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: Final Rule, rescission.

SUMMARY: This document rescinds the Department of Labor's (Department or DOL) 2018 rule entitled "Definition of Employer Under Section 3(5) of ERISA – Association Health Plans" (2018 AHP Rule). The 2018 AHP Rule established an alternative set of criteria from those set forth in the Department's pre-2018 AHP Rule (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 was a significant departure from the Department's longstanding pre-rule guidance on the definition of "employer" under ERISA. This departure substantially weakened the Department's traditional criteria in a manner that would have enabled the creation of commercial AHPs functioning effectively as health insurance issuers. The Department now believes that the core provisions of the 2018 AHP Rule are, at a minimum, not consistent with the best reading of ERISA's statutory requirements governing group health plans.

DATES: *Effective date*: This rule is effective on [INSERT DATE THAT IS 60 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER]

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. Executive Summary

This document rescinds the Department's 2018 rule entitled "Definition of Employer Under Section 3(5) of ERISA – Association Health Plans." The 2018 AHP Rule established 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 ERISA for purposes of establishing an AHP as a multiple employer group health plan. The 2018 AHP Rule was a significant departure from the Department's longstanding pre-rule guidance on the definition of "employer" under ERISA. This departure substantially weakened the Department's traditional criteria in a manner that would have enabled the creation of commercial AHPs functioning effectively as health insurance issuers. The 2018 AHP Rule's alternative criteria were, in large part, held invalid 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 2018 AHP Rule were based on an unreasonable interpretation of ERISA that was inconsistent with congressional intent that ERISA applies to employment-based benefit relationships. The Department, after further review of the relevant statutory language, judicial decisions, and longstanding pre-rule guidance, and further consideration of ERISA's statutory purposes and related policy goals, as well as the public comments received on the Department's proposed rule, now rescinds in full the 2018 AHP Rule in order to resolve and mitigate any uncertainty regarding the status of the criteria 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. The Department now believes that the provisions of the

2018 AHP Rule that the district court held invalid are, at a minimum, not consistent with the best reading of ERISA's statutory requirements governing group health plans.

II. 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 section 3(5) of ERISA. The Department's regulation at 29 CFR 2510.3–5, published in its 2018

AHP Rule,[1] which is the subject of this rescission, sought to define circumstances under which a group or association of employers constitutes an "employer" within the meaning of section 3(5) of ERISA 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, then it is generally referred to as a "bona fide" employer group or association according to the Department's pre-rule guidance first issued more than forty years ago.[2] 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 Federal appellate court, in addition to several Federal district courts, that have considered

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[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. Under the amendment, a working owner with no common law employees would have been treated as both an "employer" member of the employer group or association *and* an "employee" participant in the AHP, notwithstanding the lack of any employment relationship with any other person. This amendment to 29 CFR 2510.3–3 is also rescinded by this final rule.

[2] An information letter from the Employee Benefits Security Administration (EBSA)—previously known as the Pension and Welfare Benefits Administration (PWBA)—explained that "[t]he question of whether or not an association is an employer within the meaning of section 3(5) rests upon the dual questions of whether or not a bona fide employer association exists and, if so, whether it is acting in the interest of an employer in relation to an employee benefit plan," and also noted that "a number of factors must be considered" to determine "whether a bona fide employer association exists." Letter from Helene Benson, PWBA, to David Peters, 1979 WL 169912 (Aug. 22, 1979); Advisory Opinion No. 80-15A (March 14, 1980) ("The Department has taken the position that, in order for any group or association to satisfy this definition [association acting for its employer members], it must be a bona fide association of employers, subject, in both form and substance, to the control of its employer members.")

whether an organization was acting in the interests of employer members.[3] Moreover, to the Department's knowledge, no court has found, or even suggested, that the pre-rule guidance criteria too narrowly construed 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 determine 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 longstanding pre-rule guidance, largely taking the form of a collection of advisory opinions issued over more than four 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.[4] 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 a 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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[3] *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) (hereinafter WEAIT); *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).

[4] *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 longstanding 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; the preexisting relationships, if any, 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.[5]

C. Association Coverage under the Public Health Service Act

The Public Health Service Act (PHS Act) establishes health coverage requirements in Title XXVII that generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage. The provisions of Title XXVII of the PHS Act have been amended by the Affordable Care Act (ACA)[6] and other Federal laws. These PHS Act provisions are administered by the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). With respect to health insurance issuers, States are

[5] *See Gruber*, 159 F.3d at 788 fn. 5 (listing the Department's 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.

[6] The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010. These statutes are collectively referred to as the Affordable Care Act (ACA). The ACA reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets.

the primary enforcers of these PHS Act provisions, and if a State fails to substantially enforce them, CMS enforces them.

Under Title XXVII of the PHS Act, "individual market coverage" is any health insurance coverage that is not offered in connection with a group health plan.[7] Conversely, the term "group health insurance coverage" refers to health insurance coverage offered in connection with a group health plan.[8] The PHS Act derives its definitions of "group health plan" and "employer" from the ERISA definitions of "employee welfare benefit plan" and "employer."[9] Thus, reference to ERISA is needed when determining whether a group health plan exists for PHS Act purposes and determining whether an ERISA-covered health arrangement is properly treated as a single plan operating on behalf of multiple employers or, instead, a collection of separate and discrete employer-sponsored plans.

In guidance issued in 2002 and 2011, CMS explained how the requirements of Title XXVII of the PHS Act apply to health insurance coverage sold to or through associations.[10] Specifically, as stated in the guidance, the test for determining whether association coverage[11] is individual or group market coverage for purposes of Title XXVII of the PHS Act is the same test as that applied to health insurance coverage offered directly to individuals or employers. In other words, CMS will generally ignore – "look through" – the association to determine whether each

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[7] Section 2791(b)(5) and (e)(1)(A) of the PHS Act.
[8] Section 2791(b)(4) of the PHS Act.
[9] Section 2791(a)(1) and (d)(6) of the PHS Act.
[10] *See* 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. *See also* CMS Insurance Standards Bulletin Transmittal No. 02–02 (August 2002), available at https://www.cms.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/hipaa-02-02.pdf.
[11] For this purpose, the term "association coverage" means health insurance coverage offered to collections of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements, purchasing alliances, or purchasing cooperatives.

association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.

Consequently, coverage that is issued to or through an association, but not in connection with a group health plan, is not considered group health insurance coverage for purposes of the PHS Act. Under the PHS Act, such coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under State law.[12]

In situations involving employment-based association coverage where coverage is offered in connection with a group health plan, the coverage is considered group health insurance coverage under the PHS Act. In cases where an association is not considered an employer under ERISA, each employer member of the association is considered to sponsor its own group health plan under the PHS Act. In those cases where an association is determined to be an employer that is "acting indirectly in the interest of its employer members" and sponsors a plan under ERISA, the association coverage is considered a single group health plan under the PHS Act.

Under the PHS Act, the number of employees of the employer sponsoring the group health plan determines whether the employer is a small employer[13] or large employer[14] and thus whether health insurance coverage provided in connection with a group health plan sponsored by the employer falls into the small group market or large group market. In the situation where each employer member of the association is considered to sponsor its own group health plan, the size of each employer participating in the association determines whether that employer's coverage is subject to the small group market or large group market rules. In those 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 number of employees employed by all the employers participating

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[12] *See* 45 CFR 144.102(c).

[13] The term "small employer" generally means an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year, and who employed at least 1 employee on the first day of the plan year. Section 2791(e)(4) of the PHS Act.

[14] The term "large employer" generally means an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. Section 2791(e)(2) of the PHS Act.

in the association determines whether the coverage is subject to the small group market or large group market rules. Accordingly, the status of an association as a single "employer" within the meaning of section 3(5) of ERISA, and of the AHP as a single plan has important legal consequences. As a general matter, small group and individual market coverage is subject to Federal protections not applicable to large group market coverage, such as the ACA's premium rating requirements, single risk pool, and essential health benefit (EHB) requirements. Thus, to the extent the arrangement is not a single plan, but rather an aggregation of individual plans (or individuals), the participants covered by the arrangement are subject to these more robust protections applicable to plans in the small group market (or to individual coverage, when the insured parties are simply individuals purchasing insurance coverage outside the group market).[15] [16]

D. The 2018 AHP Rule

On June 21, 2018, the Department published the 2018 AHP Rule,[17] which was 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.[18] Relative to the longstanding pre-rule guidance, the 2018 AHP Rule substantially loosened the requirements for groups or associations to be considered bona fide groups or associations that were eligible to establish employee welfare

[15] There are other provisions of the PHS Act that apply to individual but not large group market coverage. For example, section 2746 of the PHS Act requires health insurance issuers offering individual health insurance coverage or short-term limited duration insurance coverage to make disclosures to enrollees in such coverage and provide reports to the Secretary of HHS regarding direct and indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage.

[16] *See* section 2701 of the PHS Act (premium rating), section 1312(c) of the ACA (single risk pool), and section 2707(a) of the PHS Act (EHB requirements). The ACA requires non-grandfathered health plans in the individual and small group markets to cover EHBs, which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. 42 U.S.C. 18022(b).

[17] 83 FR 28912, 28962 (June 21, 2018).

[18] E.O. 13813, 82 FR 48385 (rescinded by E.O. 14009, 86 FR 7793 (Jan. 28, 2021)).

benefit plans or to otherwise meet the definition of "employer" under section 3(5) of ERISA.[19] As published, the 2018 AHP Rule altered many of the guardrails in pre-rule guidance, which had been intended to distinguish bona fide employer associations united by common employment-based relationships from mere commercial ventures aimed at marketing insurance to employers and individuals.

Thus, paragraph (b)(1) of the 2018 AHP Rule abandoned the requirement in pre-rule guidance that the group or association acting as an employer must *exist* for purposes *other than* providing health benefits. Instead, the 2018 AHP Rule only required that the group or association 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. In a significant departure from pre-rule guidance, the rule specifically stated that "the primary purpose of the group or association" could be "to offer and provide health coverage to its employer members and their employees."[20]

Similarly, paragraph (c) of the 2018 AHP Rule provided for a looser commonality standard than the pre-rule guidance, which had insisted on a genuine commonality of interests between employer members. 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 its 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.[21] Under the pre-rule guidance, geography alone would not have been sufficient to establish commonality

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[19] *See generally* 83 FR 28912 (June 21, 2018). 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 the interest of direct employers in sponsoring an employee welfare benefit plan that is a group health plan." 83 FR 28912, 28962 (June 21, 2018).

