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Delaware, District of Columbia, Hawaii, Illinois, Iowa, Maine, Maryland, New  
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March 6, 2018

**Via Federal eRulemaking Portal**

Director Joe Canary  
Office of Regulations and Interpretations  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Ave., NW, Ste. N-5655  
Washington, DC 20210

Re: Comments on Proposed Rule: Definition of “Employer” Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 614 (Jan. 5, 2018), RIN 1210-AB85; Request for a Public Hearing

Dear Mr. Canary:

The undersigned State Attorneys General submit these comments to oppose the Department of Labor’s Proposed Rule: *Definition of “Employer” Under Section 3(5) of ERISA – Association Health Plans*, 83 Fed. Reg. 614 (proposed Jan. 5, 2018) (to be codified at 29 C.F.R. pt. 2510) (“Proposed Rule”). The Department of Labor (“Department” or “DOL”) proposes to expand the criteria for determining when employers may join together in an association to purchase health coverage, allowing individuals and small employers unprecedented ability to group together as an association in order to exempt them from many of the Affordable Care Act (“ACA”) protections that currently apply to individual and small group plans (including essential health benefit coverage and premium restrictions based on race and sex). These changes would increase the risk of fraud and harm to consumers; would undermine the current small group and individual health insurance markets; and are inconsistent with the text of the Employee Retirement Income Security Act (“ERISA”) and the ACA.

Association Health Plans (“AHPs”) have a long and notorious history of fraud, mismanagement, and deception. Over decades, Congress has legislated – including through ERISA and the ACA – to protect health care consumers from this fraudulent conduct. The Proposed Rule would reverse many of these critical consumer protections and unduly expand access to AHPs without sufficient justification or consideration of the consequences. Because the Proposed Rule is an unlawful attempt to accomplish by executive rulemaking changes in law and policy that lie within the power of Congress – and that Congress has refused or failed to adopt – we urge that the Proposed Rule be withdrawn. In addition, in light of the significant impacts this proposal would have on the States’ consumers, health care markets, and

enforcement resources, we request that the Department hold a public hearing to receive input from affected stakeholders before any regulatory changes are finalized.<sup>1</sup>

## I. Background

Section 3(5) of ERISA defines “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.” 29 U.S.C. § 1002(5). ERISA allows an “association of employers” to manage employee benefit plans offering health insurance. To protect these associations from becoming mere commercial insurance arrangements that serve only a profit motive – instead of operating as legitimate employer/employee health benefit plan arrangements as ERISA intended – the Department has consistently required that members of such associations consist of a “bona fide” group of employers with a high degree of common interest, or “*commonality of interest*,” beyond solely purchasing or offering health insurance. The association’s employer members must also themselves exercise “control,” both in form and substance, over the activities and operations of the employee welfare benefit plan.

The Proposed Rule largely eliminates these current requirements, and instead would allow *any* group of employers in the same industry or the same geographic area to form employer associations under ERISA, even if their sole purpose is simply to purchase health insurance. In short, the Proposed Rule would make three substantial changes:

1. Eradicate longstanding ERISA definitions such that associations may form solely for the purpose of purchasing or providing health plans if the employers are in the same industry or the same geographic region;
2. Deem self-employed individuals to be both employers and employees such that they can participate in employer associations; and
3. Allow most associations to be single, large employers such that they may evade many ACA requirements (now imposed on small group and individual plans).

These changes would vastly expand the ability of AHPs to form in ways that would result in fewer protections for our citizens, increased fraud within our borders, and destabilization of our individual and group markets.

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<sup>1</sup> See, e.g., U.S. Dep’t of Labor, *Hearing on Definition of the Term “Fiduciary”; Conflict of Interest Rule – Retirement Investment Advice and Related Proposed Prohibited Transaction Exemptions*, 80 Fed. Reg. 34,869 (June 18, 2015) (scheduling a four-day public hearing for August 2015 to consider issues related to the Department’s proposed conflict of interest rulemaking under ERISA); U.S. Dep’t of Labor, *Hearing on Definition of “Fiduciary”*, 76 Fed. Reg. 2142 (Jan. 12, 2011) (scheduling a two-day public hearing for March 2011 to receive input on the Department’s October 2010 fiduciary rulemaking proposal under ERISA, “to ensure that all issues are fully considered and interested persons have sufficient time to share their views on this important regulation”).

## **II. The Proposed Rule Would Facilitate Increased Fraud and Misconduct Relating to AHPs**

AHPs and other multiple employer welfare arrangements (“MEWAs”) have a lengthy and well-documented history of fraud and abuse. Although AHPs and other MEWAs are not uncommon, very few of these arrangements are covered by ERISA as they commonly fail to meet the requirements of ERISA and longstanding DOL regulations and guidance. By dramatically expanding the use of AHPs under ERISA, while also failing to include any provisions that would decrease the likelihood of future misconduct, the Proposed Rule would substantially weaken the current regulatory structure that safeguards against fraud and abuse.

### **A. There Has Been an Extensive History of Fraud and Mismanagement Associated with AHPs**

By enacting ERISA in 1974, Congress federalized the regulation of employee benefits, including employee benefits plans. Immediately after ERISA’s passage, various entities marketing MEWAs entered the health insurance market. The plans offered by these entities were rife with abuse and mismanagement and left behind a trail of unpaid claims.<sup>2</sup> When states sought to enforce their own insurance laws to regulate these plans, the entities argued that ERISA preempted state law, in many cases hindering efforts to stop fraudulent and illegal activity.<sup>3</sup> At the same time, the DOL claimed to lack authority over these insurance arrangements because most were not, in fact, ERISA plans.<sup>4</sup>

In response, Congress amended ERISA in 1982 to eliminate any doubt regarding ERISA preemption of state laws as to MEWAs, firmly declaring that MEWAs are subject to state insurance laws, *see* 29 U.S.C. § 1144(b)(6)(A), and recognizing that the federal government alone could not adequately protect consumers against the fraud and insolvency of MEWAs.<sup>5</sup>

Despite the unambiguous authority granted to the states to regulate MEWAs, entities seeking to market dubious AHPs have sought to exploit any regulatory gaps. These entities have an extensive record of fraud, gross mismanagement, and illegal activity in the marketing and operation of MEWAs and AHPs across the country.<sup>6</sup> In the late 1980s, scammers unleashed a

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<sup>2</sup> Mila Kofman, *Assoc. Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Health Policy Inst., at 2 (Summer 2005), <https://hpi.georgetown.edu/ahp.html> (providing history of attempts to regulate AHPs by state and federal governments).

