Actuaries commented that “flexible benefit rules could allow AHPs to create plans more attractive to lower-cost groups, resulting in positive selection (and lower premiums) for AHPs and adverse selection (and higher premiums) for ACA plans.” The comment pointed to potentially less comprehensive coverage of rehabilitative and habilitative services (including chiropractic, physical therapy, and other therapies) and behavioral health services, and to narrower drug formularies. (See comment letter from the American Academy of Actuaries, February 9, 2018, (Comment # 106 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00106.pdf>.) According to another public comment, AHPs can be expected to behave like unregulated individual and small group issuers, in that they will “offer more limited coverage packages that appeal distinctively to particular demographics or health profiles.” (See comment letter from Mark A. Hall, Professor of Law and Public Health, Wake Forest University School of Law, Feb 16, 2018, (Comment # 146 on EBSA webpage last accessed at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85>.) Another commenter notes that “AHPs stand to gain from using [benefit design] to avoid very high-cost enrollees and attract people who cost less to cover.” (See comment letter from the Center on Budget and Policy Priorities, March 6, 2018 (Comment # 537 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00537.pdf>.) According to another commenter, before the ACA required coverage of EHB, individual policies covered little or no maternity services, often excluded or limited mental health coverage, and often lacked pharmacy coverage. See comment letter from the Consumers Union, March 1, 2018 (Comment # 294 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00294.pdf>). One existing AHP publicly markets its ability “to design plan and deductible options, and keep costs low since MEWAs are not subject to some of the Affordable Care Act’s (ACA) mandated benefits.” See MEWA FAQs question three from the Council of Smaller Enterprises available at: <http://www.cosemewa.com/~media/Files/PDF/COSE/MEWA/2017/112116%20COSE%20Helath%20and%20Wellness%20Trust%20FAQ%20V3%20Dec%2014%20pdf.pdf?la=en>.

others, will erode access to needed healthcare services. Some comments recommended that the Department address these concerns by requiring AHPs to cover EHB and satisfy other ACA and state benefit standards. Some comments expressed concern that AHPs would reduce choice for some small businesses by increasing premiums in individual and small group markets and possibly prompting some insurers to withdraw offers in those markets. Even some businesses joining AHPs may in fact have preferred offers that are no longer available because of AHPs. The Department believes that these concerns are justified by the economic advantages that will accrue to the small businesses to which AHPs will offer more attractive choices.⁷⁸

The Department notes that AHPs operating under this final rule, like other large group plans, though not subject to the requirement to cover EHB and other requirements applicable only to issuers in the small group and individual markets, are in fact subject to some other significant benefit mandates. These include, for example, a ban on charging participants and beneficiaries higher premiums because they have a pre-existing health condition; a ban on denying coverage of an otherwise covered but pre-existing health condition; a requirement that if the plan offers dependent coverage it must do so for dependent children up to age 26; a ban on annual or lifetime dollar limits on EHB that the plan covers; for non-grandfathered plans, a requirement to cover certain preventive health services without cost-sharing; special enrollment rights (for example, upon marriage or birth of a child); for non-grandfathered plans, caps on out-of-pocket expenses for covered EHB; prohibitions on waiting periods for coverage that exceed

⁷⁸ For some discussions of the potential benefits of increased choice of health plans, see Bundorf, M. Kate, Jonathan Levin, and Neale Mahoney. 2012. "Pricing and Welfare in Health Plan Choice." *American Economic Review*, 102 (7): 3214-48. <https://www.aeaweb.org/articles?id=10.1257/aer.102.7.3214>; and Dafny, Leemore, Kate Ho, and Mauricio Varela. 2013. "Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and toward an Individual Exchange." *American Economic Journal: Economic Policy*, 5 (1): 32-58.

90 days; for non-grandfathered plans, additional protections for selection of in-network primary care providers, pediatricians, and OB/GYNs without referral and without prior authorization; non-grandfathered plan protections for coverage of emergency room services; protections for coverage of post-breast-cancer-surgery benefits; protections for the length of a hospital stay in connection with childbirth (if such stay is a covered benefit under the plan),⁷⁹ and procedural protections governing appeals of denied health claims (for non-grandfathered health plans, this also includes external review). These mandates place significant constraints on AHP benefit designs, but leave ample room for AHPs to offer more tailored, less comprehensive, and more affordable health coverage than is available in ACA-compliant individual and small group markets.⁸⁰

This final rule in effect broadens states' flexibility to tailor their local market rules to their local market conditions and policy preferences. The ACA, in particular, had constrained that flexibility with respect to individual and small group insurance. Expanded AHPs under this rule present an opportunity for states to make available to their local small businesses affordable health coverage options that the ACA had otherwise foreclosed. States' long experience

⁷⁹ ERISA does not mandate coverage of maternity benefits. However, Title VII of the Civil Rights Act (as amended by the Pregnancy Discrimination Act and administered by the EEOC) generally applies to employers with 15 or more employees and provides that pregnancy-related expenses for employees and their spouses must be reimbursed in the same manner as those incurred for other medical conditions. Historically many individual insurance policies and some policies for very small plans limited or excluded coverage for maternity care, in order to limit adverse selection. AHPs covering employers with 15 or more employers would need to ensure compliance with Title VII in connection with such coverage, and, though not required to do so, may, for administrative simplicity and other reasons, offer maternity benefits to all participants and beneficiaries regardless of a member employer's size. Some AHPs covering only working owners and very small plans may exclude coverage of such services. For more information regarding Title VII, contact the EEOC. In addition, other State law provisions may apply.

⁸⁰ One commenter acknowledged concerns that AHPs may offer less comprehensive benefits, but stated that legitimate membership organizations would not risk their goodwill and reputation with their members by offering substandard health plans.

regulating individual and small group markets and close-in knowledge of local market conditions position them to optimize AHPs' role.

Many AHPs will be subject to State benefit mandates. Pennsylvania, for example, requires policies issued in the large group market to cover in-patient and out-patient services for severe mental illness, inpatient and outpatient services for substance use disorders, autism services, childhood immunizations, and mammography.⁸¹ Where present and applicable, these types of State mandates will apply to fully insured AHPs through State regulation of the health insurance policies they purchase, or directly to self-insured AHPs as permitted under ERISA's MEWA preemption provisions. Moreover, under this final rule, States retain the authority to adopt minimum benefit standards, including standards similar to those applicable to individual and small group insurance policies under the ACA, for all AHPs. To the extent that States adopt such standards, AHPs generally will have less opportunity to expand choices of more affordable coverage options for many small businesses.

5. Economies of Scale

Many AHPs will pursue advantages of economies of scale that small businesses do not currently enjoy. AHPs sponsored by pre-existing groups or associations that perform multiple functions for their members other than offering health coverage (such as chambers of commerce or trade associations) might have more potential to deliver administrative savings than those established for the principal purpose of offering health coverage. These existing organizations may already have extensive memberships and thus may have fewer setup, recruitment, and

⁸¹ See 40 P.S. sections 764g, 908-2, 764h, 3502, 764c. (For a list of state benefit mandates, see generally http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx#State_EHB_2016).

enrollment costs than organizations newly formed to offer insurance. These existing organizations that have been limited in their ability to offer AHPs to some or all of their existing members (for example, to working owners or workers outside of a common industry) by the Department's prior interpretations could newly extend AHP eligibility to such members.

As with traditional insurers of individuals and small groups, AHPs' most promising potential for economies of scale may be an ability to negotiate discounts with healthcare providers. Such discounts may reflect a combination of (1) administrative efficiencies from economies of scale; (2) influence over providers' utilization decisions and practices; (3) reduction of any excess provider profits; and (4) sometimes modest cost-shifting to other payers who have less negotiating leverage.

Only large AHPs are likely to secure provider discounts similar to those that large health insurance issuers often can deliver to their individual and small group customers. Large issuers have the benefit of aggregating their purchasing power across all market segments in which they participate, potentially including private individual, small and large group insurance, large self-insured employer customers, Medicare Advantage, and Medicaid. These latter segments often account for a disproportionately large fraction of provider utilization volume. AHPs generally will have more potential to negotiate provider discounts if they opt to keep their provider networks narrow, so as to concentrate use and scale among available providers. Geographically-based AHPs, which this final rule allows for the first time, may be most likely to be able to secure provider discounts. On the other hand, AHPs' entry sometimes could dilute other payers'

abilities to obtain discounts,⁸² thereby increasing costs for such payers' enrollees.

Accordingly, AHPs with large shares in local health markets will be best positioned to negotiate discounts with providers. Without the benefit of this final rule, AHP participation has been constricted to date—especially as common geography has not constituted an allowable basis to form an AHP—and as a result, prior AHPs generally have been unable to achieve large local participation. Among MEWAs operating as single large group health plans (hereafter, “plan MEWAs”), total enrollment averaged just 3,437 in 2016. Twenty-eight had more than 10,000 enrollees, and four had more than 50,000, but many of these were dispersed across multiple States.

This final rule, by enabling AHPs to be comprised of otherwise unrelated small employers and working owners who share a common geographic area, will open the door for more AHPs to claim large fractions of local markets and thereby pursue advantages of scale. There are many well established, geographically based organizations, such as local chambers of commerce, that lend themselves to sponsoring AHPs, but cannot under the Department's pre-rule guidance. Under that guidance, such organizations could, and sometimes did, help their members purchase health insurance in the individual and small group markets. However, ACA and State laws and regulations governing individual and small group markets limit both the propensities of such organizations to undertake group purchasing of health insurance and the economies of scale that such organizations can achieve from group purchasing. This final rule will enable such geographically-based organizations to sponsor AHPs (plan MEWAs).

⁸² For a discussion of market concentration and issuers' market power see Sheffler, Richard M. and Daniel Arnold. “Insurer Market Power Lowers Prices in Numerous Concentrated Provider Markets.” *Health Affairs* 36, no. 9 (2017).

The large group market's regulatory flexibility is likely to encourage and enable more existing organizations to pursue more potential scale advantages for small business members. These might include some MEWAs that currently do not constitute single large group plans but instead encompass multiple plans, each sponsored separately by a participating employer (hereafter "non-plan MEWAs"). In 2016, one non-plan MEWA covered more than 50,000 enrollees in Connecticut. A second covered more than 100,000 across 22 States and more than 20,000 in Tennessee alone.⁸³ These and other heretofore non-plan MEWAs might qualify to become AHPs with large local market shares under this final rule. The final rule will also encourage the establishment of new organizations to sponsor AHPs, and will enable both existing and new AHPs to extend membership to working owners.

Under favorable conditions, AHPs may achieve other economies of scale. For example, small group and individual insurance sometimes can be beset by high distribution costs, reflecting for example commissions paid to agent and brokers who sell policies, possibly amplified by churning of small businesses into or out of the market or between issuers. AHPs, unlike large employer plans, must themselves incur some cost to distribute insurance to large numbers of small businesses. However, relative to traditional health insurance issuers and agents, some AHPs might reduce these costs, for example if they are able to take economic advantage of members' existing ties to the sponsoring group or association and/or if they are more able or inclined than traditional issuers and agents to minimize churn. Little hard data exists on the degree to which such scale advantages might flow to future AHPs, due to a rapidly changing marketplace and the restrictive requirements imposed on AHPs before this rule.

⁸³ DOL calculations based on Form M1 Filings.

Several commenters argued that these advantages have been elusive in the past, and under this rule are likely to be small and available only under certain favorable conditions. One such public comment stated that where available, “administrative savings of more than 2-3 percent appear to be highly unlikely....”⁸⁴ Administrative savings of 2-3 percent of total insurance premiums is nonetheless significant.

A 2011 report⁸⁵ found that in Washington State, issuers’⁸⁶ average loss ratio was a bit higher (and administrative costs therefore likely lower) for AHP-affiliated small groups than for community-rated small groups. However, the report notes that this difference is “consistent” with the larger average size of AHP-affiliated small groups. For similarly sized small groups, issuers’ loss ratios were similar for the AHP and community-rated segments. It is difficult to infer from this data point whether Washington State AHPs enjoy true administrative efficiencies relative to traditional individual and small group issuers. On one hand, the same report indicates that AHP premiums were substantially lower than the premiums that issuers charged small businesses outside of AHPs. If AHPs’ premiums are lower and loss ratios are the same, then all else equal, AHPs’ administrative costs are likely to be lower, if measured in dollars per member. Lower administrative costs might be evidence of greater administrative efficiency, but alternatively might be explained by the lighter regulatory load on AHPs, or by a difference in the administrative demands associated with insuring the AHPs’ population (which might use less

⁸⁴ See comment letter from Mark A. Hall, Professor of Law and Public Health, Wake Forest University School of Law, Feb 16, 2018 (Comment # 146 on EBSA webpage last accessed at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85>).

⁸⁵ Chollet, D., Mathematica Policy Research, “Association Health Plans and Community-Rated Small Group Health Insurance in Washington State-Final Report,” (September 30, 2011), http://www.statecoverage.org/files/Mathematica_assoc_healthplans_WA.pdf.

⁸⁶ Washington State generally requires AHPs to be insured, rather than self-insured.

healthcare) or providing AHP benefits (which might be less comprehensive). In addition, it is unclear whether these loss ratios take into account administrative costs that may reside with the group or association rather than with the issuer.

Large AHPs sometimes may achieve 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, AHPs sometimes may avoid the transaction cost associated with buying large group insurance from an issuer and the cost associated with the issuer's profit margin. They sometimes may avoid the potentially significant cost to comply with State rules that apply to large group issuers, including for example premium taxes, benefit mandates, market conduct rules, and solvency standards. Under this final rule, however, States retain authority to extend such rules to self-insured AHPs, and AHPs will be subject to ERISA requirements that demand sound financial management.⁸⁷

While some AHPs may achieve significant administrative efficiencies for their small business members from economies of scale, the magnitude of such savings is likely to be smaller than the savings AHPs can deliver by offering more tailored, less comprehensive benefits, offering actuarially fair price discounts to low-risk groups, and assembling favorable risk pools.

⁸⁷ Self-insurance entails operational risk. Self-insured AHPs sometimes may face more operational risk than self-insured large employers, for two reasons. First, for a given size, an AHP's claims may be more volatile than a large employers' insofar as the AHP is more exposed to unanticipated favorable or adverse selection. Second, while premiums generally represent the totality of an AHP's available revenue, a large employer may be able to tap other revenue sources to cover claims volatility, as it would any other unexpected business expense. AHPs' efforts to manage these operational risks will limit the savings available from self-insurance.

Some AHPs will successfully deliver economic value to their members even if these AHPs have relatively high administrative costs. Consequently, while some AHPs may deliver significant savings for their members from economies of scale, other AHPs may not deliver such savings or may even increase administrative costs.