[20] 83 FR 28912, 18 (June 21, 2018).

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

between businesses. For example, barbers, mechanics, and lawyers would not have been treated as having the requisite commonality of interest merely because they all have a principal place of business in the State of New York.

In a particularly striking departure from ERISA's employment-based structure, paragraph (e) of the 2018 AHP Rule specifically allowed working owners without any common-law employees to participate in AHPs, stating that the working owner would be treated as both an "employer" and "employee" for purposes of participating in, and being covered by, an AHP, notwithstanding the absence of any employment relationship with any common-law employees.[22] Under the pre-rule guidance, working owners without common-law employees generally were not permitted to be treated as employers for the purpose of participating in a bona fide employer group or association,[23] or as employees who could be participants in an ERISA-covered employee welfare benefit plan.

In part because the 2018 AHP Rule had relaxed the standards for treating arrangements as single group plans -- making it easier for small employers and working owners to purchase coverage in the large group market which is not subject to all the legal protections applicable to coverage in the individual and small group markets -- the 2018 AHP Rule expressly added nondiscrimination standards as an additional safeguard against abuse.[24] These standards aimed to reduce the danger that the new AHPs would abuse their status by cherry-picking groups of relatively healthy participants, such as by charging one participating business more for premiums than it charges other members because that business employs several individuals with chronic illness, and excluding others at the expense of the broader insurance market, which would cover a relatively sicker and more expensive population. In particular, the 2018 AHP Rule incorporated and adapted existing health nondiscrimination provisions already applicable to group health

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[22] *Id.* at 28929-33.
[23] *Id.* at 28928, n. 40.
[24] 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. 84 FR 28912, 28926-29.

plans, including AHPs, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[25]

In applying the HIPAA health nondiscrimination rules for defining similarly situated individuals under the 2018 AHP Rule, the group or association could not treat employer members 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.[26] For example, a group or association could not separately experience-rate each employer member of the association based on the health factors of their employees and meet the criteria to be a bona fide group or association of employers under the 2018 AHP Rule. The pre-rule guidance does not incorporate nondiscrimination requirements in the definition of employer, although plans must comply with all applicable laws, including the HIPAA nondiscrimination rules. As the Department noted in the preamble to the 2018 AHP Rule, the HIPAA nondiscrimination rules apply to group health plans, including AHPs, and therefore AHPs, like any other group health plan, cannot discriminate in eligibility, benefits, or premiums against an individual within a group of similarly situated individuals based on a health factor.

E. Decision Finding Core Provisions of the 2018 AHP Rule Invalid

In July 2018, eleven States and the District of Columbia (collectively, the States) sued the Department in the U.S. District Court for the District of Columbia. 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 alternative for summary judgment. On March 28, 2019, the Federal district court denied the Department's motions and granted the States' motion for summary judgment. In granting the States' motion, the district court held invalid the 2018 AHP Rule's definition of

[25] *Id.* at 28926-27.
[26] *Id*. at 28927, 28929, 28955.

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.[27] 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 "geographic 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."[28] 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.[29] 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.[30] 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.[31] The district court 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.[32] The Department's longstanding pre-rule guidance was not affected by the district court's decision.

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[27] *New York v. United States Department of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019).
[28] *Id.* at 131-34.
[29] *Id.* at 136-40.
[30] *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 ACA. *Id.* at 141. The court described the defense of the working owner test as "pure legerdemain," noting that "DOL's feat of prestidigitation transforms two individuals, neither of whom works for the other, into a total of three employers and two employees." *Id.* at 139. The court understood ERISA to require a different approach to counting employees, noting that "when one counts the employees employed by two self-employed persons without employees, the sum is zero." *Id.*
[31] *Id.* at 128.
[32] *Id.* at 141.

In 2019, the Department appealed the district court's decision.[33] Thereafter, the U.S. Court of Appeals for the District of Columbia Circuit granted the Department's request to stay the appeal.[34] 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 found invalid, the 2018 AHP Rule could not be operationalized and would provide no meaningful guidance. To minimize consequences of the district court's decision on AHP participants, the Department announced a temporary safe harbor from enforcement on April 29, 2019.[35] 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 the AHP's participants and beneficiaries to pay health benefit claims as promised.[36] 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.[37] Because the 2018 AHP Rule ceased being an alternative pathway for entities to be treated as bona fide employer groups or

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[33] *New York v. United States Department of Labor*, 363 F. Supp. 3d 109, *appeal docketed*, No. 19-5125 (D.C. Cir. May 31, 2019).
[34] *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).
[35] 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.
[36] *Id.*
[37] In addition, as explained in the April 29, 2019 statement, 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 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.*

associations after the district court's decision in 2019, 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 safe harbor from enforcement expired long ago, and the Department is not aware of any AHPs that currently exist in reliance on the 2018 AHP Rule.[38]

III. Rescission of 2018 AHP Rule

This final rule rescinds the 2018 AHP Rule in its entirety. Accordingly, 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 are rescinded.

The 2018 AHP Rule reflected a substantial departure from the Department's longstanding pre-rule guidance on the definition of "employer" under ERISA. The 2018 AHP Rule struck the wrong balance between ensuring a sufficient employment nexus and enabling the creation of AHPs. The employment relationship is at the heart of what makes an entity a bona fide group or association of employers capable of sponsoring an AHP, and of what separates bona fide employer associations from commercial ventures aimed at selling insurance to unrelated individuals and employers. The approach taken in the 2018 AHP Rule does not comport with the better reading of the statute because it goes too far in disregarding ERISA's focus on employment-based relationships. The pre-rule guidance rightly insisted on the existence of an employment relationship and on a common employment nexus between entities participating in a bona fide employer association. By departing from these standards, in the 2018 AHP Rule, the Department undermined ERISA's employment-based focus and wrongly treated as "employers"

[38] The non-enforcement policy ended at the end of the plan year or contract term that was in effect at the time of the district court's decision on March 28, 2019. *Id*. at 38.

entities whose primary purpose was the marketing of health benefits to unrelated employers and individuals.

As explained in detail below, the Department is no longer of the view that the business purpose standard, geography-based commonality standard, and working owner provision in the 2018 AHP Rule, even as bolstered by the nondiscrimination standards in paragraph (d)(4), are sufficient to distinguish between meaningful employment-based relationships and commercial insurance-type arrangements whose purpose is principally to market benefits, and to identify and manage risk. The Department's rescission of the 2018 AHP Rule makes 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 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.

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

Congress tasked the Department with administering ERISA.[39] 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.[40] 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

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[39] 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).

[40] *See* 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); *see also* 2018 AHP Rule, 83 FR 28912, 28914 (June 21, 2018) and *New York v. United States Department of Labor,* 363 F. Supp. 3d 109, 128 (D.D.C. 2019) (recognizing the Department's authority to interpret ERISA).

guidance from the Department, including the 2018 AHP Rule, has suggested the "employer group or association" provision in the section 3(5) of ERISA definition of "employer" extends the concept of an "employee benefit plan" to commercial insurance-type arrangements.

As described above, the Department's longstanding pre-rule guidance, as expressed 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. 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.[41] The Department's longstanding pre-rule guidance had also been informed by its extensive experience with unscrupulous promoters, marketers, and operators of multiple employer welfare arrangements (MEWAs).[42] AHPs generally qualify as MEWAs under ERISA. Although MEWAs can provide valuable coverage, historically MEWAs, particularly self-funded MEWAs, have disproportionately suffered from financial mismanagement or abuse,

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[41] This focus is supported by courts' interpretation of the term "employee benefit plan." *See, e.g.*, *Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Public Instruction*, 804 F.2d 1059, 1063-64 (8th Cir. 1986) (concluding that "the statute and legislative history will [not] support the inclusion of what amounts to commercial products within the umbrella of the definition" of "employee benefit plan" (citing H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)).

[42] Section 3(40)(A) of ERISA (defining MEWAs).

leaving participants and providers with unpaid benefits and bills and putting small businesses at financial risk.[43] Because of this history of abuse by MEWA promoters falsely 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[44] under State insurance laws.[45]

Employees and their dependents have too often become financially responsible for 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 as participants are left with large unpaid medical bills or even lose access to critical medical services.[46] Even when such MEWAs are not insolvent, employees and their dependents may still

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[43] 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.

[44] A "MEWA" is a "multiple employer welfare arrangement" as defined in ERISA section 3(40). A MEWA can be a single ERISA-covered plan ("plan MEWA"), or an arrangement comprised of multiple ERISA-covered plans, each sponsored by unrelated employer members that participate in the arrangement ("non-plan MEWA"). An AHP is a plan MEWA. If an ERISA-covered plan is a MEWA, States may apply and enforce their State insurance laws with respect to the plan to the extent provided by ERISA section 514(b)(6)(A) -- the extent to which depends on whether the MEWA that is an ERISA-covered plan is fully insured. If a MEWA is determined not to be an ERISA-covered plan, the persons who operate or manage the MEWA may nonetheless be subject to ERISA's fiduciary responsibility provisions if such persons are responsible for, or exercise control over, the assets of ERISA-covered plans. In both situations, the Department would have concurrent jurisdiction with the State(s) over the MEWA. *See* Department of Labor Publication, Multiple Employer Welfare Arrangements Under ERISA, A Guide to Federal and State Regulation, http://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.

[45] Section 514(b)(6) of ERISA, 29 U.S.C. 1144(b)(6).

[46] Based on the Department's enforcement data, since 2001, the Department has taken civil and criminal enforcement action, as reflected in criminal indictments, civil complaints, temporary restraining orders, and cease and desist orders involving 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. 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

become financially responsible for health claims where the AHP failed to adequately disclose the benefit limitations and exclusions under the plan.[47] The Department is concerned about the potential uptake and expansion of fraudulent and mismanaged MEWAs.

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. Over time, however, ERISA's protections have dramatically expanded with respect to 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 expressed concern about departing too dramatically from its traditional interpretation of the term "employer."[48] 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, the Department in the 2018 AHP Rule 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.

Because oversight resources are extremely limited and fraudulent operations often resist detection until claims go unpaid, significant damage can be done before State and Federal governmental entities even receive a complaint about an arrangement, making it difficult for regulators to mitigate damage and stop bad actors. The vulnerability of the participants, beneficiaries, and employers whose employees receive benefits through an AHP is further

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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.