<sup>3</sup> *Id.* at 7; *see also* U.S. Government Accountability Office (“GAO”), *Employee Benefits: States Need Labor’s Help Regulating MEWAs*, GAO/HRD-92-40, at 8 (Mar. 10, 1992), <https://www.gao.gov/assets/220/215647.pdf>; U.S. Dep’t of Labor, *MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Fed. and State Regulation*, at 3 (Aug. 2013), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf>.

<sup>4</sup> Mila Kofman, *supra* note 2, at 7.

<sup>5</sup> The House of Representatives had earlier clarified the intended scope of ERISA through a resolution stating that plans marketed by entrepreneurs to employers and employees are not covered by ERISA. *See* H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).

<sup>6</sup> *See, e.g.*, GAO, *Private Health Ins.: Employers and Individuals Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312, at 3-5 (Feb. 27, 2004), <https://www.gao.gov/assets/250/241559.pdf>; GAO,

wave of fraud and misconduct through phony unions, relying on the ERISA exemption for collectively bargained union plans. From 1988 to 1991, failed MEWAs left thousands of people in dozens of states without health insurance and nearly 400,000 patients with medical bills exceeding \$123 million.<sup>7</sup> Following a 1991 Senate Report finding that fraudsters attempted to use ERISA to avoid state oversight, Congress eventually required MEWAs to register with the DOL before operating in a state.<sup>8</sup>

A 2004 GAO Report again found that employers and individuals were vulnerable to unlicensed or “bogus” entities selling fraudulent health insurance coverage through, among other things, “associations they created or through established associations of employers or individuals.”<sup>9</sup> In total, GAO identified 144 unauthorized entities that covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002.<sup>10</sup> These entities failed to pay at least \$252 million in medical claims and state and federal regulators were able to recover only a fraction of this amount.<sup>11</sup> Although state insurance departments sought to stop these entities’ activities in their states, nationwide enforcement was hampered because many of the promoters operated across state lines and the DOL was not able to effectively clamp down on these plans.<sup>12</sup>

The ACA, passed in 2010, aimed to provide comprehensive health coverage for all, and its provisions have worked to prevent MEWA fraud in a number of ways. AHP members benefit from the protections of the individual and small group health plan market, including requirements to cover essential health benefits and meet actuarial value requirements. These protections are vitally important in light of the extensive history prior to the ACA of skimpy health plans (of the sort that the DOL now seeks to encourage) causing significant harm to consumers through, for example, medical bankruptcies, failure to cover necessary benefits, and caps on coverage. In addition, the ACA incorporated a series of enforcement tools to prevent MEWA abuses. *See, e.g.*, Sections 4376 (imposing fees on applicable self-insured MEWAs); 6601 (prohibiting false statements in connection with the marketing and sale of MEWAs – subject to up to ten years of imprisonment or fine); 6602 & 10606 (amending definition of “federal health care offense” to include violation of MEWA-related provisions); 6605 (enabling the DOL to issue administrative summary cease and desist orders against plans, including MEWAs, that demonstrate financially hazardous conditions); 6606 (requiring MEWAs to register with the Secretary of Labor before operating in a state). These enforcement tools, which include fines and imprisonment, evidence the serious concerns Congress had with respect to MEWAs – plans that the Proposed Rule now seeks to proliferate.

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*Employee Benefits: States Need Labor’s Help Regulating MEWAs*, at 3-7; Mila Kofman, et al., *Proliferation of Phony Health Ins.: States and the Fed. Govt. Respond*, Bureau of Nat’l Affairs, at 13-15 (Fall 2003).

<sup>7</sup> GAO, *Employee Benefits: States Need Labor’s Help Regulating MEWAs*, at 2-3.

<sup>8</sup> Mila Kofman, *Ass’n Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, *supra* note 2, at 12.

<sup>9</sup> GAO, *Private Health Ins.: Employers and Individuals Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, at 1-4.

<sup>10</sup> *Id.* at 4.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

**B. The Proposed Rule Would Dramatically Increase Problematic Use of AHPs by Weakening the Structural Safeguards Against Fraud and Abuse**

As States and State Attorneys General, we have extensive experience protecting individuals and small employers within our states from predatory entities that seek to defraud or deceive customers through the use of AHPs. *See infra* Part VI. In light of this experience, we believe that the Proposed Rule would invite fraud and wrongdoing in the health insurance market that will threaten the health and financial security of consumers in our states.

*First*, by weakening the “bona fide association” requirement to allow unrelated employers to associate solely for health benefit purposes, the Proposed Rule would encourage fly-by-night associations to form, engage in misconduct, and disappear with employees’ premiums. The Proposed Rule would transform the “bona fide association” conditions by (a) allowing the provision of health insurance to be the sole reason for an association’s existence; (b) not requiring the association sponsoring an AHP to have been in existence for any length of time or to demonstrate its legitimacy its any other way; (c) eliminating the requirement that the association maintain substantive control over the AHP and, instead, require only that it have “formal” control by maintaining an organizational structure with by-laws and a board of directors; and (d) allowing geographic proximity alone to establish “commonality of interest.” 83 Fed. Reg. 614, 635.

These changes would expand the treatment of “bona fide associations” to such an extent as to evade the statutory requirement that the association “act[] directly as an employer, or ... indirectly in the interest of an employer.” 29 U.S.C. § 1002(5). Under ERISA, the employer or an association on its behalf is intended to serve as the guarantor of its employees’ interests; but an association that is not truly a bona fide representative of its employer members cannot be counted on to protect them. It is the “representational link between employees and an association of employers in the same industry who establish a trust for the benefit of those employees” that provides the “protective nexus” that differentiates ERISA plans from other health insurance arrangements. *MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 186 (5th Cir. 1992). The Proposed Rule weakens the requirements to be a “bona fide association” so extensively that it would essentially eliminate any requirement of an underlying employer-employee relationship, without which small employers and employees are vulnerable to entities offering health insurance with whom they have no preexisting relationship at all. It is for this reason that Congress specifically did not include “commercial products within the umbrella of the employee benefit plan definition.” *See* H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).

