

Employee Benefits Security Administration: Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans (Final Rule) [RIN 1210-AB85] Summary

On June 21, 2018, the Employee Benefits Security Administration (EBSA) of the Department of Labor (DOL) published a final rule broadening the criteria for determining when employers can join together for the purpose of providing health insurance to their employees and be treated as a single employer under federal law and regulations (83 Federal Register 28912.)

Plans offered by groups of employers or trade groups banding together under this rule into “Association Health Plans” (AHPs) will be able, according to the EBSA, to achieve more economies of scale and to offer more affordable coverage because they will, upon the relevant effective date, be subject to fewer requirements on the establishment and maintenance of such plans.

Under the final rule, EBSA defines more broadly several relevant terms and establishes more flexible requirements to permit more employers to form AHPs, more employers to join AHPs, and more association-sponsored plans to be considered a single employer group health plan. Under the final rule,

- AHPs can form for the primary purpose of offering health coverage.
- Sole proprietors and self-employed individuals are able to join into AHPs.
- The existing requirement that AHPs must be offered to a group of employers with a common employment or business interest is expanded so that businesses or groups from different industries, if located in the same geographic area, would be considered to have a “commonality of interest.”

The final rule was developed in consultation with the Department of Health and Human Services, the Department of the Treasury, and the Internal Revenue Services. It becomes effective on August 20, 2018 and is applicable to fully-insured AHPs beginning on September 1, 2018; to existing self-insured AHPs complying with rules in effect prior to this final rule beginning on January 1, 2019, and to new self-insured AHPs formed pursuant to this rule, on April 1, 2019.

I. Background and Executive Summary

On October 12, 2017, President Trump issued Executive Order 13813, “Promoting Healthcare Choice and Competition Across the United States.” The order directed federal agencies to facilitate the purchase of health insurance across state lines and encourage more affordable and high-quality health care choices.

It specifically directed federal agencies to prioritize three areas: expanding the availability of AHPs; short-term, limited-duration insurance; and health reimbursement arrangements (HRAs). With respect to AHPs, the Secretary of Labor was directed to consider proposing regulations or revising guidance to expand access to health coverage by allowing more employers to form

AHPs and be treated as single large employers – noting the ability of large employers to spread risk more broadly among larger pools of insured individuals and to provide more affordable care. The Executive Order also directed the DOL to consider ways to promote AHP formation on the basis of common geography or industry.

Under current law and regulations, health insurance coverage 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 commercial health insurance issuers directly to individuals and small employers, unless the coverage sponsored by the association constitutes a single ERISA-covered plan.¹ As a practical matter, however, under existing sub-regulatory guidance, few associations are treated as single ERISA-covered employer plans.

Under prior rules and guidance, EBSA took the view that multiple employers can be considered as offering a single benefit plan only where the employers share common ownership or where the group or association of employers share a “commonality of interest.” Commonality of interest arose where employers share a business purpose and genuine organizational relationship unrelated to the provision of healthcare benefits, and where its employer members exercise control over that benefit plan (so-called “bona fide” employer groups or associations).

Under those rules and guidance, to be considered one of these so-called “bona fide” employer groups or associations, they were required to have a close economic or genuine organizational relationship.² If so, then the group or association was treated as a single employment-based ERISA plan and subject to one set of laws, regulations and consumer protections. All other employer groups or associations that do not meet such common ownership or share commonality of interest were considered to be like a commercial insurance arrangement that sells coverage to unrelated employers and employees. Those arrangements are subject to a different set of insurance laws, regulations and consumer protections – including a series of benefits and premium rating standards established under the Affordable Care Act (ACA).

The policy of applying the ACA rules and standards to a group or association unless the association is itself is deemed the “employer” is referred to as the “look-through” rule and was established in guidance issued by the Centers for Medicare and Medicaid Services (CMS). Under that guidance, CMS would ignore the association and “look-through” directly to each employer member’s size to determine whether the member’s health coverage is to be considered

¹ ERISA is the Employee Retirement Income Security Act of 1974. It is a federal law that establishes the rules under which private sector employer benefit plans, including health benefits offered by such an employer, must operate. According to the EBSA, it “protects the interests of employee benefit plan participants and their beneficiaries. It requires plan sponsors to provide plan information to participants. It establishes standards of conduct for plan managers and other fiduciaries. It establishes enforcement provisions to ensure that plan funds are protected and that qualifying participants receive their benefits, even if a company goes bankrupt.”

