DEPARTM **–29–P**

Employee Benefits Security Administration

29 CFR Part 2510

RIN 1210-AC16

Definition of "Employer"—Association Health Plans

AGENCY: Employee Benefits Security Administration, Department of Labor.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document proposes to rescind the Department of Labor's (Department or DOL) 2018 rule entitled "Definition of Employer – Association Health Plans" (2018 AHP Rule). The 2018 AHP Rule establishes an alternative set of criteria from those set forth in the Department's pre-rule guidance for determining when a group or association of employers is acting "indirectly in the interest of an employer" under section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA) for purposes of establishing an association health plan (AHP) as a multiple employer group health plan. The 2018 AHP Rule's alternative criteria were set aside in large part by the U.S. District Court for the District of Columbia in *New York v. United States Department of Labor.* The district court found the bona fide association and working owner provisions in the rule to be an unreasonable interpretation of ERISA, inconsistent with congressional intent that ERISA applies to employee benefits arising out of employment relationships. The Department, after further review of the relevant statutory language, judicial decisions, and pre-rule guidance, and further consideration of ERISA's statutory purposes and related policy goals, now proposes to rescind in full the 2018 AHP Rule in order to resolve and mitigate any uncertainty regarding the status of the standards that were set under the 2018 AHP Rule, allow for a reexamination of the criteria for a group or association of employers to be able to sponsor an AHP, and ensure that guidance being provided to the regulated community is in alignment with ERISA's text, purposes, and policies.

DATES: Comments are due on or before [INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: You may submit written comments, identified by RIN 1210-AC16, by one of the following methods:

Federal eRulemaking Portal: *https://www.regulations.gov*. Follow the instructions for submitting comments. To facilitate receipt and processing of comments, the Department encourages interested parties to submit their comments electronically.

Mail: Office of Regulations and Interpretations, Employee Benefits Security Administration, Room N–5655, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, DC 20210, Attention: Proposed Rescission of AHP Final Rule RIN 1210–AC16.

Instructions: All submissions must include the agency name and Regulatory Identifier Number (RIN) for this rulemaking. Any comment that is submitted will be shared with the Internal Revenue Service (IRS). If you submit comments electronically, do not submit paper copies. Comments will be available to the public, without charge, online at *https://www.regulations.gov* and *https://www.dol.gov/agencies/ebsa* and at the Public Disclosure Room, Employee Benefits Security Administration, Suite N–1513, 200 Constitution Ave., 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 posted on the internet as received and can be retrieved by most internet search engines.

Docket: Go to the Federal eRulemaking Portal at https://www.regulations.gov for access to the rulemaking docket, including any background documents and the plain-language summary of the proposed rule of not more than 100 words in length required by the Providing Accountability Through Transparency Act of 2023.

FOR FURTHER INFORMATION CONTACT: Suzanne Adelman, Office of Regulations and Interpretations, Employee Benefits Security Administration, U.S. Department of Labor, (202) 693–8500 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION:

I. Background

A. Definition of Employer Under Section 3(5) of ERISA

ERISA regulates "employee benefit plans" (classified as "employee welfare benefit plans" and "employee pension benefit plans"), and generally preempts State laws that relate to or have a connection with such plans, subject to certain exceptions. An "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, [or] death. . . ." Thus, to be an employee welfare benefit plan, the plan, fund, or program must, among other criteria, be established or maintained by an employer, an employee organization, or both an employer and an employee organization.

Section 3(5) of ERISA generally defines the term "employer" as "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan." Thus, ERISA defines the term "employer" to include the "direct" (or common-law) employer of the covered employees or "any person acting . . . indirectly in the interest of" the common-law employer, in relation to an employee benefit plan. Section 3(5) of ERISA also expressly identifies "a group or association of employers acting for an employer in such capacity" as falling within the definition of "employer." A group or association may establish an employee welfare benefit plan only when it is acting as an "employer" within the meaning of ERISA section 3(5). The Department of Labor's (Department or DOL) regulation at 29 CFR

2510.3-5, published in its 2018 rule entitled "Definition of Employer – Association Health Plans" (2018 AHP Rule),[1] which is the subject of this proposal to rescind, sought to define circumstances under which a group or association of employers constitutes an "employer" within the meaning of ERISA section 3(5) with respect to sponsorship of a group health plan and the provision of health benefits.

B. Historical Guidance Prior to the 2018 AHP Rule – "Bona Fide" Group or Association of Employers

Based on definitions in title I of ERISA, and because title I's overall structure contemplates employment-based benefit arrangements, the Department has long recognized that, even absent the involvement of an employee organization, a group or association of employers may sponsor a single "multiple employer" plan if certain criteria are satisfied. If a group or association satisfies these criteria, the Department's guidance that predates the 2018 AHP Rule (hereinafter referred to as pre-rule guidance) generally refers to these entities as "bona fide" employer groups or associations. Under that pre-rule guidance, health coverage sponsored by a bona fide employer group or association can be structured as a single, multiple employer plan covered by ERISA. The criteria specified in the pre-rule guidance are intended to distinguish bona fide groups or associations of employers that provide coverage to their employees and the families of their employees from arrangements that more closely resemble State-regulated private health insurance coverage. The Department's pre-rule guidance is consistent with the criteria articulated and applied by every appellate court, in addition to several federal district courts, that considered whether an organization was acting in the interests of

[1] 83 FR 28912 (June 21, 2018). The 2018 AHP Rule included an amendment to the Department's regulation at 29 CFR 2510.3–3, which excludes "plans without employees" from the definition of employee benefit plans covered by Title I of ERISA, to expressly address participation of working owners without any common-law employees in AHPs under that provision by cross-referencing the regulation at 29 CFR 2510.3-5 , under which a working owner was able to be treated as an employee and the working owner's business as the individual's employer for purposes of being an employer member of the bona fide group or association and an employee participant in the AHP. This proposal would also rescind that amendment to 29 CFR 2510.3–3.

employer-members.[2] Moreover, to the Department's knowledge, no court has found, or even suggested, that the pre-rule guidance criteria too narrowly construe the meaning of acting "indirectly in the interest of an employer" under section 3(5) of ERISA.

Historically, the Department has taken a facts-and-circumstances approach to determining whether a group or association of employers is a bona fide employer group or association that may sponsor an ERISA group health plan on behalf of its employer members. The Department's pre-rule guidance, largely taking the form of a collection of advisory opinions issued over more than three decades, has expressed the Department's view regarding whether, based on individual circumstances, a particular group or association was able to sponsor a multiple employer welfare plan.[3] While the language in the Department's pre-rule advisory opinions was tailored to the issues presented in the specific arrangements involved, the Department's interpretive guidance has consistently focused on three criteria: (1) whether the group or association has business or organizational purposes and functions unrelated to the provision of benefits (the "business purpose" standard); (2) whether the employers share some commonality of interest and genuine organizational relationship unrelated to the provision of benefits (the "commonality" standard); and (3) whether the employers that participate in a

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[2] *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 786-87 (3d Cir. 1998) (endorsing the Department's historical approach to determining whether an organization is acting in the interests of employer-members); *MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 185-86 (5th Cir. 1992) (consistent with the Department's pre-rule guidance, requiring that, to act in the interests of employer members, an organization must not be a commercial, "entrepreneurial venture" but must instead represent members with "a common economic or representation interest" unrelated to the provision of benefits and who established or maintained the plan); *Wisconsin Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1062-65 (8th Cir. 1986) (same); *Int'l Ass'n of Entrepreneurs of Am. Ben. Tr. v. Foster*, 883 F. Supp. 1050, 1056-62 (E.D. Va. 1995); *Assoc. Indus. Mgmt. Servs. v. Moda Health Plan, Inc.*, No. 3:14-CV-01711-AA, 2015 WL 4426241, at *2-*5 (D. Or. July 16, 2015); *Smith v. Prudential Health Care Plan Inc.*, No. CIV. A. 97-891, 1997 WL 297096, at *3-*4 (E.D. Pa. May 27, 1997).

[3] *See, e.g.*, Advisory Opinions Nos. 94-07A (Mar. 14, 1994), 95-01A (Feb. 13, 1995), 96-25 (Oct. 31, 1996), 2001-04A (Mar. 22, 2001), 2003-13A (Sept. 30, 2003), 2003-17A (Dec. 12, 2003), 2007-06A (Aug. 16, 2007), 2012-04A (May 25, 2012), and 2019-01A (July 8. 2019). S*ee also* Department of Labor Publication, "Multiple Employer Welfare Arrangements Under ERISA, A Guide to Federal and State Regulation," at www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf. Judicial decisions tended to take approaches consistent with that followed by the Department. *See also Wisconsin Educ. Assn. Ins. Trust v. Iowa State Bd. of Public Instruction,* 804 F.2d 1059, 1063-1064 (8th Cir. 1986); *MDPhysicians & Associates, Inc. v. State Bd. of Ins.,* 957 F.2d 178, 183-186 (5th Cir. 1992) [hereinafter *MDPhysicians*]; *National Business Assn. Trust v. Morgan,* 770 F. Supp. 1169 (W.D. Ky. 1991).

benefit program, either directly or indirectly, exercise control over the program, both in form and substance (the "control" standard).

A variety of factors were set forth in the Department's pre-rule guidance as relevant when applying these three general criteria to a particular group or association. These factors include how members are solicited; who is entitled to participate and who actually participates in the group or association; the process by which the group or association was formed; the purposes for which it was formed; what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; who actually controls and directs the activities and operations of the benefit program; and the extent of any employment-based common nexus or other genuine organizational relationship unrelated to the provision of benefits.[4]

C. Association Coverage under the Public Health Service Act

The Public Health Service Act (PHS Act) derives its definitions of group health plan and employer from the ERISA definitions of employee welfare benefit plan and employer.[5] Thus, reference to ERISA is needed when determining whether a group health plan exists for PHS Act purposes and determining, if one does exist whether it exists at the individual employer level or at the association level. In other words, the ERISA definitions determine whether health insurance coverage sold to or through associations is individual or group coverage for purposes of title XXVII of the PHS Act, and if group coverage, whether the sponsor of the group coverage is the association, or whether each employer-member of the association sponsors its own group coverage.