[47] *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).

[48] 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.").

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.[49]

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 in an effort 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 sell health coverage and to identify and manage risk on a commercial basis.[50]

The Department continues to be mindful of the unique potential harms 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 section 3(3) of ERISA, 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

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[49] 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.
[50] 83 FR 28912, 28928-29 (June 21, 2018).

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 AHP Rule that the district court found inconsistent with the APA and in excess of the Department's statutory authority under ERISA are, at a minimum, not consistent with the best reading of ERISA's statutory requirements governing group health plans.

B. Discussion of Decision 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.[51]

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. The Department has also closely considered the comments submitted on the proposed rescission. Based on this review, the Department has concluded it is appropriate to rescind the regulatory provisions adopted in the 2018 AHP Rule.[52] The rescission will ensure that the guidance being provided to the regulated community is in alignment with ERISA's text and purpose. In addition, the rescission aims to resolve and mitigate any uncertainty regarding the status of the standards that were set under the 2018 AHP Rule, and also to facilitate a

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[51] *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)).

[52] Section 2(c) of Executive Order 14070, "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage," provides that "agencies . . . with responsibilities related to Americans' access to health coverage shall review agency actions to identify ways to continue to expand the availability of affordable health coverage, to improve the quality of coverage, to strengthen benefits, and to help more Americans enroll in quality health coverage. As part of this review, the heads of such agencies shall examine . . . policies or practices that improve the comprehensiveness of coverage and protect consumers from low-quality coverage." 87 FR at 20689, 20690. This rescission comports with E.O. 14070 because it acknowledges that health insurance coverage offered through AHPs in the large group markets, or health coverage offered through a self-insured AHP, is not subject to the ACA's EHB requirements; consequently, individuals and small employers who receive such coverage in lieu of individual and small group market coverage subject to the ACA market reforms face the risk of becoming underinsured if their AHP offers less than comprehensive coverage. In addition, the rescission also acknowledges commenters' assertions that the 2018 AHP Rule would have negatively affected the small group and individual markets.

reexamination of the criteria required for a group or association of employers to be able to sponsor an AHP. In reaching the decision to rescind the regulation, the Department has also been mindful of the fact that the 2018 AHP Rule was only briefly in effect, it represented a significant departure from longstanding guidance, which the Department is leaving in place, and that no commenter presented any claims of ongoing reliance on it. As a result, the net effect of rescission is the continued implementation of the Department's longstanding positions on the proper analysis of the status of employer associations under ERISA, which positions are also consistent with the district court's opinion in *New York v. United States Department of Labor*.

Part of the 2018 AHP Rule's purpose was to permit small employers and working owners to purchase health coverage that did not have to comply with the protections applicable to the small group and individual markets. In this manner, the rule aimed to promote the formation of AHPs for small employers and certain self-employed individuals. As noted in the Regulatory Impact Analysis (RIA) below, the 2018 AHP Rule hypothesized that small employers and their plan participants would potentially benefit from the ability to band together to offer less generous, and less costly, benefits. At the same time, however, many comments on the proposed recission of the 2018 AHP Rule expressed concerns that echoed public comments provided to the Department during the 2018 AHP rulemaking process, which indicated that implementation of the 2018 AHP Rule would increase 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.[53] The economic analysis for the 2018 AHP Rule projected 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.

[53] *See* 83 FR 28957 (June 21, 2018). By increasing premiums for individual coverage, the expansion of AHPs may increase federal spending on premium tax credits for coverage offered through an Exchange but may be offset by reduced federal spending through displacement of some Medicaid coverage for individuals who would have transferred into AHPs under the 2018 AHP Rule.

Concerns about such adverse impacts on the health markets were echoed in many comments submitted on the proposed rescission. As AHPs tend to be large group plans, they generally are not subject to Federal benefit mandates that apply to the individual and small group markets, such as the requirement to cover EHBs. Consequently, AHPs can potentially 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 (or are not offered AHPs), causing further adverse selection, market segmentation, and higher premiums in the individual and small group markets.[54] 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 increases for individuals and other small businesses remaining in the individual and small group markets. The Department concluded at that time, however, that practical considerations and Federal nondiscrimination rules would limit such segmentation, and that States could further limit risk segmentation through regulation of AHPs as MEWAs. The Department also 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.

In the proposed rescission, however, the Department expressed the view that it was appropriate to give greater attention to the long-term impacts on market risk introduced by the 2018 AHP Rule, especially in the small group and individual markets. After close review of the comments, discussed below, the Department affirms its view that rescission of the 2018 AHP Rule is warranted, not only because of these market risks, but because the 2018 AHP Rule did not reflect the best interpretation of section 3(5) of ERISA.

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[54] The American Medical Association noted that AHPs could exclude benefits like coverage of 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).

Additionally, as commenters noted, health insurance coverage offered through AHPs in the large group markets is not subject to the requirement to offer EHBs, which means that individuals who join these AHPs may become underinsured if their AHP does not cover benefits that non-grandfathered small group and individual market health insurance coverage are required to cover, such as emergency services, prescription drug benefits, or even inpatient hospital coverage. Because AHPs generally can offer less than comprehensive coverage, they are cheaper to purchase, but there is a significantly greater likelihood that they will cover less than expected or needed. As discussed in this final rule, the 2018 AHP Rule made it easier for small employers, and possible for working owners, to band together to avoid the requirements on small group and individual health insurance coverage by qualifying as a single group health plan to purchase coverage in the large group market. Such an AHP could offer significantly less comprehensive plans, including ones that fail to cover EHBs, 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.[55]

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 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.[56]

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[55] 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).

[56] The 2018 AHP Rule acknowledged this risk. *See* 83 FR 28951, 28953 (June 21, 2018) ("[T]he Department anticipates that the increased flexibility afforded AHPs under this rule will introduce increased opportunities for mismanagement or abuse, in turn increasing oversight demands on the Department and State regulators.") *See* 83 FR 28951, 28953 (June 21, 2018).

The 2018 AHP Rule reflected a significant departure from the Department's longstanding pre-rule guidance. The Department's rescission of the 2018 AHP Rule makes 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 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.

As explained further below, the rescission also reflects a reexamination of the 2018 AHP Rule's "business purpose" standard and viability safe harbor,[57] 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 that the temporary safe harbor from enforcement announced by the Department immediately following the district court's decision has long expired.[58] The Department has thus concluded that it is appropriate to rescind the 2018 AHP Rule.

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

[57] The business purpose standard of the 2018 AHP Rule required that a group or association 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. While the 2018 AHP Rule did not include a definition of "substantial," it did provide a safe harbor for an association that would be a "viable entity" without sponsoring a health plan ("viability safe harbor"). 83 FR 28912, 28956 (June 21, 2018).

[58] *See supra* note 31.

deference to the Department's historical guidance.[59] 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.*"[60]

This requirement is reflected in longstanding pre-rule guidance focusing on whether the group or association of employers has business or organizational purposes and functions unrelated to the provision of benefits. Although neither the courts nor the Department's pre-rule guidance defined the outer limits of what could count as a sufficient purpose, the employer groups or associations that have been treated as "employer" sponsors have well developed business purposes that are unrelated to the provision of benefits.[61] The pre-rule guidance

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[59] *Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059*,* 1065 (8th Cir. 1986) ("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 & Assocs., 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).

[60] 804 F.2d 1059, 1064 (8th Cir. 1986) (emphasis added); *accord MDPhysicians,* 957 F.2d 178, 185 (5th Cir. 1992).

[61] *Compare*, *e.g.*, 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 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)."); and 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 . . . ."), *with, 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. Colo. Ass'n of Soil Conservation Dists.*, 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).

uniformly emphasized that a purpose unrelated to the provision of benefits is a critical factor for any group or association of employers to be treated as a bona fide group or association that can act as an "employer" within the meaning of section 3(5) of ERISA.

While paragraph (b) of the 2018 AHP Rule also contained a business purpose standard, it departed from the substance and intent of prior guidance by providing both that the primary purpose of the group or association could be to offer benefit coverage to the group's members,[62] and that an unrelated purpose would be sufficiently substantial "if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan."[63] For the reasons described in the proposal, the Department has concluded 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.[64] Although the 2018 AHP Rule provided that the unrelated business purpose had to be "substantial" and that the entity should be independently viable, the preamble discussion suggested that few posited purposes would be treated as too insubstantial to pass muster. For example, 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.[65]

In the preamble to the 2018 AHP rule, the Department posited that this relaxation of the standard would nonetheless work to differentiate employer groups or associations from commercial insurance ventures because the rule's control requirement and its new nondiscrimination requirement would ensure that only bona fide associations become AHPs. But even if the possibility of employer control and nondiscrimination were sufficient to warrant treating an *entity* as an employer association for purposes of section 3(5) of ERISA, the rule

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[62] 29 CFR 2520.3-5(b)(1).
[63] *Id.*
[64] 88 FR 87968, 87975-76 (Dec. 20, 2023)
[65] 83 FR 28912, 28918 (June 21, 2018).

treated *individual working owners* as "employers" for this purpose even though they neither employed nor were employed by anybody else. In addition, under the rule's terms, promoters could set up arrangements with separate contribution rates for "employer" members (including working owners) based on a variety of non-health factors that correlate with health risks, such as industry, occupation, or geography, in ways that would make the arrangement look strikingly similar to a commercial insurance venture, looking to minimize exposure to less healthy risk pools.[66] Indeed, the economic analysis for the rule projected that, as a result of such risk selection, those employers and participants that remained in the larger small group and individual markets could face premium increases between 0.5 and 3.5 percent.[67]

The Department has concluded that the 2018 AHP Rule's test does not sufficiently ensure a business purpose that advances the interest of employer members of the group or association, nor does it prevent abuse. Part of the rationale for insisting on a common business purpose unrelated to the provision of benefits is to ensure that the entity is a bona fide association acting in the interest and on behalf of employer members, rather than merely a promoter of a commercial arrangement with competing financial interests. Bona fide associations with a common purpose and shared bonds unrelated to the provision of benefits can serve as strong advocates for their employer members and ensure that those members ultimately receive the benefits of the association's advocacy for their common interests. The 2018 AHP Rule's test falls short of providing that the employer members or their association are united by much more than a common desire to obtain health benefits and therefore does not ensure that associations act in the interest of, or as strong advocates for, employer members.