6. Risk Segmentation

As noted above, AHPs established under this final rule will enjoy regulatory flexibility to design more tailored, less comprehensive health coverage and price it in a more actuarially fair manner than health insurance issuers can in the ACA-compliant individual and small group markets. Thus, AHPs will be able to offer lower premiums to many small businesses by offering actuarially fair price discounts to lower risk groups, consistent with applicable nondiscrimination provisions.

AHPs' exercise of their relative flexibility will lead to some degree of favorable risk selection toward AHPs and adverse selection against individual and small group markets. This risk segmentation will increase premiums somewhat in ACA-compliant individual and small group markets. The Department's Proposed Rule identified these considerations, reviewed mixed evidence on the likelihood and extent of risk segmentation, and predicted that the proposal's nondiscrimination rules together with AHPs' potential to deliver savings from scale advantages would substantially limit, but not entirely eliminate, such risk segmentation. Some commenters, however, asserted that even with the benefit mandates that apply in the large group market and the nondiscrimination rules included in this final rule, many AHPs, by design and/or in response to market forces, unless prevented by State regulation, will assemble disproportionately favorable risk pools and thereby subject local individual and small group markets to adverse selection and premium increases. After evaluating these comments, the

Department believes that AHPs' scale advantages generally will be insufficient to limit risk segmentation. This final rule's nondiscrimination provisions will reduce, but not eliminate, AHPs' risk-segmentation effects.

Under this final rule, AHPs' ability to segment risks will be limited by a number of forces. An AHP that forms under this final rule, and that may enroll otherwise unrelated small businesses and working owners, cannot adjust employer members' premiums based on their respective employees' health status. States may take additional steps to limit AHPs' risk segmentation effects, which would limit the ability to set actuarially fair prices and might limit AHP formation. AHPs are controlled by their members and, therefore, in some cases, AHPs' belief that their members are better off and their reputation is enhanced by offering broader benefit packages with more community-rated prices, may weigh against the competitive pressure to calibrate benefits and prices to avoid bad risks. Likewise, very large AHPs' size sometimes may itself blunt this pressure. Finally, risk selection efforts are subject to increasing costs and diminishing returns.

Nevertheless, AHPs established under the final rule will, within the general rules applying to large group plans and the specific nondiscrimination provisions in this final rule, by escaping some ACA pricing restrictions and forced cross-subsidies, will tend to segment risks. Relative to ACA-compliant issuers in the individual and small group markets, AHPs can offer more actuarially fair (and potentially much lower) prices to lower risk groups based, for example, on age, gender, or industry. Moreover, AHPs additionally can design health coverage to attract lower risk groups. At the same time, the Department finds that risk segmentation will be limited for reasons discussed above and further in this section. While under this final rule AHPs and large employer plans will have a similar federal regulatory environment, their

economic incentives will be different. Large employers design and price health benefit offers to recruit and retain productive workers and to maximize those workers' productivity.

Consequently, large employers typically offer heavily subsidized comprehensive health coverage for employees and their families. In contrast, AHPs will design and price offers for their members in competition with more heavily regulated individual and small group issuers, and possibly with one another. This favors actuarial pricing that accurately reflects risk differences between, for example, genders, age groups, and industries, and more tailored, often less comprehensive benefits, insofar as such pricing and benefits will attract favorable risk pools and facilitate lower premiums.

Some groups or associations may prefer to provide comprehensive benefits at community rates that do not discriminate among members by age or gender. Such groups or associations might be motivated by a sense of obligation toward or solidarity among members, such as workers with a common trade. Trade unions historically have negotiated comprehensive multiemployer benefit arrangements with large numbers of small and medium sized companies, with costs allocated based on hours worked rather than on actuarial factors. On the other hand, AHPs may be more vulnerable than union-negotiated arrangements to competition from other groups or associations more willing to use actuarial pricing and/or benefit limitations to provide potential savings for many of the same members. Such competitive pressure may force groups or associations to adopt actuarial pricing reflecting risk and limited benefits as defenses against adverse selection. Groups or associations that naturally comprise relatively favorable and homogenous risk pools may be best able to sustain nondiscrimination in rate setting, because they will enjoy savings that can be shared widely, and can spread thinly across young and healthy members the costs attributable to the few needing expensive care. Such AHPs, however,

while refraining from discrimination internally, could increase adverse selection against local individual and small group markets.

AHPs historically have utilized actuarial pricing. According to comments, existing AHPs often rate employer members based on health factors such as claims, and need flexibility to do so to ensure their success. Nearly all AHPs in Washington State experience rate.⁸⁸ AHPs operating under this new rule may not adjust prices actuarially for health status, but only for non-health factors such as age, gender, and industry. AHPs that under this rule extend eligibility to working owners may face even greater competitive pressure to limit benefits, because individual markets generally are more susceptible than small group markets to adverse selection.

One comment⁸⁹ provided a conceptual framework for assessing the implications of AHPs' relative pricing flexibility and predicted that AHPs would segment risks under the Proposed Rule. The comment calls attention to certain factors related to rating,⁹⁰ plan design,⁹¹

⁸⁸ Chollet, D., Mathematica Policy Research, "Association Health Plans and Community-Rated Small Group Health Insurance in Washington State-Final Report," (September 30, 2011), http://www.statecoverage.org/files/Mathematica_assoc_healthplans_WA.pdf.

⁸⁹ See comment letter from the American Academy of Actuaries, February 9, 2018, (Comment # 106 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00106.pdf>).

⁹⁰ With respect to rating, the comment identifies six factors: (1) age, (2) industry/occupation, (3) geography, (4) gender, (5) group size, and (6) separateness of the risk pool. The comment indicates that relative to individual and small group issuers, AHPs "could offer lower premiums to younger adults and higher, less attractive premiums to older people," but also might set premiums for newborns substantially higher than for older children (the ACA requires all children under 14 to be rated together). The comment continues that AHPs' unique ability to vary rates by industry or occupation will advantage them over issuers. Geographically, health insurance issuers must all rate evenly within the same state-specified zones, but AHPs could use different zones and might, for example, split a state zone into smaller segments to reflect cost differences. AHPs might additionally set higher rates for smaller groups (of say, fewer than 10), and for women of child-bearing age.

⁹¹ With respect to plan design, the comment notes that AHPs might limit covered services, network size or composition, or impose higher cost sharing (which, if the plan is not grandfathered, would still be subject to the limitations on out-of-pocket costs imposed by PHS Act 2707), all of which could contribute to favorable risk selection.

and other considerations.⁹² One comment points out that the flexibility AHPs will have to, for example, cover certain trade groups, will result in the ability to offer more affordable care to those groups than individual and small group issuers. AHPs also may offer substantially lower premiums to younger men and substantially higher premiums for younger women.⁹³ One comment points to market experience as evidence that AHPs could threaten risk pools. The comment argues that AHPs' scale advantages will be insufficient to offset their large incentives to avoid worse health risks. The comment cites a market collapse in Kentucky in the 1990s to illustrate concerns about market dynamics and regulation.⁹⁴

A publicly available report estimated that under the Department's proposal, nationwide by 2022 AHPs would increase overall premiums in individual markets by between 2.7 percent and 4.0 percent, and in small group markets by between 0.1 percent and 1.9 percent.⁹⁵ (A more

⁹² The comment emphasizes that AHPs' success and effects could vary widely depending on the local regulatory environment, and on the AHP's ability to compete with local issuers on dimensions including reputation, provider networks (and associated provider discounts), care management, and administration.

⁹³ See comment letter from BlueCross BlueShield, March 6, 2018 (Comment # 549 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00549.pdf>). According to the comment, all else equal, AHPs may rate the engineering services industry 9 percent lower than issuers operating under individual and small group market rules, and may rate the taxicab industry 15 percent higher. AHPs may rate men in their 20s more than 40 percent lower than would be consistent with individual and small group market rules, and may rate women in their late 20s and 30s more than 30 percent higher. This suggests, for example, that AHPs are likely to enroll more male than female working owners, disproportionately leaving women (and their maternity-related costs) in local individual markets.

⁹⁴ See comment letter from Mark A. Hall, Professor of Law and Public Health, Wake Forest University School of Law, Feb 16, 2018, (Comment # 146 on EBSA webpage last accessed at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85>). According to the comment, Kentucky implemented market reforms but exempted AHPs from these reforms, including rating reforms. This resulted in healthy people seeking coverage through associations, which were not community rated. This left unhealthy people to seek coverage in the regulated markets. Carriers began canceling health insurance policies and fleeing the state, leaving a decimated market. The same commenter expressed concerns that AHPs cannot duplicate large employers' advantages with respect to the composition and stability of risk pools, because each small business will select insurance options based on its own anticipated medical needs and premium offers.

⁹⁵ Avalere Health, Association Health Plans: Projecting the Impact of the Proposed Rule at 3, 5-7 (Feb. 28, 2018), available at <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf>.

recent report estimated that AHPs, together with the separate proposal to expand short-term, limited duration insurance policies, would increase premiums in individual and small group markets by from 2 percent to 3 percent.⁹⁶) A separate estimate predicted that AHPs available to all Washington, DC employers would increase premiums in the local individual market by 5 percent and small group market by 10 percent, or possibly by more if high cost employers do not consider joining AHPs.⁹⁷ Yet another predicts that premiums in Massachusetts' combined individual and small group markets could increase by more than 10 percent in the first year.⁹⁸ If the first of these sets of estimates is correct, individuals remaining in the individual and small group markets could see a combined premium increase of between \$7.7 billion and \$14.1 billion, due to the reduction in cross subsidization. This would also be the amount of the cross-subsidization those leaving to join an AHP were providing in those markets and they will now be able to retain.⁹⁹

⁹⁶ U.S. Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028." <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf>. The Department did not rely on the information contained in the CBO report, which was released after the comment period had closed, to reach its conclusions regarding the effects of the final rule on premiums, but notes that the CBO's findings are consistent with other evidence available to the Department.

⁹⁷ See letter from Oliver Wyman to Mila Kofman, February 21, 2018 regarding "the potential impact of association health plans in the District of Columbia." The Department notes that the DC market is unusual and might not be an appropriate reference to understand national implications. The DC Exchange covers approximately 17,000 people of whom 80 percent of are unsubsidized (almost the opposite of the rest of the country). Consequently AHPs' effects may be less acute on a national level than in DC.

⁹⁸ See comment letter from the Massachusetts Division of Insurance and Massachusetts's State-Based Marketplace, March 6, 2018 (Comment # 600 on EBSA webpage last accessed at: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00600.pdf>).

⁹⁹ These estimates use the Avalere Health report for estimates of the 2022 changes in premiums, and the number of individuals leaving the individual and small group markets to join an AHP. The Department estimates that there are about 25 million individuals with coverage in the individual market and 25 million individuals in the small group markets. The CBO estimates that by 2022 there will be 5 million fewer individuals in the individual market and 2 million fewer individuals in the employer-based market due to the repeal of the individual mandate. As not all individuals leaving the employer market place are in the small group market an estimate of one million is used for the number of individuals no longer being covered in the small group market due to the repeal of the individual

Some analysts examining federal AHP legislation considered in the early 2000s likewise pointed to the potential for risk segmentation, but disagreed over the likely magnitude. One report concluded that premiums for firms in State-regulated markets would increase by 23 percent.¹⁰⁰ A different study of separate but largely similar legislation predicted that these premiums would increase by just 2 percent.¹⁰¹ It is unclear whether the disagreement is attributable to differences in AHPs' expected size or expected degree of favorable selection, or other factors. However, the relevance of the reports is diminished by the fact that they were written well before the passage of legislation such as the ACA and the substantial changes to the health markets that have occurred in the interim.

A more recent report¹⁰² discussing the impact of AHPs on the individual and small group market notes that States may require AHPs to comply with "key insurance market standards and practices" that limit risk segmentation, such as State individual and small group market rules. The report notes that such steps could protect local markets from adverse selection, but would also diminish AHPs' ability to deliver choice and savings for their local members.

While some comments and other evidence support the conclusion that AHPs' flexibility under this rule will lead to risk segmentation, the comments do not allow the Department to

mandate. The following calculations were used to obtain the estimates. For the individual market: low estimate, $(25,000,000 - 5,000,000 - 710,000) * (\$14,900 * (1 - (1/1.027)))$; high estimate, $(25,000,000 - 5,000,000 - 1,110,000) * (\$15,000 * (1 - (1/1.04)))$. For the small group market: low estimate, $(25,000,000 - 1,000,000 - 1,650,000) * (\$8,100 * (1 - (1/1.001)))$; high estimate, $(25,000,000 - 1,000,000 - 3,200,000) * (\$8,300 * (1 - (1/1.019)))$.

¹⁰⁰ Karen Bender and Beth Fritchen, "Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers," Mercer Risk, Finance and Insurance report prepared for the National Small Business Association, 2003.

¹⁰¹ 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.

¹⁰² Georgetown University Health Policy Institute, Center on Health Insurance Reforms, "State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Association Health Plans," December 2017.

predict its extent. Furthermore, many comments also affirm that this rule's application of nondiscrimination rules to AHPs established under this final rule will reduce its degree.

Experience in Oregon under the ACA suggests that AHPs operating under the Department's pre-rule guidance have taken advantage of available flexibility to vary individual small businesses' premiums to reflect their respective expected costs more widely and based on more factors than permitted in individual and small group markets.¹⁰³ However, AHPs that gain large group status only under this final rule will not retain flexibility to adjust individual member employers' rates based on health status.

AHPs' potential to attract a favorable risk pool is limited by a number of factors, and AHPs themselves sometimes may suffer some degree of adverse selection. The nondiscrimination provisions of this final rule limit AHPs' ability to set actuarially appropriate prices. In addition, AHPs' efforts to select favorable risks generally would yield diminishing returns; that is, there is a point beyond which additional selection efforts would themselves cost more than could be justified by any savings from attendant selection results. AHPs under this final rule generally may not condition employer members' eligibility, benefits, or premiums on their employees' health factors. AHPs generally can condition these things on many other factors, including for example age, gender, industry, occupation, and geographic location. These factors do not fully correlate with health status, however, and there may be declining returns and/or increasing administrative costs associated with more aggressive and granular use of these

¹⁰³ Kevin Lucia, Sandy Ahn, and Sabrina Corlette, "Federal and State Policy Toward Association Health Plans in Oregon," Robert Wood Johnson Foundation and Urban Institute, October 2014.

factors to select risk. A similar argument may apply with respect to AHPs' use of benefit design or tailored marketing to select risks.