In general, unless health insurance coverage issued through a group or association constitutes a single group health plan, the group or association is disregarded in determining

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[4] *See Gruber*, 159 F.3d at 788 fn. 5 (listing DOL criteria); *Int'l Ass'n of Entrepreneurs of Am. Ben. Tr. v. Foster*, 883 F. Supp. at 1061 (same); *Hall v. Maine Mun. Emps. Health Tr.*, 93 F. Supp. 2d 73, 77 (D. Me. 2000); *Assoc. Indus. Mgmt. Servs. v. Moda Health Plan, Inc.*, 2015 WL 4426241, at *3.

[5] Section 2791(a)(1) and (d)(6) of the PHS Act.

whether the coverage offered to an individual or employer member of the association is individual, small group, or large group market coverage. The Centers for Medicare & Medicaid Services (CMS) has long maintained that the test for determining whether association coverage is individual or group market coverage for purpose of title XXVII of the PHS Act is the same test as that applied to health insurance coverage offered directly to individuals or employers.[6] As that guidance explained, coverage that is provided to associations but not related to employment is not considered group health insurance coverage for purposes of the PHS Act. If the coverage is offered to an association member other than in connection with a group health plan, the coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under State law.[7]

On the other hand, if the health insurance coverage is offered in connection with a group health plan as defined at section 2791 of the PHS Act, it is considered group health insurance coverage. The group market is divided into the small group market and the large group market. In situations involving employment-based association coverage where the group health plan exists at the individual employer level, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or large group market rules. In instances where the group or 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, because the PHS Act definitions of large employer and small employer are based on the average number of employees employed on business days during the preceding calendar year, the number of employees employed by all the employers participating in the association determines whether the coverage is subject to the small group market or large group market rules.

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[6] Centers for Medicare & Medicaid Services, 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, Insurance Standards Bulletin Series – INFORMATION (Sept. 1, 2011), available at https://www.cms.gov/cciio/resources/files/downloads/association_coverage_9_1_2011.pdf.
[7] 45 CFR 144.102(c).

In a "mixed" association where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member's circumstances, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer. For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, with respect to its individual and small employer members.

As explained below, by expanding access to AHPs, the 2018 AHP Rule sought to allow small employers and working owners to band together to purchase coverage in the large group market, thereby avoiding the application of certain legal provisions governing individual and small group markets, such as modified community rating, single risk pool, and essential health benefit requirements.

D. The 2018 AHP Rule

On June 21, 2018, the Department published the 2018 AHP Rule,[8] intended to broaden the types of employer groups and associations that may sponsor a single group health plan under ERISA. The Department issued the 2018 AHP Rule in response to a 2017 Executive order (E.O.) that was rescinded in 2021.[9] The 2018 AHP Rule substantially loosened the requirements for groups or associations to be considered a bona fide group or association that is eligible to establish an employee welfare benefit plan or to otherwise meet the definition of "employer" under ERISA section 3(5) (for example, by allowing such groups or associations to include "working owners" who have no employees).[10] But the Department expressly noted in the 2018 AHP Rule that the rule "does not invalidate any existing advisory opinions, or preclude future advisory opinions, from the Department under section 3(5) of ERISA that address other circumstances in which the Department will view a person as able to act directly or indirectly in

[8] 83 FR 28912, 28962 (June 21, 2018).
[9] E.O. 13813, 82 FR 48385 (rescinded by E.O. 14009, 86 FR 7793 (Jan. 28, 2021)).
[10] *See generally* 83 FR 28912 (June 21, 2018).

the interest of direct employers in sponsoring an employee welfare benefit plan that is a group health plan."[11]

To establish the additional and broader standard, paragraph (b) of the 2018 AHP Rule set forth eight overall criteria that a group or association must meet to be a bona fide group or association eligible to establish an ERISA plan, including criteria related to (1) purposes of the group or association, (2) status of each group member as an employer of at least one employee participant in the AHP, (3) formal organizational structure requirements for the group, (4) control of the group and the AHP by employer members, (5) a commonality requirement for employer members, (6) limitations on providing health coverage to persons other than employees and beneficiaries, (7) nondiscrimination requirements, and (8) a limitation on health insurance issuers' ability to own or control the association or plan other than being an employer member of the group or association. Paragraphs (c) and (d) added specific details on the commonality and nondiscrimination requirements, and paragraph (e) addressed the dual classification of working owners without common-law employees who could be treated as both employers and employees for purposes of participation in the employer group and the AHP.[12]

These criteria were modeled on elements of the pre-rule guidance, but the 2018 AHP Rule differed in several significant ways, discussed below,[13] that were designed to loosen some requirements of the pre-rule guidance.

While paragraph (b)(1) of the 2018 AHP Rule provided that "the primary purpose of the group or association" could be "to offer and provide health coverage to its employer members and their employees," the pre-rule guidance requires that the group or association acting as an employer must exist for purposes *other than* providing health benefits. The 2018 AHP Rule required that "the group or association also must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer

[11] 29 CFR 2510.3-5(a).
[12] 29 CFR 2510.3-5(b)(4).
[13] *Infra*, section I.D.

members and their employees." A group of employers could satisfy the business purpose standard through a safe harbor requiring only that it would be a "viable" entity in the absence of sponsoring an employee benefit plan. The pre-rule guidance, however, does not equate the business purpose standard with whether the group or association could be viable even if it did not sponsor a plan. By equating purpose with viability, the 2018 AHP Rule weakened the business purpose standard and allowed the creation of groups or associations under ERISA section 3(5) primarily for the purpose of the provision of health benefits.

Paragraph (c) of the 2018 AHP Rule provided for a broader commonality standard than the pre-rule guidance. Under the 2018 AHP Rule, a group or association of employers satisfied the commonality of interest requirement if either (1) its employer members were in the same trade or business; or (2) the principal places of business for their employer members were located within a region that did not exceed the boundaries of the same State or metropolitan area, such as the Washington Metropolitan Area of the District of Columbia (which also includes portions of Maryland and Virginia). No other common interests were required.[14] Under the pre-rule guidance, geography alone is not sufficient to establish commonality between otherwise disparate businesses.

The 2018 AHP Rule also included express nondiscrimination standards that had to be met – aside from other health coverage requirements – in order for an employer group or association to act as an employer within the meaning of ERISA section 3(5) in sponsoring a single group health plan.[15] The 2018 AHP Rule incorporated and adapted existing health nondiscrimination provisions already applicable to group health plans, including AHPs, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[16] In applying the HIPAA health nondiscrimination rules for defining similarly situated individuals, under the 2018 AHP Rule, the

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[14] 29 CFR 2510.3-5(c); *see* 83 FR 28912, 28924 (June 21, 2018).

[15] Under the 2018 AHP rule, in addition to the bona fide group or association, the underlying health coverage offered by the bona fide group or association must also meet these requirements for the bona fide group or association to qualify as an employer under the 2018 AHP Rule. 29 CFR 2510.3-5(d).

[16] 83 FR 28912, 28926-27 (June 21, 2018).

group or association could not treat member employers as distinct groups of similarly situated individuals if it wished to qualify as a bona fide group or association for purposes of sponsoring an AHP.[17] The pre-rule guidance does not include any explicit nondiscrimination requirements. The Department noted in the preamble to the 2018 AHP Rule, however, that the HIPAA nondiscrimination rules apply to group health plans, including AHPs, and noted, therefore, that AHPs, like any other group health plan, cannot discriminate in eligibility, benefits, or premiums against an individual within a group of similarly situated individuals based on a health factor.[18]

Lastly, paragraph (e) of the 2018 AHP Rule allowed working owners without any common-law employees to participate in AHPs, stating that a working owner would be treated both as an "employer" and "employee" for purposes of participating in, and being covered by, an AHP, notwithstanding the absence of any employment relationship with common-law employees.[19] Under the pre-rule guidance, working owners without common-law employees are not permitted to be treated as employers for the purpose of participating in a bona fide employer group or association and generally are not treated as employees able to be participants in an ERISA-covered employee welfare benefit plan.[20]

E. Decision Setting Aside Core Provisions of the 2018 AHP Rule

In July 2018, eleven States and the District of Columbia (collectively, the States) sued the Department in Federal district court. They argued that the 2018 AHP Rule violates the Administrative Procedure Act (APA), 5 U.S.C. 551 *et seq.*, because it exceeds the Department's statutory authority and is arbitrary or capricious. The States moved for summary judgment, and the Department moved to dismiss the lawsuit for lack of standing and cross-moved in the

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[17] 29 CFR 2510.3-5(d)(4).

[18] 83 FR 28927 (June 21, 2018). The preamble also noted that AHPs, like other group health plans, generally may make distinctions between groups of individuals based on bona fide employment-based classifications consistent with the employer's usual business practice, provided such distinction is not directed at individual participants or beneficiaries based on a health factor. Id. The Department notes that no inference should be drawn based on this proposal to rescind the 2018 AHP Rule as to whether treating the employees of each employer member of an AHP as a distinct group of similarly situated individuals is a bona fide employment-based classification for purposes of the HIPAA nondiscrimination rules.

[19] 29 CFR 2510.3-5(e).

[20] 83 FR 28912, 28928, fn. 40 (June 21, 2018).

alternative for summary judgment. On March 28, 2019, the U.S. District Court for the District of Columbia denied the Department's motions and granted the States' motion for summary judgment. In granting the States' motion, the court set aside the 2018 AHP Rule's definition of bona fide group or association of employers and the language permitting working owners without common-law employees to be treated as employees when participating in an AHP.[21] The Department's pre-rule guidance was not affected by the district court's decision.