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[66] *Id.* at 28929.

[67] The reference to the potential premium increases of between 0.5 and 3.5 percent reflects a moderate range derived from the figures cited in the cost analysis for the 2018 AHP Rule, which referred to a 2018 report that modeled the impact on premiums and source of insurance coverage under different AHP scenarios based on initial availability of AHPs, generosity of coverage of AHP plans, and projected level of risk selection by small businesses. 83 FR 28912, 28945 fn. 95 (citing Avalere Health, Association Health Plans: Projecting the Impact of the Proposed Rule at 3, 5-7 (Feb. 28, 2018), available at https://avalere.com/wp-content/uploads/2018/06/1519833539_Association_Health_Plans_White_Paper.pdf).

In the Department's view, based on its long and significant experience in this area as well as current concerns about abuse, the 2018 AHP Rule does not establish conditions that appropriately distinguish an employer group sponsoring an employee benefit plan from a commercial insurance venture. Under the rule's test, there is little to distinguish the association from any other commercial benefits promoter, except that, unlike commercial insurers, the AHP would be subject to less stringent state regulations and safeguards. As a result, the Department is concerned that the rule will unduly expose participants, beneficiaries, and unsuspecting small employers to unscrupulous operators looking to market health benefits without the protective structure and supports that apply to state-regulated insurance, such as funding and solvency requirements.[68] As noted elsewhere in this preamble, even under the current more stringent standards, MEWAs, especially self-funded MEWAs, have been frequent subjects of abuse, and in the worst cases have left participants and beneficiaries with large unpaid claims or denials of treatment.[69] These considerations reinforce the Department's conclusion that it should not have departed from its previous approach to interpreting the statutory text and its previous insistence on a strong common purpose unrelated to the provision of benefits.

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 pre-rule 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.*"[70] The court further explained that "[o]ur decision is premised on ERISA's language and Congress'

[68] *See supra* note 39.
[69] *See supra* notes 43, 46.
[70] 804 F.2d at 1063 (emphasis added).

intent" and that "[t]here [wa]s no need to resort to the Department of Labor's interpretations."[71] 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 Fifth Circuit likewise found that ERISA required a commonality of interest among employer members.[72]

The Department's pre-rule guidance requires a genuine commonality of interests between employer members. Paragraph (c) of the 2018 AHP Rule altered this standard by setting 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 2018 AHP Rule provided that participating employers could have "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). This represented a significant departure from the Department's longstanding pre-rule guidance because it treated otherwise unrelated employers in multiple unrelated trades, industries, lines of business, or professions as having the requisite commonality, simply because they resided within the same geographic locale.[73]

The preamble of the 2018 AHP Rule focused on the desired goal of the rule to spur AHP formation, but it did not adequately address the fundamental question of how geography alone,

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[71] *Id. at 1065.*

[72] *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).

[73] *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

without any other common business nexus, could provide the requisite commonality of interest. The preamble to the 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 (for example, all non-profit businesses), shared religious/moral convictions, or shared business size.[74] The Department rejected such broad categories as falling within the common nexus standard because it had concluded that a standard this lax would be "impossible to define or limit" and would "eviscerate" the commonality requirement.[75] The 2018 AHP Rule concluded that, as a policy matter, these line-drawing concerns did not apply to groups with geographic commonality. However, the discussion in the 2018 AHP Rule was, at best, incomplete because it focused mostly on the benefits of having more AHPs but did not explain 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.

As explained in the proposal, the Department is now of the view that a commonality requirement based on common geography alone (same State or multi-State area) does not adequately establish commonality.[76] The same reasons why the Department rejected other expansions of the commonality requirement militate against adopting geographic commonality as well. There is little basis for treating disparate employers engaged in disparate enterprises with

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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.).").

[74] 83 FR 28912, 28926 (June 21, 2018). 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—would not be sufficient to establish commonality of interest for a national group or association 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."

[75] *Id*.

[76] 88 FR 87968, 76-77 (Dec. 20, 2023).

disparate interests in different urban or rural settings as having a sufficient common nexus merely because they are all in the same State.[77]

While the Department acknowledges that employers within the same geographic locale can share other common interests that result in a sufficient common 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 section 3(5) of ERISA an association composed of unrelated employers all operating in any specific State or multi-State area 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.

3. Working Owners.

The 2018 AHP Rule allowed certain self-employed persons without any common-law employees to participate in AHPs as "working owners."[78] The 2018 AHP Rule established wage, hours of service, and other conditions for when a working owner would be treated as both an "employer" and "employee" for purposes of participating in, and being covered by, an AHP.[79] The 2018 AHP Rule treated these self-employed 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

[77] In recent years, the case for relying on geography as a basis for commonality has likely been further reduced by the adoption of remote workplace flexibilities and virtual office technologies, which reduce the tie between the worker and any particular geographic location.
[78] 29 CFR 2510.3–5(e).
[79] *See id.*at § 2510.3–3(c).

employer and an employee, even though the working owners had no employees and were not employed by another person or entity.

The Department now believes that the 2018 AHP Rule gave too little weight to ERISA's focus on the employment relationship in treating working owners as both employees and employers notwithstanding the absence of any employment relationship with anybody. While the 2018 AHP Rule's approach promoted the creation of plan MEWAs, it came at the expense of the better reading of the statute's references to employers and employees. ERISA applies when there is an employer-employee relationship. This relationship, as suggested by the very title of the Act (the *Employee* Retirement Income Security Act), and the Act's reliance on "employer" and "employee" to define what counts as an ERISA-covered plan, is central to the statutory framework. ERISA generally regulates employment-based relationships, not the sale of insurance to individuals outside such relationships. 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 and is meant to reflect *genuine* employment relationships. The Department is now of the view that ERISA calls for a higher standard for determining 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.[80] These requirements did not, however, reflect the existence of a *genuine* employer-employee relationship, as in the exchange between an employee and an employer of personal

[80] 83 FR 28931 (June 21, 2018).

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

Upon further reflection, the Department is now concerned that, by removing the prior (and more stringent) employer-employee nexus requirement, 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, upholding the purpose of the statute requires drawing appropriate distinctions between employers and associations acting "in the interest of an employer" on the one hand, and entrepreneurial insurance-type ventures 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 section 3(5) of ERISA, has concluded that the better interpretation of such case law 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 *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon,* the Supreme 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.[81] Several circuit court opinions also emphasize the

[81] *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon,* 541 U.S. 1, 6 (2004). *See also* Advisory Opinion 99-04A (Feb. 4, 1999) (outside of a bona fide group or association analysis under section 3(5) of ERISA, concluding that nothing in the definitions of Title I of ERISA precluded a working owner who had initially participated in a multiemployer pension plan as an employee of a contributing employer from continuing to participate in that plan) and Advisory Opinion 2006-04A (April 27, 2006) (individual who actively performed work for his own company that would otherwise be covered by a collective bargaining agreement if he were not a "supervisor" under federal labor law may continue to participate in multiemployer pension plan that he previously participated in as a covered employee).

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 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* . . . ."[82] 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 section 3(5) of ERISA because the "employee-employer relationship is predicated on the relationship between two different people."[83] Similarly, in *Marcella v. Capital Districts Health Plan, Inc.*, the Second Circuit found that working owners without common-law employees are not employers.[84] 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.[85] These holdings are consistent with the Department's traditional interpretation of "employee" in 29 CFR 2510.3–3(b) and (c).[86]

C. Alternatives to Complete Rescission of the 2018 AHP Rule.

As part of its deliberations as to whether to rescind the 2018 AHP Rule, the Department considered several alternatives to this rulemaking. The Department contemplated removing only

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[82] *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (emphasis added).
[83] *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.").
[84] *Marcella v. Capital Dists. 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").
[85] *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).
[86] In 1996, HIPAA added provisions of ERISA and the PHS Act, which specified that for purposes of part 7 of Title I 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." Section 732(d) of ERISA; Section 2722(d) of PHS Act. 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).

certain provisions of the 2018 AHP Rule. For example, the Department considered rescinding the working owner provision, which represents a significant departure from the pre-rule guidance. Similarly, the Department considered removing the geographic commonality provision, which also represents a dramatic departure from the pre-rule guidance. However, the Department decided against a rescission of only the specific provisions invalidated 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" that properly reflect the limits of ERISA's definition of "employer" in section 3(5) 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.[87] Without the core provisions held invalid by the district court, the 2018 AHP Rule could not be operationalized and would provide no meaningful guidance.

The Department also considered rescinding the 2018 AHP Rule and codifying the pre-rule guidance. The Department recognizes that there could be benefits to codifying its longstanding pre-rule guidance. The pre-rule guidance is largely in the form of advisory opinions, which do not have the same authority as regulations and technically are not precedential.[88] 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

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[87] *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.").

[88] 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."

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 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. As discussed further below, the Department received comments on the proposed rescission supporting codifying the pre-rule guidance, supporting codifying the pre-rule guidance with modifications, and opposing codification of the pre-rule guidance. The Department is proceeding to fully rescind the 2018 AHP Rule without proposing any additional guidance at this time. The Department takes the comments on potential future guidance under advisement, and such comments will inform the Department's decision regarding any future efforts on this matter.

IV. Requests for Public Comments

In the proposal, the Department requested comments from interested parties on all aspects of the proposal to rescind the 2018 AHP Rule in its entirety. In the Department's view, ERISA's statutory purposes are 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 asked for 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 longstanding pre-rule guidance as it relates to group health plans (including, for example, the HIPAA nondiscrimination rule's 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 Department received 58 comment letters, all of which are posted on the Department's website and on Regulations.gov.[89] An overwhelming majority of commenters support rescission of the 2018 AHP Rule in whole or in part. Comments are discussed below in Section V. Our evaluation focused on ensuring that the Department's

[89] To directly access the rulemaking docket, *see* https://www.regulations.gov/docket/EBSA-2023-0020.

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 employee welfare benefit plans.[90]

V. Discussion of Public Comments on NPRM

A. The 2018 AHP Rule and the Affordable Care Act.

Many comments focused on the impact of the 2018 AHP Rule on the ACA. These comments largely fell into two categories: (1) whether AHPs formed under the 2018 AHP Rule (which generally were not subject to the ACA's requirement to cover EHBs) would offer less comprehensive coverage[91] to working owners and small employers than coverage in the individual and small group markets; and (2) whether the 2018 AHP Rule would have affected the ACA individual and small group market risk pools through risk segmentation. Other commenters noted that the 2018 AHP Rule's working owner provision conflicted with the ACA's protections for individuals enrolling in individual market plans[92] and with the definition of "employer" in the ACA.[93]

With respect to comments raising the issue of AHPs offering less comprehensive coverage, commenters stated that AHPs operating under the 2018 AHP Rule, unlike individual

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[90] 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.

