



PROPOSED ACTION
MEMORANDUM

Protecting Consumers and Markets from Association Health Plans

Department of Labor
December 2020

I. Summary

The Trump administration dramatically relaxed decades-old standards that applied to association health plans (AHPs) under the Employee Retirement Income Security Act of 1974 (ERISA). The Trump administration did so even though some AHPs have a long history of being used as a vehicle to defraud members and leave millions in unpaid claims after becoming insolvent. The Trump-era rule—which made it even easier to establish AHPs sponsored by illegitimate associations and allowed the enrollment of self-employed individuals into AHPs—exacerbates the risk of AHP fraud and insolvency. Further, because AHPs are not subject to most of the Affordable Care Act’s (ACA’s) consumer protections, these plans can cherry-pick healthier individuals. This adverse selection leads to higher premiums in the traditional individual and small group markets, and can leave AHP enrollees without essential coverage if they become sick.

This memorandum proposes that the Department of Labor (Department), in consultation with the Department of Health and Human Services (HHS) and the Department of the Treasury, rescind the current rule via notice-and-comment rulemaking and codify the Department’s long-standing prior test regarding when associations qualify as a bona fide group for purposes of ERISA. This prior interpretation had provided an important check on risky AHPs. The Department should also consider issuing a Request for Information (RFI) to solicit comments on AHPs and other types of arrangements being used to evade the ACA’s individual and small group market requirements under the guise of ERISA.

The rulemaking timeline could depend on the timing of a decision from the D.C. Circuit Court of Appeals (D.C. Circuit) on the validity of the Trump administration’s rule. If the D.C. Circuit has not yet issued a decision, the Department could initiate the new rulemaking recommended here, inform the D.C. Circuit, and withdraw its appeal or ask for a delay in the decision. Even if the D.C. Circuit has already issued a decision, the Department would not be barred from rulemaking.

II. Justification

Although the ACA imposed at least some new consumer protections on all types of private health insurance plans, the law’s most significant reforms apply only to the individual and small group markets—with far fewer changes that apply to the large group market. Insurers and businesses thus have an incentive to characterize their coverage as large group coverage (rather than individual or small group coverage). AHPs offer one mechanism for doing so as insurers and businesses to try to skirt ACA requirements and claim ERISA preemption from state insurance regulation.

While some AHPs provide quality coverage to members, there is a long and well-documented history of AHP fraud and insolvency.¹ While the Department has taken some enforcement action against AHPs,² federal officials acknowledge that its enforcement efforts “often were too late to prevent or fully recover major financial losses.”³ States have had a better track record on fraudulent AHPs,⁴ but fraud and abuse by AHPs

¹ Mila Kofman et al., “Association Health Plans: What’s All the Fuss About?” *Health Affairs* 25(6) (2006).

² Since 1985, the Department has pursued a total of 968 civil enforcement cases involving MEWAs and 317 criminal MEWA-related cases. These enforcement actions resulted in more than \$235 million in civil monetary restitution and \$173 million in criminal restitution. 83 Fed. Reg. 28912, 28952 (Jun. 21, 2018).

³ *Id.*

⁴ Mila Kofman, Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud, Georgetown University (2005), <https://hpi.georgetown.edu/ahp/>.

has continued.⁵ By expanding the availability of AHPs and relaxing prior standards, the Department itself recognized that it was opening the door to potential fraudulent behavior, insolvency, and unpaid claims.⁶

Beyond this history of fraud and abuse, AHPs promote risk segmentation and adverse selection against the ACA markets. This is because AHP coverage need not comply with the same protections that otherwise apply in the individual and small group markets, and can design products in a way that keeps premiums low and discourages enrollment of sicker employers or self-employed individuals. AHPs can, for instance, decline to cover entire benefit categories and underwrite member groups based on non-health factors (such as age, industry, and gender). As a result, AHPs can offer lower premiums that attract healthier risk.⁷ Unsurprisingly then, the Department's expansion of AHPs was expected to increase premiums in the ACA individual and small group markets,⁸ while potentially leaving those enrolled in AHP coverage without the benefits they need if they become sick.