Specifically, the district court concluded that the 2018 AHP Rule's criteria for establishing AHPs unreasonably construed ERISA's requirement that the association act "indirectly in the interest of an employer" because the 2018 AHP Rule's "substantial business purpose" and "geographical commonality" requirements were not drawn narrowly enough to limit AHPs to those that act in the interest of employers, thus unreasonably expanding the definition of "employer."[22] In addition, the district court ruled that the 2018 AHP Rule's expansion of the term "employer" under ERISA to include working owners without common-law employees (when members of an association) was unreasonable because it was contrary to ERISA's text and central purpose of regulating employment-based relationships.[23] Regarding ERISA's text and purpose, the district court held that Congress did not intend for working owners without common-law employees to be included within ERISA — either as individuals or when joined in an employer association.[24] In conclusion, the district court held that the 2018 AHP Rule was inconsistent with ERISA and the APA because the provisions unlawfully failed to limit bona fide associations to those acting "in the interest of" their employer members, within the meaning of ERISA, thus exceeding the Department's statutory authority.[25] The district court

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[21] *New York v. United States Department of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019).
[22] *Id.* at 131-34.
[23] *Id.* at 136-40.
[24] *Id*. at 137. The district court concluded that the provision was contrary to ERISA and the APA and that it relied on "a tortured reading" of the Affordable Care Act (ACA). *Id.* at 141.
[25] *Id.* at 128.

remanded the 2018 AHP Rule to the Department to consider how the severability provision of the 2018 AHP Rule affects any of its remaining provisions.[26]

The Department appealed the district court's decision.[27] Thereafter, at the Department's request, the U.S. Court of Appeals for the District of Columbia Circuit granted the Department's request to stay the appeal.[28] Subsequently, the Department informed the appeals court that it would undertake notice and comment rulemaking on a proposal to rescind the 2018 AHP Rule. The appeal pending before the D.C. Circuit remains stayed.

The Department considered the severability clause issue raised by the district court and concluded that, without the core provisions that the district court set aside, the 2018 AHP Rule would have no operationalizable substance and provide no meaningful guidance. To minimize consequences of the district court's decision on AHP participants, the Department announced a temporary enforcement policy on April 29, 2019.[29] Specifically, the Department announced that it would not pursue enforcement actions against parties for potential violations stemming from actions taken prior to the district court's decision and in good faith reliance on the 2018 AHP Rule, as long as parties met their responsibilities to association members and their participants and beneficiaries to pay health benefit claims as promised.[30] In addition, the Department announced that it would not take action against existing AHPs for continuing, through the remainder of the applicable plan year or contract term that was in force at the time of the district court's decision, to provide health benefits to members who enrolled in good faith reliance on the 2018 AHP Rule before the district court's order.[31] Because the 2018 AHP Rule ceased being an

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[26] *Id.* at 141.
[27] *New York v. United States Department of Labor*, 363 F. Supp. 3d 109, *appeal docketed*, No. 19-5125 (D.C. Cir. May 31, 2019).
[28] *New York v. United States Department of Labor*, No. 19-5125 (D.C. Cir. Feb. 8, 2021) (order granting consent motion to hold case in abeyance).
[29] Press Release, Employee Benefits Security Administration, U.S. Department of Labor Statement Relating to the U.S. District Court Ruling in State of New York v. United States Department of Labor (Apr. 29, 2019), available at https://www.dol.gov/newsroom/releases/ebsa/ebsa20190429.
[30] *Id.*
[31] In addition, as explained in the April 29, 2019 statement, the Department of Health and Human Services (HHS) had advised the Department that HHS would not pursue enforcement against nonfederal governmental plans or health insurance issuers for potential violations of title XXVII of the PHS Act caused by actions taken before the

alternative pathway for entities to be treated as bona fide employer groups or associations after the district court's decision, the Department anticipated that parties who established AHPs in reliance on the 2018 AHP Rule would wind them down and that no new AHPs would be formed in reliance on the 2018 AHP rule until the judicial process ended. The Department's temporary enforcement policy period expired long ago, and the Department is not aware of any AHPs that currently exist in reliance on the 2018 AHP Rule.

II. Proposal to Rescind

The Department proposes to remove the 29 CFR 2510.3-5 regulation established by the 2018 AHP Rule and the related amendment to the 29 CFR 2510.3-3 regulation made by the 2018 AHP Rule. This proposed rule, if finalized, would rescind the 2018 AHP Rule in its entirety.

A. Authority to Define "Employer" in ERISA Section 3(5)

Congress tasked the Department with administering ERISA.[32] The Department has clear authority to interpret the term "employer," including defining when a "group or association of employers" may act "indirectly in the interest of an employer" in establishing an employee benefit plan and has done so in numerous advisory opinions.[33] As emphasized elsewhere in this preamble, the courts and the Department have consistently stressed that ERISA's definition of "employee benefit plan," including the definition's reference to arrangements "established or maintained by an employer or employee organization, or both," envisions employment-based arrangements. No court decision or guidance from the Department, including the 2018 AHP Rule, has suggested the "employer group or association" provision in the ERISA section 3(5)

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district court's decision in good faith reliance on the rule's validity, through the remainder of the applicable plan year or contract term that was in force at the time of the district court's decision. HHS had also advised the Department that HHS would not consider States to be failing to substantially enforce applicable requirements under title XXVII of the PHS Act in cases where the State adopted a similar approach with respect to health insurance coverage issued within the State. *Id.*

[32] 29 U.S.C. 1135 (delegating authority to the Secretary of Labor to "prescribe such regulations as he finds necessary or appropriate to carry out the provisions of [ERISA]"); *see Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003) (deferring to the Department's interpretation of an ERISA provision).

[33] *See* 2018 AHP Rule, 83 FR 28912, 28914 (June 21, 2018); *New York v. United States Department of Labor,* 363 F. Supp. 3d 109, 128 (D.D.C. 2019). *See also* Advisory Opinions Nos. 94-07A (Mar. 14, 1994), 95-01A (Feb. 13, 1995), 96-25A (Oct. 31, 1996), 2001-04A (Mar. 22, 2001), 2003-13A (Sept. 30, 2003), 2003-17A (Dec. 12, 2003), 2007-06A (Aug. 16, 2007), 2012-04A (May 25, 2012), and 2019-01A (July 8. 2019).

definition of "employer" extends the concept of an "employee benefit plan" to commercial insurance-type arrangements.

As described above, the Department's pre-rule guidance, as articulated in advisory opinions, has traditionally applied a facts-and-circumstances approach to determine whether a group or association of employers is a bona fide employer group or association capable of sponsoring an ERISA plan on behalf of its employer members. As noted above, this pre-rule guidance focuses on three general criteria: (1) whether the group or association has business or organizational purposes and functions unrelated to the provision of benefits; (2) whether the employers share some commonality of interest 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. While there are many organizations of employers, the Department's pre-rule guidance makes clear that only certain entities consisting of more than one employer meet the definition of a bona fide group or association of employers under ERISA.

Before the 2018 AHP Rule, the Department's approach to these determinations had consistently focused on employment-based arrangements, as contemplated by ERISA, rather than commercial insurance-type arrangements that lack the requisite connection to the employment relationship.[34] The Department's longstanding pre-rule guidance has also been informed by its extensive experience with unscrupulous promoters, marketers, and operators of multiple employer welfare arrangements (MEWAs).[35] AHPs generally qualify as MEWAs under ERISA. Although MEWAs can provide valuable coverage, historically MEWAs, particularly

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[34] "We are mindful of the potentially harmful effects of an overly broad interpretation of the term 'employee benefit plan' when coupled with the policy of section 514. As we have already noted, we do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the definition. Where a 'plan' is, in effect, an entrepreneurial venture, it is outside the policy of section 514 . . . . In short, to be properly characterized as an ERISA employee benefit plan, a plan must satisfy the definitional requirement of section 3(3) in both form and substance." *Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Public Instruction*, 804 F.2d 1059, 1063-64 (8th Cir. 1986) (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)).

[35] ERISA section 3(40)(A) (defining MEWAs).

self-funded MEWAs, have disproportionately suffered from financial mismanagement or abuse, leaving participants and providers with unpaid benefits and bills and putting small businesses at financial risk.[36] Because of this history of abuse by MEWA promoters claiming ERISA coverage and protection from State regulation, Congress amended ERISA in 1983 to provide an exception to ERISA's broad preemption provisions for the regulation of plan and non-plan MEWAs under State insurance laws.[37]

Employees and their dependents have too often become financially responsible for paying medical claims they were promised would be covered by the plan after paying premiums to fraudulent or mismanaged MEWAs, which could include AHPs. Because these entities often become insolvent, individuals and families bear the risk, and the impact can be devastating and can include being deprived of medical services if they cannot afford to pay out-of-pocket for medical claims that are not paid by the AHP.[38] Even before such MEWAs become insolvent, employees and their dependents may still become financially responsible for medical claims where the AHP failed to adequately disclose the limitations and exclusions under the plan.[39] The

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[36] For discussions of this history, see: (1) U.S. Gov't Accountability Office, GAO-92-40, "States Need Labor's Help Regulating Multiple Employer Welfare Arrangements.", March 1992, at https://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." Feb. 2004, at https://www.gao.gov/new.items/d04312.pdf; and (3) Kofman, M. 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, pp. 17-33.

[37] ERISA section 514(b)(6), 29 U.S.C. 1144(b)(6).