AHPs that are barred from adjusting employer members' rates based on health status (namely, those that qualify as large group plans under this final rule but not under the Department's pre-rule guidance) are likely to face some potential for adverse selection, particularly where competing with other AHPs and/or other non ACA-compliant plans for some of the same enrollees. At least one comment notes that AHPs, while vulnerable to adverse selection, would be without applicable "offsetting stabilization mechanisms" such as the "subsidies, risk adjustment, reinsurance, open enrollment provisions, and coverage mandate" that the ACA provided in individual and small group markets.¹⁰⁴ To limit AHPs' vulnerability to adverse selection, this final rule allows them to exclude working owners and to limit annual open enrollment opportunities¹⁰⁵ as suggested by some commenters. AHPs also may pursue a strategy of limiting benefits in order to protect against adverse selection.

Comments also demonstrate that successful AHPs can coexist with stable and viable individual and small group markets, even if those AHPs operate under looser rules, are able to set more actuarially fair prices, and realize some degree of favorable selection relative to local

¹⁰⁴ See comment letter from Aetna, March 6, 2018 (Comment # 472 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00472.pdf>).

¹⁰⁵ The Department notes that, of course, AHPs must provide special enrollment periods under certain circumstances. For example, current employees and their dependents that have experienced a loss of coverage must have an opportunity to enroll in the plan under a special enrollment period if they are otherwise eligible to enroll and the coverage was previously offered at a time when the employee had other health coverage. Additionally, special enrollment periods must be provided for certain dependent beneficiaries who experience a qualifying life event such as marriage, birth, or adoption. See ERISA section 701(f) and 29 CFR 2590.701-6. In addition, a group health plan, and health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days. See PHS Act section 2708 and ERISA section 715. See also 29 CFR 2590.715-2708.

small group markets. Comments and other public evidence suggest that such conditions now prevail in some form in Oregon and Washington State, for example.¹⁰⁶

A 2014 report examines Oregon’s AHP market.¹⁰⁷ Before the ACA, Oregon exempted AHP coverage from individual and small group market rules. Oregon later eliminated this exemption, but AHPs that qualify as single, large group plans under ERISA remained outside the relevant rules, and many Oregon AHPs claimed this status, the report says. These AHPs tended to rate employer members on health status or claims experience, and other factors not allowed in individual or small group markets, and such pricing flexibility gave AHPs “a competitive edge ... particularly with healthy small groups.” The report predicted that AHPs would grow.

A 2011 report¹⁰⁸ documented AHPs’ “robust” role in Washington’s markets in the years leading up to the passage of the federal ACA. Washington, unlike many other States (and notwithstanding the Department’s contrary past guidance with respect to MEWA’s status under ERISA¹⁰⁹), historically had recognized AHPs sponsored by associations formed for the purpose

¹⁰⁶ See comment letter from State of Washington, Office of Insurance Commissioner, March 6, 2018 (Comment # 531 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00531.pdf>; See also comment letter from Forterra Inc., on behalf of its parent company, the Association of Washington Business, March 6, 2018 (Comment #577 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00577.pdf>; See also Chollet, D., Mathematica Policy Research, "Association Health Plans and Community-Rated Small Group Health Insurance in Washington State-Final Report," at p. 20 (September 30, 2011), http://www.statecoverage.org/files/Mathematica_assoc_healthplans_WA.pdf; See also comment letter from the Robert Wood Johnson Foundation, March 3, 2018 (Comment #334 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00334.pdf>; See also Kevin Lucia, Sandy Ahn, and Sabrina Corlette, “Federal and State Policy Toward Association Health Plans in Oregon,” Robert Wood Johnson Foundation and Urban Institute, October 2014.

¹⁰⁷ Kevin Lucia, Sandy Ahn, and Sabrina Corlette, “Federal and State Policy Toward Association Health Plans in Oregon,” Robert Wood Johnson Foundation and Urban Institute, October 2014.

¹⁰⁸ Chollet, D., Mathematica Policy Research, “Association Health Plans and Community-Rated Small Group Health Insurance in Washington State-Final Report,” (September 30, 2011), http://www.statecoverage.org/files/Mathematica_assoc_healthplans_WA.pdf;

¹⁰⁹ Under that guidance, AHPs sponsored by associations formed for the purpose of providing health coverage generally did not constitute single, large group plans under ERISA. Instead under ERISA such arrangements

of providing insurance. It required AHPs to be insured (rather than self-insured), but exempted issuer sales through AHPs from small group rating rules, allowing them to rate on claims experience, health status, gender, non-standard age factors, and other variables that were prohibited in the community-rated small group market. AHPs operated both within and across industries, and covered both large and small employers. In 2008 AHPs claimed approximately one-half of Washington's small group market and more than one-third of its combined small and large group market. For small groups, the report found that AHP premiums (\$246 per member per month) were lower than community rated premiums (\$316 per member per month). This difference "likely" is attributable mostly to risk segmentation favoring AHPs over community-rated small group markets and "the larger size of AHP small groups relative to community rated small groups,"¹¹⁰ and partly to less comprehensive benefits, the report says. The medical loss ratio was a bit higher (and administrative costs therefore likely lower) for AHP small groups than for community rated small groups, but the report notes that this difference is "consistent" with (and so might be attributable to) the larger average size of AHP small groups. This suggests that AHPs enjoyed either no or little administrative cost advantage over unaffiliated small groups. AHPs tended to rate based on health status (60 percent of enrollees) and/or claims experience (87 percent of enrollees). AHP growth in Washington was more than offset by contraction of other

generally constituted MEWA encompassing multiple separate plans sponsored by the MEWAs participating employers. Prior to the implementation of the ACA, this status under ERISA did not prevent states from recognizing such AHPs as large groups under state law or otherwise excepting them from state rules that governed small group insurers.

¹¹⁰ This may affect premiums in two ways. First, per-member administrative costs may decrease with (small) group size. Second, very small groups generally subject insurers to more adverse selection than somewhat larger groups.

group coverage.¹¹¹ AHPs' historically substantial market share in Washington State stands as evidence that they delivered economic advantage to many small businesses there relative to choices available in community rated small group markets. However, it is likely that some or much of this advantage came at the expense of other small businesses that paid higher prices in community-rated markets, or went without insurance.

Washington AHPs' experience may differ from new AHPs' experience under this final rule, for many reasons. For example, Washington's experience generally is limited to the small group market, while new AHPs can offer coverage to working owners who may now be purchasing in individual markets, where the potential both for savings for AHP enrollees and adverse selection against other risk pools will be different and possibly greater. In addition, while Washington AHPs have rated members based on health status, AHPs operating under this final rule cannot, so such AHPs' potential to offer targeted savings and select risk relative to small group markets are more limited.

The impact of this final rule on State individual and small group risk pools is highly dependent on State regulatory practices. States under this final rule retain broad authority to pursue steps to optimize AHPs' role in their local markets.

¹¹¹ From 2005 to 2008, enrollment in AHPs increased 11 percent, while enrollment in the large group and community rated small group market decreased nearly 12 percent resulting in an overall decline in group coverage during this period. As a result, 87,000 fewer workers and dependents (-5.2 percent) were enrolled in any insured group coverage in 2008 than in 2005. Source: Chollet, D., Mathematica Policy Research, "Association Health Plans and Community-Rated Small Group Health Insurance in Washington State-Final Report," (September 30, 2011), http://www.statecoverage.org/files/Mathematica_assoc_healthplans_WA.pdf. For reference, at the same time nationally, the number of private employees enrolled in their employers' insurance plans grew from 61 million to 63 million. See *Medical Expenditure Panel Survey, Insurance Component, 2016 Chartbook*, U.S. Agency for Healthcare Quality and Research, September 2017, https://meps.ahrq.gov/data_files/publications/cb21/cb21.pdf.

In response to requests in comments on the Proposed Rule, this final rule makes clear that AHPs can attach rewards and penalties to individual enrollees' participation in wellness programs. These rewards and penalties are separate from (and may add to or offset) pricing differences based on risk factors such as age, gender or industry. Under federal rules, financial rewards or penalties can be as much as 30 percent of an enrollee's total premium, or 50 percent where the additional 20 percentage points are associated with tobacco use. Wellness programs must be designed to promote health, and not to penalize or screen out individuals in poor health. Their rewards must be reasonably available to all. In practice, however, some permissible program designs and practices nonetheless may tend to deliver fewer rewards or more penalties to less healthy individuals, who, relative to healthier individuals, may on average find participation to be more costly or less appealing. Consequently, while AHPs operating under this new rule may not condition premiums on health status, some AHPs' wellness programs in practice may have a disparate negative impact on those in poorer health. Such wellness programs sometimes could yield additional favorable selection toward AHPs.

The Department believes that the provisions of this rule and States' broad authority to adjust local rules, combined with the attendant benefits of extending insurance to small businesses and working owners, strike the right balance to both limit and justify consequent adverse selection against local markets.

7. Individual and Small Group Markets

The Department separately considered AHPs' potential impacts on both the individual and small group markets. With respect to individual markets, many of those insured there now

might become eligible for AHPs.¹¹² AHPs operating under this final rule could enroll both working owners and the employees of small businesses that do not currently offer insurance but elect to join AHPs and begin offering insurance. The latter group has grown as small firms' propensity to offer health coverage for employees has declined substantially from 47 percent of establishments in 2000 to 29 percent in 2016.¹¹³ Of the 25 million U.S. individuals under age 65 who were insured in individual markets in 2015, approximately 3 million were working owners or dependents thereof, and an additional 12 million were employees of small businesses 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 25 million workers and dependents.¹¹⁴ While all of these individuals could become eligible for AHPs under this final rule, some are more likely than others to become eligible, and among those who do become eligible, some are more likely than others to enroll.

¹¹² Under the rule, working owners must earn wages or self-employment income from the trade or business for providing personal services to the trade or business and either (1) work at least 20 hours per week or at least 80 hours per month providing personal services to the trade or business, or (2) earn income from the trade or business that at least equals the working owner's cost of coverage for the working owner and any covered beneficiaries in the group health plan sponsored by the group or association in which the individual is participating.

¹¹³ 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. The Department's calculations are 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.

¹¹⁴ These estimates were derived from 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 Department revised its methodology in estimating the universe of potential individuals affected by the regulation between the proposed and final rule. The initial estimates did not restrict the definition of working owners to those working at least 20 hours per week, and so this restriction was added, which reduced the number of working owners and their dependents from 20 million in the proposal to 15 million in the final. Additionally, in the Proposed Rule, current source of insurance for dependents of working owners and employees at small firms not offered insurance were only counted if they were the same as family member identified as having potential AHP access. For the final rule, dependents' source of insurance is counted whether or not their insurance matches.

The Proposed Rule described some relevant features of individual and small group markets under the ACA and existing State rules. Here the Department presents considerations raised by subsequent developments, comments on the Proposed Rule, and other newly identified information. Importantly, it considers the role of individual market subsidies, the reduction of the individual shared responsibility payment to \$0 for those who do not have minimum essential coverage and do not have an exemption beginning in 2019, and the role of other (non-AHP) non ACA-compliant plans in individual and small group markets.

AHPs' impact on local individual markets is likely to differ based on market sub-segments and the effect of State regulation. To the extent not prevented by State rules, AHPs are likely to result in some adverse selection and associated premium increases in the individual and small group markets. States' approaches are likely to vary widely and to range from steps that maximize AHPs' flexibility¹¹⁵ and impacts to those that minimize them.¹¹⁶

With respect to individual markets, as discussed earlier, consequent to this final rule premiums are likely to increase modestly on average. The increases might vary widely across local markets. As noted above, in 2015, approximately 3 million individual market enrollees were working owners or their dependents. It is likely that under this final rule AHPs will offer insurance to many of these individuals. AHP coverage offers generally are likely to be most affordable and attractive to categories of individuals with lower expected claims, such as young

¹¹⁵ For example, Iowa recently enacted legislation lowering barriers for certain AHPs. See Iowa SF2349 – An Act Relating to Health Plans Established by Associations of Employers or Sponsored by Certain Agricultural Organizations, enacted on April 2, 2018.

¹¹⁶ For example, Massachusetts historically has limited AHPs flexibility. See comment letter from the Massachusetts Division of Insurance and Massachusetts's State-Based Marketplace, March 6, 2018 (Comment # 600 on EBSA webpage last accessed at: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00600.pdf>).

single men, and for the 1 million of the 3 million working owners with incomes too high to qualify for subsidies on the Exchanges (more than four times the poverty threshold).

Also as noted above, about 12 million people insured in individual markets were employees of small private businesses or dependents thereof. Among those, some strong candidates for AHP enrollment are those with incomes too high to qualify for premium tax credit subsidies whose small employers already offer them insurance, who number 800,000. Another 1.4 million have offers from small employers but lower incomes. To the extent that their offers are affordable and provide minimum value, such individuals are ineligible for ACA subsidies on Exchanges and therefore likely to be strong candidates for AHP enrollment. The remaining 9 million are currently without offers from their small employers, and consequently would gain AHP eligibility if their small employers join an AHP to begin offering health coverage to these employees. However, a majority of these 9 million are eligible for subsidies on exchanges.¹¹⁷ Small employers generally are less likely to begin offering coverage to employees whose demand for such an offer is weak because they currently have access to subsidized comprehensive coverage. Because of this, AHPs will likely enroll only a portion of all current individual market enrollees with connections to small businesses. Notwithstanding these limitations, in light of the very large numbers of Americans who work for small employers, who are working owners, or who are dependents of employees of small employers or working owners, the Department expects AHPs to deliver health insurance to millions of people.

¹¹⁷ 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.

Recent economic research shows that small businesses with 49 or fewer employees have a high after-tax price elasticity for offering employer-sponsored health insurance to their employees. For small businesses, a one percent reduction in the after-tax price would cause a 0.82 percent increase in the likelihood of offering employer-sponsored health insurance, the research found. For medium-sized business with 50 to 499 employees, a one percent reduction in the after-tax price would cause a 0.35 percent increase in the likelihood of offering employer-sponsored health insurance. For large businesses with 500 or more employees, however, the after-tax price elasticity for offering employer-sponsored health coverage is not statistically different from zero. The high after-tax price elasticity for small businesses cannot be directly applied to project a potential net increase in offers under the final rule, for two reasons. First, AHP coverage is likely to differ from ACA-compliant small group coverage not only with respect to price but also with respect to benefit design and comprehensiveness. Second, AHPs will set different premiums for different members conditional on cost related factors such as age, gender, and industry, so it is unclear whether the employers most inclined to respond to price decreases will see large or small decreases, or no decreases. Nonetheless, this research does corroborate the proposition that lower premiums from the expansion of AHP plans under the final rule will cause some small businesses that do not currently offer employer-sponsored health coverage through the ACA-compliant small-group market to begin offering employer-sponsored health coverage to their employees through AHPs. The Department did not rely on this research to reach any conclusions regarding the effects of the final rule on the likelihood that small businesses would begin offering health coverage through AHPs. Instead, the Department includes this information as a supplement to corroborate its findings.