*Second*, the Proposed Rule would further weaken protections against fraud and mismanagement by allowing individuals who purport to own a business to join AHPs as employers even though they have no employees (“working owners”). 83 Fed. Reg. 614, 636. The Proposed Rule would not require the association sponsoring the AHP to obtain any evidence beyond the written representation of the working owner that he or she in fact owns a qualifying business. *Id.* This provision is particularly susceptible to abuse because it opens the door for fraudsters to market to individuals and then enroll them if they “check a box” confirming compliance with the written representation requirement in the Proposed Rule. The AHP could

then collect premiums, and, in the event that a policyholder submits claims, conduct an “audit” that results in the policy being cancelled or rescinded when it turns out that the individual did not, in fact, qualify as a “working owner” as defined in the Proposed Rule. AHP promoters have long marketed fraudulent or deceptive health plans to individuals through associations with whom the individuals have no relationship other than the provision of health insurance; if the Department grants them explicit permission to do so, they will again seize the opportunity to enroll untold numbers of individuals in similar plans.

The potential for fraud is particularly concerning given the characteristics of the “working owners” that AHP promoters are likely to target if the Proposed Rule is promulgated. For example, a business owner may require workers to establish their own LLCs so that the owner can misclassify these individuals as independent contractors even though they might otherwise meet the legal definition of employees. These employers would then very plausibly work with promoters to offer these employees access to AHPs that provide few benefits and little security, while nonetheless creating the impression that their employees are enrolling in comprehensive health care coverage. Workers in these situations, who are already subject to wage theft and other abuses, will be prime targets for unscrupulous AHPs when they should be considered employees eligible for employer-sponsored insurance in the first place. Similarly, “gig economy” workers could be taken advantage of through “employers” who promise health insurance, but arrange for skimpy AHP coverage instead, leaving these workers exposed to unexpected medical bills and without coverage for necessary medical services. Workers such as these are very likely to be harmed given the propensity of AHP promoters to engage in fraud and abuse or, at minimum, to offer skimpy plans with limited coverage.

*Third*, the Proposed Rule seeks to allow AHPs to provide coverage to a massively expanded universe of “employers” at the “association-level,” rather than at the “employer-level.” 83 Fed. Reg. 614, 618-19. The ACA’s regulation of most AHPs at the “employer-level,” generally as small groups, has reigned in much of AHPs’ fraud and abuse.<sup>13</sup> By moving so many small employers and individuals out of these markets and into the large group market, the Proposed Rule would undermine the ACA’s requirement of providing comprehensive coverage to individuals as well as to employees of small employers.<sup>14</sup> For example, the Proposed Rule would allow small employers and “working owners” who do not share a true commonality of interest and who do not belong to a bona fide association in any meaningful way to be regulated as a single large employer, outside of the individual and small group plan protections of the ACA, opening the door to fraud and abuse. 83 Fed. Reg. 614, 618-19. Moreover, the Proposed

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<sup>13</sup> The Centers for Medicare & Medicaid Services in 2011 set forth: “[I]n most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations, the size of each individual employer participating in the association determines whether that employer’s coverage is subject to the small group market or the large group market rules. In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the ‘employer,’ the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.” Memorandum from Gary Cohen, Acting Dir., Office of Oversight, Ctrs. for Medicare & Medicaid Servs., (Sept. 1, 2011) (“CMS 2011 Guidance”), available at [https://www.cms.gov/CCIIO/Resources/Files/Downloads/association\\_coverage\\_9\\_1\\_2011.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf). This guidance was also codified by New York. N.Y. Ins. Law § 4317(d)–(e).

<sup>14</sup> *Id.*

Rule's application will result in segmentation of the health care market into inexpensive plans with little coverage for the healthy and expensive full coverage for those with preexisting conditions.

### **III. The Proposed Rule Would Violate the Administrative Procedure Act Because It Is Contrary to ERISA, and Because It Is an Arbitrary and Capricious Change of Longstanding Agency Position**

#### **A. The Proposed Rule's Weakening of the "Bona Fide Association" Definition, if Finalized, Would Be Unlawful**

The Department's proposal to change the "bona fide association" conditions is inconsistent with ERISA and several decades of case law applying ERISA, and would therefore be contrary to law and in excess of statutory authority. See *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."). Further, because the Proposed Rule is also inconsistent with the DOL's own longstanding position, this change would be arbitrary and capricious under the Administrative Procedure Act ("APA").

#### **1. The Proposed Rule's New "Commonality of Interest" Requirements Are Contrary to ERISA**

Section 3(5) of ERISA defines "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." 29 U.S.C. § 1002(5). When enacting ERISA, Congress's intent was clear: to maintain an employee benefit plan under ERISA, an association must be tied to the employees or the contributing employers by genuine economic or representational interests unrelated to the provision of health insurance benefits, and employer members participating in the plan must exercise actual control over the program.

Relying on a "plain reading of ERISA's language considered against the backdrop of express and implicit congressional intentions," Courts of Appeal have consistently held that the "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.*" *Wis. Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1063, 1065 (8th Cir. 1986) (emphasis added) ("decision is premised on ERISA's language and Congress' intent"); see also *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1998) ("commonality of interest requirement is well-established in the case law"); *MDPhysicians Inc.*, 957 F.2d at 185. This "common economic or representation interest" requires either that there be an "economic relationship between employees and a person acting directly as their employer" or a "representational link between employees and an association of employers in the same industry who establish a trust for the benefit of those employees." *MDPhysicians Inc.*, 957 F.2d at 185-86. Where the "only

relationship between the sponsoring [entity] and . . . recipients stems from the benefit plan itself,” the “relationship is similar to the relationship between a private insurance company . . . and the beneficiaries of a group insurance plan,” and is simply not covered by ERISA. *Wis. Educ. Ass’n Ins. Tr.*, 804 F.2d at 1063.