[38] Based on DOL enforcement data, since 2001, the Department has taken civil and criminal enforcement action, such as criminal indictments, civil complaints filed, temporary restraining orders, and cease and desist orders on 108 fraudulent and mismanaged MEWAs and their operators. Just since 2018, the Department was forced to take civil and criminal enforcement action against 21 MEWAs in order to protect participants and beneficiaries from fraud or mismanagement of these arrangements. Further, the Department has civilly recovered over $95 million from mismanaged or fraudulent MEWAs in the last five years alone. *See* EBSA National Enforcement Project – Health Enforcement Initiatives at www.dol.gov/agencies/ebsa/about-ebsa/our-activities/enforcement#national-enforcement-projects; U.S. Department of Labor Files Complaint to protect Participants and Beneficiaries of failing Medova MEWA operating in 38 states, available at https://www.dol.gov/newsroom/releases/ebsa/ebsa20201218; Federal Court Appoints Independent Fiduciary as Claims Administrator of Medova Arrangement, available at https://www.dol.gov/newsroom/releases/ebsa/ebsa20210412; Federal Court Orders Kentucky Bankers Association to Pay $1,561,818 In Losses to Benefits Plan After U.S. Department of Labor Finds Violations, available at https://www.dol.gov/newsroom/releases/ebsa/ebsa20201015; MEWA Enforcement Fact Sheet, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/mewa-enforcement.pdf.

[39] *See* 83 FR 28912, 28952 (June 21, 2018) (highlighting that many of the Department's civil enforcement cases involving MEWAs involved failure to follow plan terms or health care laws, failure to provide plan benefits, or reporting and disclosure deficiencies).

Department is concerned about the potential uptake and expansion of fraudulent and mismanaged MEWAs, especially at a time when over 90 million low-income children and adults are in the process of renewing their Medicaid and Children's Health Insurance Program (CHIP) coverage, and may need to transition to other sources of coverage if they no longer qualify.[40]

ERISA's overarching purpose is to protect participants and beneficiaries. The provisions of Title I of ERISA were initially enacted primarily to address public concern that funds of private pension plans were being mismanaged and abused. ERISA's protections have expanded over time for private group health plans as well. Both Federal regulators and State insurance regulators have devoted substantial resources to detecting and correcting mismanagement and abuse, and in some cases, prosecuting wrongdoers. Even the 2018 AHP Rule makes clear that DOL did not intend to depart too dramatically from its traditional interpretation of the word "employer."[41] While the Department sought to expand the scope of covered entities, it recognized the danger that too broad an expansion could result in "associations" masquerading as bona fide employer groups or associations merely to promote the commercial sale of insurance. For that reason, DOL adopted and clarified the pre-rule guidance condition that the employers who participate in the AHP must control the group or association and the plan, and added an express nondiscrimination requirement as a counterweight to abuse. Thus, even in the context of the 2018 AHP Rule, DOL was concerned about the danger of expanding the meaning

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[40] During the COVID-19 public health emergency, States were required to maintain enrollment of nearly all Medicaid enrollees. This "continuous enrollment condition" ended on March 31, 2023, under the Consolidated Appropriations Act, 2023. State Medicaid programs have 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid. CHIP provides health coverage to eligible children, through both Medicaid and separate CHIP programs. HHS has estimated that 15 million beneficiaries could lose Medicaid or CHIP coverage as a result of Medicaid unwinding. *See* HHS, Assistant Secretary for Planning and Evaluation, Office of Health Policy, "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022, available at https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf.

[41] 83 FR 28912 ("[T]he regulation continues to distinguish employment-based plans, the focal point of Title I of ERISA, from commercial insurance programs and other service provider arrangements.").

of the "group or association of employers" clause in ERISA section 3(5) to cover commercial insurance-type arrangements.

In fact, because available oversight resources are extremely limited and fraudulent operations resist detection until claims go unpaid, significant damage can be done before the Government even receives a complaint about an arrangement, making it difficult for regulators to mitigate damages and stop bad actors. The vulnerability of participants, beneficiaries, and the small employers whose employees receive benefits through an AHP is further heightened when the standard for becoming a bona fide group or association is weakened. A weakened standard also can hinder efforts by States to regulate MEWAs, including AHPs, within their borders.[42]

The preamble of the 2018 AHP Rule implies as much in explaining the importance of incorporating the nondiscrimination provision in paragraph (d)(4) of the 2018 AHP Rule. As noted above, paragraph (d)(4) of the 2018 AHP Rule sought to prohibit AHPs from treating member employers as distinct groups to distinguish AHPs from commercial insurance issuers. In discussing the importance of a requisite connection or commonality to lessen concerns about fraud, the preamble of the 2018 AHP Rule explained that because the final rule relaxed the Department's pre-rule guidance on the groups or associations that may sponsor a single ERISA-covered group health plan, paragraph (d)(4) was especially important in the context of the new, broader arrangements to distinguish a group or association sponsored AHP from commercial-insurance-type arrangements, which lack the requisite connection to the employment relationship and whose purpose was, instead, principally to identify and manage risk on a commercial basis.[43]

The Department is no longer of the view that the business purpose standard, commonality standard, and working owner provision in the 2018 AHP Rule, even bolstered by the nondiscrimination standards in paragraph (d)(4), are sufficient to distinguish between meaningful employment-based relationships as compared to commercial insurance-type arrangements whose

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[42] U.S. Gov't Accountability Office, GAO-92-40, "States Need Labor's Help Regulating Multiple Employer Welfare Arrangements." March 1992, pg. 2-3 at https://www.gao.gov/assets/220/215647.pdf.
[43] 83 FR 28912, 28928-29 (June 21, 2018).

purpose is principally to identify and manage risk. The Department continues to be mindful of the unique risks to participants, beneficiaries, small employers, and health care providers in the context of AHPs and any other form of MEWAs. These concerns underscore the need to limit ERISA-covered AHPs to true employee benefit plans that are the product of a genuine employment relationship and not artificial structures marketed as employee benefit plans, often with an objective of attempting to sidestep otherwise applicable insurance regulations or misdirect State insurance regulators. Such artificial vehicles are not "employee benefit plans" as defined in ERISA section 3(3), nor, as explained above, would it be consistent with the purpose of the statute to treat them as such. In sum, upon further evaluation and consistent with the sound administration of ERISA, the Department has concluded that it should rescind the 2018 AHP Rule from the Code of Federal Regulations (CFR). The Department now believes that the provisions of the 2018 Rule that the district court set aside as inconsistent with the APA and in excess of the Department's authority are, at a minimum, not consistent with the best reading of the statutory requirements governing group health plans.

B. Discussion of Decision to Propose to Rescind

Under Supreme Court precedent, an agency has the discretion to change a policy position provided that the agency acknowledges changing its position, the new policy is permissible under the governing statute, there are good reasons for the new position, the agency believes that the new policy is better, as evidenced by the agency's conscious action to change its policy, and the agency takes into account any serious reliance interests in the prior policy.[44]

The Department has further reviewed the relevant statutory language, judicial decisions, and pre-rule guidance, and further considered ERISA's statutory purposes and related policy goals. Based on this review, the Department has concluded it is appropriate to propose to rescind the regulatory provisions adopted in the 2018 AHP Rule in order to ensure that guidance being

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[44] *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 220-23 (2016); *see id*. At 225 (Ginsburg, J., concurring) (restating the rule governing an agency's reversal in policy, as articulated in *F.C.C. v. Fox Television Stations, Inc*., 556 U.S. 502, 515 (2009)).

provided to the regulated community is in alignment with ERISA's text, purposes, and policies, resolve and mitigate any uncertainty regarding the status of the standards that were set under the 2018 AHP Rule, and facilitate a reexamination of the criteria for a group or association of employers to be able to sponsor an AHP.

The intent of the 2018 AHP Rule was to expand access to affordable health coverage for employees of small employers and certain self-employed individuals by lessening restrictions on the formation of AHPs, and thereby allow for the purchase of health insurance through the less regulated large group market. As discussed further in this rulemaking, the Department is now of the view, however, that the business purpose standard, the viability safe harbor in the business purpose standard, the geography-based commonality standard, and the working owner provisions of the 2018 AHP Rule do not align with the best reading of ERISA's text and statutory purposes.

In addition, and independently, information presented to the Department during the public comment process of the 2018 AHP rulemaking indicates that implementation of the 2018 AHP Rule would have increased adverse selection against the individual and small group markets by drawing healthier, younger people into AHPs, thus increasing premiums for those remaining in those markets.[45] AHPs can also tailor plan benefits so that individuals with preexisting conditions, or those who are otherwise anticipated to have higher health care costs are discouraged from joining AHPs, causing further adverse selection, market segmentation, and higher premiums in the individual and small group markets.[46] The Department acknowledged in the 2018 AHP Rule that the rule's "increased regulatory flexibility" would necessarily result in some segmentation of risk that favors AHPs over individual and small group markets and some premium increase for individuals and other small businesses remaining in the individual and small group markets. The Department concluded, however, that practical considerations and

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[45] *See* 83 FR 28957 (June 21, 2018).

[46] The American Medical Association noted that AHPs could exclude benefits like insulin, maternity care, mental health services and rehabilitative services that are particularly important to certain workers in blue-collar professions. *See*, *e.g.*, Brief for American Medical Association and Medical Society of the State of New York as Amici Curiae in Support of Plaintiffs' Motion for Summary Judgment, at *16, *New York v. U.S. Department of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019) (No. 1:18-CV-01747-JDB).

Federal nondiscrimination rules would limit such segmentation, and that States may further limit risk segmentation through regulation of AHPs as MEWAs and assumed some premium protection for subsidy-eligible taxpayers with household incomes at or below 400 percent of the federal poverty level purchasing coverage on Exchanges. The Department is now of the view that the Department should give greater attention to the long-term impacts on market risk that the 2018 AHP Rule introduced, especially in the small group and individual markets.