A publicly available report estimated that between 2.4 million and 4.3 million individuals would move from the individual and small group markets combined, and enroll in AHPs by 2022 under a moderate enrollment scenario, between 710,000 and 1.1 million of which would move from the individual market.¹¹⁸ This estimate also projected significant premium decreases by moving to AHPs (between \$1,900 to \$4,100 lower than the yearly premiums in the small group market and \$8,700 to \$10,800 lower than the yearly premiums in the individual market by 2022, depending on the generosity of AHP coverage offered). This translates into aggregate premium decreases of between \$9.3 billion and \$25.1 billion, with the former corresponding to more generous AHP benefits. The Department does not have sufficient data to assess the accuracy of these estimates.

A large majority of individuals insured on Exchanges will have some insulation from any premium increases resulting from the exit of individuals to AHPs, because the ACA provides a tax credit that in effect caps the premiums that those eligible taxpayers with household incomes at or below 400 percent of the federal poverty level must pay on Exchanges for coverage in a benchmark “silver” plan with an actuarial value of approximately 70 percent. That cap rises with income, to about \$9,400 for a family of 4 at 400 percent of the federal poverty level. Consequently such a family enrolling in the benchmark plan and facing a potential premium increase from a base of \$9,400 or more would be largely insulated from that increase.

¹¹⁸ The report estimates that the Proposed Rule will result in a projected to shift of between 710,000 and 1.1 million individuals out of the individual market, and 1.7 million to 3.2 million out of the small group market by 2022. It estimates that 2.4 million individuals would move from the individual and small group markets combined and enroll in AHPs under a low enrollment scenario, while 4.3 million would move to AHPs under a high enrollment scenario. See Avalere Health, Association Health Plans: Projecting the Impact of the Proposed Rule at 3, 5-7 (Feb. 28, 2018), available at <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf>. These figures do not appear to include otherwise uninsured individuals but are estimates of movement to AHPs from both the individual and small group markets.

Not all exchange participants will be fully insulated from increases in individual market premiums. This includes individuals with household incomes above 400 percent of the federal poverty level (for a family of four, with an annual household income of approximately \$100,000 or more), individuals whose current premiums are below the applicable cap (they are exposed to premium increases up to the cap), and individuals who elect plans that cost more than the benchmark plan. Further, those insured in the small group and individual markets outside the Exchanges might also have premium increases. The Department estimates that 6 million individuals insured in individual markets in 2015 have household incomes above 400 percent of the federal poverty level and either have no connection to a small business or work for a small employer that does not offer them insurance. These individuals could be exposed to premium increases as a result of the implementation of AHPs, and generally are unlikely to qualify for AHP enrollment. The Department estimates that an additional 2 million insured in individual markets in 2015 have household incomes above 400 percent of the federal poverty level and either connection to working ownership or offers from small employers. These individuals are relatively likely to qualify for AHP enrollment but could be exposed to premium increases if they remain in the individual market.¹¹⁹

Some individuals facing premium increases may elect to go without insurance. This is especially true because Public Law 115-97, enacted December 22, 2017, will reduce to 0 percent the individual shared responsibility payment for failure to maintain minimum essential coverage

¹¹⁹ It is likely that many (but not all) of these, especially working owners with low expected claims, will gain access to affordable, attractive offers from AHPs.

or have an exemption effective beginning in 2019.¹²⁰ AHPs under this rule are likely to extend coverage to some individuals who otherwise would have dropped coverage in response to the reduction of the individual shared responsibility payment. On the other hand, some individuals who face premium increases as a result of this final rule and who might have retained coverage to avoid the individual shared responsibility payment might instead drop coverage. At the same time, the reduction of the individual shared responsibility payment to \$0 might prompt some individuals who would have joined AHPs to remain uninsured instead.

With respect to small group markets, as with individual markets, this rule can be expected to increase premiums modestly on average, and those increases will vary across local markets. One estimate finds that between 1.7 million and 3.2 million enrollees will migrate from small group markets to AHPs by 2022.¹²¹

A recent report examined small group market experience under the ACA.¹²² The report identified movement between the small group and individual markets, as small employers begin to offer or stop offering insurance to their employees in response to changing government policies and local individual and small group market conditions. Overall offer rates have declined, but less than stakeholders predicted. Premium increases on average (3.1 percent

¹²⁰ The reduction to \$0 of the individual shared responsibility payment in 2019 is projected to decrease individual market insurance coverage by 3 million in 2019 and 5 million by 2027. See Congressional Budget Office, “Repealing the Individual Health Insurance Mandate: An Updated Estimate” (November 2017), www.cbo.gov/publication/53300.

¹²¹ Avalere Health, *Association Health Plans: Projecting the Impact of the Proposed Rule* at 3, 5-7 (Feb. 28, 2018), available at <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf>.

¹²² See Sabrina Corlette, Jack Hoadley, Kevin Lucia, and Dania Palanker, “Small Business Health Insurance and the ACA: Views from the Market 2017,” Robert Wood Johnson Foundation and Urban Institute, July 2017. For additional perspectives on small group markets under the ACA see Amy B. Monahan and Daniel Schwarcz, “Saving Small Employer Health Insurance,” *Iowa Law Review* Vol. 98:1935, 2013; and Deborah Chollet, “Self-Insurance and Stop Loss for Small Employers,” Mathematica Policy Research, June 30, 2012.

annually between 2011 and 2015) have been moderate and in-line with large employer markets and Medicare. Relative to individual markets, where the ACA compressed rates substantially, forcibly reducing premiums for many high-risk families and thereby increasing premiums for many lower-risk ones, rates in small group markets changed little, for several reasons. First, risk itself generally varies less among small groups (or at least among larger small groups) than among individuals and families. Second, the report asserts that in many places the ACA's small group rules have not been fully implemented as scheduled. Issuers and small employers in many locations so far have been allowed and have opted to retain non ACA-compliant, so-called "grandmothered" policies¹²³ whose prices are lower for low-risk groups than would be the case in the ACA-regulated small group market. Third, even under the ACA and other laws, small employers have more access than individuals to options outside of ACA regulated markets, and some have pursued these options. The options include "level funded" arrangements where the plan or employer self-insures expected claims but purchases stop-loss insurance for most large claims; qualified small employer health reimbursement arrangements, which may provide reimbursement for any qualified medical expense, including premiums for individual market coverage, so long as certain requirements are met; purchase of insurance that constitutes excepted benefits such as indemnity coverage; and sometimes AHPs that qualified under the Department's pre-rule guidance as single, large group plans. For these reasons, in many small group markets, AHPs under this rule may be unlikely to increase significantly the degree of risk

¹²³ Issuers and small employers in many locations so far have been allowed to retain plans that, under certain circumstances, under a transitional policy, are not considered to be out of compliance with certain ACA market reforms, whose prices are lower for low-risk groups than would be the case for plans that comply with those ACA market reforms.

segmentation and premium dispersion that currently exists – though they may preserve segmentation that otherwise would have waned as ACA implementation continued. AHPs’ effects might be larger where States more tightly regulate small group markets (unless such States also tightly regulate AHPs).

On May 23, 2018 after the comment period for the proposed rule had closed, the U.S. Congressional Budget Office (CBO) issued a report titled “Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018 to 2028.”¹²⁴ In this report, the CBO analyzed the effects of the proposed rule for Association Health Plans issued on January 5, 2018 and the proposed rule for Short-Term, Limited Duration Insurance issued on February 21, 2018. The report states that “[i]n 2023 and later years, about 90 percent of the 4 million people purchasing AHPs and 65 percent of the 2 million people purchasing STLDI plans would have been insured in the absence of the proposed rules, CBO and JCT estimate. Because the people newly enrolled in AHPs or STLDI plans are projected to be healthier than those enrolled in small-group or nongroup plans that comply with the current regulations governing those markets, their departure would increase average premiums for those remaining in other small-group or nongroup plans. As a result, premiums are projected to be 2 percent to 3 percent higher in most years.” The Department did not rely on the information contained in the CBO report to reach its conclusions regarding the effects of the final rule on the insured persons, but notes that the CBO’s findings are consistent with the Department’s own findings.

¹²⁴ U.S. Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028.” <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf> Estimates include the impacts of both the proposed AHP rule and the proposed Short-term, limited duration rule.

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 final rule. Among 42 million individuals under age 65 enrolled in Medicaid or CHIP in 2015, 2 million were working owners or dependents thereof, and 13 million were employees of small businesses or dependents thereof.¹²⁵ It is unclear how many Medicaid enrollees will gain AHP eligibility, or how many of those that do might elect to enroll in AHPs. Many will face strong economic incentives to continue relying exclusively on Medicaid, which generally charges no premium, imposes little or no cost sharing, and is comprehensive.

9. *The Uninsured*

Twenty-eight million individuals in the U.S. lacked health insurance coverage in 2015.¹²⁶ Of the 28 million uninsured, approximately 3 million are working owners or dependents thereof and an additional 12 million are employees of small businesses or dependents thereof.¹²⁷ The reduction to \$0 beginning in 2019 of the individual shared responsibility payment is projected to increase the uninsured population by 4 million in 2019 and 13 million by 2027.¹²⁸ Because AHPs often can offer more affordable alternatives to individual and small group insurance policies, this rule is expected to extend insurance coverage to some otherwise uninsured

¹²⁵ 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.

¹²⁶ 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.

¹²⁷ 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.

¹²⁸ Congressional Budget Office, “Repealing the Individual Health Insurance Mandate: An Updated Estimate” (November 2017), www.cbo.gov/publication/53300.

individual families and small groups. On the other hand, some who face premium increases as a result of this final rule might choose to drop insurance coverage altogether.

The Department lacks data to quantify the effect of the final rule on the uninsured population. Publicly available estimates shed only limited light on the question. By one publicly available estimate, AHPs under the Proposed Rule by 2022 on net would add 130,000 individuals to the uninsured population.¹²⁹ However, it appears that this estimate may have neglected AHPs' potential to enroll individuals who would otherwise have been uninsured, focusing only on those who might drop insurance because of individual or small group market premium increases stemming from risk segmentation. Moreover, it is unclear whether this estimate took full account of the interactions among the proposed AHP rule, the ACA's continuing premium tax credit subsidies, and the reduction to \$0 of the ACA's individual shared responsibility payment in 2019. If the estimate did not fully account for these interactions, it is likely to be too pessimistic. Some individuals and small businesses whose premiums will increase because of AHPs' risk segmentation effects might drop insurance, but ACA subsidies could limit this potential. Likewise, AHPs are likely to enroll many individuals who otherwise would have dropped insurance in response to the reduction to \$0 of the individual shared responsibility payment in 2019. By another publicly available estimate, non ACA-compliant policies that resemble AHPs in some relevant respects might reduce the number of uninsured by

¹²⁹ See Avalere Health, "Association Health Plans: Projecting the Impact of the Proposed Rule" at 3, 5-7 (Feb. 28, 2018), available at: <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf>.

1.7 million.¹³⁰ This facially more optimistic estimate may more fully reflect the interactions between expanded availability of AHP-like policies on the one hand, and subsidies and the individual shared responsibility payment reduction on the other. On the other hand, because this estimate pertains not to AHPs but to certain other non ACA-compliant policies, it is unclear whether or how it can be compared with the first estimate. In light of these uncertainties, the Department is unable to predict with confidence whether this final rule on net will reduce or increase the number of Americans without any health coverage.

AHPs are likely to influence the *composition* of the uninsured population such that it includes, for example, proportionately fewer working owners and individuals from low-risk demographics, and proportionately more individuals from high-risk demographics, than would otherwise be the case. Individuals who themselves expect to incur high health costs would be less likely to drop insurance, however. Moreover, states may pursue steps to more generously subsidize high risk individuals.

Various studies of past federal and State reforms that tightened or loosened individual and small group market rules confronted a substantially different health insurance marketplace and hence are of only modest value in predicting the final rule's effects. The studies show that the changes may 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

¹³⁰ See Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 2018, available at https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

coverage.¹³¹ AHPs' potential to expand coverage may be greater than this experience suggests, however. The final rule differs markedly from previous policy reforms that past studies examined. Furthermore, market conditions and the size and composition of the uninsured population are different today and may continue to be different. Generally it is likely that relative to past decades, fewer lower-income individuals are uninsured.¹³² Also as noted earlier, small firms' propensity to offer insurance to their employees has fallen, suggesting potential opportunities for AHPs to expand coverage.

As previously noted, CBO recently analyzed the effects for the proposed rule for Association Health Plans issued on January 5, 2018 and the proposed rule for Short-Term, Limited Duration Insurance (STLDI) issued on February 21, 2018. CBO stated that “[i]n 2023 and later years, about 90 percent of the 4 million people purchasing AHPs and 65 percent of the 2 million people purchasing STLDI plans would have insured in the absence of the proposed rules, CBO and JCT estimate.” Thus, about 400,000, or 10 percent of the 4 million people purchasing AHPs, would come from the ranks of the uninsured. (It is unclear whether this latter estimate would have been higher or lower in the absence of the STLDI proposal, which is not part of this final rule but remains under consideration. Absent STLDI, some otherwise uninsured individuals who would have gained STLDI coverage might gain AHP coverage instead. On the

¹³¹ The regulatory impact analysis of the Proposed Rule cites evidence to this effect.

¹³² ACA Medicaid expansions and subsidies extended coverage to many more low income individuals. See Michael E. Martinez, Emily P. Zammitti, and Robin A. Cohen, “Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2017,” U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, February 2018, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201802.pdf>; and Sara R. Collins, Munira Z. Gunja, Michelle M. Doty and Herman K. Bhupal, “First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–March 2018,” May 1 2018, <http://www.commonwealthfund.org/publications/blog/2018/apr/health-coverage-erosion?omnicid=EALERT1395236&mid=ainserro@ajmc.com>.

other hand, some individuals facing premium increases or losing small employer offers consequent to AHPs who would have signed up for STLDI policies, absent such policies might drop insurance and become uninsured.) The Department did not rely on the information contained in the CBO report to reach its conclusions regarding the effects of the final rule on uninsured persons, but notes that the CBO's findings are consistent with the Department's own findings.