Moreover, under the Proposed Rule, AHPs would be allowed to organize for the sole purpose of offering health insurance coverage. Establishing an AHP for this purpose is the definition of a commercial insurance arrangement, rather than in service of an employer-employee relationship as intended by ERISA. This proposed change is inconsistent with Congress’s intent of protecting ERISA plans from becoming mere commercial, for-profit insurance arrangements. *See Int’l Ass’n of Entrepreneurs of Am. Benefit Tr. v. Foster*, 883 F. Supp. 1050, 1057 (E.D. Va. 1995) (describing the circumstance of companies that market insurance products and characterize themselves as ERISA benefit plans to avoid state regulation, and noting that these plans “are no more ERISA plans than is any other insurance policy sold to an employee benefit plan”) (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)).

Despite this uniform judicial interpretation of ERISA, the Department is proposing to redefine the bona fide association and commonality of interest requirements so that they no longer ensure that the association and the employees have a “common economic or representation interest unrelated to the provision of benefits.” The Proposed Rule goes as far as allowing employers connected *only* by geography to satisfy the commonality of interest requirement, and for associations that exist for the sole purpose of providing health insurance to be deemed bona fide. 83 Fed. Reg. 614, 635. The DOL asserts that neither its “previous advisory opinions, nor relevant court cases, have ever held that the Department is foreclosed from adopting a more flexible test in a regulation . . . in determining whether a group or association can be treated as acting as an ‘employer’ or ‘indirectly in the interest of an employer,’ for purposes of the statutory definition.” 83 Fed. Reg. 614, 617. However, the Department may not seek to issue a new regulatory interpretation that is counter to the unambiguous statutory language and the courts that have interpreted the statute. *See Public Citizen, Inc. v. Mineta*, 340 F.3d 39, 54-62 (D.C. Cir. 2003) (vacating rule because agency interpretation contravened legislative intent and plain reading of statute).

## **2. The DOL Does Not Offer Reasoned, Evidence-Based Rationales for Reversing Its Longstanding Position**

The Proposed Rule would also be arbitrary and capricious because it would reverse several decades of consistent agency interpretation without reasoned support. *See Perez v. Mortgage Bankers Ass’n*, 135 S. Ct. 1199, 1209 (2015) (explaining that “the APA requires an agency to provide more substantial justification when ‘its new policy rests upon factual findings that contradict those which underlay its prior policy’”) (quoting *F.C.C. v. Fox Tel. Stations, Inc.*, 556 U.S. 502, 515 (2009)); *see also Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 57 (1983).

*First*, the Proposed Rule acknowledges but fails to address the long history of fraudulent and abusive conduct by AHPs and other MEWAs. The DOL concedes that “[h]istorically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving



participants and providers with unpaid benefits and bills.” 83 Fed. Reg. 614, 631. The Department also acknowledges that “the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse, increasing potential oversight demands on the Department and State regulators.” *Id.* at 632. In a footnote, the Department cites reports authored by the GAO and articles detailing the history of financial abuses associated with MEWAs. *Id.* at 614, n. 24. The DOL, however, does nothing else with these sources – whether to explain how the Proposed Rule would safeguard against the historical “financial mismanagement or abuse” it acknowledges, or to discuss any methods for preventing such fraud, or even mitigating the costs associated with a proliferation of abusive MEWAs. This is so despite the extensive records of this conduct maintained by the DOL, which may well show that entities that have engaged in fraud or gross mismanagement have operated in the very same ways that the Proposed Rule now seeks to encourage.<sup>15</sup> The justification provided by the Department – to allow more people to benefit from cheaper, less comprehensive plans – is woefully inadequate in the face of the clear history of fraud and abuse in the marketplace.

*Second*, the Proposed Rule allows AHPs to form on the basis of a “single industry or trade,” *or* a common geographic region within a single state or multi-state metropolitan area, and dilutes the prior commonality of interest requirements to the point of elimination. The Proposed Rule now requires only formal association documents and the right of association members to elect the association’s directors or officers that control the group or association. 83 Fed. Reg. 614, 620. Nothing in the Proposed Rule vests employer members with actual control over the directors or officers as is currently required by DOL guidance; instead, it appears to cede authority to govern the association to an elected body and *not* to the employer members. *See* DOL Adv. Op. 94-07A, 1994 ERISA LEXIS 11 (Mar. 14, 1994) (association’s governing documents provided “no effective way for members to affect the Board or operations of” AHP and trust operating plan and thus failed the control requirements). There is nothing in the Proposed Rule that explains how employer members of the association can adequately guard against the adverse interests of those who would treat the AHP as a commercial enterprise, the purpose of which is to make money for its promoter, service providers and salesforce. The DOL’s failure to provide reasoned and evidenced-based explanations for its departure from longstanding agency policy would be arbitrary and capricious if the Proposed Rule is enacted, and thus, the DOL should withdraw the Proposed Rule and start anew.

### **3. The Department’s Failure to Include Any Quantitative Analysis of the Costs and Benefits of the Proposed Rule Is Unjustifiable**

In addition, in proposing these extensive changes to how AHPs are defined and regulated, the Department has declined to include any quantitative analysis of the costs and benefits of the Proposed Rule. The failure to quantify the estimated costs to employees and health care consumers hinders the public’s ability to comment on the Department’s proposal, and is likely arbitrary and capricious under the APA.

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<sup>15</sup> As other commenters have observed, the DOL’s failure to make public and to analyze in the Proposed Rule its extensive data concerning AHP fraud and abuse provides a sufficient basis alone to require that the DOL withdraw the Proposed Rule and fundamentally reconsider its approach to this issue.

The Department’s Regulatory Impact Analysis acknowledges that this proposal is “economically significant,” and that the Department was therefore required to assess – including by quantifying – the costs and benefits of the proposal. 83 Fed. Reg. 614, 625. But despite acknowledging AHPs’ history of “financial mismanagement and abuse,” the Department makes no effort to assess the economic impact of weakening the requirements for groups seeking to qualify as bona fide associations. *Id.* at 631. Nor does the DOL quantify the likely costs of a proliferation of AHPs in the form of the additional resources to be needed by state and federal agencies to monitor AHPs and enforce state and federal standards. The Department makes only the general assumption that AHPs “are an innovative option” that “can help reduce the cost of health coverage” because AHPs will “help small businesses ... to group together to self-insure or purchase large group health insurance.” 83 Fed. Reg. 614, 615. In particular, the Department fails to quantify the likely attendant costs of a proliferation of AHPs on the existing individual and small group ACA markets.<sup>16</sup>

Agencies are obligated to provide reasons, not bare conclusions, to support an action. *Amerijet Int’l Inc. v. Pistole*, 753 F.3d 1343, 1350 (D.C. Cir. 2014) (“conclusory statements will not do; an agency’s statement must be one of reasoning”) (internal quotations omitted). Failing to quantify the costs of a proposal that could have as significant an impact on the health care market as this one would be arbitrary and capricious if absent in a final rule. *See Ctr. for Biological Diversity v. Nat’l Highway Traffic Safety Admin*, 538 F.3d 1172, 1201 (9th Cir. 2008) (“[T]here is no evidence to support [the agency’s] conclusion that the appropriate course was not to monetize or quantify the value of carbon emissions reduction at all.”).