Additionally, health insurance coverage offered through AHPs in the large group markets is not subject to the requirement to offer essential health benefits, which means that individuals who join these AHPs may become underinsured if their AHP offers only "skinny" coverage. Health plans that do not include benefits that non-grandfathered small group and individual market health insurance coverage are required to cover, such as maternity or prescription drug benefits, or even inpatient hospital coverage, are sometimes referred to as "skinny plans." Because they offer less than comprehensive coverage, they are cheaper to purchase; however, participants and beneficiaries may not understand the significant limitations on such coverage. As discussed in this preamble at section I.C., the 2018 AHP Rule allowed small employers and working owners to band together to qualify as a single group health plan to purchase coverage in the large group market, thus avoiding the requirements on small group market and individual health insurance coverage and making it easier for AHPs to offer such skinny plans, resulting in participants and beneficiaries being vulnerable to high out-of-pocket costs and potentially not having access to benefits for care when they most need it.[47]

The Department is also concerned that the 2018 AHP Rule could interfere with the goal of increasing affordable, quality coverage because the rule increases the possibility that

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[47] The Department notes concerns expressed by commenters that low barriers to entry to become an AHP could result in groups or associations with less of a connection to the member employer's community and unscrupulous operators siphoning off members by limiting their membership to healthier groups and offering lower rates for health coverage to their members. Commenters to the 2018 AHP notice of proposed rulemaking (NPRM) also expressed the concern that it could fragment the individual and small group markets, resulting in increased premiums. Commenters further communicated that organizations that form on the basis of offering health benefits could increase the prevalence of unscrupulous promoters that do not have strong incentives to maintain a credible reputation. *See* 83 FR 28912, 28917, and 28943 (June 21, 2018).

individuals who join AHPs will be subject to mismanaged plans. As noted above, ERISA generally classifies AHPs as MEWAs. Historically, MEWAs, especially self-funded MEWAs, have disproportionately suffered from financial mismanagement or abuse, leaving participants and providers with unpaid benefits and bills.[48]

The 2018 AHP Rule reflected a substantial change and significant departure from the Department's pre-rule guidance. While the alternative pathway provided in the 2018 AHP Rule has been unavailable as a basis for forming an AHP since the district court's decision, the Department's proposal to rescind the 2018 AHP Rule, if finalized, would make clear that this significant departure from pre-rule guidance no longer represents the Department's interpretation of when a group or association can constitute an "employer" for purposes of sponsoring a group health plan under ERISA. The proposed rescission leaves in place the longstanding pre-rule guidance that has been consistently supported and relied upon in numerous judicial decisions because it fosters a sufficient employer-employee nexus and proper oversight of AHPs, while remaining consistent with ERISA's text and purpose. The proposed rescission would also facilitate a reexamination of the rule's "business purpose" standard and viability safe harbor, the geography-based commonality alternative, and the working-owner provisions, including the potential those provisions have for encouraging abusive health care arrangements, especially self-insured programs, that sell low quality or otherwise unreliable health insurance products through MEWAs to unsuspecting employers, particularly small businesses. Further, the Department does not believe that there is a basis for reliance on the 2018 AHP Rule given the fact that the temporary enforcement policy period announced by the Department immediately following the district court's decision has long expired.[49] The Department has thus concluded for several reasons that it is appropriate to propose to rescind the 2018 AHP Rule.

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[48] *See* 83 FR 28951, 28953 (June 21, 2018).
[49] *See supra* note 25.

1. Business Purpose Standard

The courts of appeals have uniformly interpreted ERISA's definition of employer to require common interests other than the provision of welfare benefits, independent of any deference to the Department's historical guidance.[50] The decision of the Eighth Circuit Court of Appeals in WEAIT is instructive; there, the court held that "[t]he definition of an employee welfare benefit plan is grounded on the premise that the entity that maintains the plan and the individuals that benefit from the plan are tied by a common economic or representation interest, *unrelated to the provision of benefits.*"[51] The pre-rule guidance also uniformly emphasized that a purpose unrelated to the provision of benefits is a critical factor for any group or association of employers to be a bona fide group or association able to act as an "employer" sponsoring an "employee benefit plan" under ERISA. Although neither the courts nor the DOL's pre-rule guidance articulated a generally applicable standard for measuring the sufficiency or substantiality of the unrelated purpose, employer groups or associations that were found to be able to sponsor an ERISA plan tended to have well developed and shared business purposes unrelated to the provision of benefits.[52]

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[50], *Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Board of Public Instruction, 804 F.2d 1059,* 1065 (8th Cir. 1986) [hereinafter *WEAIT*] ("Our decision is premised on ERISA's language and Congress' intent. There is no need to resort to the Department of Labor's interpretations."); *see MDPhysicians & Associates, Inc. v. State Bd. Of Ins.,* 957 F.2d 178, 186 n.9 (5th Cir. 1992) ("Although we ground our decision on the statutory language of ERISA and the intent of Congress, we recognize that [Department of Labor] opinions 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'") (citation omitted).

[51] 804 F.2d 1059, 1064 (8th Cir. 1986) (emphasis added); *accord MDPhysicians,* 957 F.2d 178, 185 (5th Cir. 1992).

[52] *See*, *e.g.*, *MDPhysicians*, *supra* note 3, at 185-87 (holding that a MEWA that made health coverage available to "'employers at large' in the Texas panhandle" did not have sufficient common economic or representational interest) (citation omitted); *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1998) (endorsing district court's finding of no commonality of interest "because 'there was no nexus among the individuals benefitted by the [p]lan and the entity providing those benefits, other than the [p]lan itself' since [the association] 'was comprised of disparate and unaffiliated businesses' who [sic] had no relationship prior to the inception of the [p]lan") (citation omitted); *Plog v. Colorado Ass'n of Soil Conservation Districts*, 841 F. Supp. 350, 353 (D. Colo. 1993) (rejecting claim that association was an "employer" under ERISA because the association was open to any person who paid the association fee); Advisory Opinion No. 2019-01A (July 8, 2019) ("Ace is a hardware retailer cooperative and is the largest cooperative, by sales, in the hardware industry. . . . Ace facilitates access to materials, supplies and services, as well as engages in activities that support Ace retail owners' operation of their retail hardware businesses. Ace currently serves approximately 2,700 retail owners who operate approximately 4,400 Ace stores in the U.S. In addition, approximately 120 corporate stores are owned and operated as wholly-owned subsidiaries of Ace."); Advisory Opinion 2017-02AC (May 16, 2017) ("The First District Association (FDA) has been operating as an independent dairy cooperative organized under Minnesota Chapter 308A since 1921. . . . FDA's articles of incorporation provide that, among other related purposes, FDA's purposes and activities include the purchase, sale, manufacture, promotion and marketing of its members' dairy and agricultural products and engaging in other

Paragraph (b) of the 2018 AHP Rule also contained a business purpose standard. In relevant part, it provided that a group or association of employers must have at least one "substantial" business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees, even if the primary purpose of the group or association is to offer such coverage to its members.[53] The 2018 AHP Rule did not define "substantial" for this purpose, but created a broad safe harbor that allowed a group or association to meet the business purpose standard "if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan."[54] On further consideration, the Department is concerned that the business purpose standard and accompanying viability safe harbor are too loose to ensure that the group or association sponsoring the AHP is actually acting in the employers' interest or to effectively differentiate an employee health benefit program offered by such an association from a commercial insurance venture. Although the rule provided that a business purpose had to be "substantial," the preamble's discussion of what counts as "substantial" was confusing and in some tension with the word's ordinary meaning. At one point, the preamble suggested that merely "offering classes or educational materials on business issues of interest to members" was *per se* sufficient to qualify as substantial.[55] Moreover, the existence of the viability safe harbor suggested that some associations that were not viable (but for sponsoring an AHP) could still have a substantial business purpose under the rule.

In the preamble to the 2018 AHP rule, DOL posited that this relaxation of the standard would nonetheless work to differentiate employer groups or associations from commercial

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activities in connection with manufacture, sale or supply of machineries, equipment or supplies to its members."); Advisory Opinion 2005-24A (Dec. 30, 2005) ("WAICU's purposes and activities include representing its members at State and national forums, encouraging cooperation among its members to utilize resources effectively, and encouraging collaboration with other institutions of higher learning for the benefit of Wisconsin citizens. WAICU's services to its members include professional development for officers, research, public relations, marketing, admissions support, and managing collaborative ventures among the members (e.g., WAICU Study Abroad Collaboration)."); Advisory Opinion 2001-04A (Mar 22, 2001) ("The Association was incorporated in Wisconsin in 1935 for the purpose of promoting automotive trade in the State of Wisconsin . . . .").

[53] 29 CFR 2520.3-5(b)(1).

[54] *Id.*

[55] 83 FR 28912, 28918 (June 21, 2018).

insurance ventures because the rule's control requirement and its new nondiscrimination requirement would ensure that only bona fide associations become AHPs. However, as described above, DOL has reexamined the rule's treatment of those features and does not view those elements of the 2018 AHP Rule as sufficient to mitigate problems with the business purpose standard and ensure the rule distinguishes bona fide employer groups or associations acting as an employer with respect to an employee benefit plan from a commercial insurance venture. For example, under the 2018 AHP Rule, especially the working owner provisions, promoters would be able to set up arrangements with separate contribution rates for "employer" members based on a variety of non-health factors, such as industry, occupation, or geography, in ways that would make the arrangement look strikingly similar to a commercial insurance venture.[56] The 2018 AHP Rule attempted to address the Department's policy concerns related to fraud and insolvency by requiring that a group or association of employers have at least one substantial business purpose unrelated to offering or providing employee welfare benefits. In the Department's current view, based on its long and significant experience in this area as well as current concerns about abuse, by permitting the provision of benefits as the entity's primary purpose and the low bar of the substantial business purpose standard and viability safe harbor, the 2018 AHP Rule does not establish conditions that appropriately distinguish an employer group sponsoring an employee benefit plan from a commercial insurance venture. Rather, for the reasons discussed in this preamble, it may instead expose participants, beneficiaries, and unsuspecting small employers to unscrupulous operators.[57]

Moreover, the Department no longer believes that the 2018 AHP Rule appropriately addressed the concerns expressed by commenters, and now shared by the Department, related to market fragmentation and reduction in the average size of AHPs, which could impact employer

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[56] *Id.* at 28929.
[57] *See supra* fn. 39.

groups' ability to take advantage of their market power and economies of scale, which would ultimately impact the affordability for participants receiving benefits through the AHP.