10. Operational Risks

A number of comments on the Proposed Rule expressed concern that AHPs will be vulnerable to the same sorts of mismanagement and abuse that historically afflicted a large number of MEWAs.¹³³ They argued that the Proposed Rule, by relaxing the criteria for groups or associations to sponsor plan MEWAs/AHPs, would contribute to such vulnerability, and questioned whether the Department and the States could sufficiently police AHPs. They questioned, for example, whether employer members can be expected to meaningfully control AHPs in cases where MEWA promoters pursuing profit launch new associations and, as founding association members, assume initial control of new AHPs. They contended that insurance markets that offer few affordable options for small businesses are fertile ground for problem MEWAs. They called on the Department to more closely examine its own experience policing MEWAs, and to factor that experience into its assessment of AHPs' potential impacts and into its deliberations about a possible final rule. Accordingly, this final rule reflects additional examination of the Department's experience policing MEWAs, and includes revised

¹³³ See for example comment 680 from Marc I. Machiz, available at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00680.pdf>.

provisions that address many of the commenters' concerns.

ERISA generally classifies AHPs as MEWAs. Historically, some MEWAs have suffered from financial mismanagement or abuse, leaving participants and providers with unpaid benefits and bills.¹³⁴ Both the Department 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 the Department expanded authority to monitor MEWAs and intervene when MEWAs are at financial or operational risk, and both the Department's and the States' enforcement efforts are ongoing.

The Department stresses that AHPs are also subject to existing federal regulatory standards governing MEWAs, and sponsors of AHPs would need to exercise care to ensure compliance with those standards. The ACA's additional enforcement tools and improvements in the MEWA registration and reporting requirements were designed to reduce MEWA fraud and abuse. Under ERISA section 521, the Secretary may issue an ex parte cease and desist order if it appears to the Secretary that the alleged conduct of a MEWA 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. As an example, a MEWA can be

¹³⁴ 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 (3) 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.

found to create an immediate danger “for failure to establish and implement a policy or method to determine that the MEWA is actuarially sound with appropriate reserves and adequate underwriting.” 29 CFR 2560.521-1(b)(3). 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. Generally, any conduct by a fiduciary that meets the requirements for the issuance of a cease and desist or summary seizure is a violation of his fiduciary duties.

The ACA also expanded reporting and required registration for MEWAs with the Department. MEWA registration requirements require plan and non-plan MEWAs to file Form M-1 under ERISA section 101(g) and 29 CFR 2520.101-2 prior to operating in a State. Further, all employee welfare benefit plans that are MEWAs subject to the Form M-1 requirements are required to file the Form 5500, regardless of the plan size or type of funding.¹³⁵ In addition, the ACA added new criminal penalties under ERISA section 519 for any person who knowingly submits false statements or makes false representations of fact about the MEWA’s financial condition, the benefits it provides, or its regulatory status as a MEWA in the marketing of a MEWA. The ACA also amended ERISA section 501(b) to impose criminal penalties on any person who is convicted of violating the prohibition in ERISA section 519.

The Department recently examined the universe of these reports for MEWAs (including AHPs) operating in each year from 2012 through 2016. According to this examination, in 2016,

¹³⁵ 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. The Department has verified receipt of the required Form 5500 from approximately two-thirds of plan MEWAs filing Forms M-1. While more than 90 percent of 2012 Form M-1 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.

536 MEWAs covered approximately 1.9 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 small fraction 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 final rule, which is intended to facilitate the establishment of more new plan-MEWAs/AHPs, all of which would be required to report annually to the Department.

A little more than one-half of reporting MEWAs operate in just one State, while a handful operate in all 50 States. In 2016, 58 MEWAs reported expanding operations into one or more new States. States with the most plan-MEWAs/AHPs in 2016 included California (122), Texas (98), Washington (95), New York (94), and Ohio (91). Only one had fewer than 20 (Hawaii had 17). Self-insured MEWAs generally are more vulnerable to financial mismanagement and abuse than fully-insured ones. MEWAs were most likely to be entirely or partly self-insured in certain western States including North Dakota (42 percent), Wyoming (41 percent), and Montana (37 percent). About one-fourth of reporting MEWAs are entirely or partly self-insured in all the States in which they operate, and another 4 percent are entirely or partly self-insured in some States. The remaining majority does not self-insure and instead is fully insured by issuers in all States in which they operate. Nearly all reporting MEWAs offered health coverage, and many offered other additional welfare benefits (such as dental, vision, life insurance, and/or disability insurance).

While plan MEWAs generally are required to file both Form M-1 and Form 5500, many fail to file both or report potentially inconsistent information across the two forms. Among plan MEWAs filing Form M-1 for 2015, approximately two-thirds can be linked readily with a corresponding Form 5500, suggesting that many either fail to file one or both forms, or file inconsistent identifying information that inhibits linking the two. Among those that can be linked, information provided sometimes is not consistent across the two forms. In addition, among self-insured MEWAs, 41 percent indicated that they had not obtained actuarial opinions about their financial stability. MEWAs must indicate on Form M-1 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. As of 2016 nearly none reported lack of compliance with the former, but 14 percent reported that they did not comply with the trust requirement. These apparent reporting and operational deficiencies underscore the need for the Department and States to allocate resources to effectively oversee AHP operations and prevent mismanagement and abuse.

Since 1985, the Department's records indicate that it has pursued a total of 968 civil enforcement cases involving MEWAs, affecting more than 3 million participants. Among these cases, 338 involved allegations of fiduciary violations, 215 involved allegations of prohibited transactions (generally involving financial conflicts of interest), and 301 yielded monetary restitution of more than \$235 million from the violations. (Many of these and other related cases involved other types of violations such as failure to follow plan terms or healthcare laws, provide plan benefits, or reporting and disclosure deficiencies.) The Department's enforcement efforts often were too late to prevent or fully recover major financial losses. The Department generally does not consistently measure or record those associated unpaid claims or their financial impacts

on patients and healthcare providers. The Department additionally has pursued 317 criminal MEWA-related cases, resulting in 118 convictions and guilty pleas, and \$173 million in ordered restitution.¹³⁶

This rule includes provisions intended to protect AHPs against mismanagement and abuse. It requires the group or association to have a formal organizational structure with a governing body and by-laws or other similar indications of formality appropriate for the legal form in which the group or association is operated. This requirement is 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 rule also requires employer members to control the functions and activities of the group or association and the employer members that participate in the plan to control the plan. This requirement is necessary both to satisfy ERISA’s requirement that the group or association must act directly or indirectly in the interest of employers in relation to the employee benefit plan to meet the definition of employer, 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 that may be vulnerable to abuse. In addition, the final rule allows only employer members to participate in the AHP, and health coverage must only be available to or in connection with a member of the group or association, in order for the group or association to qualify as bona fide. Together, these criteria are intended to ensure that groups or associations sponsoring AHPs are bona fide employment-based groups or associations and more likely to be resistant to abuse.

¹³⁶ Since 1985 EBSA’s case information database system has experienced various upgrades and enhancements, impacting the collection of data on MEWA cases. Due to these changes over the more than 30 years, the reported number of MEWA cases may be slightly under or over estimated.

An AHP sponsored by a bona fide group or association under this final rule is a group health plan under ERISA. Accordingly, AHPs are subject to all of the provisions of Title I of ERISA applicable to group health plans. Therefore, participants and beneficiaries receiving their health coverage through AHPs are entitled to the same protections under ERISA that are available to participants in single employer group health plans. For example, AHPs may not exclude coverage for preexisting conditions, impose lifetime and annual dollar limits on essential health benefits, or discriminate based on health factors. AHPs that provide dependent coverage must permit dependents to remain enrolled until they reach the age of 26. AHPs may not rescind a participant's or beneficiary's coverage except in the event of fraud or intentional misrepresentation of a material fact.

Nevertheless, the Department anticipates that the increased flexibility afforded AHPs under this rule will introduce increased opportunities for mismanagement or abuse, in turn increasing oversight demands on the Department and State regulators. A report responding to Executive Order 13813 notes that States can require self-insured AHPs to meet the same solvency and governance standards as issuers and to participate in guaranty funds that protect policyholders when issuers fail. States also can clarify or enact laws allowing their insurance departments to place AHPs into receivership if needed.¹³⁷ In this regard, the Department affirms above in this preamble that the final rule does not modify or otherwise limit existing State authority as established under section 514 of ERISA. Section 514(b)(6) of ERISA gives the Department and State insurance regulators joint authority over MEWAs, including AHPs (which

¹³⁷ Georgetown University Health Policy Institute, Center on Health Insurance Reforms, "State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Association Health Plans," December 2017.

are a type of MEWA), to ensure appropriate consumer protections for employers and employees relying on an AHP for healthcare coverage. Nothing in the final rule changes this joint structure, or is meant to reduce the historically broad role of the States when it comes to regulating MEWAs.

11. Federal Budget Impacts

The rule is likely to have both positive and negative effects on the budget, with some increasing and others reducing the deficit. On balance, the final rule's net impact on the federal budget is likely to be negative, increasing the deficit.

In 2005, the Congressional Budget Office (CBO) estimated the potential budget impacts of a 2005 legislative proposal to expand AHPs. As noted earlier, that legislative proposal predated the ACA and differed from this final rule, and the impacts of that proposal likely would differ from the impacts of this final rule in the market in 2018 and 2019. Under the 2005 legislation and contemporaneous law, many individuals joining AHPs previously would have been uninsured or purchased individual policies without the 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 the Department to hire 150 additional employees and spend

an additional \$136 million over 10 years to properly oversee AHPs.¹³⁸ Together these budget impacts would have increased the federal deficit by \$317 million over 10 years.

Today, many individuals who might have been uninsured in 2005 instead are enrolled in Medicaid or insured and receiving subsidies on Exchanges. When joining AHPs, these individuals in effect would trade existing subsidies for tax exclusions. Market forces generally favor individuals capturing the larger available subsidy, so it is more likely that higher income individuals will have an incentive to enroll in AHPs. To the extent that AHPs may increase premiums in Exchanges, subsidies paid there may also increase. This arguably could improve equity, insofar as transfers from taxpayers are likely to be more progressive than the cross-subsidies from low-risk individuals such transfers would replace. In 2017 approximately 8 million individuals insured on Exchanges received \$34 billion in tax credit subsidies.¹³⁹ If, however, AHPs enroll some Medicaid enrollees or some individuals otherwise receiving large subsidies on individual Exchanges, savings from these impacts might offset a portion of these deficit increases.

12. Applicability Date

As discussed later in the preamble, the final rule includes a phased or staged applicability date that provides prompt expansion of AHP availability while addressing certain concerns raised by commenters. The final rule allows fully insured plans to begin operating under the new rule on September 1, 2018. Existing self-insured AHPs can begin operating under the new rule

¹³⁸ 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>.

¹³⁹ U.S. Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027,” September 2017.

on January 1, 2019, and new self-insured AHPs can begin on April 1, 2019. This phased approach will provide prompt relief to individuals seeking affordable health coverage through AHPs while allotting some additional time for the Department and State authorities to address concerns about self-insured AHPs' vulnerability to financial mismanagement and abuse.

Some comments urge quick action to make AHPs available. Many express impatience for more affordable alternatives to ACA-compliant small group and especially individual policies. These comments appear to be motivated by both the sharp premium increases and scarcity of choices that characterize certain local markets. Absent more affordable alternatives, many small businesses have opted to go without insurance. It is likely that, absent alternatives, more would drop insurance in 2019 as premiums continue to increase and the individual shared responsibility payment is reduced to \$0. Many of those who did not drop insurance would be forced to make other economic sacrifices to maintain coverage.

Other comments call for delay. Some comments say delay is needed to accommodate the annual cycle for insurance policy premium approvals by State insurance regulators. The cycle for calendar year 2019 in many States is already underway (March through May, according to one comment),¹⁴⁰ and the uncertain impact of the final rule on the individual market and small group market may or may not be factored into individual and small group ACA-compliant issuers' 2019 premiums for those markets. If AHPs enter markets in 2019 and ACA compliant issuers' rates for the individual and small group markets fail to account for associated adverse

¹⁴⁰ See comment letter from BlueCross BlueShield, March 6, 2018 (Comment # 549 on EBSA webpage last accessed at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00549.pdf>).

selection, those rates may be insufficient to cover the issuers' expenses. Some comments accordingly call for applicability of the final rule to be delayed until at least 2020.

Some comments urge delay to reduce risks of mismanagement and abuse. Effective AHPs need time to establish robust governance structures, financial arrangements, and businesses practices. Comments claim that any AHP that rushes to begin or expand operations in 2019 could pose risks. The Department and State authorities both need time to build and implement adequate supervision and possible infrastructure to prevent fraud and abuse and possibly to revise other relevant rules to optimize AHPs' role in local markets.¹⁴¹

Commenters pointed out that State insurance regulators actively provide oversight and enforcement in the MEWA area to, among other things, prevent fraud, abuse, incompetence and mismanagement, and avoid unpaid health claims. Many States say they will need time for new AHP specific legislation and/or modification of existing regulations and expanded funding for enforcement programs. Commenters also said time will be needed for State regulators to coordinate with the Department on the scope of State authority to regulate, especially with respect to inter-state AHP operations.

Commenters also called for the Department to increase its enforcement activities. This increase would require Congress to appropriate additional funding for the Department's oversight of expanded AHPs and for the Department to expand staff and related enforcement support resources to meet that broader enforcement/oversight mission.

¹⁴¹ As noted above, the Department intends to reexamine existing reporting requirements for AHPs/MEWAs, including the Form M-1 and possibly the Form 5500, and may be asked to propose class or individual prohibited transaction exemptions for AHPs that want to use affiliates to serve as their administrative service providers or act as issuers providing benefits under the AHP.

This final rule's phased applicability dates aim to balance the prompt promotion of more affordable health coverage options with caution about market and operational risks. Expanded AHP operations beginning on or after September 1, 2018 will be limited to fully insured AHPs because these AHPs are best positioned to take advantage of this earliest opportunity to offer coverage to individuals and small business and likely to be less susceptible to problems and more prepared to deliver reliable coverage in an orderly fashion. First, such AHPs must be fully insured and therefore protected by already established State oversight of large group issuers' financial stability and market conduct. Second, it is likely that many or most of the earliest AHP growth will build upon existing AHP or group and association operations. This might include for example: (1) an existing plan MEWA/AHP expanding availability to more industries and/or to working owners; (2) an existing non-plan MEWA that currently distributes small group policies to small businesses in multiple industries converting itself into a plan MEWA/AHP that offers large group policies covering the same and possibly additional businesses; and (3) an existing local group or association, such as a local chamber of commerce, that currently does not offer members health insurance partnering with a local large-group issuer to establish an AHP for its members.