<https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/what-is-erisa>

² This requirement is described in several departmental Advisory Opinions as well as judicial decisions: Advisory Opinion 94-07A; Advisory Opinion 2001-04A; Wisconsin Educ. Assn. Trust v. Iowa State Bd. of Public Instruction, 804 F.2d 1059, 1064 (8th Cir. 1986). See also MD Physicians & Associates, Inc. v. State Bd. of Ins., 957 F.2d 178 (5th Cir. 1992), cert. denied, 506 U.S. 861 (1992); National Business Assn. Trust v. Morgan, 770 F. Supp. 1169 (W.D. Ky. 1991).

an individual insurance plan, a small group market insurance plan or a large group plan.³ EBSA notes that under these rules, it is possible that different members of the same association could have coverage that is subject to the individual market, small group market, and/or large group market rules, as determined by each member's circumstances.

EBSA asserts that nothing prevents them from proposing and adopting a more flexible regulatory test for a single employer-based benefit plan which it finalizes in this new rule.

EBSA reviews some of the requirements applicable to plans that are considered to be individual, small group, or large group plans. Under this final rule, more AHPs will be considered offered by a single employer. By combining the employees of all of those smaller employers together and treating as a single employer, the likelihood that an AHP will be considered a large group is increased. In that case the rules applicable to large employers would apply instead of those applicable to small group or individual employer groups.

| | Individual | Small | Large/ Insured | Large/ Self-insured |
|--------------------------------------|------------|-------|-------------------|------------------------|
| Essential Health Benefits | X | X | | |
| Risk Adjustment | X | X | | |
| Single Risk Pool | X | X | | |
| Limitations on Premium Rating | X | X | | |
| Medical Loss Ratio | X | X | X | N/A |

Source: Health Policy Alternatives table based on EBSA discussion in the preamble to the proposed rule at 83 FR 618.

In the preamble to the final rule, EBSA summarizes the legislative history of AHPs. Historically, while some of those insurance arrangements have offered stable and quality health care coverage, there is a history of fraudulent operations as well as failures of AHPs due to underfunding among other reasons. A lack of clear federal or state oversight authority slowed or prevented regulators from detecting funding, fraud or other AHP problems, sometimes leaving members with unpaid claims. Congress clarified the authority of the states to prevent abuse or plan failures by establishing in 1983 that states were not preempted from regulating a “multiple employer welfare arrangement” (MEWA – an AHP is a type of MEWA) that is also an employee welfare benefit plan and that is not fully insured. For those arrangements that are fully insured, states can establish standards for solvency and reserve levels but other state insurance laws are pre-empted from applying (although the laws may apply to the insurers themselves).

Because abuses and plan failures continued, the ACA took further steps to limit AHP abuses. It expanded reporting requirements and criminal penalties on MEWA fraud. It also gave the

³ See CMS Insurance Standards Bulletin Series— (September 1, 2011) available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf. See also CMS Insurance Standards Bulletin Transmittal No. 02-02 (August 2002) available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/hipaa_02_02_508.pdf.

Secretary of Labor additional authority to take immediate action to close a MEWA determined to be in a financially hazardous condition.

EBSA received over 900 comments in response to the proposed rule from stakeholders including group health plan participants, consumer groups, employer groups, employers and sole-proprietors, employer associations, individual health insurance issuers and trade groups. EBSA specifically notes comments from small business owners who raised concerns about the high cost of health insurance and who supported the proposed rule.

II. Provisions of the Final Rule

EBSA finalizes with several modifications (described below) based on public comments, new 29 CFR 2510.3-5, which establishes more flexible rules for sponsors of multiple employer group health plans such as those offered by associations to encourage more of them to form AHPs and to allow more plans offered by AHPs to be considered a single ERISA-covered plan.

In finalizing the rule, EBSA clarifies that existing AHPs may continue to rely on previous AHP guidance. This is in response to some commenters who expressed concern that if existing AHPs had to meet the final rule's new requirements there could be some loss of coverage. These commenters argued that AHPs did not design their operations with the new requirements in mind and may not be able to comply with the new conditions without reducing existing coverage options. EBSA agrees that would be an undesirable result and concludes that an employer group or association that complies with either the new rule or the pre-rule guidance can be considered to be acting as an "employer" in a way that distinguishes it from commercial health insurance.

Definition of Employer for the Purpose of Sponsoring a Multiple Employer Group Health Plan. Many of the proposed provisions in §2510.3-5(a) and (b) are finalized without change. Changes are noted below. The provisions of this section describe who can act as an "employer" in sponsoring a multiple employer group health plan. For purposes of being able to establish and maintain such a plan, an "employer" is any person acting directly as an employer or any person acting indirectly in the interest of an employer in relation to the plan. A bona fide group or association is deemed to be able to act in the interest of an employer by satisfying the following criteria.

- A bona-fide group's primary purpose **may** be to offer and provide health coverage to its employer members and their employees. The final rule, however, adds the requirement that 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 this "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.
- 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.