[91] Health plans that do not include benefits that non-grandfathered small group and individual market health insurance coverage are required to cover, such as emergency services or prescription drug benefits, or even inpatient hospital coverage, are sometimes referred to as "less comprehensive coverage" plans.

[92] *See supra* notes 15, 16.

[93] According to one commenter, under the 2018 AHP Rule, an AHP could be comprised of participants who are common-law employees, common-law employees and working owners, or comprised of only working owners. In all cases, the working owner could be treated as an employee and the business as the individual's employer for purposes of being an employer member of the association and an employee participant in the AHP which, according to the commenter, violates both the ACA and ERISA. The commenter believes that coverage offered to "working owners" fits squarely within the ACA's and PHS Act's definition of "individual health insurance coverage" and, therefore, coverage consisting of only working owners cannot be considered group health insurance coverage. *See* comment from Timothy Stoltzfus Jost (Feb. 15, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00011.pdf.

and small group market insurance coverage that must offer certain benefits under the ACA, would not have been required to provide EHBs, including emergency services, prescription drug benefits, or even inpatient hospital care. Because an AHP is generally self-funded or funded through large group market insurance coverage and therefore not subject to EHB requirements, several of these commenters stated that AHPs could impose benefit design and association eligibility rules to "cherry pick" healthier individuals. Other commenters countered this assertion, stating that AHPs before the 2018 AHP Rule, as well as those that briefly existed under it, covered many (if not all) of the ACA's EHBs voluntarily if they were self-insured plans, or under State law insurance mandates if they were insured plans. These commenters also pointed to other Federal laws that would have restricted the ability of AHPs formed under the 2018 AHP Rule to offer less than comprehensive coverage.[94]

Many commenters stated that the 2018 AHP Rule would have negatively affected the health insurance markets. These commenters argued that AHPs, which generally—as previously noted—are self-funded or funded through large group market insurance coverage, would be permitted to use rating factors such as age, gender, and industry that are prohibited in the small group and individual markets.[95] These commenters asserted that the use of these rating factors would negatively impact the individual and small group market risk pools. They stated that AHPs formed under the 2018 AHP Rule would offer lower premiums to healthier and younger enrollees, drawing those individuals away from the small group and individual markets, thereby increasing premiums for the individuals remaining in those markets, and eventually reducing the availability of plan choices in those markets.[96]

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[94] The Federal laws mentioned include HIPAA, the Women's Health and Cancer Rights Act of 1998, the Genetic Information Nondiscrimination Act of 2008, and Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA").

[95] Section 2701 of the PHS Act, as added by the ACA, implemented at 45 CFR 147.102, restricts variation in premium rates based on age to a 3:1 ratio.

[96] One commenter representing a State Exchange painted a more severe outcome. This commenter stated that the 2018 AHP Rule would have eventually caused the collapse of the private health insurance markets across the nation, leading to higher premiums for small businesses and individuals, leaving people who need comprehensive coverage with no private options, and forcing people to become uninsured. *See* comment from the District of Columbia Health Benefit Exchange Authority (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00033.pdf.

Some commenters disputed that the 2018 AHP Rule would have resulted in adverse selection and market segmentation. These commenters stated that AHPs faced various restrictions or operated within various parameters that would have prevented them from marketing coverage only to healthier individuals, including that (1) AHP coverage is employer-based, which means that AHPs could not seek out only healthy individuals; (2) AHPs could not base plan rates on individual health status or pre-existing conditions; (3) government subsidies would have shielded most participants from any increases in individual health insurance coverage costs; and (4) AHPs would have covered new lives rather than draw individuals away from existing small group or individual market plans.

After careful consideration of public comments on the proposal, the Department acknowledges that health insurance coverage offered through AHPs in the large group markets, or health coverage offered through a self-insured AHP, is not subject to the ACA's EHB requirements; consequently, individuals and small employers who receive such coverage in lieu of individual and small group market coverage subject to the ACA market reforms face the risk of becoming underinsured if their AHP offers less than comprehensive coverage.[97] In addition,

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[97] The Department is also cognizant that the district court in *New York v. United States Department of Labor*, 363 F. Supp. 3d 109, 117-18 (D.D.C. 2019), referred to former President Trump's Executive Order 13813 and comments by then Secretary of Labor Alexander Acosta as evincing an intent—by way of the 2018 AHP Rule—to sidestep major elements of the ACA. On October 12, 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," stating, in relevant part, that "[e]xpanding access to AHPs will also allow more small businesses to avoid many of the PPACA's costly requirements." Executive Order 13813, 82 FR 48385 (Oct. 17, 2017). In remarks to the National Federation of Independent Businesses, President Trump further stated: "Alex [Acosta] and the Department of Labor are taking a major action that's been worked on for four months now—and now it's ready—to make it easier for small businesses to band together to negotiate lower prices for health insurance and *escape some of Obamacare's most burdensome mandates through association health plans*." *See* Remarks by President Trump at the National Federation of Independent Businesses 75th Anniversary Celebration, June 19, 2018 (emphasis added), available at www.trumpwhitehouse.archives.gov/briefings-statements/remarks-president-trump-national-federation-independent-businesses-75th-anniversary-celebration/. In a Wall Street Journal op-ed, then Secretary of Labor Alex Acosta wrote: "Companies with 50 or fewer employees are subject to the law's benefit mandates and rating restrictions, while large companies are not. This is backward. Small businesses should face the same regulatory burden as large companies, if not a lighter one. AHPs will help level the playing field." *See* Alexander Acosta, "A Health Fix For Mom and Pop Shops," June 18, 2018, available at www.wsj.com/articles/a-health-fix-for-mom-and-pop-shops-1529363643.

the Department also acknowledges the strength of arguments that the 2018 AHP Rule could have negatively affected the small group and individual markets.[98]

At the same time, however, this rescission is ultimately based on the Department's interpretation of ERISA, not the ACA. Also, because the district court held certain provisions of the 2018 AHP Rule invalid, the agency does not have strong data on the number and nature of AHPs formed under the 2018 AHP Rule. Irrespective of these possible negative impacts, however, the Department is rescinding the 2018 AHP Rule based on its view that the geographic commonality, business purpose and working owner provisions of the 2018 AHP Rule were inconsistent with the best interpretation of the statutory language in section 3(5) of ERISA.

B. Geographic Commonality.

The 2018 AHP Rule provided that an association could be treated as having the requisite commonality of interest necessary to constitute a bona fide group or association of employers where the employers share "geographic commonality," defined as each employer having a principal place of business in the same geographic region that does not exceed the boundaries of a single State or metropolitan area (even if the metropolitan area included more than one State).

One commenter disagreed with the proposal's rejection of the 2018 AHP Rule's geography-based commonality standard.[99] This commenter argued that the proposal failed to offer good reasons for rejecting this standard and that geography-based business groups have been a feature of the American economy for many generations. The commenter stated that businesses often share an interest in the existence of prosperity, safety, a thriving economy, and a skilled and abundant workforce within their shared State or urban area. While the proposal mostly critiques the reasoning of the 2018 AHP Rule, according to this commenter, in order to

[98] *See supra* note 52 (discussing the President's directive to Federal agencies in E.O. 14070 "to identify ways to continue to expand the availability of affordable health coverage, to improve the quality of coverage, to strengthen benefits, and to help more Americans enroll in quality health coverage").

[99] *See* comment from Paul J. Ray (Dec. 22, 2023) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00001.pdf.

make this affirmative change, the Department must offer its own reasons why geographic commonality does not create the requisite commonality.

Conversely, many commenters on this issue supported the rescission of the geography-based commonality standard, with several of these commenters noting that this standard is so broad that employers with no common interests whatsoever, other than existing within the same boundaries, could participate in an AHP, making such an AHP indistinguishable from commercial insurance arrangements. These commenters, for example, argued that mere shared existence within a service area does not meaningfully correspond to a sufficient, or necessarily any, employment-based nexus of the caliber required by ERISA. In stark contrast, the commonality standards recognized in the Department's longstanding pre-rule guidance (such as commonality based on industry, trade, or occupation) effectively ensure common bonds that mitigate the danger of discriminatory (and commercial) rating practices, asserted the commenters.

Similarly, another commenter observed that the geography-based commonality standard in the 2018 AHP Rule essentially allowed an AHP to operate like an insurance company, rather than an association acting "in the interest of" participating employer members, except that self-funded AHPs would not be subject to the protective insurance market rules, including certain rating rules, that commercial insurance is required to comply with.[100] The commenter argued that this outcome not only may negatively impact many consumers but is also hard to square with the widely held view that ERISA requires a genuine employment relationship to sponsor an AHP. Yet another commenter observed that the 2018 AHP Rule would permit "agglomerations of wildly dissimilar businesses with different or even potentially conflicting needs and priorities," whereas what is needed and required by ERISA is commonality of interest among members to assure that the association will act, employer-like, in the interest of the people whose

[100] *See* comment from the Center on Budget and Policy Priorities (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00035.pdf.

coverage it is sponsoring.[101] Finally, many commenters expressed concern that the inclusion of the State-based geography standard for commonality would create uncertainty in enforcement for AHPs operating across State lines; more specifically, these commenters asserted that loosening the commonality standard in the way permitted by the rule (e.g., permitting an AHP to establish commonality based on its employer members all operating in a common metropolitan area that crosses State lines) likely would lead to more fraud, abuse, and insolvencies.

The Department shares the concerns of these commenters that the geographic commonality test in the 2018 AHP Rule has significant shortcomings in terms of meaningfully restricting coverage to associations of employers with a sufficient employment nexus. Although 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 does not believe that the 2018 AHP Rule articulated a sufficient 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, recognizing an AHP as an association composed of unrelated employers all operating in any specific State, with no other commonality, does not go far enough in ensuring that AHPs are operating in the interest of employers and are not merely operating as traditional health insurance issuers in all but name without having to meet the state regulatory standards that traditional health issuers are subject to.[102] Plumbers, social workers, seed companies, yoga instructors, and mining companies are unlikely to share any special common interest or bond

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[101] *See* comment from the Partnership to Protect Coverage (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00044.pdf.

