Proposed Rules

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

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2510

RIN 1210–AB85

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

AGENCY: Employee Benefits Security Administration, Department of Labor.

ACTION: Proposed rule.

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

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

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

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

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

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

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

SUPPLEMENTARY INFORMATION:

A. Overview

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

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

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

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

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

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

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

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

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

B. Purpose of Regulatory Action

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

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

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

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

C. Background

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

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

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

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

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

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

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

2. Federal and State Regulation of Multiple Employer Welfare Arrangements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Overview of Proposed Regulation

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

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

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

The proposed regulation would remove existing restrictions in the Department's sub-regulatory guidance on ERISA section 3(5) to allow employers to more easily join together in organizations that offer group health coverage to member employers and their employees under one group health plan. Specifically, the regulation would allow employers to band together for the express purpose of offering health coverage if they either are: (1) in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area (even if the metropolitan area includes more than one State). As discussed elsewhere in this document, the restrictions in the Department's existing advisory opinions were intended to help distinguish healthcare arrangements sponsored by an entity acting as an ''employer'' within the meaning of section 3(5) of ERISA from commercial-insurance-type arrangements that lack the requisite connection to the employment relationship. The Department has concluded that other conditions in this proposal can adequately serve that purpose while removing the condition that the employer association must have a purpose other than offering health coverage as a potential undue restriction on the establishment and maintenance of AHPs under ERISA. The proposal also would allow associations to rely on other characteristics upon which they previously relied to satisfy the commonality provision of paragraph (c) of the proposed rules, because the Department's existing sub-regulatory guidance applies the commonality requirement as a facts and circumstances test, and the Department intends that any employer group or association that meets the commonality requirement in the Department's existing sub-regulatory requirement should also be treated as meeting the commonality requirement in the proposed regulation. The Department seeks comment on whether the final rule, if adopted, should also recognize other bases for finding a commonality of interest.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Health Nondiscrimination Protections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Request for Public Comments

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

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

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

6. Request for Information

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

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

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

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

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

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

Regulatory Impact Analysis

1.1. Executive Orders

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

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

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

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

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

1.2. Introduction and Need for Regulation

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

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

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

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

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

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

1.3. AHPs' Potential Impacts

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

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

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

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

1.4. Potential Advantages of Scale

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

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

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

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

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

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

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

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

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

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

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

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

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

1.5. Increased Choice

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

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

1.6. Risk Pooling

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

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

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

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

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

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

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

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

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

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

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

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

1.7. Individual and Small Group Markets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.8. Medicaid

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

1.9. The Uninsured

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

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

1.10. Operational Risks

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

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

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

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

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

[48] *Id.*

[49] *Id.*

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

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

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

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

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

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

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

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

1.11. Federal Budget Impacts

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

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

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

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

1.12. Regulatory Alternatives

In developing this proposal DOL considered various alternative approaches.

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

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

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

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

optimize small businesses' access to them.

- *Relaxing the control requirement.* The proposal generally requires that association members control the AHP. Relaxing this requirement might encourage more and faster establishment and growth of AHPs, as entrepreneurs identify and seize opportunities to reap and share with enrollees the economic benefits AHPs can deliver. DOL believes, however, that relaxing this requirement would increase the risk that AHPs would be vulnerable to mismanagement or abuse. Additionally, the Department's authority to loosen this requirement is unclear in light of ERISA's text.
- *Including only fully-insured AHPs.* DOL considered prohibiting broadening the circumstances under which an AHP is treated as a single plan under ERISA only for fully insured AHPs. Historically, self-insured MEWAs have been particularly vulnerable to financial mismanagement and abuse. MEWA promoters sometimes have used self-insurance both to evade State oversight and to maximize opportunities for abusive financial self-dealing, often with highly negative consequences for their enrollees. Nonetheless, DOL recognizes that well-managed self-insured AHPs may be able to realize efficiencies that insured AHPs cannot. In light of this potential, and considering the enforcement tools that the ACA added to DOL's arsenal, DOL elected to allow AHPs to continue to self-insure under this proposal. This provision will serve to further promote the establishment and growth of effective AHPs, but it will also compel DOL to commit additional resources to AHPs' oversight.
- *Limiting or increasing AHPs' product and/or price flexibility.* As noted earlier, this proposal allows small businesses to band together to obtain advantages that attend the provision of insurance by a large employer, including access to the large-group market. The large-group market is not subject to certain product and pricing restrictions that govern the individual and small group markets. As noted earlier, some stakeholders expressed their concern that allowing small businesses to escape these restrictions could lead to excessive risk segmentation and might destabilize some local individual and small group markets. The Department considered, but rejected, subjecting AHPs to constraints similar to those applicable to the individual and small group markets. The goal of the proposed rule is to allow AHPs to leverage advantages available to large employers to assemble large, stable risk pools, pursue administrative savings, and offer small businesses more, and more affordable, health insurance options. In light of that objective, imposing the product and pricing restrictions that distinguish the individual and small group markets from the large group market would have been too limiting. The flexibility also may increase AHPs' market reach, making more affordable options available to more small businesses than would be possible without it. This proposal would mitigate AHPs' potential to segment risk and destabilize individual and small group markets by applying nondiscrimination rules that bar them from conditioning eligibility, benefits, or premiums on the health status of small businesses' employees. Some stakeholders argue that nondiscrimination provisions themselves unduly restrict AHPs and could prevent AHP formation (and hence lower the number of insured people). DOL considered, but rejected, omitting the nondiscrimination provisions in part. These provisions, among other functions, serve to distinguish AHPs from commercial insurers as a legal matter.