## **B. The Proposed Rule’s Dual Treatment of Sole Proprietors as Both Employers and Employees Is Unlawful**

### **1. The Proposed Rule’s Treatment of Sole Proprietors Is Contrary to ERISA**

In a dramatic departure from judicial precedent interpreting ERISA, the Proposed Rule takes the unprecedented step of defining “sole proprietors” – referred to in the Proposed Rule as “working owners” – as both employers *and* employees. 83 Fed. Reg. 614, 621. This dual treatment of sole proprietors as employers and employees conflicts with ERISA and judicial interpretation of the statute’s text. *See* 29 U.S.C. § 1002(5). This precise question was squarely before the Second Circuit in *Marcella v. Capital Dist. Physicians’ Health Plan, Inc.*, 293 F.3d 42 (2d Cir. 2002). In *Marcella*, the court examined whether plaintiff, an independent contractor, could be a member of an AHP governed by ERISA. Membership in the plan at issue was open to “businesses with employees, but also to sole proprietorships without employees and to

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<sup>16</sup> Projections forecast that the Proposed Rule, if finalized, will lead to 3.2 million enrollees shifting out of the ACA’s individual and small group markets into AHPs by 2022 and that the Proposed Rule would increase premiums for those remaining in the individual ACA market by 3.5 percent. *See Association Health Plans: Projecting the Impact of the Proposed Rule*, Avalere (Feb. 28, 2018), <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf>.

individuals such as plaintiff, *neither of which can logically be considered an ‘employer’...*. 293 F.3d at 48 (emphasis added). The Second Circuit held that “[t]he plain language of the statute would, therefore, seem to preclude finding that the group is ‘a group or association of employers,’ because not all members of the Chamber are employers.” *Id.* (quoting Section 3(5) of ERISA).

The Department cites *Yates v. Hendon*, 541 U.S. 1 (2004), to support its argument that self-employed working owners can participate in large group coverage through an association even if they have no employees, but *Yates* asked a different question. In *Yates*, the Court held that a working owner (*i.e.* the employer) can also qualify as a participant of an ERISA plan only “[i]f the plan covers one or more employees other than the business owner and his or her spouse.” 541 U.S. at 6. In fact, the Court explicitly noted that “[c]ourts agree that if a benefit plan covers *only* working owners, it is not covered by Title I” of ERISA. *Id.* at 21, n. 6 (citing cases from the Second, Sixth, Ninth, and Eleventh Circuits) (emphasis added).

## **2. The DOL Does Not Offer Reasoned, Evidence-Based Rationales for Its “Working Owner” Definition as Both Employer and Employee**

The Proposed Rule’s expanded definition of “employer” to include sole proprietors also conflicts with well-established existing regulations. Most significantly, 29 C.F.R. § 2510.3-3(b) specifically excludes “any plan, fund, [and] program ... under which no employees are participants covered under the plan” from the definition of ERISA-covered plans, and uses the specific example of a plan where “only [] sole proprietor[s] are participants” as *not* covered by ERISA. *See id.* at (c)(1) (“[a]n individual and his or her spouse shall *not* be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse.”) (emphasis added). The Proposed Rule, which newly defines sole proprietors as employers and employees subject to ERISA, does not provide adequate justification for this significant proposed change.

Indeed, the Department acknowledges the strain of defining “sole proprietors” as both employers and employees, and attempts to minimize this well-established regulation, asserting its application is limited to “narrow circumstance” despite its previously broad application. 83 Fed. Reg. 614, 621. Ultimately, the Department is forced to concede that an amendment of current regulation may be the only way to avoid this irreconcilable conflict:

[T]o the extent the regulation could result in working owners not being able to participate as employees even in some circumstances, the Department believes the policies and objectives underlying this proposal support an amendment of the 29 CFR 2510.3-3 regulation so that it clearly does not interfere with working owners participating in AHPs as envisioned in this proposal.... Accordingly, and to eliminate any potential ambiguity regarding the interaction of this proposal with the regulation at 29 CFR 2510.3-3, this proposal also includes a technical amendment of paragraph (c) of 2510.3-3 to include an express cross-reference to the working owner provision in this proposal. 83 Fed. Reg. 614, 621-22.

The stated policies and objectives to support such a change do not provide adequate legal support. The Department ultimately invites comment on ways to ensure that working owners who join an AHP are genuinely engaged in a trade or business. 83 Fed. Reg. 614, 622. But similar to the loosening of bona fide association and commonality of interest requirements, the DOL does not support the proposition of working owners as both employers and employees with plausible justification for this significant – and illogical – change. Notwithstanding that this unprecedented dual treatment of working owners as employer and employee will open the door to negative consequences, the DOL has failed to present adequate explanation for its reversal of longstanding agency policy, judicial precedent, and existing regulations.

#### **IV. The Proposed Rule Conflicts with the ACA’s Statutory Scheme and Congressional Intent**

The intent of the Proposed Rule is not covert: the President himself plainly cited the sabotage of the ACA as the clear purpose of the Proposed Rule. While signing the Executive Order directing this rulemaking, he stated he was “taking crucial steps towards saving the American people from the nightmare of Obamacare,”<sup>17</sup> and tweeted the following day that “ObamaCare is a broken mess. Piece by piece we will now begin the process of giving America the great HealthCare it deserves!”<sup>18</sup> Just days ago, the President reiterated these points, saying at the Conservative Political Action Conference that “piece by piece by piece, Obamacare is just being wiped out.”<sup>19</sup> Given the President’s goal to destroy – rather than faithfully execute – the ACA, the Proposed Rule unsurprisingly conflicts with the ACA in its attempt to undermine the Act through executive means, as set forth in detail below.