Additional expanded AHP operations under this final rule will be limited to currently existing self-insured AHPs beginning on or after January 1, 2019. Starting then, such AHPs could, for example, expand availability to additional industries within a geographic location and/or to working owners without employees, subject to the provisions of this final rule. Existing self-insured AHPs already have been subject to ERISA's fiduciary standards of loyalty and care, and barred from engaging in financial conflicts of interest (except where permitted under an applicable prohibited transaction exemption). Moreover, this final rule leaves intact

States' broad authority to oversee these AHPs. Therefore, self-insured AHPs that expand operations pursuant to this final rule's January 1, 2019 applicability date will be the same entities, overseen by the same federal and State authorities, as in the recent past. Extending these entities' ability to offer more affordable health insurance to additional small businesses and working owners justifies any attendant extension of their operational risks.¹⁴²

The last expansion of AHP operations under this final rule applies to new self-insured AHPs' operations beginning on or after April 1, 2019. This modest delay of the applicability date for such AHPs is intended to enable and encourage them to fully prepare for sound operations and provide sufficient time for the Department and the States to implement a robust supervisory infrastructure and program. The Department intends to immediately increase its focus on compliance guidance and enforcement in collaboration with the States.

As noted later in this preamble, this final rule's prompt but phased applicability dates aim to balance quick access to affordable insurance with due caution about adverse market impacts and operational risks. Market forces may favor AHPs that grow fastest in areas where needs are greatest, but such needs magnify AHPs' potential to do both good and harm. The sequencing of applicability dates – fully insured AHPs first, existing self-insured AHPs second, new self-insured AHPs last – responds to this tension by opening the door soonest for earlier growth by lower risk arrangements. Early availability of more affordable insurance for small businesses, especially for those who otherwise would forgo coverage, justifies any possible disruption to

¹⁴² Some self-insured AHPs historically have subjected consumers to fraud, mismanagement, and abuse. Six in ten MEWAs that self-insure in all or some States in which they operated in 2016 reported obtaining opinions about their financial stability from independent actuaries.

individual and small group issuers who have already begun setting 2019 rates and the markets in which they operate.

Further, consistent with EBSA's longstanding commitment to providing compliance assistance to employers, plan sponsors, plan fiduciaries, other employee benefit plan officials and service providers in understanding and complying with the requirements of ERISA, the Department intends to provide affected parties with significant assistance and support during the transition period and thereafter with the aim of helping to ensure the important benefits of the final rule are implemented in an efficient and effective manner.

AHPs' growth and impacts are likely to be more gradual than the phased applicability dates alone would allow. Some comments suggest that many of the most substantial and fully insured AHPs are expected to choose to delay modifying their programs to reflect the new AHP rule and new enrollment activity until calendar year 2020 (the next rating cycle), when the rate environment is more settled and certain.

13. Regulatory Alternatives

As required by EO 12866, the Department considered various alternative approaches in developing this final rule that are discussed below.

Retain the Department's existing AHP sub-regulatory guidance. As discussed above, in response to the Proposed Rule, several commenters requested the Department allow entities meeting the Department's previous sub-regulatory guidance defining the term "bona fide group or association of employers" to continue to rely on such guidance without meeting the criteria set forth in the new rule. They argued that existing AHPs that relied on the Department's pre-rule guidance on "bona fide group or association of employers" did not design their operations with the new requirements in mind. As a consequence, they may not be able to comply with the new

conditions without reducing existing options for affordable healthcare. A primary rationale for the commenters was that some type of grandfathering would accommodate AHPs that have used experience-rating for each employer member in the past to prevent undue disruption and burdens associated with coming into compliance with new rules that are inconsistent with long-standing business practices.

Other commenters asserted that allowing new entities to satisfy the Department's prior guidance under a grandfathering approach potentially would result in more choice for small businesses by allowing them to choose from providing coverage in plans in the traditional health insurance market, the grandfathered AHP market, and the newly expanded AHP market under the final rule.

On the other hand, some commenters were opposed to the Department adding a grandfathering provision, because exempting groups or associations from the nondiscrimination requirements and allowing them to experience rate member employers would result in some entities offering coverage in ways that are inconsistent with the final rule and put new AHPs at a competitive disadvantage compared to grandfathered AHPs.

After considering these comments, the Department has determined that the requirements of the final rule do not supplant the Department's previously issued guidance. As stated above, the final rule expands the opportunities for employer groups or associations to form AHPs by establishing an alternative mechanism for meeting the "employer" requirements specifically by relaxing the commonality requirement, allowing the employer group or association to exist for a principal purpose of offering health coverage, and providing coverage to working owners without employees.

The Department intends for the criteria set forth in this final rule to provide an alternative

basis for groups or associations to meet the definition of an “employer” under ERISA section 3(5). Accordingly, the final rule does not require employer groups and associations meeting the criteria under the Department’s prior AHP guidance to comply with the nondiscrimination provision of the final rule (although, of course, the HIPAA health nondiscrimination rules continue to apply to the AHP, as a group health plan). Therefore, such AHPs may treat each employer-member as a distinct group of similarly situated individuals to the extent permissible under current HIPAA health nondiscrimination rules based on the facts and circumstances of the particular situation. Allowing new AHPs to operate pursuant to either this new rule or the Department’s pre-rule guidance, rather than simply grandfathering existing AHPs to continue operating as before, ensures that new AHPs can compete with existing ones on equal footing.

Modifying the control requirement. The proposal generally required that groups or association members control the AHP’s functions and activities, including the establishment and maintenance of the group health plan in order for the group or association to qualify as bona fide. Such control under the proposal could be direct or indirect through the regular election of directors, officers, or other similar representatives that control the group or association and the establishment and maintenance of the plan.

A number of commenters supporting the Proposed Rule acknowledged that a control test is necessary to ensure that groups or associations act “in the interest” of participating employers in relation to the group health plan, as required by section 3(5) of ERISA. A number of commenters who generally opposed the proposal were skeptical that the proposed control test could adequately protect against fraudulent MEWAs and other entities that may not act in the best interest of the employer members. A few commenters opposed the proposed control test entirely. These commenters generally expressed apprehension about the logistics of requiring

participating employer members to control the functions and activities of a large group or association.

After careful consideration of these comments, the Department has determined that the control test is necessary to satisfy the statutory requirement in ERISA section 3(5) that the group or association must act “in the interest of” the employer members in relation to the employee benefit plan in order to qualify as an employer. The control test is also necessary 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.

The Department, however, slightly modified the language in the final rule to better align the control test with the Department’s existing sub-regulatory guidance. Specifically, as revised, the control test provides that the functions and activities of the group or association must be controlled by its employer members in order for it to qualify as bona fide. The control test also requires the group or association’s employer members that participate in the group health plan to control the plan. Control must be present both in form and in substance. The determination of whether control exists is based on a facts and circumstances test.

Subjecting AHPs to ACA individual and small group market rules. A number of public comments raised the risk that AHPs would exercise their flexibility in ways that harm local individual and small group markets. Some advocated a level playing field where AHPs compete with issuers under the same rules. However, AHPs’ flexibility to offer products and premiums that more closely align with their members’ preferences is a significant benefit for those members. That flexibility also frees AHPs from some regulatory overhead, and may enable some AHPs to achieve the scale necessary for administrative efficiency and market power.

States retain discretion to regulate AHPs. For these reasons, this final rule does not subject AHPs to the ACA's individual and small group market rules.

Allowing new AHPs to exist for the sole purpose of providing insurance. The Proposed Rule stated that a bona fide group or association of employers may act as an employer sponsoring a group health plan if it exists for the purpose, in whole or in part, of sponsoring a group health plan that it offers to its employer members. This represents a departure from previously issued sub-regulatory guidance, which required a group or association to exist for purposes other than providing health benefits in order to act as an employer for purposes of sponsoring a group health plan.

As discussed earlier in this preamble, many commenters, including some who were otherwise supportive of the Proposed Rule, objected to this provision. Several commenters believed that, because most small businesses already have the opportunity to belong to a chamber of commerce or other professional group or association, allowing a group or association to be formed solely for the purpose of sponsoring a group health plan is unnecessary to achieve the Department's goals. Commenters believed that a proliferation of associations established for the exclusive purpose of sponsoring an AHP could diminish the value of existing trade and professional groups. Similarly, a proliferation of groups or associations could also diminish the market power of existing AHPs and those that may be formed by groups and associations that exist for other purposes. In particular, a proliferation of groups or associations could limit these entities' opportunities to achieve the economies of scale that make AHPs an attractive vehicle for providing affordable coverage in the first place. Commenters also argued that allowing groups and associations formed for the sole purpose of offering an AHP could invite unscrupulous

promoters to enter the market with mismanaged and thinly funded AHPs that could engage in fraudulent and abusive practices.

Commenters offered numerous suggestions for alternative criteria determining a bona fide group or association of employers for purposes of the new rule with the aim that those eligible be limited to legitimate, well-managed, and well-intended organizations with the ability to properly operate an AHP. Some commenters supported retaining the requirement in the Department's prior guidance that the group or association exist for other purposes unrelated to the provision of benefits in order for the group or association to qualify as bona fide. Some suggested requiring a group or association to exist for a specified minimum length of time before it could sponsor an AHP. Others suggested requiring the group or association to meet certain criteria for tax-exempt organizations, have minimum revenues unrelated to AHP operations, or demonstrate by other means the capacity to oversee the administrative requirements associated with managing the complexities of an AHP.

After consideration of the public comments, the Department determined that some modification of this provision is appropriate, because the intent of this final rule is to expand access to AHP coverage options, while protecting plan participants and beneficiaries from imprudent, abusive, or fraudulent arrangements. Removing undue restrictions for existing groups and associations as well as for newly-formed groups and associations of employers and working owners is critical to achieving the Department's goal of expanding choice in health coverage options. But the Department shares concerns regarding operational risks such as fraud and insolvency that commenters believed would be more likely with respect to AHPs offered by newly-formed groups and associations that exist solely for the purpose of sponsoring an AHP. In addition, the Department's revisions of the final rule are responsive to concerns that, in the

absence of some purpose other than providing health benefits, there may be insufficient basis for treating the group or association as the sort of employment-based group or association contemplated by ERISA section 3(5). Accordingly, the Department is modifying this provision in the final rule to establish a general legal standard requiring a group or association of employers to have at least one substantial business purpose unrelated to offering and providing health care coverage or other employee benefits to its employer members and their employees, even if the primary purpose of the group or association is to offer such coverage to its members. Although the final rule does not define the term “substantial business purpose,” the rule contains an explicit safe harbor under which a substantial business purpose is considered to exist in cases where the group or association can establish that it would be a viable entity even in the absence of sponsoring an employee benefit plan and states that a business purposes does not require a for-profit purpose. The Department believes these modifications assist substantially in drawing a clean line between entities that might exist only to underwrite and sell insurance, on the one hand, and those that qualify as an “employer” under section 3(5) of ERISA, on the other, because of their other substantial business purpose.

Determining Effective and Applicability Date. As discussed above, the Proposed Rule did not include a discussion of the effective and applicability date for the rule and exemptions. Nevertheless, the Department received a significant number of comments regarding the importance of properly timing implementation of the final rule. Some commenters suggested that the effective date of the final rule should be no less than a year after it is published in the Federal Register. Others suggested an effective date of January 1st of the first full calendar year to fall at least 12 months from the date of publication of the final rule. Still others urged an effective date of January 1, 2020, or later. Still others argued that the effective date should be no

less than three years after publication of the final rule for self-insured AHPs with a grandfathering exemption date of December 31, 2017 that will allow existing bona fide AHPs to remain operational.

After careful consideration of the public comments, the Department has determined that it is important for the final rule to become effective on the earliest possible date to provide plans, plan fiduciaries, plan participants and beneficiaries, and other stakeholders with certainty that will allow them to allocate capital and other resources and make decisions to prepare to implement AHPs pursuant to the final rule.

The Department considered providing the same applicability date for fully insured and self-insured AHPs, but instead chose the following trifurcated applicability dates: September 1, 2018 for new fully insured arrangements; January 1, 2019, for existing self-insured plan MEWAs that meet the employer definition by satisfying the Department's existing sub-regulatory guidance and want to comply with the final rule; and April 1, 2019 for new self-insured AHPs. The Department believes that this approach will allow AHPs in each category to become operational as soon as possible while providing adequate time for plans and their affected service providers to adjust to the final rule. The Department has concluded that a phased or staged compliance date would address the concerns raised in the comments while also facilitating an immediate expansion of AHP availability in the marketplace.

Omitting Working Owners from AHP Eligibility. The Department considered whether to omit from AHP eligibility working owners with no employees. Some commenters questioned whether their inclusion was consistent with ERISA's application to employers only. Some saw their inclusion as likely to produce too much adverse selection against local individual markets. Other commenters, however, argued that working owners currently are particularly

disadvantaged by the limited choices and high prices that afflict many local individual markets, and consequently can gain much from AHP eligibility.

Under this final rule, AHPs can extend eligibility to both employers and working owners without employees. The Department separately considered eligibility for each, together with the respective separate implications for local small group and individual markets, and concluded that each was separately justified. The expansion of AHP opportunities for small employers under this rule will make more affordable choices available to many, including choices provided by geographically-based AHPs that benefit from large local market shares. This justifies any attendant adverse selection against local small group markets. Likewise, the extension of AHP eligibility and choices to working owners will make more affordable choices available to many, including some who otherwise would have dropped insurance altogether. Relative to small employers, the stakes for many working owners are likely to be higher. Working owners without employees currently are confined to local individual markets, many of which are beset by very limited choices and/or very high or rapidly increasing premiums. AHPs can offer many such working owners far more affordable alternatives. Relative to small group markets, such affected individual markets may be both more fragile and more susceptible to adverse selection, but the attendant risks for most individuals insured there are limited by the availability of subsidies for most individuals who purchase coverage on Exchanges. The availability of more affordable options for working owners justifies consequent cost increases for taxpayers and for affected individuals.

The final rule does not disturb states' authority to regulate AHPs in order to optimize their benefits for working owners and/or ameliorate any attendant negative consequences for local ACA-compliant individual markets.

Expanding or Omitting the Proposed Rule's Paragraph (d)(4) Nondiscrimination

Provision. As stated earlier in this preamble, the Proposed Rule included certain nondiscrimination requirements that built on the existing health nondiscrimination provisions applicable to group health plans under HIPAA, as amended by the ACA, referred to as the HIPAA health nondiscrimination rules.¹⁴³ The proposal prohibited the group or association from treating member employers as distinct groups of similarly-situated individuals when applying the HIPAA health nondiscrimination rules for defining similarly-situated individuals if the group or association wishes to qualify as bona fide. Therefore, groups or associations that conditioned individual employer members' eligibility for benefits or premiums on their respective employees' health status could not qualify as bona fide.