1.13. Conclusion

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

2. Paperwork Reduction Act

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

3. Regulatory Flexibility Act

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

Need for and Objectives of the Rule

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

Affected Small Entities

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

- Some of the 25 million individuals under age 65 who currently are covered in individual markets, including approximately 3 million who are sole proprietors or dependents thereof, and an additional 6 million who are employees of small businesses or dependents thereof.
- The 25 million individuals under age 65 who currently are covered in small group markets.
- Some of the 28 million individuals under age 65 who currently lack insurance, including 2 million who are sole proprietors or dependents thereof, and an additional 5 million who are employees of small businesses or dependents thereof.

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

Impact of the Rule

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

Duplication, Overlap, and Conflict With Other Rules and Regulations

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

4. Congressional Review Act

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

5. Unfunded Mandates Reform Act

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

6. Federalism Statement

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

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

7. Executive Order 13771 Reducing Regulation and Controlling Regulatory Costs

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

List of Subjects in 29 CFR Part 2510

Employee benefit plans, Pensions.

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

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

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

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

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

§ 2510.3–3 Employee benefit plan.

* * * * *

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

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

§ 2510.3–5 Employer.

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

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

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

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

(2) Each employer member of the group or association participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the plan;

(3) The group or association has a formal organizational structure with a governing body and has by-laws or other similar indications of formality;

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

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

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

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

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

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

(1) Employers being in the same trade, industry, line of business or profession; or

(2) Employers having a principal place of business in a region that does not exceed the boundaries of the same State or the same metropolitan area (even if the metropolitan area includes more than one State).

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

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

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

(3) The group health plan sponsored by the group or association must comply with the rules of § 2590.702(c) of this chapter with respect to nondiscrimination in premiums or contributions required by any participant or beneficiary for coverage under the plan, subject to paragraph (d)(4) of this section.

(4) In applying the nondiscrimination provisions of paragraphs (d)(2) and (3) of this section, the group or association may not treat different employer members of the group or association as distinct groups of similarly-situated individuals.

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

Example 1. (i) *Facts.* Association *A* offers group health coverage to all members. According to the bylaws of Association *A,* membership is subject to the following criteria: All members must be restaurants located in a specified area. Restaurant *B,* which is located within the specified area, has several employees with large health claims. Restaurant *B* applies for membership in Association *A,* and is denied membership based on the claims experience of its employees.

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

Example 2. (i) *Facts.* Association *C* offers group health coverage to all members. According to the bylaws of Association *C,* membership is subject to the following criteria: All members must have a principal place of business in a specified metropolitan area. Individual *D* is a sole proprietor whose principal place of business is within the specified area. As part of the membership application process, Individual *D* provides certain health information to Association *C.* After learning that Individual *D* has diabetes, based on *D*'s diabetes, Association *C* denies Individual *D*'s membership application.

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

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

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

Example 4. (i) *Facts.* Association *G* sponsors a group health plan, available to all employers doing business in Town *H.* Association *G* charges Business *I* more for premiums than it charges other members because Business *I* employs several individuals with chronic illnesses.

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

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

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

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

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

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

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

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

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

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

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

(iv) Who either:

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

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

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

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 81

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

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

AGENCY: Environmental Protection Agency (EPA).

ACTION: Advanced notice of proposed rulemaking.

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

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