2. Geographic Commonality

There is a substantial body of case law interpreting ERISA's definition of employer to require common interests other than the provision of welfare benefits, independent of any deference to the Department's historical guidance. For example, in WEAIT the Eighth Circuit concluded that "[t]he definition of an employee welfare benefit plan is grounded on the premise that the entity that maintains the plan and the individuals that benefit from the plan are tied by a common economic or representation interest, *unrelated to the provision of benefits.*"[58] The court further explained that "[o]ur decision is premised on ERISA's language and Congress' intent" and that "[t]here [wa]s no need to resort to the Department of Labor's interpretations."[59] Like the commonality of interest requirement articulated by the Eighth Circuit in *WEAIT* – a requirement that court explained was grounded in ERISA – in *MDPhysicians*, the court also found that ERISA required a commonality of interest among employer members.[60]

Paragraph (c) of the 2018 AHP Rule set forth alternative ways an association could be treated as having the requisite commonality of interest necessary to constitute a bona fide group or association of employers. The employers who participate in the group or association could have had "industry commonality," which means they were in the same trade, industry, line of business, or profession. Alternatively, the participating employers could have had "geographic commonality" if each employer had a principal place of business in the same geographic region that did not exceed the boundaries of a single State or metropolitan area (even if the metropolitan area included more than one State). In a departure from the pre-rule guidance, the 2018 AHP

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[58] 804 F.2d at 1063 (8th Cir. 1986).
[59] *Id. at 1065.*
[60] *MDPhysicians*, 957 F.2d at 186 n.9 ("Although we ground our decision on the statutory language of ERISA and the intent of Congress, we recognize that [Department of Labor] opinions 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'") (citation omitted); *id*. at 185-87 (holding that a MEWA that made health coverage available to "'employers at large' in the Texas panhandle" did not have sufficient common economic or representational interest).

Rule permitted an employer group or association to establish the requisite commonality of interest based on a common geographic location alone, even if the membership within the geographic locale comprises otherwise unrelated employers in multiple unrelated trades, industries, lines of business, or professions.[61]

The preamble of the 2018 AHP Rule focused on the desired goal of the rule, to spur AHP formation, but did not adequately address the fundamental question of how geography alone provided for a commonality of interest. The preamble to 2018 AHP Rule did not dispute the importance of commonality. Indeed, the 2018 AHP Rule rejected suggestions that commonality could be established by shared ownership characteristics (all women-owned businesses; all minority-owned businesses; all veteran-owned businesses), shared business models (e.g., all non-profit businesses), shared religious/moral convictions, or shared business size.[62] DOL did so because it concluded that a standard this lax would be "impossible to define or limit" and would "eviscerate" the commonality requirement.[63] The AHP rule concluded that, as a policy matter, these line-drawing concerns did not apply to groups with geographical commonality, but the discussion was incomplete at best because it focused mostly on the benefits of having more AHPs, without providing any convincing explanation of how geographic commonality was an employment-based commonality that was different from the shared ownership, shared business models, shared religious/moral convictions, and shared business size criteria that the Department rejected. Upon further consideration, DOL now agrees that a commonality requirement based on

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[61] *But see* Advisory Opinion No. 2008-07A (Sept. 26, 2008) ("In the Department's view, however, the Bend Chamber [of Commerce]'s structure is not the type of connection between employer members that the Department requires for a group or association of employers to sponsor a single 'multiple employer plan.' Rather, the Department would view the employers that use the Bend Chamber's arrangement as each having established separate employee benefit plans for their employees. Although we do not question the Bend Chamber's status as a genuine regional chamber of commerce with legitimate business and associational purposes, the primary economic nexus between the member employers is a commitment to private business development in a common geographic area. This would appear to open membership in the Bend Chamber, and in turn participation in the proposed health insurance arrangement, to virtually any employer in the region. The other factors the Bend Chamber cites do not directly relate to a connection between the member employers, the association, and the covered employees; instead, such factors are characteristics that evidence the reliability of the Bend Chamber's operations (*e.g.*, cash assets of $100,000 or more, physical office space, years in operation, etc.).").

[62] 83 FR 28912, 28926 (June 21, 2018).

[63] *Id*.

common geography alone (same State or multi-State area) is not adequate as a means for making sure that commonality exists. The same reasons why DOL rejected other expansions of the commonality requirement militate against adopting geographic commonality as well. Although it is true that the existence of state-wide chambers of commerce demonstrates that certain statewide groups might have shared interests such that they could create an association, this form of commonality is too loose and undermines the commonality requirement's ability to ensure that AHP status is restricted to bona fide associations.

While the Department acknowledges that employers within the same geographic locale can share other factors that rise to the level of sufficient economic and representational interest, the Department is now concerned that the 2018 AHP Rule did not articulate an appropriate basis for treating common geography alone as a shared interest with respect to the employment relationship. Just as would be the case for associations consisting of employers whose membership is based on common business size, the Department is concerned that recognizing under ERISA section 3(5) an association composed of unrelated employers all operating in any specific State with no other commonality also would not sufficiently respect the genuine commonality of interest requirement under ERISA, which is intended to ensure that AHPs are operating in the interest of employers and are not merely operating as traditional health insurance issuers in all but name.[64]

3. Working Owners

The 2018 AHP Rule allowed certain self-employed persons without any common-law employees to participate in AHPs as "working owners."[65] The 2018 AHP Rule established wage, hours of service, and other conditions for when a working owner would be treated as both an

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[64] The preamble of the 2018 AHP Rule explained that a test that would treat all nationwide franchises, all nationwide small businesses, or all nationwide minority-owned businesses, as having a common employment-based nexus—no matter the differences in their products, services, regions, or lines of work—wouldn't be sufficient to establish commonality of interest for a national group or association and AHP because it would be impossible to define or limit (e.g., business owners who support democracy) and, "in the Department's view, would effectively eviscerate the genuine commonality of interest required under ERISA." 83 FR 28912, 28926 (June 21, 2018).
[65] 29 CFR 2510.3-5(e).

"employer" and "employee" for purposes of participating in, and being covered by, an AHP.[66] The 2018 AHP Rule treated persons as employers even though they had no employment relationship with anybody other than themselves. Thus, a group or association could become an employer by virtue of its working owner members being classified as both an employer and an employee, even though the working owners had no employees and also were not employed by another person or entity.

The Department believes that the 2018 AHP Rule struck the wrong balance between ensuring a sufficient employment nexus and enabling the creation of plan MEWAs and failed to appropriately account for the consequences of the working owner provision. ERISA applies when there is an employer-employee nexus. This employer-employee nexus is the heart of what makes an entity a *bona fide* group or association of employers capable of sponsoring an AHP. In other words, the standard is meant to reflect *genuine* employment relationships. The Department is now of the view that ERISA calls for a higher standard for what constitutes a bona fide group or association of employers than is evidenced in the 2018 AHP Rule. In the ERISA context, the bona fide group or association of employers consists of actual employers who, as of the time they join the group or association, hire, and pay wages or salaries to other people who are their common-law employees working for them. Under the 2018 AHP Rule, although working owners had to meet requirements related to the number of hours devoted to providing personal services to the trade or business or the amount of income earned from the trade or business in order to participate in an AHP, these requirements related to differentiating self-employed individuals from individuals engaged in hobbies that generate income or other de minimis commercial activities.[67] They did not, however, reflect the existence of an employer-employee relationship as in the exchange between an employee and an employer of personal services for wages and other

[66] *See id.*at § 2510.3-3(c).
[67] 83 FR 28931 (June 21, 2018).

compensation (such as health benefits offered through a group health plan) that would be expected in a common-law employment relationship.

By removing the requirement for a genuine employer-employee nexus, we now are concerned on further reflection that the 2018 AHP Rule departs too far from ERISA's essential purpose and fails to take appropriate account of the underlying basis for the *bona fide* group or association of employers standard. As stated previously, this purpose and basis require drawing appropriate distinctions between employers and associations acting "in the interest of an employer" on the one hand, and entrepreneurial ventures selling insurance on the other. A strong employer-employee nexus condition also helps reduce the vulnerability of MEWAs to fraudulent behavior and mismanagement. Routinely treating people as "employers" when they have no employees risks converting ERISA from an employment-based statute, as Congress intended, to one that regulates the sale of insurance to individuals, without regard to an employment relationship.

The Department, upon further review of relevant Supreme Court and circuit court judicial decisions, and consistent with the Department's reconsidered view of working owners (without common-law employees) for purposes of ERISA section 3(5), has concluded that the better interpretation of such case law, for purposes of furthering ERISA's statutory purposes and related policy goals, is that a working owner may act as an employer for purposes of participating in a bona fide employer group or association under circumstances where there are also common-law employees of the working owner. In the Supreme Court's decision, *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon,* the Court held that a working owner and spouse were eligible to participate in the corporation's ERISA plan, provided that at least one common-law employee of the corporation participated in its plan.[68] Several circuit court opinions also emphasize the existence of an employment relationship when determining if an owner is an employer and/or employee. As the Eleventh Circuit stated in *Donovan v. Dillingham*, "[t]he gist

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[68] *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon,* 541 U.S. 1, 6 (2004).

of ERISA's definitions of employer, employee organization, participant, and beneficiary is that a plan, fund, or program falls within the ambit of ERISA only if the plan, fund, or program covers ERISA participants because of their employee status *in an employment relationship* . . . ."[69] In *Meredith v. Time Insurance Company*, the Fifth Circuit held that the Department could reasonably decline to treat a sole proprietor both as an employer and employee under ERISA section 3(5) because the "employee-employer relationship is predicated on the relationship between two different people."[70] Similarly, in *Marcella v. Capital Districts Health Plan, Inc.*, the Second Circuit found that working owners without common-law employees are not employers.[71] Further, as indicated in *Donovan*, just as the statutory definition of "employer" under ERISA requires an employee, the statutory definition of "employee" under ERISA requires the employee to work for another.[72] These holdings are consistent with the Department's traditional interpretation of "employee" in 29 CFR 2510.3-3(b) and (c).[73]

C. Alternatives to Complete Rescission of the 2018 AHP Rule

As part of its deliberations as to whether to propose rescission, the Department considered several alternatives for this rulemaking. The Department contemplated proposing rescission to remove only certain provisions of the 2018 AHP Rule. For example, the Department considered proposing to rescind the working owner provision, which represents the

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[69] *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (emphasis added).