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

merely because they are all located in a single State like New York, California, or Pennsylvania (or in a single metropolitan multi-state area).

Accordingly, after considering all of the comments, the view of the Department in this final rule is that a commonality requirement based on common geography alone (same State or multi-State area) does not represent the best approach to interpreting the statutory definition of employer because such commonality does not ensure that the AHP is not a commercial health insurance entity in practice. Although it may be one relevant factor to consider along with other factors, the Department's reconsidered view is that geography alone should not be the sole test for commonality under section 3(5) of ERISA.

C. Business Purpose Standard.

The "business purpose" standard of the 2018 AHP Rule provided, in relevant part, 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. While the 2018 AHP Rule did not include a definition of "substantial," it did provide a safe harbor for an association that would be a "viable entity" without sponsoring a health plan. Without addressing substantiality, it also clarified that "a business purpose" includes promoting common economic interests in a given trade or employer community and is not required to be a for-profit activity. Thus, regardless of the safe harbor, associations that merely sponsor conferences or offer classes or educational materials on business issues of interest to the association members would be deemed to pass the business purpose test.

Several commenters explicitly supported the rescission of this standard. One commenter argued that the 2018 AHP Rule's definition of "employer" is at odds with the text and purpose of ERISA, by "hollowing out" the longstanding business purpose standard under pre-rule guidance such that the business purpose standard and viability safe harbor would fail to ensure a sufficient

employment nexus.[103] A State insurance regulator emphasized that an AHP rule should contain a requirement that ties employer members together for business reasons other than health care coverage, and eligibility should be legitimately employment-based.[104]

A number of commenters strongly objected to the provision in the 2018 AHP Rule explicitly allowing the primary purpose of the group or association to consist of offering health coverage to its members. According to these commenters, this provision makes AHPs functionally indistinguishable from health insurance issuers, invites unscrupulous promoters to enter the market with mismanaged and inadequately funded AHPs, and could increase the prevalence of fraudulent and abusive practices. They registered their concern that permitting an AHP to be created for the primary purpose of offering health coverage is equivalent to setting up an insurance company, but without the standards that apply to insurance issuers to ensure that promises are kept, bills are paid, and consumers are protected. One commenter[105] argued that such an outcome contradicts congressional intent articulated with the addition to ERISA of section 514(b)(6) (referred to as the "Erlenborn amendment"): "[C]ertain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in the profiting from the provision of administrative services are establishing insurance companies and related enterprises. . . . They are no more ERISA plans than any other insurance policy sold to an employee benefit plan."[106]

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[103] *See* comment from the Partnership to Protect Coverage (Feb. 20, 2024) last accessed athttps://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00044.pdf.

[104] *See* comment from the Pennsylvania Insurance Department (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00045.pdf.

[105] *See* comment from the District of Columbia Health Benefit Exchange Authority (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00033.pdf.

[106] House Committee on Education and Labor, Activity Report of Pension Task Force (94th Congress 2d Session, 1977) quoted in Cong. Rec. (daily ed. May 21, 1982) (statement of Rep. Erlenborn). States, prior to 1983, were effectively precluded by ERISA's broad preemption provisions from regulating any employee benefit plan covered by Title I of ERISA. As a result, a State's ability to regulate MEWAs was often dependent on whether the particular MEWA was not an ERISA-covered plan. In an effort to address this problem, the U.S. Congress amended ERISA in

While no commenter explicitly defended the 2018 AHP Rule's business purpose standard, one commenter suggested it could be revised to require that members have a "shared business and economic purpose," provided the group or association was organized for purposes unrelated to the provision of benefits.[107] Examples provided include "a common interest in promoting a vibrant local economy" or having "a common interest in local, state, and federal regulations of business practices."[108]

The Department shares the commenters' concerns 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.[109] In addition, a weakened business purpose standard also can hinder efforts by States to regulate MEWAs, including AHPs, within their borders. On reexamination, the Department's reconsidered view is that the 2018 AHP Rule's relaxed business purpose test, especially when combined with the rule's other loosened standards on commonality of interest and working owners, cannot be counted on to sufficiently differentiate bona fide employer groups or associations acting as an employer from commercial insurance ventures despite the rule's control and nondiscrimination standards.

1983 (Sec. 302(b), Pub. L. 97-473, 96 Stat. 2611, 2613 (29 U.S.C. 1144(b)(6); "Erlenborn-Burton Amendment") to establish an exception to ERISA's preemption provisions for MEWAs. This exception was intended to eliminate claims of ERISA-plan status and Federal preemption as an impediment to State regulation of MEWAs by permitting States certain regulatory authority over MEWAs that are ERISA-covered employee welfare benefit plans.

[107] *See* comment from The Coalition to Protect and Promote Association Health Plans (Feb. 19, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00019.pdf.

[108] *Id*.

[109] 83 FR 28912, 28918 (June 21, 2018).

D. Working Owners.

The 2018 AHP Rule allowed certain self-employed persons without any common-law employees to participate in AHPs as "working owners." It did this by establishing wage, hours of service, and other conditions for when a working owner would be treated as both an "employer" and "employee" for purposes of participating in, and being covered by, an AHP.[110] Commenters on the proposed recission of the 2018 AHP Rule disagreed on whether to rescind the "working owner" provision, with most commenters in favor of rescission.

Commenters opposing the rescission offered little reasoning as to why the working owner provision, specifically, should be retained. One commenter suggested that the provision should be retained and clarified to include interns and apprentices of trades regardless of whether such individuals work a full-time schedule or are paid for their work.[111]

Most commenters on the working owner provision, however, supported its full rescission. Several commenters, for example, pointed to the inclusion of "working owners" in an AHP comprised only of working owners as clearly inconsistent with ERISA. One of these commenters added that such inclusion also is inconsistent with court decisions interpreting the terms "employer" and "employee" under ERISA. Further, according to the commenter, the Department's regulation at 29 CFR 2510.3–3, which provides that an ERISA plan does not include a program under which no employees are participants covered under the plan, and the decision in *Yates v. Hendon*, recognize the longstanding position of Federal agencies that an ERISA plan must have at least one employee participant other than the owner to be a group health plan.[112] Indeed, a couple of commenters observed that one person cannot be in an employment relationship with themselves, and that AHPs should not include working owners

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[110] 29 CFR 2510.3–5(e).
[111] *See* comment from the National Association of Home Builders (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00056.pdf.
[112] *See* comment from Timothy Stoltzfus Jost (Feb. 15, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00011.pdf.

that do not have common-law employees. Some commenters stated that allowing an AHP comprised only of sole proprietors will necessarily lead to more fraud and insolvencies. Acknowledging that the 2018 AHP Rule included some "minimal standards" for AHPs – for example, that AHPs have a formal organizational structure, and that participating employers have some level of control over the AHP – one of the commenters argued that sole proprietors are not in a position to exert meaningful control over an AHP because they are not in a position to determine whether the person setting up and running the AHP has the needed skills and experience or to provide adequate oversight of the AHP's operations.[113]

The Department has reexamined the 2018 AHP Rule's treatment of working owners and determined, as suggested by many commenters, that ERISA's text, fundamental purpose, and pre-rule guidance counsel against the appropriateness of the alternative criteria codified by the 2018 AHP Rule. In this regard, the Department has concluded that the better reading of the statute requires a consistent focus on employment-based relationships, as distinct from commercial ventures formed to market health benefits to unrelated parties, including individuals who are not even in an employment relationship. The pre-rule guidance rightly insisted on the existence of an employment relationship and on a common employment nexus between entities participating in a bona fide employer association. By departing from these standards, the 2018 AHP Rule undermined ERISA's employment-based focus and wrongly treated as "employers" entities whose primary purpose was the marketing of health benefits to unrelated employers and individuals.

E. Total Rescission Versus Partial Rescission.

An overwhelming majority of commenters support rescission of the 2018 AHP Rule in some fashion. A few commenters discussed whether, if the Department decides to rescind the 2018 AHP Rule, the Department should rescind the rule in whole or in part. One commenter

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[113] *See* comment from the District of Columbia Health Benefits Exchange Authority (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00033.pdf.

asserted that the Department should not rescind the entire 2018 AHP Rule, but instead should rescind only the provisions that the court held invalid.[114] This commenter suggested that a total rescission would provide a less comprehensive framework than a partial rescission. Further, this commenter argued that a total rescission would cause a reversion to the prior body of applicable law, composed entirely of guidance documents issued over many decades and restricted by their terms to the parties and specific factual scenarios at issue. A different commenter suggested that the rule should stand at least with respect to AHPs meeting the same trade, industry, line of business or profession test.[115] Another commenter urged the Department not to rescind the rule but rather work to improve it.[116]

By contrast, many commenters favored a total rescission of the 2018 AHP Rule. Some reasoned that the rule would be nonsensical if codified without the sections that were held invalid by the district court. Others reasoned that the remaining portions would not be sufficient to prevent mismanagement, underinsurance, and potential harm to consumers. A number of commenters argued that only a full rescission would restore the *status quo ante*, which aligns with judicial precedent, is supported by State regulatory infrastructure, respects the ACA, and has created an effective regulatory framework to support legitimate AHPs for the past 30 years.

The Department agrees that a full rescission, as proposed, is the best course of action. If the Department simply eliminated the provisions that the district court held invalid in its decision in *New York v. United State Department of Labor*, the provisions remaining would not provide an adequate definition of "employer" that properly reflects the limits of ERISA's definition of "employer" in section 3(5) and Congress' focus on employment-based arrangements, as opposed to the ordinary commercial provision of insurance outside the employment context. The

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[114] *See* comment from Paul J. Ray (Dec. 22, 2023) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00001.pdf.

[115] *See* comment from Bernstein, Shur, Sawyer & Nelson, P.A. (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00041.pdf.

[116] *See* comment from the Council for Affordable Health Coverage and Health Benefits Institute (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00037.pdf.

remaining provisions also 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. Following the district court's decision, described above, the Department considered the severability clause issue raised by the district court and concluded that, without the core provisions that the district court held invalid, the 2018 AHP Rule could not be operationalized and would provide no meaningful guidance.