*First, the Proposed Rule is contrary to and will undermine the ACA’s individual, small group and large group structure.* The ACA categorizes health plans as large group, small group or individual, offering the greatest protections to small group and individual plans.<sup>20</sup> In its simplest terms, the Proposed Rule seeks to expand the category of “large groups” so that the many consumers previously protected by the ACA’s individual and small group provisions will, through AHPs, become members of large group plans outside of many of the ACA’s protections. Specifically, the Proposed Rule provides that unrelated small employers and “working owners” may band together solely for the purchase of insurance to form a single large employer, thereby undermining the market structure set forth by the ACA, which defines these small employers as part of the small group market, and “working owners” as part of the individual market. 42 U.S.C. § 18024(a)(1)-(3). The ACA builds this small group and individual market structure into

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<sup>17</sup> Donald J. Trump, President of the U.S., Remarks at Signing of Executive Order Promoting Healthcare Choice and Competition (Oct. 12, 2017), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-executive-order-promoting-healthcare-choice-competition/>.

<sup>18</sup> Zachary Tracer, *Trump Moving ‘Step by Step’ to Take Apart Obamacare on His Own*, Bloomberg (Oct. 13, 2017, 2:46 PM), <https://www.bloomberg.com/news/articles/2017-10-13/trump-orders-an-end-to-key-obamacare-insurance-subsidies>.

<sup>19</sup> Mathew Yglesias, *Donald Trump’s CPAC Speech Is a Reminder That He’s Not Really in Charge of His White House*, Vox (Feb. 23, 2018, 1:10 PM), <https://www.vox.com/2018/2/23/17044770/trump-cpac-2018-speech>.

<sup>20</sup> 42 U.S.C. § 18024(a); *see, e.g.*, 42 U.S.C. § 300gg–6 (requiring individual and small group health plans to provide coverage for ten essential health benefits); *see also* CMS 2011 Guidance, *supra*, note 13.

the ACA itself, as well as the Public Health Services Act (“PHSA”) and ERISA.<sup>21</sup> The Proposed Rule, which candidly seeks to expand access to cheaper plans that do not have to abide by the ACA individual and small group rules, anticipates regulating these AHPs as large employers, and is thus in conflict with all three of these statutes. 83 Fed. Reg. 614, 615-16.

The ACA’s individual, small group and large group market structure is clearly defined in 42 U.S.C. § 18024 and 42 U.S.C. § 300gg–91(e). Each market receives different ACA protections, with the individual and small group markets afforded the greatest protections. For example, the ACA requires small group plans to utilize adjusted community rating to calculate premiums, which prevents insurers from varying premiums within a geographic area based on age, gender, health status, or other factors.<sup>22</sup> 42 U.S.C. § 300gg(a). The ACA also requires individual and small group plans to cover ten essential health benefits, including pediatric services, maternity care, prescription drugs and coverage for mental health services. 42 U.S.C. § 18022(b). Large group plans, in contrast, are not subject to community rating or essential health benefit mandates, or many other requirements, including premium restrictions based on health status, gender or age.<sup>23</sup> 42 U.S.C. § 300gg(a).

These ACA market designations are also effectuated through amendments to the PHSA, and certain of these reforms are imported directly into ERISA. *See* 29 U.S.C. § 1185d (as amended by § 1536(e) of the ACA) (importing requirements of 42 U.S.C. §§ 300gg through 300gg–28 into ERISA “as if included” in that Act).<sup>24</sup> For example, the essential health benefits and community rating requirements of the ACA, applying only to individual and small group

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<sup>21</sup> *See, e.g.*, 42 U.S.C. §§ 300gg(a)-300gg–28 (applying PHSA requirements to group plans based on market size); 29 U.S.C. § 1185d (provision of ERISA enacted by the ACA importing PHSA provisions into ERISA); 42 U.S.C. § 300gg–91(e) (defining individual and very small group market levels for purposes of imported PHSA provisions).

<sup>22</sup> ACA; Health Insurance Market Rules; Rate Review; Final Rule, 45 C.F.R. §§ 144.101–144.214, 147.100–147.200, 150.101–150.465, 154.101–154.301, 156.10–156.1256 (2013), *available at* <https://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf>.

<sup>23</sup> Large employers are required to provide their employees with insurance coverage or pay a penalty (“the employer mandate”). Through the employer mandate, the ACA imposes standards on the employer itself, rather than regulating the plan offered by the employer or the insurance issuer selling the plan. These standards include that employers must offer coverage that achieves 60% actuarial value as measured against essential health benefits, or be at risk of paying a penalty of up to \$3,000 per employee. 26 U.S.C. §§ 4980H(b), 36B(c)(2)(C)(ii). They must also provide a summary of benefits and coverage, and notice of the right to designate a primary care physician and gynecologist without prior authorization; set limits on out-of-pocket maximums; and comply with various reporting requirements. U.S. Senate, *The Patient Protection and Affordable Care Act as Passed Section-by-Section Analysis with Changes Made by Title X Included within Titles I – IX, Where Appropriate*, 1, 1-2, *available at* <http://www.dpc.senate.gov/healthreformbill/healthbill53.pdf> (last visited Mar. 5, 2018).

<sup>24</sup> 29 U.S.C. § 1185d (as amended by § 1563(e) of the ACA) inserted this language into ERISA: “[T]he provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart.” Part A of Title 27 of the PHSA covers §§ 300gg through 300gg–28 of Title 42. *See* 29 U.S.C. § 1185d(a)(2) (as amended by § 1563(e) of the ACA) (“[T]o the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.”).

plans, are incorporated into ERISA. 42 U.S.C. § 300gg–6.<sup>25</sup> Thus, ERISA itself was amended to incorporate the market structure and protections of the ACA.