[70] *Meredith v. Time Ins. Co.*, 980 F.2d 352, 358 (5th Cir. 1993); *id*. ("When the employee and employer are one and the same, there is little need to regulate plan administration. . . . It would appear axiomatic that the employee-employer relationship is predicated on the relationship between two different people. . . . We conclude that the power to so define the scope of ERISA has been delegated by Congress to the Department of Labor, and find no reason to disturb the Department's conclusion that ERISA does not intend to treat the spouse of a sole proprietor as an employee.").

[71] *Marcella v. Capital Districts Health Plan, Inc.,* 293 F.3d 42, 48 (2d Cir. 2002); *id*. at 49 (holding that "a group or association . . . that contains non-employers cannot be an 'employer' within the meaning of ERISA").

[72] *Baucom v. Pilot Life Ins. Co*., 674 F. Supp. 1175, 1180 (M.D.N.C. 1987). In *Baucom*, "[r]eturning to ERISA's language, the court observe[d] that, despite its limitations, the statutory definition of 'employee' mandates that an employee must work for another." *Id.* (citation omitted).

[73] In 1996, HIPAA added provisions of ERISA and the PHS Act, which specified that for purposes of part 7 of title 1 of ERISA and title XXVII of the PHS Act "[a]ny plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care . . . to present or former partners in the partnership . . . shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan." ERISA section 732(d); PHS Act section 2722(d). For a group health plan, the term employee also includes any bona fide partner. 26 CFR 54.9831-1(d)(2); 29 CFR 2590.732(d)(2); 45 CFR 146.145(c)(2).

most significant departure from the pre-rule guidance. Similarly, the Department considered proposing to remove the geographic commonality provision, another provision representing a dramatic departure from the pre-rule guidance, since geography is not, on its own, an interest with respect to an employment relationship. However, the Department decided against proposing a rescission of just the specific provisions set aside by the district court. The Department is concerned that the provisions that would remain in the 2018 AHP Rule would not provide an adequate definition of "employer" in ERISA section 3(5) that properly reflect the limits of ERISA's definition of "employer" and Congress' focus on employment-based arrangements, as opposed to the ordinary commercial provision of insurance outside the employment context, and, for the reasons discussed above, would be missing key elements necessary for a comprehensive framework for a group or association to demonstrate that it is acting "indirectly in the interest of an employer" within the meaning of section 3(5) of ERISA.[74]

The Department also considered a proposal to rescind the 2018 AHP Rule and instead codify, in the CFR, the pre-rule guidance. The Department recognizes that there could be benefits to codifying the pre-rule guidance. The pre-rule guidance is largely in the form of advisory opinions, which do not have the same applicability as regulations and technically are not precedential.[75] Application of the Department's pre-rule guidance thus requires interested parties to compare their specific circumstances to various opinions the Department issued to determine whether the Department has addressed analogous facts and circumstances. Nonetheless, the Department concluded that it would be better to seek comment from interested parties on whether the Department should first propose a rule either codifying the pre-rule

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[74] *See, e.g., Gruber v. Hubbard Bert Karla Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1988) ("[T]o qualify as an 'employer' for ERISA purposes, an employer group or association must satisfy both the commonality of interest and control requirements.").

[75] Advisory opinions are issued pursuant to ERISA Procedure 76-1, which in Section 10 describes the effect of advisory opinions as follows: "An advisory opinion is an opinion of the department as to the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions. The opinion assumes that all material facts and representations set forth in the request are accurate and applies only to the situation described therein. Only the parties described in the request for opinion may rely on the opinion, and they may rely on the opinion only to the extent that the request fully and accurately contains all the material facts and representations necessary to issuance of the opinion and the situation conforms to the situation described in the request for opinion."

guidance or creating alternative criteria and then consider that input as part of a comprehensive reevaluation of the definition of "employer" in the AHP context.

III. Requests for Public Comments

The Department seeks comments from interested parties on all aspects of this proposal to rescind the 2018 AHP Rule in its entirety. In the Department's view, ERISA's statutory purposes would be better served by rescinding the 2018 AHP Rule and removing it from the published CFR while the Department considers alternatives and engages with interested parties. In addition to comments on rescission of the 2018 AHP Rule, the Department also seeks comments on whether the Department should propose a rule for group health plans that codifies and replaces the pre-rule guidance, issue additional guidance clarifying the application of the Department's pre-rule guidance as it relates to group health plans (including, for example, the HIPAA nondiscrimination rule application to AHPs), propose revised alternative criteria for multiple employer association-based group health plans, or pursue some combination of those or other alternative steps. The public comments will inform the Department's decision on whether to finalize this proposal to rescind the 2018 AHP Rule and will also assist the Department in determining if it should engage in future rulemaking on AHPs under ERISA section 3(5). The Department intends that its evaluation will focus on ensuring that the Department's regulatory policy and actions in this area honor the Department's long held view, reiterated in the preamble to the 2018 AHP Rule, that Congress did not intend to treat commercial health insurance products marketed by private entrepreneurs, who lack the close economic or representational ties to participating employers and employees, as ERISA-covered welfare benefit plans.[76] Comments should be submitted in accordance with the instructions at the beginning of this document.

This proposal and solicitation of public comments is focused on group health plans and does not include retirement plans and welfare plans other than group health plans (e.g., disability

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[76] 83 FR 28912, 28928 (June 21, 2018); Advisory Opinions Nos. 94–07A (Mar. 14, 1994), available at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/1994-07a, and 2001–04A (Mar. 22, 2001), available at www.dol.gov/agencies/ebsa/employers-andadvisers/guidance/advisory-opinions/2001-04a.

plans). The Department acknowledges that its final rule on association retirement plans (ARPs), which was issued after the 2018 AHP Rule and after the district court decision in *New York v. United States Department of Labor*, includes commonality, business purpose, and working owner provisions that parallel the provisions in the 2018 AHP Rule.[77] In addition, ERISA has parallel language in the definitions of pension and welfare plan and does not explicitly provide a basis for distinguishing between the two rules. However, there are specific retirement plan considerations that involve issues beyond the scope of this rescission proposal. The Department does not intend to address the ARP rule, which was separately promulgated, in this rulemaking.

IV. Regulatory Impact Analysis

A. Relevant Executive Orders for Regulatory Impact Analyses

Executive Orders (E.O.s) 12866[78] and 13563[79] 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). E.O. 13563 emphasizes the importance of quantifying costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. E.O. 13563 directs agencies to propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs; the regulation is tailored to impose the least burden on society, consistent with achieving the regulatory objectives; and in choosing among alternative regulatory approaches, the agency has selected those approaches that maximize net benefits. E.O. 13563 recognizes that some benefits are difficult to quantify and provides that, where appropriate and permitted by law, agencies may consider and discuss qualitative values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts.

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[77] 29 CFR 2510.3-55; Definition of "Employer" Under Section 3(5) of ERISA—Association Retirement Plans and Other Multiple-Employer Plans, 84 FR 37508 (July 31, 2019).
[78] 58 FR 51735 (Oct. 4, 1993).
[79] 76 FR 3821 (Jan. 21, 2011).

Under E.O. 12866 (as amended by E.O. 14094), the Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs determines whether a regulatory action is significant and, therefore, subject to the requirements of the E.O. and review by OMB. As amended by E.O. 14094, section 3(f) of E.O. 12866 defines a "significant regulatory action" as a regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $200 million or more; or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, Territorial, or Tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in the Executive order.

OMB has designated this action a "significant regulatory action" within the meaning of section 3(f)(1) of E.O. 12866, as amended. Key to this designation is that the Department is proposing to rescind a rule that was itself significant under section 3(f)(1).

However, it should also be noted that the 2018 AHP Rule was never fully implemented.[80] While the Department gave AHPs established under the 2018 AHP Rule a temporary safe harbor from enforcement after the district court's decision setting aside the 2018 AHP Rule, that time has long expired, and the Department is not aware of any AHPs that currently exist under the framework of the 2018 AHP Rule.

Consequently, any costs and benefits that would have been anticipated in response to the approach taken in the 2018 AHP Rule were never fully experienced and have long since lapsed for those plans that formed and briefly existed pursuant to the 2018 AHP Rule. The 2018 AHP

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[80] The applicability date provision in the 2018 AHP Rule allowed fully insured plans to begin operating under the rule on September 1, 2018, existing self-insured AHPs could begin operating under the rule on January 1, 2019, and new self-insured AHPs could begin operating under the rule on April 1, 2019. The preamble explained that this phased approach was intended to allot some additional time for the Department and State authorities to address concerns about self-insured AHPs' vulnerability to financial mismanagement and abuse. *See* 83 FR 28912, 28953 (June 21, 2018).

Rule hypothesized that plans serving small employers and their participants potentially would have benefitted from the ability to band together to offer less generous benefits, and thus reduce their costs. At the same time, however, other plans and participants were assumed to bear the costs, with the 2018 AHP Rule's economic analysis projecting that those employers and participants that remained in the small-group and individual markets could face premium increases between 0.5 and 3.5 percent, resulting in an increase in the number of uninsured individuals caused by those that exited the individual market due to higher premiums. The Department's regulatory impact analysis accompanying the 2018 AHP Rule did not anticipate the litigation or the district court's decision, which largely nullified the assumed costs and benefits. Accordingly, the Department assumes that the costs of this proposal, the rescission of the 2018 AHP Rule, would effectively be zero, while the benefits would be limited to settling any uncertainty caused by the litigation surrounding the regulation and the Department's reexamination of the appropriate criteria for a group or association of employers to sponsor an AHP.