- The group or association has a formal organizational structure with a governing body and by-laws or other similar indications of formality.
- The functions and activities of the group or association are controlled by its employer members, and the employer members that participate in the group health plan control the plan in both form and substance.

The language of this “control test” is modified slightly from the proposed version to better align with the rules in effect under prior guidance. In response to commenters concerned that this provision will be ineffective, is impractical for groups with many members, or should be eliminated altogether, EBSA disagrees. It considers the control test to be necessary to meet ERISA requirements in section 3(5) under which a group or association must act “in the interest of” the employer members.

Some commenters requested additional guidance or examples of the type of control that EBSA would consider to meet this test. EBSA points out that it would not expect members to manage the day-to-day operations or affairs of the plan and would consider all relevant facts and circumstances in this determination. EBSA identifies the following factors that it considers relevant (but not exclusive): whether employer members nominate and elect officers, board members, or trustees; whether member have the authority to remove officers, directors or trustees; whether employer members have the ability to veto decisions.

- The employer members have a commonality of interest (described in greater detail below).
- The group or association does not make health coverage available other than to an employee of a current employer member; a former employee of a current employer member of the group or association who became eligible for coverage under the group health plan when an employee of the employer; and a beneficiary of those individuals (e.g., spouses and dependent children.)

In response to comments, CMS adds additional clarification to this provision stating that its objective is to provide the same options for defining participants as would apply if the employer was establishing its own independent health plan. The final rule adds that a working owner may only be included if he or she continues to meet the definition of a working owner (described below and in new section 2510.3-5(e)(2)). EBSA also states that in its view, the provisions are clear that when applicable, an AHP must provide for COBRA continuation coverage and other post-employment coverage as required under current law.

- The group or association and its coverage complies with nondiscrimination provisions (described in greater detail below).
- The group or association is not a health insurance issuer or owned or controlled by a health insurance issuer nor its subsidiary or affiliate.

Some commenters supported this rule, others objected. EBSA declines to loosen the rule and states that it does not believe it would be consistent with the rule to have insurance issuer representatives on the board of AHPs. EBSA points out, however, that issuers could sponsor an AHP for their own employees and in that circumstance would be controlling the AHP in their capacity as employers of covered employees and not in their capacity as a health insurance issuer.

In response to clarification about whether other types of health insurance providers such as network providers or healthcare organizations could establish an AHP, EBSA declines to provide a list of those entities that would be prohibited from establishing an AHP in its capacity as a health plan provider but notes that the control requirement would ensure that such an organization, if establishing an AHP, is only doing so in its capacity as an employer.

EBSA also notes that there is nothing in this rule that would prevent a health insurance issuer from providing administrative services to an AHP.

Some commenters recommended broadening the kinds of organizations that could be considered bona fide groups or associations under the rule. Recommendations included tax-exempt organizations such as scientific, literary, and educational groups. Others recommended that individuals in professional associations be allowed to organize an AHP or join into an AHP if their employer does not join. EBSA declines changes to this provision indicating that its authority to define such groups as an employer is limited under ERISA section 3(5) to benefits in an employment context.

Several commenters argued that the rule conflicts with the text of the ACA by allowing small employers and individuals who, under that statute, are required to provide coverage for essential health benefits (EHBs), to band together to obtain health insurance that does not comply with that requirement. EBSA disagrees and states that although the ACA revised and added to Title XXVII of the Public Health Service Act (PHSA), it did not modify the underlying PHSA framework for determining whether health insurance coverage issued through associations was individual or group health insurance coverage. EBSA notes that the PHSA 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 is considered a group health plan for purposes of the ACA provisions in Title XXVII of the PHSA. EBSA states that it is simply using its rulemaking authority to define a statutory term in a way that allows more employers to join together more broadly to promote or establish AHPs to expand access to affordable health coverage.

AHPs Can Exist for the Sole Purpose of Offering Health Coverage (§2510.3-5 (b)(1)). The proposed rule would have eliminated sub-regulatory guidance requiring that a group or association must exist for a bona fide purpose other than offering health coverage to an employer under ERISA. The final rule, however, while allowing a bona-fide group or association to provide health coverage as its primary purpose, also requires that the group or association 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.

EBSA notes that this change is made in response to commenters who raised concerns about the proliferation of such groups which could oversaturate the market and diminish the market power of AHPs. Other commenters raised concerns that some of those AHPs would be poorly managed or provide inadequate coverage, or in other ways be unscrupulous. Others felt the provision increased the probability of fraud and abuse among new AHPs.

EBSA points out that for this “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. Further, it notes that there is nothing that would prevent a pre-existing group or association to create a wholly owned subsidiary to administer an AHP as its sole purpose so long as the group or association continues to have a substantial business purpose unrelated to the provision of healthcare benefits.