The Department considered expanding or omitting this provision from the final rule. Some commenters criticized this provision as an undue obstacle to AHPs' proliferation and growth. Some expressed concern that the provision would expose AHPs to adverse selection, while some noted that some existing AHPs currently do condition employer members' eligibility for benefits and/or premiums on their employees' health status. Other commenters praised the provision as a necessary and justified check against AHPs' ability to segment good risks from ACA-compliant individual and small group markets. Some generally criticized discrimination based on health status as contrary to fairness and an obstacle to access and affordability to individuals with health problems who need insurance most. Some argued that this provision alone was inadequate to protect ACA-compliant markets from adverse selection and to preserve fairness, access, and affordability for people with health problems, and that AHPs additionally

¹⁴³ 29 CFR 2590.702(d)(3). See also 29 CFR 2590.702(d)(4) Example 5.

should be subject to some or all of the ACA and state rules applicable to the individual and small group markets in which they operate.

After careful consideration of the comments, the Department agrees that it is unnecessary and would be counterproductive to outlaw currently existing lawful and successful AHP practices. Therefore, AHPs established under pre-rule guidance will retain the same flexibility as in the past to condition individual employer members' premiums on their respective employees' health status, to the extent permissible under the current HIPAA nondiscrimination rules based on the facts and circumstances of the particular situation.¹⁴⁴

The Department notes that this final rule's nondiscrimination provisions will limit AHPs' flexibility to set actuarially fair prices, and will reduce risk segmentation that favors AHPs over individual and small group markets. This final rule newly authorizes multi-industry, geographically-based AHPs, and AHPs that include working owners. In combination, the flexibility to condition employer members' premiums on health status and the ability to claim a large local market share would pose a greater potential for adverse selection against ACA-compliant markets than that presented by existing AHPs. The Department further notes that this final rule's nondiscrimination provision will increase AHPs' exposure to adverse selection, and with it their propensity to defend against adverse selection by limiting some benefits.

However, after careful consideration of the comments, the Department decided the nondiscrimination provision in paragraph (d)(4) should be retained. As discussed in section B.2.g. of the preamble, above, under the heading Nondiscrimination, because the final rule relaxes the Department's pre-rule guidance on the groups or associations that may sponsor a

¹⁴⁴ See discussion in section B.2.g. of the preamble, above, under the heading Nondiscrimination.

single ERISA-covered group health plan, it is especially important to maintain paragraph (d)(4) as proposed. In the context of these new, broader arrangements, paragraph (d)(4) helps ensure that the group or association is distinguishable from commercial-insurance-type arrangements.

14. Conclusion

The expansion of AHPs under this final rule will provide small businesses, including working owners, with additional and more affordable health insurance options that will more closely match their preferences. Many employees of small businesses will appreciate the more affordable health insurance provided through AHPs. Relative to ACA-regulated health insurance issuers in individual and small group markets, AHPs will be able to offer more affordable options by pursuing economies of scale and offering more tailored, often less comprehensive benefit packages that are priced in a more actuarially fair manner.

Increased regulatory flexibility will necessarily result in some segmentation of risk that favors AHPs over individual and small group markets. However, practical considerations and federal nondiscrimination rules will limit such segmentation. States may further limit risk segmentation. Favorable selection toward AHPs will help reduce premiums for many small businesses, but will increase premiums somewhat for individuals and other small business remaining in the ACA-compliant individual and small group markets. Subsidy-eligible taxpayers with household incomes at or below 400 percent of poverty purchasing coverage on Exchanges generally will be protected from these premium increases.

Operational risks demand increased federal and state oversight. Overall, this rule delivers social benefits that justify any attendant social costs.

15. Paperwork Reduction Act

The final 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).

16. 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 certifies that a final rule is not likely to have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires the agency to present a final regulatory flexibility analysis (FRFA) of the final rule. The Department has determined that this final 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 FRFA of the final rule, below.

Need for and Objectives of the Rule

This final rule is intended and expected to deliver benefits primarily to the employees of many small businesses and their families including many working owners, as well as many small businesses themselves. As discussed in more detail in section 2 of the RIA, this final rule would encourage the establishment and growth of AHPs. AHPs may offer many small businesses and working owners additional and more affordable health benefit options than otherwise are available to them in the individual and small group markets.

Affected Small Entities

The Small Business Administration estimates that 99.7 percent of employer firms meet its definition of a small business.¹⁴⁵ The applicability of these final rules does not depend on the size of the firm as defined by the Small Business Administration. Small businesses, including sole proprietors can join AHPs as long as they are eligible to do so and the AHP sponsor meets the requirements of the final rule. The Department believes that the smallest firms, those with less than 50 employees, are most likely to benefit from the savings and increased choice derived from AHP coverage under the final rule and include some subset of:

- The 25 million individuals under age 65 who currently are covered in individual markets, including approximately three million who are sole proprietors or dependents thereof, and an additional 12 million who are employees of small businesses or dependents thereof;¹⁴⁶
- The 28 million individuals under age 65 who currently lack insurance, including three million who are sole proprietors or dependents thereof, and an additional 12 million who are employees of small businesses or dependents thereof;¹⁴⁷ and
- The 1.6 million private, small-firm establishments (those with fewer than 50 employees) that currently offer insurance and the four million that do not.¹⁴⁸

¹⁴⁵ SBA Office of Advocacy Frequently Asked Questions.

https://www.sba.gov/sites/default/files/FAQ_Sept_2012.pdf.

¹⁴⁶ 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.

¹⁴⁷ 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.

¹⁴⁸ DOL calculations based on the Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey-Insurance Component, 2016. Medical Expenditure Panel Survey Private Sector Insurance Component, Table I.A.1 and Table I.A.2.

Impact of the Rule

As stated above, by expanding AHPs, this final rule would provide additional and more affordable health coverage options for many small businesses, thereby potentially yielding economic benefits for participating small businesses and their employees. The rule may impact individual and small group issuers whose enrollees might switch to AHPs; many of these issuers would likely be small entities. Some small businesses obtaining coverage in the small group health insurance market will experience an increase in premiums. Some of those will not receive attractive alternative offers from AHPs. Some of those may see decreased choice and may even stop offering insurance to their employees due to the premium increases or to issuers withdrawing some offers. The final rule allows states to continue to regulate AHPs, which can serve to mitigate any adverse impacts on small businesses due to the expansion of AHPs.

The RIA and preamble to the final rule includes a discussion of the changes to the Proposed Rule in response to comments. These changes include applying phased applicability dates, modifying the “control” requirement, allowing continued reliance on previous AHP rules so existing AHPs can continue to operate as they do today and new AHPs can form under the Department’s previously issued guidance, lowering the hours worked threshold for working owners without employees to 20 hours per week, and requiring AHPs to be established and maintained for at least one substantial business purpose that is not sponsoring a group health plan. The “Regulatory Alternatives” section of the RIA above discusses significant regulatory alternatives considered by the Department.

Duplication, Overlap, and Conflict with Other Rules and Regulations:

The final rule would not conflict with any relevant federal rules. As discussed above, the final rule would merely broaden the conditions under which a group or 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. In the final rule, the Department affirms that the rule does not modify existing State authority as established under ERISA section 514(b)(6), which gives the Department and state insurance regulators joint authority over MEWAs, including AHPs, to ensure appropriate consumer protections for employers and employees relying on an AHP for health coverage. Nothing in the final rule changes this joint structure, or is meant to reduce the historically broad role of the States when it comes to regulating MEWAs.

17. Congressional Review Act

The final 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 will be transmitted to Congress and the Comptroller General for review.

The final rule is a “major rule” as that term is defined in 5 U.S.C 804, because it is likely to result in an annual effect on the economy of \$100 million or more.

18. 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 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 rule 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. The rule merely broadens the conditions under which AHPs will be treated as large group health benefit plans under ERISA, the ACA and state law.

19. 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, this final rule 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 final rule 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 ERISA section 514(b)(6)(A)(ii) 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, ERISA section 514(b)(6)(A)(i) provides that only those state insurance laws that regulate the maintenance of specified contribution and reserve levels may apply to the AHP, although the States, of course, retain regulatory authority over the insurance company

itself and any policies it issues. The Department notes that state rules vary widely in practice, and many States regulate AHPs less stringently than individual or small group insurance.

In the course of developing this final rule, the Department consulted directly with a number of state officials, including state insurance department representatives and state-based Exchange representatives, as well as with the National Association of Insurance Commissioners.

The Department received many comments, including from several state insurance regulators, asserting that it is very important for the Department not to draft or implement the final rule in a manner that undermines or impairs the current ERISA preemption provisions that broadly permit states to regulate AHPs. They maintained that if the final rule prevents states from applying their insurance laws to AHPs, market fragmentation could result, because AHPs could be established in a state with less restrictive issuer and rating rules relative to other states. These commenters argued that AHPs operating in multiple states should be required to abide by the regulations of each of the states in which the plan operates, and not just the state in which the group or association or their AHP is deemed to be domiciled. Another commenter suggested that the final rule should distinguish self-insured AHPs, which have historically presented problems in the market, from fully-insured AHPs, which are backed by licensed insurance companies and subject to oversight by state insurance commissioners and HHS. A few commenters asked that DOL promulgate a rule under ERISA section 520 which authorizes the Department to make persons operating AHPs subject to otherwise preempted state insurance laws to prevent fraud and abuse.

The main point of these commenters is that the Department should make a clear and unequivocal statement in the final rule that States retain full authority to set and enforce solvency standards for all AHPs, and comprehensive licensure requirements and oversight for non-fully-

insured AHPs including benefit, rating and consumer protection standards, and laws specifying who is eligible to apply for licensure. The Department agrees that the final rule does not modify existing state authority. ERISA section 514(b)(6) gives the Department and state insurance regulators joint authority over MEWAs, including AHPs (which are a type of MEWA), to ensure appropriate regulatory and consumer protections for employers and employees relying on an AHP for healthcare coverage. The Department therefore states in this final rule that nothing in the rule changes this joint structure, or is meant to reduce the historically broad role of the States when it comes to regulating MEWAs, including AHPs.

Thus, under this framework, if an AHP established pursuant to this final rule is not fully insured, any state law that regulates insurance may apply to the MEWA to the extent that such state law is “not inconsistent” with ERISA. If an AHP is fully insured, state laws that regulate the maintenance of specified contribution and reserve levels (and that enforce those standards) may apply to the MEWA, and state insurance laws are generally saved from preemption when applied to insurance companies that sell policies to AHPs and to insurance policies that AHPs purchase to provide benefits. In addition, with respect to fully-insured AHPs, the Department’s view is that ERISA section 514(b)(6) clearly enables states to subject such AHPs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of State insurance law necessary to ensure compliance with the State insurance reserves, contributions and funding requirements.

20. 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 rule is expected to be an EO 13771 deregulatory action, because it will 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.

D. Effective Date, Applicability Dates and Severability

Although the Proposed Rule did not contain a separate discussion of an effective date or applicability date for the final rule, the Department received a significant number of comments regarding the importance of properly timing implementation of the final rule. The comments supporting delay pointed to a number of challenges in moving forward with new AHPs on an expedited schedule. For example, some asserted that early applicability dates would be poor matches for state timelines for setting premium rates. According to some commenters, the annual cycle for insurance policy premium approvals supports an applicability date after January 1, 2019. According to one commenter, in many states, the critical period for 2019 pricing is March through May of 2018. As a result, the impact of this rule may or may not be factored into 2019 premiums. Similarly, some commenters suggested that many fully-insured AHPs and the largest self-insured AHPs are expected to choose to delay modifying their programs until calendar year 2020, when the implications of the rule and the rate environment is more settled and certain. Commenters supporting delay also argued that the effect of an immediate effective date may be to encourage the establishment of AHPs that enter the market (both self- and fully-insured arrangements) prematurely without the proper administrative processes necessary to avoid consumer harm (e.g., adequate reserves and appropriate premium structures). They expressed concern that this could result in an initial AHP implementation marked by a higher concentration of riskier, or even fraudulent, structures capturing the market.

Many commenters also noted that regulators, as well as AHPs, need time to prepare for change. For example, there will be a need to modify existing reporting requirements for AHPs

and other MEWAs, including at least the Form M-1 and possibly the Form 5500. That will require APA rulemaking and/or Paperwork Reduction Act notice and comment processes that optimally would need to be completed in advance of the applicability date of the new AHP rule. Similarly, there may be a need for class or individual prohibited transaction exemptions in the case of AHPs that want to use affiliates to be administrative service providers to the AHP or to act as issuers providing benefits under the AHP. ERISA requires a notice and comment process for issuance of prohibited transaction exemptions, which necessarily takes time. Similarly, the final rule importantly depends on state insurance regulators for oversight and enforcement to, among other things, prevent fraud, abuse, incompetence and mismanagement, and avoid unpaid health claims. Some states say they will need time for new AHP-specific legislation and/or modification of existing regulations and enforcement programs.

The comments also included specific suggestions. For example, some said the applicability date of the new rule needs to be delayed for no less than a year after it is published in the Federal Register. Others suggested an applicability date of January 1 of the first full calendar year to fall at least 12 months from the date of publication of the final rule. Still others urged an applicability date of January 1, 2020, or later. Others argued that the applicability date should be delayed no fewer than three years for self-insured AHPs with a grandfathering exemption date of December 31, 2017 that will allow existing bona fide AHPs to remain operational. Some said the final rule should not become applicable until Congress has appropriated funding for DOL oversight of an expanded universe of AHPs. Some commenters expressed skepticism about the Department's ability to effectively police AHPs for abuse at current resource levels and stressed the need for increased resources and coordination between the States and the Department.

The Department has determined that a prolonged delay in applicability of the final rule is not in the public interest. As noted above, the Department received many comments from individuals in immediate distress due to the unavailability of affordable healthcare coverage and expressing the challenges they have faced since the enactment of the ACA. A significant number of commenters expressed serious concerns regarding the rising cost of health insurance. Many of them were small business owners that currently do not offer health insurance to their employees and who cited ever-increasing costs as the primary reason for their inability to provide their employees and their families with affordable health coverage. Even business owners that do provide health coverage stressed that the premiums are exceedingly costly, and the increases in premiums are frequent and unsustainable. Many self-employed individuals, for example real estate agents, stated that they are forced to purchase insurance in a volatile individual insurance market, which tends to offer fewer choices at much higher costs. These business owners said they wanted access to AHPs at the earliest possible date to obtain more affordable healthcare coverage for themselves and their employees.

These concerns were also important in the Department's consideration of the request for a public hearing by some commenters who opposed the proposal. The Department was not persuaded that a public hearing is necessary or appropriate in connection with this rulemaking. A substantial and comprehensive public record has already been established through the comment process, which generated over 900 comment letters, many of which included substantial attachments and citations to reports and other data. The Department does not believe that a public hearing would meaningfully add data and information germane to the examination of the merits of the proposal or would provide substantive factual information that would assist the Department in improving the rule in material ways. Furthermore, the Department believes

that it has made changes to the rule and included clarifications in this preamble that address the important issues raised by parties who requested a hearing. The Department believes that the scope and depth of the public record that has been developed also belies arguments by some that a 60 day comment period was not a sufficient period of time to provide the data needed to support their arguments against the proposal.