III. Current State

Group health plans under ERISA are subject to far fewer federal and state health insurance requirements compared to fully insured coverage in the individual and small group markets. Many group health plans consist of a single employer offering benefits to its own employees. However, the definition of “employer” under ERISA § 3(5) includes an association of employers so long as the association acts “in the interest of an employer.”⁹ For associations that satisfy this standard, the AHP is regulated as a group health plan under ERISA.

Under the Department's historical interpretation, a “bona fide” group or association of employers is one that is bound together by a commonality of interest (other than simply providing a health plan) with vested control of the association so that they effectively operate as a single employer.¹⁰ Thus, eligible association members had to share a common interest, join together for purposes other than providing health insurance, exercise control over the AHP, and have one or more common law employee in addition to the business owner and spouse. Enrollment had also long been limited to employees, former employees, and their families or beneficiaries; individuals (such as sole proprietors with no common law employees) had not been able to enroll in group health AHPs. The Department had reaffirmed this position as recently as May 2017.¹¹

Then, in 2018, the Department issued a new rule altering its interpretation of “employer” under Section 3(5) (2018 Rule).¹² Issued in response to an Executive Order,¹³ the goal of the 2018 Rule was to “facilitate[] the

⁵ See, e.g., Robert Pear, “Cheaper Health Plans Promoted by Trump Have a History of Fraud,” *New York Times* (Oct. 21, 2017).

⁶ 83 Fed. Reg. at 28953 (“[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.”).

⁷ One insurer association estimated that AHPs could rate engineers 9 percent lower than insurers could and rate taxi drivers 15 percent higher; young men could be rated more than 40 percent lower by AHPs compared to insurers while young women could be rated more than 30 percent higher. *Id.* at 28945. Note that AHPs established under prior Department rules (“pathway one” AHPs) can underwrite based on health factors; this was generally prohibited for the new AHP types (“pathway two” AHPs).

⁸ Katie Keith, Reports Find Risk of Non-ACA-Compliant Plans to be Higher Than Federal Estimates, Health Affairs Blog (Mar. 4, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180303.392660/full/> (summarizing analyses of the proposed rule from Avalere and Oliver Wyman).

⁹ See 29 U.S.C. § 1002(5) (defining “employer” as “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity”).

¹⁰ The Department would apply a facts-and-circumstances approach to assess whether (i) the association has business or organizational purposes and functions unrelated to providing benefits; (ii) the employers share some commonality and genuine organizational relationship unrelated to providing benefits; and (iii) the employers exercise control over the benefit program, either directly or indirectly and both in form and substance.

¹¹ See Advisory Opinion 2017-02AC (May 16, 2017), <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/advisory-opinions/2017-02ac>.

¹² See 83 Fed. Reg. at 28912-64.

¹³ See Exec. Order No. 13813 of October 12, 2017, 82 Fed. Reg. 48385-87 (Oct. 17, 2017) (directing the Department to reconsider its definition of “employer” under ERISA and promote AHP formation based on geography or industry).

adoption and administration of AHPs and expand[] access to affordable health coverage, especially for employees of small employers and certain self-employed individuals.”¹⁴ The Department accomplished this goal by relaxing the three prior criteria for bona fide associations—primary purpose, commonality of interest, and control—and allowed working owners (sole proprietors with no common law employees) to enroll in an AHP. States retained the authority to regulate AHPs, and the 2018 Rule included a severability provision.

A coalition of Democratic attorneys general, led by New York, successfully challenged the 2018 Rule. Days before the most controversial parts would have gone into effect,¹⁵ a federal district court set aside the 2018 Rule’s major provisions.¹⁶ The court found that the Department’s interpretation of “employer” to include working owners and groups without a true commonality of interest was unreasonable and “clearly an end-run” around the ACA.¹⁷ The Department’s interpretation, the court held, failed to limit meaningfully the types of associations that qualify to sponsor an ERISA plan and was thus inconsistent with Congress’s intent that only an employer association acting “in the interest of” its members falls under ERISA. The 2018 Rule was remanded to the Department to determine how the rule’s severability provision affects the remaining provisions.