Broader Commonality of Interest Requirement (§2510.3-5 (c)). EBSA finalizes, with changes, proposed rules allowing employers to band together and be considered a single employer under ERISA for the purpose of offering health coverage if they either are: (1) in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same state or metropolitan area (even if the metropolitan area includes more than one state).

By allowing employers who have a principal place of business within the same geographic area to be considered a single employer for this purpose, a common business interest is no longer necessary. Businesses from different industries purchasing health coverage through an AHP can be considered to have a commonality of interest if they are located together with other businesses within a geographic region such as a state or metropolitan area.

EBSA adds a condition to this rule – that such tests for commonality cannot be used as a subterfuge for discrimination as prohibited in finalized §2510.3-5(d) (described below). In addition, the final rules states that in the case of a group or association that is sponsoring a group health plan and that is itself an employer member, the group or association is deemed to be in the same trade, industry, line of business, or profession as the other employer members of the group or association.

In response to comments, EBSA declines to add definitions or additional specificity for the terms “trade,” “industry,” “line of business,” and “profession” stating that it will consider the use of any generally-accepted classification systems.

EBSA received many comments raising concerns about the geographic test for commonality. Some requested clarification of what constitutes a metropolitan area for this purpose. EBSA declines to add specificity noting that it will use any generally-accepted classification system and prefers to remain flexible. Other commenters raised concerns that the permissiveness of the provision would promote AHPs choosing to offer coverage in particular states to avoid oversight and that the provision would undermine states’ ability to assist consumers because their jurisdiction doesn’t extend across state lines. Commenters suggested requiring AHPs to offer coverage in contiguous areas to prevent their ability to redline higher risk neighborhoods or

populations; establishing an independent task force to resolve issues of interstate regulation, and creating a process to verify plan service areas to ensure they comply with the geography test. EBSA generally declined to make additional changes in response to commenters' concerns or recommendations noting that the rules are intended to not be overly restrictive. In the preamble, it states that other provisions of federal and state law sufficiently address concerns with redlining and that it believes that the two tests for commonality balance the need for flexibility with the other concerns expressed by stakeholders.

Non-Discrimination (§2510.3-5(d)). EBSA finalizes its proposals with one clarification (and with several new examples) that plans offered by groups or associations are subject to the following non-discrimination requirements:

- The group or association is prohibited from conditioning membership on any health factor of an employee (including former employees and family members). Health factors include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
- The group health plan sponsored by the group or association is prohibited from discriminating with respect to eligibility for benefits or in setting premiums or contributions required by any participant or beneficiary under the plan. Eligibility for benefits includes enrollment, effective coverage dates, waiting periods, late or special enrollment, and eligibility for benefit packages.
- In applying the non-discrimination provisions, a group or association is prohibited from treating different employer members of the group or association differently from other employer members who are within similarly situated groups *based on health status*. (The italicized phrase is added in the final rule.) EBSA says that the group or association could, however, treat groups differently across different groups of similarly situated individuals so long as the distinct groups are based on bona fide employment-based classifications that are consistent with the employer's usual business practice. Some examples include full- versus part-time status, geographic location, membership in a collective bargaining unit, date of hire, length of service, current versus former employee, different occupations. Other distinct groups that would be permitted would be those based on relationship of the participant to the employee – for example marital status, age or student status.

EBSA provides a number of examples to illustrate the application of the non-discrimination provisions including three new examples illustrating circumstances where an AHP could charge different premiums to different member employers and be in compliance with the rules described above. One additional new example was added to illustrate the allowable variation in premiums based on participation in a wellness program. They appear on 83 Federal Register 28963-28964.

“Working Owners.” EBSA adopts proposed paragraph (e) with several major changes made in response to comment. As proposed, paragraph (e) would have established that a “working owner” (sole proprietor or self-employed individual) could be considered to be both an employer and an employee. That would allow the sole proprietor or self-employed individual to participate in an AHP if he or she (i) has an ownership right in their trade or business; (ii) earns wages or self-employment income from providing personal services to it; (iii) is not eligible to participate in any subsidized group health plan maintained by any other employer of the individual or his or

her spouse; and (iv) works at least 30 hours per week or 120 hours per month providing personal services to the trade or business.

The first major change is that EBSA drops the requirement that a working owner must not be eligible to participate in any subsidized group health plan maintained by any other employer of the individuals or his or her spouse. Some commenters opposed the provision as being a “marriage penalty.”

Other commenters felt that the hours worked provisions were too restrictive and didn’t allow for workers in jobs or industries with unpredictable hours or schedules to participate. In response EBSA changes the hours worked requirements from the proposed rule to allow for working owners to be those who work *on average at least 20 hours per week or at least 80 hours per month* and drops altogether the requirement that their working income must exceed the cost of coverage in the AHP.