After careful consideration of the public comments, the Department has determined that it is important for the final rule to become effective on the earliest possible date to provide certainty regarding the Department's interpretation for affected entities, with a staged series of applicability dates for pre-existing and new AHPs to respond to implementation issues. Accordingly, the final rule is effective [INSERT DATE 60 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER], however see below for a discussion of the staggered applicability dates.

The Department acknowledges the issues raised about insurance rate setting processes, state regulator and DOL preparedness for oversight roles, and steps other stakeholders may need to take to revise governing structures, memberships, and benefit offerings. At the same time, the Department needs to balance these concerns against the immediate need for improved options for healthcare coverage. The Department believes that a staged applicability process is an appropriate way to respond to those concerns in light of the public demand for help. Specifically, September 1, 2018 is the applicability date for fully-insured AHPs; January 1, 2019 is the applicability date for existing self-insured AHPs that are in compliance with the Department's previous sub-regulatory guidance on bona fide groups or associations, and that choose to expand the group or association and its plan pursuant to the terms of the final rule (e.g., in order to expand to a broader group of individuals, such as working owners without

employees); and April 1, 2019 is the applicability date for new self-insured AHPs formed pursuant to the final rule.

The Department expects fewer oversight and operational issues for fully-insured AHPs. This is, in part, because many fully-insured AHPs already exist. Issuers have already developed products and services tailored to those plans. Application of state insurance regulations presents fewer issues because of the existing state rules that govern insurance companies and the policies they sell to employment-based group health plans. And fully-insured AHPs have traditionally been least likely to experience fraud. Allowing existing self-insured AHPs formed under the Department's pre-rule guidance next to expand consistent with the final rule similarly involves employment-based group health plans that currently exist and with respect to which state insurance regulators have had regulatory authority for many years. The Department does not believe that changes to those existing and already regulated AHPs should present immediate or acute new challenges for state regulators. Delaying the applicability of the final rule for new self-insured AHPs until nearly a year after publication of the final rule in the Federal Register is consistent with and adequate to the objective of managing implementation of the final rule in a way that allows stakeholders, including states and state insurance regulators, an appropriate amount of time to tailor their groups or associations, plans, and regulations. This is true especially because self-insured AHPs, while offering very important benefits when properly managed, have historically been at greater risk of fraud, and are also less common than fully-insured AHPs at this time. Thus, State regulators may benefit from extra time to strengthen their enforcement programs where self-insured AHPs are concerned. Furthermore, a special applicability date is not needed for existing AHPs operating as multiple employer plans pursuant to pre-rule advisory opinions issued by the Department because this rule is an alternative to, and

does not preclude employer groups or associations from relying on, the Department's pre-rule advisory opinions either before or after the effective date of this final rule. This final rule also does not incorporate the Department's pre-rule advisory opinions into this regulation, and, accordingly, does not change the legal force of any advisory opinions issued by the Department under ERISA.¹⁴⁹ The Department has procedures to answer inquiries from individuals or organizations regarding other circumstances in which the Department will view a person as an employer under ERISA section 3(5) that is able to sponsor a group health plan. We invite individuals who seek clarification regarding whether a group or association is an employer under previously-issued subregulatory guidance (e.g., whether there is a sufficiently close nexus between the employers to maintain a multiple employer plan) to seek informal compliance assistance or request a formal advisory opinion.¹⁵⁰

The Department has a longstanding practice of providing compliance assistance to employers, plan sponsors, plan fiduciaries, other employee benefit plan officials and service providers to foster understanding and compliance with the requirements of ERISA. Consistent with that practice, the Department intends to provide affected parties with significant assistance and support to promote the efficient and effective implementation of the final rule. The Department also intends to examine the current Form M-1 for appropriate changes to address reporting and disclosure issues and other general improvements in information collection related to AHPs under the final rule. As discussed earlier in this preamble, MEWA registration requirements require plan and non-plan MEWAs to file the Form M-1 under ERISA section

¹⁴⁹ ERISA Advisory Opinion Procedure 76-1, Section 10. (available at FR Doc. 76-25168 and www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/filing-requests-for-erisa-aos).

¹⁵⁰ Id.

101(g) and 29 CFR 2520.101-2. All AHPs under the final rule will be required to file the Form M-1 regardless of the plan size or type of funding. The Department will also be working with other federal and state regulators to prepare for the new plan structures. Groups or associations should also seek qualified legal counsel to determine whether any proposed structure or operations may create potential prohibited transactions. In that case, the group or association may apply to the Department under ERISA section 408(a) for an exemption from the prohibited transaction provisions to avoid ERISA personal liability for the prohibited transaction and civil penalty assessments.

The Department acknowledges commenters' concerns about whether it has the tools and capacity to adequately oversee an expanded AHP marketplace and protect the public from harms that have materialized in the past from fraudulent and poorly operated MEWAs, including many that were not AHPs and some that were or claimed to be AHPs. However, the Department has a long history of regulating ERISA-covered group health plans, including plan-MEWAs, and AHPs under the final rule will be in that category. Significantly, recent changes in federal law equipped the Department with new "cease and desist" authority to quickly intervene in cases when MEWAs (including AHPs) pose a risk the public. This new authority augments the criminal penalties for healthcare fraud enacted as part of HIPAA. Further, as noted elsewhere in this preamble, the States' traditional oversight and police authority over MEWAs (and AHPs) is not diminished by or because of this final rule. This decision was deliberate, in recognition by the Department of the vast expertise of the States in combating MEWA fraud and mismanagement, and is supported by the majority of public commenters. Even more so than in the past, the Department intends to coordinate and work with the States in exercising the joint oversight responsibilities conferred by section 514 of ERISA. The Department presently has

written agreements in place with 34 States to foster cooperative enforcement efforts. The Department will review these agreements to make sure they continue to serve their purpose under the final rule. Further, as necessary and feasible, more agreements with other States will be put into place in concert with the delayed applicability dates in the final rule. In addition, the Department intends to review existing reporting requirements for AHPs to enhance the oversight capability of federal and State regulators. New reporting requirements would focus on capturing data to minimize the risk of unpaid claims. In concert with any new reporting requirements, the Department, if necessary, will consider imposing AHP-specific audit requirements with conditions that are designed to identify and minimize potential risks for AHP's failing to pay health claims when due.

Finally, the final rule includes a severability provision that provides that if any of the provisions in the final rule are found to be invalid or stayed pending further agency action, the remaining portions of the rule would remain operative and available for qualifying employer groups or associations. For example, a ruling by a federal court that the "working owners" provision in section 2510.3-5(e) is void will not impact the ability of an employer group or association to meet the "commonality of interest" requirement in section 2510.3-5(c) by being located in the same geographic locale.

List of Subjects in 29 CFR Part 2510

Employee benefit plans, Pensions.

For the reasons stated in the preamble, the Department of Labor amends 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. A bona fide group or association shall be deemed to be able to act in the interest of an employer within the meaning of section 3(5) of the Act by satisfying the criteria set forth in paragraphs (b) through (e) of this section. This section does not invalidate any existing advisory opinions, or preclude future advisory opinions, from the Department under section 3(5) of the Act that address other circumstances in which the Department will view a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan that is a group health 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 primary purpose of the group or association may be to offer and provide health coverage to its employer members and their employees; however, the group or association also must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees. For purposes

of satisfying the standard of this paragraph (b)(1), as a safe harbor, a substantial business purpose is considered to exist if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan. For purposes of this paragraph (b)(1), a business purpose includes promoting common business interests of its members or the common economic interests in a given trade or employer community, and is not required to be a for-profit activity;

(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 are controlled by its employer members, and the group's or association's employer members that participate in the group health plan control the plan. Control must be present both in form and in substance,

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

(6)(i) The group or association does not make health coverage through the group's or association's group health plan available other than to:

(A) An employee of a current employer member of the group or association;

(B) A former employee of a current employer member of the group or association who became eligible for coverage under the group health plan when the former employee was an employee of the employer; and

(C) A beneficiary of an individual described in paragraph (b)(6)(i)(A) or (b)(6)(i)(B) of this section (e.g., spouses and dependent children).

(ii) Notwithstanding paragraph (b)(6)(i)(B) of this section, coverage may not be made available to any individual (or beneficiaries of the individual) for any plan year following the plan year in which the plan determines pursuant to reasonable monitoring procedures that the individual ceases to meet the conditions in paragraph (e)(2) of this section (unless the individual again meets those conditions), except as may be required by section 601 of the Act.

(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.

(8) The group or association is not a health insurance issuer described in section 733(b)(2) of the Act, or owned or controlled by such a health insurance issuer or by a subsidiary or affiliate of such a health insurance issuer, other than to the extent such entities participate in the group or association in their capacity as employer members of the group or association.

(c) Commonality of interest—(1) Employer members of a group or association will be treated as having a commonality of interest if the standards of either paragraph (c)(1)(i) or (c)(1)(ii) of this section are met, provided these standards are not implemented in a manner that is subterfuge for discrimination as is prohibited under paragraph (d) of this section:

(i) The employers are in the same trade, industry, line of business or profession; or

(ii) Each employer has a principal place of business in the same region that does not exceed the boundaries of a single State or a metropolitan area (even if the metropolitan area includes more than one State).

(2) In the case of a group or association that is sponsoring a group health plan under this section and that is itself an employer member of the group or association, the group or association will be deemed for purposes of paragraph (c)(1)(i) of this section to be in the same

trade, industry, line of business, or profession, as applicable, as the other employer members of the group or association.

(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 on any health factor, as defined in § 2590.702(a) of this chapter, of any individual who is or may become eligible to participate in the group health plan sponsored by the group or association.

(2) The group health plan sponsored by the group or association must 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 the employees of different employer members of the group or association as distinct groups of similarly-situated individuals based on a health factor of one or more individuals, as defined in § 2590.702(a) of this chapter.

(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 does not satisfy 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 does not satisfy 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, if the plumbing company employer chooses to join the association. 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) and, as a consequence, satisfies 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, the employees of Business I cannot be treated as a separate group of similarly-situated individuals from other members based on a health factor of one or more individuals 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 does not satisfy the requirements in paragraph (d)(4) 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 satisfies paragraph (d)(3) and (d)(4) of this section.

Example 6. (i) Facts. Association L sponsors a group health plan, available to all its 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 between groups of otherwise similarly situated individuals that on its face is based on geography (which is not a health factor), but that is directed at one or more individuals based on a health factor (cancer), 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, the conditions of paragraphs (d)(3) and (d)(4) of this section are not satisfied.

Example 7. (i) Facts. Association P is an agriculture industry association. It sponsors a group health plan that charges employers different premiums based on their primary agriculture subsector, defined under the terms of the plan as: crop farming, livestock, fishing and aquaculture, and forestry. The distinction is not directed at individual participants or beneficiaries based on a health factor.

(ii) Conclusion. In this Example 7, the premium distinction between members is permitted under paragraphs (d)(3) and (d)(4) because it is not based on a health factor and is not directed at individual participants and beneficiaries based on a health factor.

Example 8. (i) Facts. Association Q is a retail industry association. It sponsors a group health plan that charges employees of employers different premiums based on their occupation: cashier, stockers, and sales associates. The distinction is not directed at individual participants or beneficiaries based on a health factor.

(ii) Conclusion. In this Example 8, the premium distinction is permitted under paragraph (d)(3) and (d)(4) of this section because it is not based on a health factor and is not directed at individual participants and beneficiaries based on a health factor.

Example 9. (i) Facts. Association R sponsors a group health plan that is available to all employers with a principal place of business in State S. Employers are charged different premiums based on their industry subsector, defined under the terms of the plan as: construction, education, health, financial services, information services, leisure and hospitality, manufacturing, transportation, natural resources, and other. In addition, within any employer, employees are charged different premiums based on part-time versus full-time status (part time status is defined, under the terms of the plan, as regularly working at least 40 hours, but less than 120 hours, per month). These distinctions are not directed at individual participants or beneficiaries based on a health factor.

(ii) Conclusion. In this Example 9, the premium distinctions between employer members of a State AHP based on industry, and between employees of employer members who are working part-time versus full-time, are permitted under paragraphs (d)(3) and (d)(4) of this section because these distinctions are not based on a health factor or directed at individual participants and beneficiaries based on a health factor.

Example 10. (i) Facts. Association T sponsors a group health plan that offers a premium discount to participants who participate in a wellness program that complies with section 2590.702(f) of this chapter.

(ii) Conclusion. In this Example 10, providing a reward (such as a premium discount or rebate, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive, as well as avoiding a penalty such as the absence of a premium surcharge or other financial or nonfinancial disincentive) in return for adherence to a wellness program that satisfies conditions of § 2590.702(f) of this chapter is permissible under this paragraph (d).

(e) Dual treatment of working owners as employers and employees -- (1) A working owner of a trade or business without common law employees 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 the requirement in 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 the

requirement in paragraph (b)(6) that the group or association does not make health coverage offered to employer members through the association available other than to certain employees and former employees and their beneficiaries.

(2) The term “working owner” as used in this paragraph (e) of this section means any person who a responsible plan fiduciary reasonably determines is an individual:

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

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

(iii) Who either:

(A) Works on average at least 20 hours per week or at least 80 hours per month providing personal services to the working owner’s trade or business, or

(B) Has wages or self-employment 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) The determination under this paragraph must be made when the working owner first becomes eligible for coverage under the group health plan and continued eligibility must be periodically confirmed pursuant to reasonable monitoring procedures.

(f) Applicability dates—(1) This section is applicable on September 1, 2018, for employee welfare benefit plans that are fully insured and that meet the requirements for being an association health plan sponsored by a bona fide group or association of employers pursuant to paragraphs (b) through (e) of this section.

(2) This section is applicable on January 1, 2019, for any employee welfare benefit plan that is not fully insured, is in existence on [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER], meets the requirements that applied before [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER], and chooses to become an association health plan sponsored by a bona fide group or association of employers pursuant to paragraphs (b) through (e) of this section (e.g., in order to expand to a broader group of individuals, such as working owners without employees).

(3) This section is applicable on April 1, 2019, for any other employee welfare benefit plan established to be and operated as an association health plan sponsored by a bona fide group or association of employers pursuant to paragraphs (b) through (e) of this section.

(g) Severability. If any provision of this section is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this section and shall not affect the remainder thereof.

Preston Rutledge,
Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

BILLING CODE 4510-29-P

[FR Doc. 2018-12992 Filed: 6/20/2018 8:45 am; Publication Date: 6/21/2018]