Even if considered imperfect to some commenters, the pre-rule guidance establishes criteria 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. This rescission does not affect the ability to operate or form an AHP pursuant to the pre-rule guidance. 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 employer members.[117] Moreover, to the Department's knowledge, no court has found, or even suggested, that its longstanding pre-rule guidance criteria too narrowly construe the meaning of acting "indirectly in the interest of an employer" under section 3(5) of ERISA.

F. Defense of the 2018 AHP Rule in Court.

A few commenters in favor of the 2018 AHP Rule asserted that the Department should abandon or withdraw the proposed rescission, leave the 2018 AHP Rule in place, and defend the rule in the U.S. Court of Appeals for the D.C. Circuit. However, the Department is no longer of the view that the business purpose standard, geography-based commonality standard, and working owner provision in the 2018 AHP Rule, even as bolstered by the nondiscrimination standards in paragraph (d)(4) and the control requirements, are sufficient to distinguish between meaningful employment-based relationships and commercial insurance-type arrangements whose purpose is principally to market benefits and identify and manage risk. The Department

[117] *See supra* note 2.

continues to be mindful of the unique risks to individuals, 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 Federal law applicable to the individual and small group markets. Such arrangements are not "employee benefit plans" as defined in section 3(3) of ERISA, 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 in its entirety. The Department now believes that the provisions of the 2018 AHP Rule that the district court found inconsistent with the APA and in excess of the Department's statutory authority under ERISA are, at a minimum, not consistent with the best reading of section 3(5) of ERISA. As the court noted in *Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Board of Public Instruction*, "[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."[118]

G. Effect of Rescission on the 2019 Association Retirement Plan Rule.

The proposal addressed only the 2018 AHP Rule. It did not solicit comments on whether to simultaneously rescind the Department's final rule on association retirement plans (2019 ARP Rule).[119] However, the proposal acknowledged the existence of the 2019 ARP Rule; that it was issued after the 2018 AHP Rule and after the district court decision in *New York v. United States Department of Labor*; and that it includes commonality, business purpose, and working owner

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[118] *Wisconsin Educ. Assn. Ins. Trust v. Iowa State Bd. of Public Instruction*, 804 F.2d 1059, 1063 (8th Cir. 1986)
[119] 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).

provisions that parallel the provisions in the 2018 AHP Rule.[120] The proposal also acknowledged that ERISA has parallel language in the definitions of pension and welfare plan and does not explicitly provide a basis for distinguishing between the AHP and ARP rules.[121] However, the proposal stated that because there are specific retirement plan considerations that involve issues beyond the scope of the proposed rescission, the Department decided not to address the 2019 ARP Rule in the proposal.

A couple of commenters disagreed with this decision, asserting that it would be arbitrary and capricious not to address the 2019 ARP Rule given that the same applicable statutory text, the definition of "employer" in section 3(5) of ERISA, is the subject of both rules. In support of this position, one of the commenters quoted the Department's reasoning from the preamble to the 2019 ARP Rule, which stated as follows: "It makes sense to have consistent provisions for AHPs and [ARPs], because the Department is interpreting the same definitional provisions in both contexts and because many of the same types of groups or associations of employers that sponsor AHPs for their members will also want to sponsor [ARPs]."[122] Noting some take-up success under the 2019 ARP Rule, one of the commenters implied that the Department is being arbitrary and capricious by ignoring the possibility of a similar level of success for AHPs absent the rescission.[123]

That the Department has deliberately decided to proceed with the rescission of the 2018 AHP Rule, while reserving judgment on the 2019 ARP Rule, is neither probative nor suggestive of an arbitrary and capricious process either in the case of this final rule or with respect to future action, if any, taken on the 2019 ARP Rule. In much the same way that the Department exercised its discretion to promulgate the two rules on separate timelines, it has similar discretion to

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[120] 88 FR 87968, 87978-79.
[121] *Id*. *See also* 29 U.S.C. 3(1) (defining "welfare plan"), 3(2) (defining "pension plan"), and 3(5) (defining "employer").
[122] 84 FR 37508, 37513.
[123] *See* comment from Paragon Health Institute (Feb. 17, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00015.pdf.

undertake additional regulatory action with respect to the 2019 ARP Rule on a different timeline. Moreover, unlike the 2018 AHP Rule, the 2019 ARP Rule extends coverage to "bona fide professional employer organization" arrangements in addition to association retirement plans. Given the different scope, provisions, and policy considerations associated with the two rules, and the fact that only the AHP Rule has been held invalid in judicial proceedings, the Department believes it is appropriate to initially proceed with rescission of the 2018 AHP Rule, and to reserve judgment on any additional action with respect to the 2019 ARP Rule for a separate rulemaking effort.

Also, as the Department explained in the preamble to the proposal, retirement plans raise different issues from group health plans. Retirement plans and group health plans are subject to an array of different laws, regulators, and market forces. As just one example highlighted by commenters on the proposal, group health plans generally are subject to the ACA and retirement plans are not. Additionally, multiple employer retirement plans do not have a history of financial mismanagement or abuse to the same extent as multiple employer group health plans.[124] Although this final rule rescinds the 2018 AHP Rule, the Department has made no decision on whether to rescind or modify the 2019 ARP Rule, which was promulgated through a separate notice and comment process. However, if the Department decides to make changes to the 2019 ARP Rule, it will do so separately and through a notice-and-comment rulemaking process as was done with the final rule being adopted today.

H. Effect of Rescission on Access to Health Coverage through Association Health Plans.

Commenters are concerned that rescinding the 2018 AHP Rule will undermine the use of AHPs as a means of gaining access to health benefits. One commenter asserted that after the 2018 AHP Rule went into effect, small businesses created new associations and offered health

[124] *Supra* note 41.

coverage at premium rates significantly lower than previous small-group plans.[125] This commenter, however, did not address whether any of the purported savings attributed to newly formed AHPs resulted from AHPs that were formed following the 2018 AHP Rule but in accordance with pre-rule guidance, from AHPs formed pursuant to the alternative criteria under the 2018 AHP Rule, or some combination thereof, or whether any AHPs formed pursuant to the alternative criteria would have also satisfied the pre-rule criteria (and therefore could have continued to operate under the pre-rule guidance, regardless of the decision in *New York v. United States Department of Labor*). This commenter also asserted that newly created AHPs produced savings of nearly 30 percent for some employers. However, the Department is unable to independently validate the savings asserted by this commenter, or the extent to which those savings, if any, were attributable to less generous benefits, risk selection or other practices that were potentially harmful to the larger market for health benefits, or individuals being covered by low-quality, limited plans.[126]

The Department recognizes that a number of AHPs were established and briefly existed as a result of the 2018 AHP Rule. However, after the district court's decision holding the 2018 AHP Rule invalid, and the Department's subsequent guidance that parties should cease establishing AHPs (under the alternative criteria pursuant to the 2018 AHP Rule) and to wind down any that were in existence, commercial AHPs permitted under the 2018 AHP Rule halted by the end of 2019. Therefore, the rescission itself has no effect independent of the effects of the

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[125] *See* comment from the Opportunity Solutions Project (Feb. 2, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00003.pdf.

[126] The savings reported by the commenter was based on a 2019 study of 28 newly formed, active AHPs established under the 2018 AHP Rule provisions. The savings claims are described as "the maximum savings" though the term is not defined. The study compares each business's current non-AHP plan to the business's AHP plan options (the study also reported that the average number of plan options (*e.g.* PPO, HMO, HDHP) was 11). The "average maximum savings" of the 4 self-funded AHPs was 29 percent, and the average maximum savings for the 24 fully insured AHPs was 23 percent. Association Health Plans, *First Phase of New Association Health Plans Revealing Promising Trends*. www.associationhealthplans.com/reports/new-ahp-study/ accessed on March 12, 2024. This finding is not the average savings across all employers in the AHPs and does not account for differences in insurance coverage richness.

district court's opinion and the expiration of the winding-down period provided in the Department's long expired temporary safe harbor from enforcement.

I. Costs of Rescinding the 2018 AHP Rule.

A couple of commenters discussed potential costs associated with rescinding the 2018 AHP Rule. One commenter stated that the proposal does not acknowledge certain costs that such a rescission would entail.[127] This commenter suggests that the proposal overlooks the investments made in dozens of new AHPs organized under the 2018 AHP Rule and how their rescission "materializes losses from investments with delayed returns." This commenter also asserted that the rescission limits the AHP market to AHPs established pursuant to the Department's pre-rule guidance and suggested the uncertainties attendant to that guidance may discourage new investments in AHP-related technology and ventures, stifling innovations and the savings they might produce. This commenter also suggested that the rescission systemically reinforces higher than necessary health insurance costs for small businesses, money that might otherwise be spent on new hiring or raises. The commenter further suggested that higher premiums, in turn, discourage small businesses from offering coverage, increasing the Government's cost as more people must rely on ACA premium tax credits. But a different commenter was of the view that, because AHPs established under the 2018 AHP Rule had little opportunity to exist due to the district court's opinion, there is little real-world evidence of the effect the 2018 AHP Rule would have had on the market.[128] In addition, a significant number of commenters articulated a preference for the pre-rule guidance.

After the district court invalidated the 2018 AHP Rule, the Department gave AHPs established under the rule a temporary safe harbor from enforcement to allow such existing AHPs to wind down and announced that new AHPs should not be established in reliance on the

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[127] *See* comment from Paragon Health Institute (Feb. 17, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00015.pdf.

[128] *See* comment from AHIP (Feb. 20, 2024) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00043.pdf.

rule. That temporary safe harbor from enforcement has long expired, and the Department is not aware of any AHPs that currently exist under the framework of the 2018 AHP Rule. Because the 2018 AHP Rule was never fully implemented and any AHPs established in reliance on the rule have long since terminated, the Department is unable to definitively determine any costs and benefits that would have been incurred in response to the approach taken in the 2018 AHP Rule.

J. Need for Future Rulemaking.

In addition to comments on rescission of the 2018 AHP Rule, the proposal also solicited comments on whether the Department should propose a rule for group health plans that codifies and replaces the pre-rule guidance. This solicitation included a request for views on whether to issue additional guidance clarifying the application of the Department's longstanding 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 intent was that the public comments would inform the Department's decision on whether to finalize the proposal to rescind the 2018 AHP Rule and would also assist the Department in determining if it should engage in future rulemaking on AHPs under section 3(5) of ERISA. Overall, comments were mixed on whether future rulemaking is necessary or appropriate, with no clear consensus.