Under the proposed rule, the group or association would not have been required to verify the working owner’s eligibility and could “reasonably rely” on written representations from the individual, such as an attestation, as long as the association has no knowledge to the contrary. EBSA received comments recommending a verification or audit process to confirm that participating working owners met the eligibility requirements or other standards to strengthen verification. Other commenters sought clarification that issuers would be held harmless in the event of fraudulent enrollments.

In response, in the final rule, EBSA eliminates language specifying that plan issuers could “reasonably rely on written representations from the individual” to determine eligibility. The final rule adds a requirement that a determination of eligibility must be made and a working owner’s continued eligibility must be periodically confirmed using reasonable monitoring procedures. EBSA points out that plan fiduciaries have obligations under ERISA to ensure that only eligible individuals participate and receive benefits and that nothing in the rule precludes groups or association from establishing their own verification processes.

Comprehensiveness of AHP Coverage, Application of ERISA Group Health Plan Requirements and other Federal Laws

Many commenters raised concerns that AHPs would provide limited benefits or benefits with high cost sharing because so many would not be subject to the ACA’s essential health benefits requirements. They raised the possibility that these limited benefits plans would draw healthier risk out of the traditional individual and small group markets for insurance and therefore lead to adverse selection and instability in those markets. They recommended that EBSA require AHPs to offer minimum value benefits or that it establish other minimum benefits requirements.

EBSA declines to make changes related to these concerns citing the following rationale:

- Such requirements would reduce AHPs flexibility to tailor benefits or provide more affordable options;
- AHPs are not likely to offer low level benefits because that would jeopardize their relationships with members;

- Certain federal minimum benefits apply, in particular those requiring coverage of preventive health services and immunizations recommended by the U.S. Preventive Services Task Force and other related bodies. The Civil Rights Act also requires non-discrimination in coverage of pregnancy-related expenses.
- State laws may apply. EBSA points out that ERISA saves from pre-emption state laws regulating MEWAs and allows states to extend benefit mandates to self-insured AHPs.
- All non-grandfathered group health plans are subject to a maximum out-of-pocket cap and annual and lifetime dollar limits on EHBs.

In the preamble to the final rule, EBSA addresses the application of mental health parity requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires that financial requirements and treatment limitations for mental health and substance use disorder benefits be no more restrictive than those placed on medical and surgical benefits. MHPAEA exempts small employers from the requirements. DOL, in consultation with the Department of Health and Human Services, interprets those requirements to be applied to the size of the AHP rather than to individual employers within an AHP.

With respect to COBRA continuation requirements, which likewise includes an exemption for employers of fewer than 20, EBSA indicated that it will consult with Treasury and the IRS and issue future guidance on its applicability to AHPs.

EBSA points out that the use of Voluntary Employees' Beneficiary Associations (VEBAs) to hold plan assets is beyond the interpretive jurisdiction of DOL and directs those interested in more information on the use of VEBAs to 26 CFR 1.501(c)(9)-1 through -8, and Revenue Procedure 2018-5.

In response to comment, EBSA notes that franchisors and franchisees that participate in an AHP are not considered joint employers under ERISA or the Fair Labor Standards Act. According to EBSA, nothing in the final rule indicates that participating in an AHP gives joint employer status and does not involve any agreement between employers to share employee services or control.

ERISA Preemption and State Regulation of AHPs

Many commenters, including state insurance regulators, raised concerns about the rule undermining or impairing states' ability to regulate AHPs under state insurance laws. In response, EBSA states that the final rule does not modify or otherwise limit existing state authority under section 514 of ERISA. Under that section,

- If an AHP is fully insured:
 - Section 514(b)(6)(A)(i) provides that state laws that regulate the maintenance of contribution and reserve levels may apply; and
 - Other 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.

It states that “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 requirements of State insurance law necessary to ensure compliance with the State insurance reserves, contributions and funding obligations.”

- If an AHP is not fully insured, 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 law is “not inconsistent” with ERISA.

EBSA does not address what it means to be inconsistent with ERISA.

Some commenters requested that EBSA clarify how state laws apply when they address particular areas that are inconsistent with or in direct conflict with areas addressed in this rule. Still others recommended broader federal oversight. EBSA declines these requests and recommendations stating that the provisions of ERISA section 514 are clear and well established via both DOL rules and guidance as well as federal court rulings.