In addition, in direct conflict with the Proposed Rule, the ACA provides that only in very narrow circumstances can employers join together to be treated as a single employer. This is achieved through the ACA’s incorporation of the “aggregation rules” from the Internal Revenue Code (“IRC”). These aggregation rules determine when multiple business entities should be treated as a single employer. The ACA incorporates the IRC’s aggregation rules, which state that an employer “treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 [the Internal Revenue Code of 1986]” should be treated as “1 [single] employer” for purposes of the ACA” (the “aggregation rule”). *See, e.g.*, 42 U.S.C. § 18024(b)(4)(A). Pursuant to these rules, businesses may be treated as a single employer when they are in a controlled group of corporations or under common control.<sup>26</sup> The ACA employs these aggregation rules in **eight** provisions.<sup>27</sup> Most significantly, 42 U.S.C. § 18024(b)(4)(A) uses the aggregation rule in order to determine employer size for small group and large group definitions; 26 U.S.C. § 45R(e)(5)(A) (as amended by § 1421 of the ACA) requires entities that meet the aggregation rule be considered a single employer for purposes of determining health insurance credits for small employers; and 26 U.S.C. § 4980H(c)(2)(C)(i) (as amended by § 1513 of the ACA) requires application of the aggregation rule to calculate employer size for the purpose of the employer mandate. Many of the provisions incorporated into ERISA include these narrow aggregation rules as well because they depend on the distinction between large and small group plans.<sup>28</sup>

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<sup>25</sup> *See also* 42 U.S.C. § 300gg(a)(1) (adjusted community rating for individuals and small group employers); § 300gg–1 (guaranteed availability of coverage); § 300gg–2 (guaranteed renewability of coverage); § 300gg–3 (prohibition of preexisting condition exclusions or other discrimination based on health status); § 300gg–5 (non-discrimination in health care); § 300gg–11 (no lifetime or annual limits); § 300gg–13 (coverage of preventive health services).

<sup>26</sup> In defining a “single employer,” the IRC looks to whether the employers operate under “common control,” perform functions (e.g. management services) for one another, or demonstrate a shareholder or partnership relationship; the IRC limits the “single employer” designation to companies that have a “common owner or . . . are otherwise related.” 26 U.S.C. §§ 414(b), (c), (m); *Determining If an Employer Is an Applicable Large Employer*, IRS, <https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer> (last updated Nov. 22, 2017).

<sup>27</sup> *See, e.g.*, 26 U.S.C. § 4980I(f)(9) (as amended by § 9001 of the ACA) (utilizing the aggregation rule to determine which entities are to be taxed for high cost employer-sponsored coverage); 26 C.F.R. 51.1 (describing regulations issued to “provide guidance on the annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs by section 9008 of the [ACA]”, which uses the aggregation rule to identify these branded prescription pharmaceutical manufacturers and importers); 26 U.S.C. § 162(m)(6)(C)(ii) (as amended by § 9014 of the ACA) (requiring “two or more persons” to be treated as “single employers” when identifying the covered health providers to which the ACA’s limitation on excessive remuneration applies); 26 U.S.C. § 125(j)(5)(D)(ii) (as amended by § 9022 of the ACA) (using a related aggregation rule for purposes of identifying eligible employers that maintain “simple cafeteria plans”); 26 U.S.C. § 48D(c)(2)(B) (as amended by § 9023 of the ACA) (identifying taxpayers that are eligible to receive the qualifying therapeutic discovery project credit by applying the aggregation rule).

<sup>28</sup> *See* 29 U.S.C. § 1185d (importing requirements of 42 U.S.C. §§ 300gg through 300gg–28 into ERISA “as if included” in that Act); 42 U.S.C. § 300gg–91(e) (defining market levels for purposes of 42 U.S.C. §§ 300gg through 300gg–28 in relation to aggregation rules); *see also* 42 U.S.C. § 300gg(a)(1) (describing community rating); § 300gg–6 (describing group plans that must cover essential health benefits).

Thus, the ACA – as well as the PHSA and ERISA itself – already have aggregation rules for determining when and for what purposes individuals and small employers should be grouped together to be considered a single large employer. The Proposed Rule – which seeks to allow *all* employers in common industry or close geographic location to form a “single large employer” – plainly conflicts with these narrow aggregation rules.<sup>29</sup> Such a vast new definition of “single large employer” far exceeds the ACA’s aggregation rules, as applicable under ERISA, the IRC, the PHSA, and the ACA, and therefore clearly conflict with these statutes.

In addition, the Proposed Rule’s new classification of “working owners” is directly inconsistent with the ACA. Under the ACA, including under provisions imported into ERISA by the ACA, sole proprietors without employees are treated as individuals – not as employers – protected by the individual market. *See, e.g.*, 42 U.S.C. § 300gg–91(d)(6), (e)(2), (e)(4) (defining “large employer” and “small employer,” and then defining “employer” to include “only employers of two or more employees”).<sup>30</sup> Moreover, the Proposed Rule offers neither justification nor evidence that the DOL considered the Rule’s effect on these various statutory schemes, nor did it suggest ways that the Rule’s conflict with law and prior guidance can be resolved (discussed *supra* Part III).

By enabling individual and small groups to be deemed large group plans, the Proposed Rule will allow associations made up of individuals and small employers to evade the ACA’s individual and small group protections. This will fulfill the goal of the Proposed Rule to avoid comprehensive coverage and facilitate the sale of cheaper plans “across State lines.” Exec. Order No. 13813, 82 Fed. Reg. 48385 (Oct. 17, 2017). In fact, AHPs formed pursuant to the Proposed Rule may be subject to even fewer requirements than large employers currently are, since there may be no *actual* employer – just an association created solely for the purpose of providing health coverage. Congress’s intent in enacting the ACA could hardly have been clearer: it established definitions for participation in and protections for large group, small group, and individual plans, and narrow rules for determining when multiple businesses can be treated as a single employer. It then applied those standards under ERISA “as if included” in that Act. This blatant attempt by the DOL to avoid the clear text and purpose of the ACA is contrary to law.

*Second, the Proposed Rule will undermine the fundamental ACA provisions that pool risk with the result of destabilizing small group and individual insurance markets.* Section 1312(c) of the ACA, “Single Risk Pool,” imposes rules on the individual and small group markets to create a diverse risk pool in order to ensure the provision of affordable health care for healthy

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<sup>29</sup> In particular, by crafting specific rules when applying ACA protections to group health plans under ERISA, Congress directly required the DOL to follow the IRC’s narrow aggregation rules, barring the Department from applying another standard it prefers under more general ERISA language as a means to undercut the ACA. *See RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012) (Scalia, J., for a unanimous court) (internal citations and quotation marks omitted) (“[I]t is a commonplace of statutory construction that the specific governs the general. That is particularly true where, as [here], Congress has enacted a comprehensive scheme and has deliberately targeted specific problems with specific solutions.”).