The Trump administration appealed the district court’s ruling to the D.C. Circuit without asking for a stay. As such, the court’s decision prevented the formation of new self-insured AHPs under the 2018 Rule. Existing fully insured and self-insured AHPs that had already been formed under the 2018 Rule were able to remain in effect through the end of the plan year or contract term but had to cease marketing to new members and could not renew this coverage without coming into compliance with the ACA.¹⁸ Neither the Department nor HHS would take enforcement action against any violations that occurred before the court’s decision, so long as the entity made those decisions in good-faith reliance on the validity of the AHP rule.¹⁹

The D.C. Circuit granted the Department’s request for expedited appeal, and oral argument was held in November 2019. However, the D.C. Circuit has yet to issue a ruling.

IV. Proposed Action

The Department should amend 29 C.F.R. § 2510.3-5 to eliminate the 2018 Rule’s definition of “employer” under ERISA. If the D.C. Circuit still has not issued a decision over the validity of the 2018 Rule, the Department could quickly initiate rulemaking, inform the court of this new development, and withdraw its appeal or ask for a delay in the decision. (As discussed below, the Department would not be barred from rulemaking even if the D.C. Circuit has issued a decision.)

Beyond simply eliminating the 2018 Rule, the Department should codify its prior test for a bona fide group or association of employers. Doing so would make clear that the prior test applies, and eliminate confusion about the Department’s interpretation following rescission of the 2018 Rule. Although the prior test has not been codified in regulations, it has been laid out in advisory opinions dating back to at least 1989, as well as

¹⁴ 83 Fed. Reg. at 28912. The 2018 Rule created a *new* pathway for the formation of AHPs (“pathway two” AHPs) while allowing existing AHPs to continue to operate (“pathway one” AHPs). Pathway one AHPs must continue to meet the Department’s prior, more stringent standards; they cannot, for instance, enroll working owners in AHP coverage.

¹⁵ The 2018 Rule had staggered applicability dates. It applied to fully insured AHPs beginning on September 1, 2018; existing self-insured AHPs beginning on January 1, 2019; and new self-insured AHPs on April 1, 2019.

¹⁶ *New York v. Dep’t of Labor*, 363 F. Supp. 3d 109, 118 (D.D.C. 2019).

¹⁷ *Id.* at 117.

¹⁸ Department, Federal District Court Ruling in *State of New York v. United States Department of Labor* Concerning Department of Labor’s Final Rule on Association Health Plans (May 2019),

<https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/ahp-q-and-a-court-ruling-part-2.pdf>

¹⁹ See Department, Statement Relating to the U.S. District Court Ruling in *State of New York v. United States Department of Labor* (Apr. 29, 2019), <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/completed-rulemaking/1210-AB85/ahp-statement-court-ruling>

case law applying ERISA.²⁰ By codifying the prior test, the Department would make clear that it intends to rely on prior advisory opinions and case law.

The Department could also add any other factors it deems necessary to distinguish employment-based benefit arrangements under ERISA from commercial insurance marketing programs in the individual and small group markets. The Department could, for instance, clarify the circumstances in which professional employer organizations, limited partners, or other group purchasing arrangements can (or cannot) be considered a bona fide group or association of employers. The Department could also issue an RFI to solicit comments on AHPs and other types of arrangements being used to evade the ACA's individual and small group market requirements under the guise of ERISA.

While the 2018 Rule is not directly at issue in recent litigation over an arrangement offered by Data Marketing Partnership and LP Management Services,²¹ that challenge has spotlighted limited partnership arrangements as an even broader expansion of this AHP-style loophole. Additional considerations or discussion of these types of arrangements could encourage the Department and state officials to address coverage arrangements like Data Marketing Partnership.