Commenters requested that there be broader federal regulation and oversight rather than combined state and federal regulation which sometimes results in a patchwork of state requirements that are particularly challenging for cross-state AHPs to comply with. In response, EBSA notes that ERISA section 514(b)(6)(B) allows it to provide exemptions for non-fully insured MEWAs from certain state insurance regulations but this authority is not unlimited. It doesn’t permit DOL from exempting any fully-insured AHP from any state insurance law that can apply to a fully-insured MEWA plan. But it notes that it provides a future mechanism for preempting state insurance laws that “go too far” in regulating non-fully insured AHPs.

Finally, EBSA clarifies the application of a number of existing requirements to AHPs including ERISA requirements relating to fiduciary responsibility, notice and disclosure requirements, and ACA expanding reporting and registration requirements.

III. Economic and Regulatory Impact Analysis

EBSA concluded that the rule meets the criteria requiring a regulatory impact analysis (RIA). The analysis draws on recent data related to large and small employer coverage, individual market coverage and existing AHP/MEWA coverage. The analysis begins with a brief discussion of problems that have historically characterized the small group market, both prior to and after the enactment of the ACA, including challenges achieving the economies of scale and sustainable risk pools that typify large employer groups. EBSA restates its view that the ACA has not succeeded in increasing the affordability of coverage for small employers and that steps must be taken to reduce the barriers to AHPs that are created by its existing interpretation of the conditions under which an AHP is an employer-sponsored plan under ERISA.

As reiterated in the RIA, the rule provides new, affordable health insurance options through AHPs for many Americans by:

- (1) Relaxing the existing requirement that associations sponsoring AHPs must exist for a reason other than offering health insurance;
- (2) Relaxing the requirement that association members share a common interest, as long as they operate in a common geographic area;
- (3) Making clear that associations whose members operate in the same industry can sponsor AHPs, regardless of geographic distribution; and
- (4) Clarifying that working owners and their dependents are eligible to participate in AHPs.

EBSA explicitly asserts that one of the advantages of the rule is “to offer small businesses relief from ACA and state rules that restrict issuers’ product offerings and pricing in individual and small group markets.”

Potential Impacts

EBSA says that “insuring more American workers, and offering premiums and benefits that faithfully match employees’ preferences, are the most important benefits of this rule.” It argues that the rule is designed to “prevent potentially adverse impacts on individual or small group risk pools that might otherwise carry social costs.” Potential effects on tax subsidies and revenue as well as on Medicaid are also noted. It intends for the proposal’s impacts, and of AHPs themselves, to net out to be positive although “the incidence, nature and magnitude of both positive and negative effects are uncertain.” EBSA notes that numerous factors complicate a prediction of the rule’s impact. These include:

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

Because of these uncertainties, EBSA provides a mostly qualitative impact assessment.

a. Increased Choice

EBSA describes the many ways in which it believes that the final rule will increase the ability of small business to be able to offer more attractive and affordable health options than are available under prior rules. It responds to commenters concerns about the potential for AHPs to increase adverse selection in the small group and individual markets, ultimately eroding access to healthcare services. It notes that AHPs operating under the rule, like other large group plans, although not subject to EHB requirements will still be subject to state laws as well as other federal mandates including:

- The existing prohibitions on charging higher premiums based on a pre-existing health condition and on denying coverage based on a health condition;
- The existing requirement to cover dependents to age 26;
- The ban on annual or lifetime dollar limits on EHB that the plan covers;
- For non-grandfathered plans, the 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 EHBs;
- Prohibitions on waiting periods for coverage that exceed 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), and procedural protections governing appeals of denied health claims (for non-grandfathered health plans, this also includes external review).

b. Potential Advantages of Scale

EBSA asserts that the potentially large scale of AHPs, “under the right conditions,” would result in lower insurance premiums compared to existing small group and individual insurance market arrangements, thus expanding the affordability of coverage to more Americans. This is achievable if AHPs can enjoy advantages of scale available to large employer groups, including administrative efficiencies, self-insurance, and market power. Each of these is addressed:

- Being able to avoid some or all of the potentially high cost associated with health insurance issuers’ marketing, enrollment, underwriting and rating for large numbers of individual families or small employer groups. However, some AHPs may internalize these administrative costs in the form of employers’ cost to form associations and AHPs’ own efforts to recruit and enroll association members and to sign members up for coverage.
 - EBSA suggests that under the rule, existing organizations that already provide health insurance to their members (e.g., local chambers of commerce) but have been impeded by current regulations, will be in a better position to achieve administrative savings by becoming an AHP. Other entities, however, “might thrive by delivering savings to members by other means, such as by offering less comprehensive benefits, even if their administrative costs are higher.”
- Self-insurance is another potential way to maximize savings, since the AHP may be in a better position than individual small employers to do this cost-effectively.
 - EBSA notes in this context that state revenue may also decline in states that tax insurance premiums.⁴
- Treated as large groups, AHPs may be able to achieve savings by negotiating discounts with suppliers. This may be possible in negotiations with insurers; AHPs that self-insure may also

⁴Not explained in the RIA is that this is true because private-sector, self-insured ERISA plans are exempt from state premium taxes.

be able to obtain discounts and other savings through direct negotiations with hospitals, providers, and third party administrators.