In accordance with E.O. 12866, this proposed rule was reviewed by OMB.

B. Background.

An AHP is a health plan formed by a group or association of employers to provide health care coverage for their employees. AHPs have been in existence for some time and are a subset of MEWAs. Under the pre-rule guidance, to qualify as a bona fide employer group or association capable of establishing a single group health plan under ERISA, the group or association had to satisfy the business purpose standard, commonality standard, and control standard, which, along with factors that may be considered in applying these standards, are described above in section II.B. of this preamble. If these standards are not satisfied, a health care arrangement sponsored by the group or association is not treated as a single group health plan. Rather, in general, unless health insurance coverage issued through a group or association constitutes a single group health plan, the group or association is disregarded in determining whether the coverage offered to an

individual or employer member of the association is individual, small group, or large group market coverage. The scope of these standards, additional nondiscrimination and working owner provisions, and how treatment of AHPs is different under the 2018 AHP Rule are discussed in section I.C. of the preamble.

As noted in section I.E. of this preamble, on March 28, 2019, the U.S. District Court for the District of Columbia set aside the 2018 AHP Rule's definition of bona fide employer groups or associations and the language equating working owners with employees. In response, the Department announced its temporary enforcement policy designed to minimize undue consequences of the district court's decision on AHP participants.[81]

C. Need for Regulatory Action.

As discussed in section I.E. of this preamble, the district court set aside the 2018 AHP Rule as inconsistent with ERISA's definition of "employer" and of persons "acting in the interest of an employer." The district court concluded that the 2018 AHP Rule's standards for determining "employer" status were overbroad and inconsistent with Congress' intent to draw a distinction between genuine employers and persons standing in the shoes of employers, on the one hand, and commercial entities marketing benefits to unrelated employers, on the other.[82] After further consideration, the Department has concluded that the 2018 AHP Rule does not comport with the best interpretation of ERISA's text and animating purposes in the context of AHPs and should be rescinded while the Department reconsiders its specific provisions and possible different regulatory approaches. The Department is proposing to rescind the 2018 AHP Rule in its entirety to provide clarity to entities that wish to sponsor an AHP about the need to

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[81] *See supra* note 25.
[82] *See supra* at section II.E. of this preamble for a discussion of the decision in *New York v. United States Department of Labor*.

rely upon the criteria in the Department's pre-rule guidance and court decisions on the ERISA section 3(5) definition, as opposed to the terms of the 2018 AHP Rule.

D. Affected Entities.

The Department does not believe that any entities currently rely upon the 2018 AHP Rule, now that the district court has set aside most of the 2018 AHP Rule and the temporary enforcement policy period has long expired. Rescinding the 2018 AHP Rule would simply maintain the status quo. At the time the Department first promulgated the 2018 AHP Rule, the Department identified 153 entities as potential "early adopters" that had signaled their intent to form an AHP under the 2018 AHP Rule. Of these early adopters, 112 of these entities ultimately submitted the required Form M-1, one other entity advised the Department that it intended to file a Form M-1, two indicated they were not required to file a Form M-1, 15 told the Department that they were not pursuing an AHP, one was under investigation for reasons unrelated to the early adopter program, and the remainder were unresponsive to further Department outreach.

E. Benefits.

The proposed rule would rescind the 2018 AHP Rule and provide clarity to parties about the continuing unavailability of the 2018 AHP Rule as an alternative to the Department's pre-rule guidance. At the time the 2018 AHP Rule was finalized, the Department also anticipated that it would have to increase dramatically its MEWA enforcement efforts and enhance its coordination with State regulators because of the anticipated increase in the number of AHPs attributable to the new 2018 AHP Rule. Because the 2018 AHP Rule was set aside by the district court, the Department has not had to address a dramatic increase in the number of insolvent MEWAs, although existing fraudulent and mismanaged MEWAs remain a significant challenge to the agency.

F. Costs.

Although the 2018 AHP Rule was finalized, it was never fully implemented, and no parties appear to currently rely on the 2018 AHP Rule, given the district court's decision and the expiration of the Department's temporary enforcement policy. As a result, the Department does not believe that rescinding the 2018 AHP Rule would result in any costs. The Department seeks comments on this assumption and any costs interested parties anticipate related to this proposal.

V. Paperwork Reduction Act.

The 2018 AHP Rule was not subject to the requirements of the Paperwork Reduction Act of 1995[83] because it did not contain a collection of information as defined in 44 U.S.C. 3502(3). Accordingly, this proposal to rescind the 2018 AHP Rule also does not contain an information collection as defined in 44 U.S.C. 3502(3).

VI. Regulatory Flexibility Act.

The Regulatory Flexibility Act (RFA) imposes certain requirements on rules subject to the notice and comment requirements of section 553(b) of the APA or any other law.[84] Under section 603 of the RFA, agencies must submit an initial regulatory flexibility analysis (IRFA) of a proposal that is likely to have a significant economic impact on a substantial number of small entities, such as small businesses, organizations, and governmental jurisdictions. However, because the 2018 AHP Rule was never fully implemented and the Department is not aware of any existing AHP that was formed in reliance on the rule, this proposed rescission of the 2018 AHP Rule would not have a significant economic impact on a substantial number of small entities.

Pursuant to section 605(b) of the RFA, the Assistant Secretary of the Employee Benefits Security Administration hereby certifies that the proposed rule, if promulgated, would not have a significant economic impact on a substantial number of small entities. The Department invites comments on this certification. As discussed above, at the time the Department first promulgated

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[83] 44 U.S.C. 3501 *et seq*.
[84] 5 U.S.C. 551 *et seq*.

the 2018 AHP Rule, the Department identified only 153 entities as potential "early adopters" that had signaled their intent to form an AHP under the 2018 AHP Rule. Ultimately, 112 of these entities submitted the required Form M-1, one other entity advised the Department that it intended to file a Form M-1, two indicated they were not required to file a Form M-1, 15 told the Department that they were not pursuing an AHP, one was under investigation for reasons unrelated to the early adopter program, and the remainder were unresponsive to further Department outreach. Since the district court set aside the 2018 AHP Rule and the temporary enforcement policy period has expired, any AHPs that formed before the decision in reliance on the 2018 AHP Rule should have wound down, and the Department is not aware of any new AHPs that have formed in reliance on the 2018 AHP Rule. Accordingly, rescission of the 2018 AHP Rule would not have an impact on existing AHPs formed in accordance with the pre-rule guidance.

VII. Unfunded Mandates.

Title II of the Unfunded Mandates Reform Act of 1995 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.[85] In 2023, that threshold is approximately $177 million. For purposes of the Unfunded Mandates Reform Act, as well as E.O. 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.[86]

VIII. Federalism.

E.O. 13132 outlines the fundamental principles of federalism. It also requires Federal agencies to adhere to specific criteria in formulating and implementing policies that have

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[85] 2 U.S.C. 1501 *et seq*. (1995).
[86] 58 FR 58093 (Oct. 28, 1993).

"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 these 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 proposal. The preamble to the 2018 AHP Rule included a discussion of federalism implications of the rule, which largely focused on and confirmed that the 2018 AHP Rule did not modify State authority under ERISA section 514(b)(6), which gives the Department and State insurance regulators joint authority over MEWAs, including AHPs, to ensure appropriate regulatory and consumer protections for employers and employees relying on an AHP for health care coverage. Because the 2018 AHP Rule was never fully implemented and the Department is not aware of any entities currently relying on the 2018 AHP Rule, the Department does not believe its rescission would have a substantial direct effect on the States, on the relationship between the National Government and the States, or on the distribution of power and responsibilities among the various levels of government that were discussed in the 2018 AHP Rule. Nonetheless, the Department notes that the level and type of State regulation of MEWAs vary widely. The Department is aware that some States have enacted or are considering State laws modeled on the 2018 AHP Rule that are intended to recognize AHPs as employee benefit plans for purposes of State regulation. In fact, CMS on behalf of HHS recently issued a final determination pursuant to section 2723(a)(2) of the PHS Act, section 1321(c)(2) of the ACA, and 45 CFR 150.219 that the Commonwealth of Virginia has not corrected the failure to substantially enforce certain Federal market reforms with respect to issuers offering health insurance coverage through an association of real estate salespersons under such a State law, specifically section 38.2- 3521.1 G of the Code of Virginia, as enacted by HB 768/SB 335 (2022).[87] The Department is interested in input from affected

[87] The CMS letter, dated September 6, 2023, is available at www.cms.gov/files/document/letter-virginia-governor-and-insurnace-commissioner-hb-768sb-335-2022-final-determination.pdf.

States, including State insurance regulators and other State officials, regarding whether they see potential federalism implications that might arise from rescission of the 2018 AHP Rule.

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(1), 1002(2), 1002(3), 1002(5), 1002(16), 1002(21), 1002(37), 1002(38), 1002(40), 1002(42), 1002(43), 1002(44), 1031, and 1135; and Secretary of Labor's Order No. 1- 2011, 77 FR 1088. Secs. 2510.3-101 and 2510.3-102 also issued under sec. 102 of Reorganization Plan No. 4 of 1978, 5 U.S.C. App. (E.O. 12108, 44 FR 1065, 3 CFR, 1978 Comp., p. 275) and 29 U.S.C. 1135 note.

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

§ 2510.3–3 Employee benefit plan.

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(c) *Employees*. For purposes of this section and except as provided in § 2510.3–55(d):

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§ 2510.3–5 [Removed and Reserved]

3. Remove and reserve § 2510.3–5.

Signed at Washington, DC, this 11th day of December 2023.

Lisa M. Gomez,

Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor.

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