Regardless of whether the Department codifies additional considerations or not, it should use notice-and-comment rulemaking with a sixty-day comment period. This is consistent with the length of the comment period on the 2018 Rule. An extra cautious approach would be to hold a public hearing on the new rule; the Department did not do so for the 2018 Rule, concluding that a public hearing was not necessary.²²

Authority to Codify Prior AHP Standards

The Department has the authority to rescind the 2018 Rule's interpretation in 29 C.F.R. § 2510.3-5 and codify its long-standing prior AHP standards. The Department could argue that the plain text of the definition of "employer" compels the Department's historical approach to defining bona fide groups or associations of employers. As discussed more below, the Department would argue that the definition of "employer"—combined with Congress's intent in enacting ERISA and the ACA and case law—compels the Department's prior interpretation.

Alternatively, the Department could argue that the definition of "employer" in Section 3(5) is ambiguous, and the Department can reasonably resolve this ambiguity. This was the Department's position in the 2018 Rule,²³ and is consistent with the district court's opinion²⁴ and other case law.²⁵ The Department has the authority to reasonably interpret Section 3(5) and change a prior interpretation, so long as the interpretation is "rational, based on consideration of the relevant factors and within the scope of the authority delegated to the agency

²⁰ See, e.g., *Wis. Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1063, 1065 (8th Cir. 1986); see also *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1998); *MD Physicians & Assoc., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir. 1992); Advisory Opinion 2008-07A (Sep. 26, 2008); Advisory Opinion 2003-17A (Dec. 12, 2003); Advisory Opinion 1996-25A (Oct. 31, 1996); Advisory Opinion 89-13A (Jul. 20, 1989).

²¹ See *Data Marketing Partnership v. Labor*, 2020 WL 5759966 (N.D. Tex. Sep. 28, 2020). The company had argued that its limited partnership arrangement fell within the meaning of ERISA § 3(1) and should thus be treated as a single-employer group health plan fully exempt from state regulation under ERISA. The Department rejected that argument in an advisory opinion, concluding that the presence of a single employee participant is insufficient to extend ERISA coverage to all limited partners under multiple ERISA provisions (albeit not Section 3(5)). Advisory Opinion 2020-01A (Jan. 24, 2020). The Department filed a notice of appeal to the Fifth Circuit Court of Appeals on November 27, 2020.

²² 83 Fed. Reg. at 28960.

²³ The Department noted that it had "simply used its rulemaking authority to define a statutory term"—in this case, the terms "employer" and "indirectly in the interest of an employer." 83 Fed. Reg. at 28914, 17. The Department also cited its general rulemaking authority under 29 U.S.C. § 1135. *Id.* at 28691.

²⁴ See 363 F. Supp. 3d at 128 (citing the Department's implementing authority and past case law as well as the fact that the Department noted its view that the statute was ambiguous).

²⁵ See, e.g., *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003) (deferring to a Department interpretation of an ERISA provision); see also *Matincheck v. John Alden Life Ins. Co.*, 93 F.3d 96, 100 (3d Cir. 1996) (finding ERISA statutory definitions of employer and employee to be ambiguous).

by the statute.”²⁶ In adopting a new interpretation, the Department must explicitly acknowledge the change in position, offer a reasoned explanation that directly addresses why it is changing its interpretation, address why those arguments are no longer persuasive, consider alternatives (including maintaining the current interpretation), address reliance interests based on the 2018 Rule, and explain why the statute supports their interpretation.²⁷

Legal and Policy Justifications for Adopting Prior AHP Standards

Eliminating the 2018 Rule and replacing it with the Department’s prior interpretation would undoubtedly be a permissible construction of Section 3(5). This prior interpretation is more faithful to the statute and consistent with the text, other implementing regulations, advisory opinions and case law, and the goals of ERISA and the ACA.