- Given the local nature of health care services, this generally requires scale and large geographic market share. Thus, self-insured AHPs with geographically concentrated membership are more likely to realize such savings than are AHPs whose membership is spread thinly across states.
- Alternatively, AHPs may dilute other payers' market power to command provider discounts, thereby increasing costs for such payers' enrollees.
- The overall net effects on competition are thus unclear.

c. Risk Segmentation

EBSA acknowledges that AHP's exercise of flexibility will naturally lead to some degree of favorable risk selection. But it believes that the non-discrimination provisions of the final rule will reduce the impact of risk segmentation. EBSA further points out that there are other factors that will limit such segmentation such as the existing prohibitions on adjusting premiums based on health status and states' ability to apply laws and regulations to limit segmentation.

EBSA makes the following arguments:

- AHPs will be able to offer more actuarially fair prices to lower risk groups;
- Some members of AHPs may prefer more comprehensive benefits and because the AHPs must be controlled by its members, they have the ability to provide them;
- The impact of the final rule will be highly dependent on states' regulatory practices.

EBSA also summarizes several analyses submitted in response to the request for information in the proposed rule. Several conclude that premiums will rise after imposition of the final rule but the magnitude varies across the analyses. Others cite historical experience of markets that collapsed following a risk segmentation spiral. Another describes the experience in Washington where AHPs have had a robust market share but were found to have little administrative cost advantage.

d. Individual and Small Group Markets

Using recent data on health insurance coverage status, EBSA argues that the rule will expand the availability of more affordable coverage:

- 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 6 million were employees of small businesses that did not offer employees or their dependents insurance. Potentially, these groups might become eligible for AHPs.
- An estimated 2.4 to 4.3 million people would enroll in AHPs by 2022 under a moderate enrollment scenario and would experience reductions in their premiums.
- To the extent that premiums rise overall in the individual market, many people will be insulated from those increases because they qualify for income-based subsidies in exchange plans.

- Several analyses estimate premiums will rise in the small group market including a Congressional Budget Office (CBO) analysis which found that about 4 million people would purchase AHP coverage and premiums would rise between 2 and 3 percent.⁵

e. Medicaid

EBSA notes the Medicaid expansion that has occurred under the ACA in many states and says that some Medicaid-eligible workers may become eligible to enroll in AHPs under this proposal. Among 42 million individuals under age 65 enrolled in Medicaid or the Children's Health Insurance Program in 2015, 2 million were working owners or dependents thereof, and 13 million were employees or employees' dependents of small businesses that did not offer insurance.

f. The Uninsured

Of the 28 million uninsured in 2015, approximately 3 million were working owners or dependents thereof and an additional 8 million were employees of small businesses that did not offer insurance. EBSA posits that some of these uninsured will become eligible for an AHP under the rule and that because the individual mandate penalty has been reduced to \$0, AHPs might provide an alternative source of coverage for those people leaving plans because they are no longer subject to a penalty for being uninsured. EBSA cites several reports estimating the impact on the uninsured but observes that the estimates vary widely and that various studies of past federal and state reforms that tightened or loosened individual or small group market reforms are of only modest value since much has changed. EBSA suggests that the composition of the uninsured population is also likely to change under the final rule since working owners and people with lower health risk may be attracted to AHPs.

g. Operational Risks

EBSA describes commenters' concerns about the history of financial mismanagement and abuse by MEWAs, often leaving participants and providers with unpaid benefits and bills. It describes past efforts by federal and state regulators to oversee MEWAs and provides recent DOL data on MEWAs. These data were last examined recently by EBSA for MEWAs operating in 2012 through 2016:

- In 2016, 536 MEWAs covered approximately 1.9 million employees, most reporting as ERISA plans that covered employees of two or more employers. Nearly all covered more than 50 employees and therefore constituted large-group employer plans for purposes of the ACA. A few were 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 rule; if so, they would have to report annually to the DOL.

⁵ CBO "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>.