Many commenters expressed a preference for rescission but no future rulemaking on AHPs under section 3(5) of ERISA. These commenters suggested that the facts-and-circumstances approach of the pre-rule guidance (buttressed with State regulatory infrastructure) is adequate, has worked well to honor ERISA's employment-based nexus, and that no formal notice-and-comment rulemaking is needed.[129] Some of these commenters were concerned that a

[129] New rulemaking could, according to these commenters, undermine the best practices built by employers over decades under the pre-rule guidance and disrupt the balance upon which bona fide associations, employers, and insurers rely. Some of these commenters noted that attempting to codify pre-rule guidance issued over several decades would likely result in gaps and ambiguities, creating more confusion for small employers. One of these commenters further asserted that the lengthy, formal rulemaking process would hinder the Department from

future rulemaking effort might negatively impact existing bona fide AHPs.[130] Others cautioned that the Department should not engage in rulemaking to create new and separate requirements around rating practices within the AHP market, suggesting that rulemaking of that type would be reaching beyond the Department's statutory authority.

Other commenters, however, recommended that the Department give serious consideration to codifying the core principles in the Department's pre-rule guidance into the CFR through notice-and-comment rulemaking following this rescission. These commenters focused on the benefits and efficiencies of transparency and streamlining access to these principles.

Still others suggested that future rulemaking could both incorporate and expand upon the core principles in the Department's pre-rule guidance. Ideas for expansion included provisions on more effective MEWA enforcement, mandatory benefit levels (incorporating provisions that mirror the ACA small group market requirements into any future rulemaking), enhanced financial reporting by AHPs, restrictions on alternative coverage arrangements that undermine and threaten progress under the ACA, and disclosures by AHPs to participating employers and enrollees regarding the extent to which the AHP coverage includes the ACA's essential health benefits.

Other ideas for regulatory expansions in a future rulemaking project under section 3(5) of ERISA included strong nondiscrimination protections, provisions on working owners (some commenters recommended prohibitions on working owners being able to join AHPs, but others recommended including them), provisions requiring associations to disclose compensation they receive from the AHPs they sponsor or from the participating employers or enrollees obtaining

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contemporaneously responding to industry trends while also restricting industry exploration of new arrangements that could pool employers' resources more efficiently to maximize the healthcare benefits available to employees and their dependents.

[130] Several commenters argued that any future codification of the pre-rule guidance must preserve the structure of existing MEWAs that were set up in good faith in accordance with pre-rule guidance, including the ability to use experience ratings of their employer members consistent with State insurance law (which they say is essential for them to offer affordable and comprehensive coverage), without adding any new requirements that would necessitate expensive restructuring of these MEWAs.

coverage, provisions delineating concurrent State and Federal enforcement roles, and provisions codifying and enforcing the CMS "look-through rule."[131]

The commenters' ideas and suggestions on a potential future rulemaking project involving AHPs are not directly relevant to the Department's rescission of the 2018 AHP Rule. Moreover, some of their ideas for expansion are beyond the scope of a rulemaking project defining "employer" under section 3(5) of ERISA. However, the Department will take the recommendations for future rulemaking under advisement.

VI. Regulatory Impact Analysis

A. Relevant Executive Orders for Regulatory Impact Analyses

Executive Orders (E.O.s) 12866[132] and 13563[133] 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; tailor their regulations to impose the least burden on society, consistent with obtaining regulatory objectives; and select, in choosing among alternative regulatory approaches, 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 qualitatively values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts.

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

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[131] *Supra* note 9.
[132] 58 FR 51735 (Oct. 4, 1993).
[133] 76 FR 3821 (Jan. 21, 2011).

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, and reviewed the final rule in accordance with E.O. 12866. Key to this designation is that the Department is rescinding a rule that was itself significant under section 3(f)(1).

It should be noted that the 2018 AHP Rule was never fully implemented.[134] While the Department gave AHPs established under the 2018 AHP Rule a temporary safe harbor from enforcement after the district court's March 28, 2019 decision holding invalid the core provisions of 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 Rule hypothesized that plans serving small employers and their participants potentially would have benefitted from the ability to band together to offer tailored plans that omit certain benefits,

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[134] Consistent with the applicability date provision in the 2018 AHP Rule, fully insured plans could 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).

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 encompass 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 rulemaking, 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.

The Department, in response to the proposal, received a comment arguing that in assessing the cost of the rulemaking, the Department should have used partial implementation of the 2018 AHP Rule as its baseline.[135] The commenter argued that the Department should have implemented those parts of the 2018 AHP Rule that the district court did not hold invalid. The cost of rescinding the 2018 AHP Rule would then be the foregone benefits for individuals who would have relied on a scaled-down version of the 2018 AHP Rule.

The Department has explained why it determined that full rescission of the 2018 AHP Rule was appropriate, as discussed above in Section V.E. Because of the district court's decision, and the fact that parties are not relying on the 2018 AHP Rule to operate AHPs, the costs and benefits of the 2018 AHP Rule assessed against the baseline suggested by the commenter would be especially uncertain. Accordingly, the Department's analysis mostly reflects the fact that the 2018 AHP Rule was never fully implemented and the Department, therefore, reiterates that the

[135] *See* comment from Paul J. Ray (Dec. 22, 2023) last accessed at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC16/00001.pdf.

costs of this rulemaking, the rescission of the 2018 AHP Rule, would effectively be zero relative to the baseline projected from current prevailing conditions, while the benefits would be limited to settling any uncertainty caused by the litigation surrounding the 2018 AHP Rule and the Department's reexamination of the appropriate criteria for a group or association of employers to sponsor an AHP. Additionally, as observed in Section II.E. above, the district court held invalid the core provisions of the 2018 AHP Rule. Without the stricken provisions, the 2018 AHP Rule could not be operationalized and would provide no meaningful guidance.

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 offered by the group or association is not treated as a single group health plan, and the group or association is disregarded in determining whether health insurance coverage offered to an individual or employer member of the association is individual, small group, or large group market coverage for purposes of Title XXVII of the PHS Act. 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 II.D. of the preamble.

As noted in Section II.E. of this preamble, on March 28, 2019, the U.S. District Court for the District of Columbia held invalid the 2018 AHP Rule's definition of bona fide employer groups or associations and the working owner provisions. In response, the Department

announced its temporary enforcement policy designed to minimize undue consequences of the district court's decision on AHP participants.[136]

C. Need for Regulatory Action.

As discussed in Section II.E. of this preamble, the district court held invalid the 2018 AHP Rule as inconsistent with ERISA's definition of persons "acting indirectly 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 employment-based arrangements, on the one hand, and commercial entities marketing benefits to unrelated employers, on the other.[137] 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 and should be rescinded while the Department reconsiders its specific provisions and possible different regulatory approaches. The Department's rescission of the 2018 AHP Rule in its entirety also provides clarity to entities that wish to sponsor an AHP with respect to the need to rely upon the criteria in the Department's longstanding 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, given that the district court has held invalid most of the 2018 AHP Rule and the temporary enforcement policy period has long expired. Rescinding the 2018 AHP Rule simply maintains 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

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[136] *See supra* note 31.
[137] *See supra* at Section II.E. of this preamble for a discussion of the decision in *New York v. United States Department of Labor*.

required Form M-1,[138] 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 final rule rescinds the 2018 AHP Rule and provides clarity to parties about the continuing unavailability of the 2018 AHP Rule as an alternative to the Department's longstanding 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 held invalid 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.

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[138] The Form M-1 is a report for MEWAs and Certain Entities Claiming Exception (ECEs) that offer medical benefits, including AHPs. MEWAs are required to file annual reports with the Department, as well as special filings associated with certain events. In particular, all MEWAs that provide medical benefits, including AHPs that intend to begin operating, are required to file an initial registration Form M-1 at least 30 days before engaging in any activity. Such activities include, but are not limited to, marketing, soliciting, providing, or offering to provide medical care benefits to employers or employees who may participate in the AHP. This filing alerts the Department and State insurance regulators to new entrants into insurance markets, which can give States and regulators time to communicate with these new entities before they begin operation. For additional information on the Form M-1 *see* https://www.dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/forms/m1-2023.pdf.

VII. Paperwork Reduction Act.

The 2018 AHP Rule was not subject to the requirements of the Paperwork Reduction Act of 1995[139] because it did not contain a collection of information as defined in 44 U.S.C. 3502(3). Accordingly, this final rule to rescind the 2018 AHP Rule also does not contain an information collection as defined in 44 U.S.C. 3502(3).

VIII. Regulatory Flexibility Act.

The Regulatory Flexibility Act (RFA)[140] imposes certain requirements on rules subject to the notice and comment requirements of section 553(b) of the APA or any other law.[141] Under section 604 of the RFA, agencies must submit a final regulatory flexibility analysis (FRFA) of a final rule 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 rescission of the 2018 AHP Rule will 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 final rule will not have a significant economic impact on a substantial number of small entities. As discussed above, at the time the Department first promulgated 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 held invalid the 2018 AHP

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[139] 44 U.S.C. 3501 *et seq*.
[140] 5 U.S.C. 601 *et seq.*
[141] 5 U.S.C. 551 *et seq.*

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 will not have an impact on existing AHPs formed in accordance with the pre-rule guidance.

IX. 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.[142] In 2024, that threshold is approximately $183 million. For purposes of the Unfunded Mandates Reform Act, this final rule does not include any Federal mandate that the Department expects would result in such expenditures by State, local, or Tribal governments, or the private sector.[143]

X. 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 "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 section

[142] 2 U.S.C. 1501 *et seq*. (1995).
[143] 58 FR 58093 (Oct. 28, 1993).

514(b)(6) of ERISA, 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 will 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.[144]

XI. Congressional Review Act.

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act, 5 U.S.C. 801 et seq.) OIRA has determined that this rule meets the criteria set forth in 5 U.S.C. 804(2). Accordingly, this rule has been transmitted to the Congress and the Comptroller General for review.

List of Subjects in 29 CFR Part 2510

Employee benefit plans, Pensions.

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

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

[144] For example, CMS, on behalf of HHS, 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 Virginia State law, specifically section 38.2-3521.1 G of the Code of Virginia, as enacted by HB 768/SB 335 (2022). 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.

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.

* * * * *

(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 22nd day of April, 2024.

Lisa M. Gomez,

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

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