First, the Department could conclude that the 2018 Rule’s current interpretation of “employer” is inconsistent with the text and purpose of ERISA. ERISA regulates benefit plans that arise from employment relationships and simply does not extend to health benefits outside of an employment relationship. While some employer associations can qualify as employers under ERISA, they can do so only if the group or association of employers acts *in the interest of* an employer. In significantly relaxing the Department’s prior standards, the 2018 Rule impermissibly reached beyond employment relationships by (i) including working owners, and (ii) failing to ensure that bona fide associations will truly act “in the interest of” employer members. As such, the 2018 Rule’s standards are insufficient to show that an association and its members are connected by a true employment nexus as required under ERISA, and the types of arrangements authorized under the 2018 Rule too closely resemble commercial insurance arrangements that fall outside of ERISA’s scope.

Beyond ERISA, the Department could note that the 2018 Rule is inconsistent with the text and purposes of the ACA, which adopted three distinct sets of rules for three distinct markets. The 2018 Rule undermines this part of the ACA by picking and choosing the circumstances under which an association offering coverage to small groups and individuals meets the definition of an “employer” under ERISA. The 2018 Rule also undermined HHS’s “look through” doctrine initially adopted under HIPAA and extended by HHS under the ACA.²⁸ By allowing working owners and small businesses to be grouped together to form a large group, the 2018 Rule led to “absurd results” with respect to the ACA.²⁹

These arguments track the conclusions reached by the district court in vacating major parts of the 2018 Rule. Even if the D.C. Circuit reverses that decision, the Department may be able to rely on these arguments to revise the rule (while acknowledging the D.C. Circuit’s decision).

Second, the Department could cite the desire to revise its rules in a way that maintains consistency with decades of prior case law and advisory opinions. Even if the Department opts not to replace the text at 29

²⁶ *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42 (1983) (internal quotations and citations omitted). Agencies cannot, however, rely on factors that Congress did not intend for it to consider, fail to consider an important aspect of the problem, offer an explanation that runs counter to the evidence, or adopt a position that is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. *Id.* at 43.

²⁷ *See Dep’t of Commerce v. New York*, 588 U.S. ___, 139 S.Ct. 2551, 2575-76 (2019); *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (1999) (*Fox*). The agency’s burden is not to convince a reviewing court that the new policy is better than the old policy, but that the new policy is permissible under the relevant statute, there are good reasons for it, and the agency believes it to be better. *Fox* at 515.

²⁸ Under this doctrine, federal reforms are applied based on whether a participating individual or employer obtained individual, small group, or large group coverage through the association. *See* Timothy Jost, Implementing Health Reform: Association Health Plans, Health Affairs Blog (Sep. 1, 2011), <https://www.healthaffairs.org/doi/10.1377/hblog20110901.013412/full/> (“AHPs were traditionally regulated under HIPAA according to the market in which they sold their products: associations that sold coverage to individuals were regulated as individual plans and those that marketed to small groups were regulated as small group plans.”).

²⁹ 363 F. Supp. 3d at 140 (criticizing the Department’s interpretation on working owners that “transforms two individuals, neither of whom works for the other, into a total of three employers and two employees,” which strains both the reading of ERISA’s definition of “employee” and the ACA’s definition of “employer”).

C.F.R. § 2510.3-5, it should confirm in the preamble of the notice proposing repeal of the 2018 Rule that it will rely on prior case law and advisory opinions. That body of precedent clearly defined the Department's test for bona fide groups or associations, and barred sole proprietors from enrolling in group health AHPs. The Department could conclude that, upon reconsideration of the 2018 Rule, there is no need to disrupt or otherwise set aside this long-standing precedent to expand the availability of AHP group coverage, including to working owners.

Third, there are several factual and policy reasons that justify eliminating the 2018 Rule and help the Department explain why it believes the revised interpretation is better policy (and not merely legally permissible). The Department would be expected to cite concerns about fraud and unpaid claims, risk segmentation and adverse selection, and regulatory burdens on federal and state regulators.