- A little more than one-half of reporting MEWAs operate in 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), and New York (94) and Ohio (91). Only one state had fewer than 20 (Hawaii had 17).
- MEWAs were most likely to be self-insured in certain western states including Wyoming (41 percent), Montana (37 percent), and North Dakota (42 percent).
- About one-fourth of reporting MEWAs were self-insured in all the states in which they operated, and another 4 percent were self-insured in some states. The remaining did not self-insure and instead purchased insurance from issuers in all states in which they operated.⁶

EBSA reports on some MEWA compliance data (some indicate that they do not comply with the requirement that assets be held in trust) and argues that the rule's safeguards against AHP mismanagement and abuse are designed to address such shortcomings. It anticipates, however, that the "flexibility afforded AHPs under this rule will introduce increased opportunities for mismanagement or abuse, in turn increasing potential oversight demands on the Department and State regulators."

h. Federal Budget Impacts

EBSA estimates that, on balance, the net effect of the rule would be to reduce the federal deficit but that this would depend on how people sort out in terms of their sources of coverage. It describes a 2005 CBO estimate of an AHP proposal estimating that the legislation would increase the deficit by \$317 million over 10 years (in part due to increased hiring at DOL to oversee AHPs). EBSA believes that current factors would produce different results. Since the enactment of the ACA, fewer Americans are uninsured and health insurance subsidies are available through the Exchanges. EBSA observes that with the availability of Exchange subsidies it is likely that AHPs will mostly enroll higher income individuals. To the extent that AHPs result in higher Exchange premiums, subsidies there will increase, adding to the federal deficit. Resources allocated to support DOL's efforts to prevent and correct potential mismanagement and abuse could add more to it. If, however, AHPs do enroll some Medicaid enrollees or individuals receiving large subsidies on individual Exchanges, savings from these impacts might offset a portion of these deficit increases. EBSA also contends that direct subsidies from taxpayers are more progressive than cross-subsidies from low-risk to high-risk individuals in the Exchanges.

i. Regulatory Alternatives

EBSA describes policy alternatives that it considered:

⁶ MEWAs may offer other welfare benefits, such as dental or vision, life or disability benefits. The EBSA says that of those MEWAs reporting, nearly all offered at least health insurance.

- Retaining existing rules and interpretations but it sees them as limiting access to affordable coverage options;
- Relaxing the requirement that association members control the AHP would encourage AHP growth and development but also increase the risk that AHPs would be vulnerable to mismanagement or abuse. In addition, the authority for DOL to do this “is unclear in light of ERISA’s text;”
- Including only fully-insured AHPs given the history of fraud and abuse problems with self-insured AHPs but EBSA “recognizes that well-managed self-insured AHPs may be able to realize efficiencies that insured AHPs cannot,” noting that including self-insured AHPs in its proposal would have required additional resources to be committed to AHP oversight; and
- Limiting or increasing AHPs’ product and/or price flexibility. Limiting flexibility would impede the goals of EBSA to treat AHPs like large employer plans. Including nondiscrimination rules guards against risk segmentation effects. Increasing flexibility by not including the nondiscrimination provisions was rejected though to distinguish AHPs from commercial insurers “as a legal matter.”

EBSA ends this discussion by noting that operational risks may demand increased federal and state oversight and that the rule could increase the federal deficit.

IV. Paperwork Reduction Act

EBSA states that rule is not subject to the requirements of the Paperwork Reduction Act because it does not contain a collection of information.

V. Regulatory Flexibility Act

EBSA has determined that this rule, which broadens 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. This section reiterates earlier observations about the numbers of individuals who are covered in the individual and small group markets, the number who are sole proprietors or their dependents, and the number of uninsured individuals and small-firm establishments. EBSA asserts that the rule will yield economic benefits for small businesses by expanding coverage options and affect individual and small group market issuers whose enrollees might switch to AHPs.

VI. Congressional Review Act

EBSA says that the rule is a major rule (likely to result in an annual effect on the economy of \$100 million or more) and is subject to the Congressional Review Act. It will be transmitted to the Congress and the Comptroller General for review.

VII. Unfunded Mandates Reform Act

The rule does not include any federal mandate that would result in expenditures in any one year by state, local and tribal governments in the aggregate or by the private sector of \$100 million or more.

VIII. Federalism Statement

In the EBSA's view, the regulation has federalism implications because it will have direct effects on states, the relationship between the national government and the states, and on the distribution of power and responsibilities among various levels of government. It believes these effects are limited, insofar as the rule does not change AHPs' status as large group plans and MEWAs, under ERISA, the ACA, and state law. It observes that:

- If an AHP is not fully insured, then under section 514(b)(6)(A)(ii) of ERISA, any state insurance law that regulates insurance may apply to the AHP to the extent that such state law is not inconsistent with ERISA.
- If, on the other hand, an AHP is fully insured, section 514(b)(6)(A)(i) of ERISA provides that only those state insurance laws that regulate the maintenance of specified contribution and reserve levels may apply to the AHP.
- State rules vary widely in practice, and many states regulate AHPs less stringently than individual or small group insurance.