Many of these rationales will be bolstered by the prior rulemaking record, where commenters raised concerns about fraud, risk segmentation, benefit gaps, and consumer confusion.³⁰ Most analyses of the effects of the 2018 Rule found that millions of people would shift from the individual and small group markets to AHP coverage.³¹ This, in turn, would cause premiums to rise in those markets and increase the ranks of the uninsured. Those studies were generally consistent with analysis by the Congressional Budget Office, which expected about 3.7 million more people to enroll in AHPs, leading premiums in the small group market to rise by about 3%.³² These impacts are among the reasons why the vast majority of stakeholders opposed the AHP rule outright or expressed serious concerns.³³

The Department itself estimated that individuals that remained in the ACA-compliant markets could face premium increases of between \$7.7 billion and \$14.1 billion.³⁴ The Department also cited comments to acknowledge that some small employers may face higher premiums, and that the 2018 Rule could erode choice and affordability for consumers in the ACA-compliant markets, leaving some small businesses and working owners uninsured or less able to invest in their business.³⁵

Fourth, while the Department must acknowledge and account for reliance interests of associations, enrollees, and states, these reliance interests are limited. Because major parts of the rule were vacated ahead of the rule's final effective date, the 2018 Rule was only in effect for existing entities for a short window of time.³⁶ To the extent that these entities offered coverage under the 2018 Rule, this coverage could not be marketed to new enrollees or renewed after the court's decision in March 2019. Given how much time has passed, there should be few, if any, current enrollees in AHPs authorized under the 2018 Rule. To confirm this information, the Department could solicit data on current enrollment in the AHPs allowed to offer coverage pursuant to the 2018 Rule.

Setting aside current enrollees, nothing in the 2018 Rule or the district court's decision disturbs existing "pathway one" AHPs. Those arrangements predated the 2018 Rule and can continue to operate under the Department's prior advisory opinions. Associations can continue to offer that type of coverage, and enrollees in those AHPs should have faced no disruption to their coverage.

³⁰ See, e.g., National Association of Insurance Commissioners, Comment Letter (Mar. 6, 2018), https://www.naic.org/documents/index_health_reform_section_180306_comments_assoc_plan_nprm.pdf;

Coalition of State Attorneys General, Comment Letter (Mar. 6, 2018), https://oag.ca.gov/system/files/attachments/press_releases/multi_state_ag_comment_letter.pdf; Center on Budget and Policy Priorities, Comment Letter (Mar. 6, 2018), <https://beta.regulations.gov/comment/EBSA-2018-0001-0528>.

³¹ Keith, *supra* note 8; see also Sabrina Corlette et al., New Rules to Expand Association Health Plans, *The Actuary* (May 2018), <https://theactuarymagazine.org/new-rules-to-expand-association-health-plans/>.

³² Congressional Budget Office, How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans (Jan. 2019), https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

³³ Noam N. Levey, "Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments," *Los Angeles Times* (May 30, 2018).

³⁴ 83 Fed. Reg. at 28945.

³⁵ *Id.* at 28944.

³⁶ The Departments' enforcement stance applied to any fully insured or existing self-insured AHPs from September 1, 2018 through late March 2019.

Finally, some states have enacted legislation to authorize AHPs under the 2018 Rule.³⁷ But many of these laws expressly rely on the Department's interpretation and have not yet gone into effect in light of the litigation. Some laws, such as North Carolina's law, explicitly direct alternative action if the 2018 Rule is held to be invalid.³⁸

³⁷ See, e.g., Mercer, More States Approve Pathway 2 Association Health Plans (Oct. 21, 2019), <https://www.mercer.com/our-thinking/law-and-policy-group/more-states-approve-pathway-association-health-plans.html>. Other states increased their regulation of AHPs in response to the 2018 Rule. See Kevin Lucia et al., In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets, The Commonwealth Fund (Nov. 27, 2018), <https://www.commonwealthfund.org/blog/2018/initial-state-approaches-association-health-plans>.

³⁸ See N.C. S.B. 86 (2019) § 7(a)-(b) (directing the insurance department to conduct a feasibility study of AHP options under Section 1332 of the ACA if a final judicial order is issued striking down the 2018 Rule).