<sup>30</sup> The ACA also amends the PHSA (42 U.S.C. § 300gg–91) by incorporating: “The term ‘employer’ has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1002(5)], except that such term shall include only *employers of two or more employees*.” (emphasis added). Thus, the PHSA also defines employer owners without any employees as individuals, and not as employers.

and sick alike. 42 U.S.C. § 18032(c).<sup>31</sup> The Proposed Rule, again, conflicts with this structure, as AHPs will likely attract healthy individuals out of the existing individual and small group markets, and leave the remaining offerings to turn into “sick” plans whereby premiums will dramatically increase. This will leave those whom the ACA was implemented to help – the sick, elderly, those with preexisting conditions – with unaffordable or inadequate coverage.<sup>32</sup>

For example, since most AHPs will not be required to offer the ACA’s essential health benefits, they will opt not to include services that are more expensive or that are required by individuals with greater health care needs. For instance, while complying with the Proposed Rule’s non-discrimination provisions, an AHP could opt not to include maternity coverage. This would naturally dissuade potential members who plan to have children from joining the AHP, and they will likely obtain coverage from an ACA-compliant exchange plan. Or an AHP could choose not to cover mental health and substance use disorder treatment, again with the expectation that individuals who need or are likely to need these services for themselves or their families will obtain coverage on the ACA exchanges. The same motivations will cause AHPs to exclude other expensive benefits such as cancer treatment or certain prescription drugs. This market segmentation will lower prices for healthier individuals and groups in the AHPs, but cause premiums to spike (likely out of reach) for people who need these essential health care services – in direct conflict with the ACA’s goal of spreading risk, particularly within the small group and individual markets.<sup>33</sup>

The Proposed Rule will also encourage AHPs to form in those industries that attract a younger, healthier, and male workforce (*e.g.*, technology or engineering) or in those geographic areas that have healthier populations (*e.g.*, wealthy communities and/or non-rural areas). The Proposed Rule places no restrictions on this type of risk selection. The Proposed Rule dismisses these risks as speculative and argues that AHPs will also form in industries with older and less healthy workers by delivering sufficient administrative savings to offset the additional costs of insuring this population. 83 Fed. Reg. 614, 628-29. However, the DOL provides no evidence to support the proposition that AHPs can deliver administrative savings that an insurance company cannot. Indeed, all available evidence and analysis is to the contrary.<sup>34</sup>

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<sup>31</sup> The “single risk pool” provision is also referenced in the PHSA provisions imported into ERISA. *See, e.g.*, 29 U.S.C. § 1185d (importing 42 U.S.C. § 300gg, among other protections, into ERISA).

<sup>32</sup> Although the Proposed Rule’s non-discrimination provisions are beneficial, they are inadequate to ensure that AHPs are unable to structure themselves to attract healthier individuals and groups while dissuading individuals who may have a greater need for health care services from enrolling in the AHP. Indeed, we have repeatedly seen AHPs that are designed to do precisely this. (*See, e.g., supra* at Part II).

<sup>33</sup> The Proposed Rule speculates that because large employers do not offer skimpy coverage to their employees, AHPs likely will not do so either. 83 Fed. Reg. 614, 628. However, there are fundamental differences between large employers and AHPs that the Proposed Rule simply ignores. Large employer plans typically provide comprehensive benefits because large employers employ a diverse set of individuals with varying health needs and must offer benefit packages to satisfy all current and potential employees. AHPs, on the other hand, allow self-employed individuals and small businesses to pick their insurance plan based on the particular coverage that they need at the time given their current health needs. These individuals and small groups have every reason to enroll in skimpy, cheap coverage that appeals to their own narrow demographic group or health profile.

<sup>34</sup> *See, e.g.*, Mark Hall, et al., *HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed*, HEALTH AFFAIRS 20(1): 142-53 (2001), available at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.20.1.142> (identifying numerous alternative means to save on health care coverage costs); Kaiser Family Foundation et al., *Employer Health Benefits 2017 Annual Survey*, KAISER FAMILY FOUND. (2017), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017> (presenting findings on



These consequences are in clear violation of the language and purpose of the ACA. Also clear is the APA's prohibition against rulemaking in conflict with established law, and as such, the Proposed Rule violates the APA.

## **V. The Proposed Rule Is Contrary to Longstanding DOL Interpretation of ERISA That Has Been Ratified by Congress**

Not only is the Proposed Rule contrary to the ACA in key respects, but it also is contrary to the DOL's longstanding interpretation of "bona fide association." Congress has ratified this longstanding interpretation over decades in a series of statutory schemes, including and most notably in the ACA, which was the capstone of Congress's decades-long efforts to address access to health care through individual and group insurance markets.

As the Supreme Court has explained, "[w]here an agency's statutory construction has been 'fully brought to the attention of the public and the Congress,' and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned." *N. Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 535 (1982) (citation omitted); *see, e.g., Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 846 (1986) ("It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the 'congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress.'") (citation omitted).

As set forth *supra* in Parts I through III, the DOL has long maintained that only a "bona fide association" of employers bound by a "commonality of interest" can meet the definition of "employer" under 29 U.S.C § 1002(5).<sup>35</sup> The Department has consistently held that most MEWAs are not regulated by ERISA as employee welfare benefit plans, and indeed that ERISA itself forecloses such an interpretation, unless such entities qualify as "bona fide associations" under these well-established, narrow principles. *See e.g.,* Brief for Petitioner-Appellant DOL at \*7, *Donovan v. Dillingham*, 668 F.2d 1196 (11th Cir. 1982) (No. 80-7879) ("[T]he statutory language of ERISA precludes a finding that a single, umbrella-like ERISA plan has been created in these cases."); *see also Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982) ("An issue in other cases has been whether a multiple employer trust – the enterprise – is itself an

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strategies that private and non-federal public employers have used to shift health care costs to employees and thus reduce employer costs of health care coverage provision).

<sup>35</sup> *See, e.g.,* DOL Adv. Ops., 80-40A, 1980 ERISA LEXIS 38 (July 9, 1980) ("bona fide" association depends on a number of factors, including control by employers over association, but does not cover "several unrelated employers" executing trust agreements as a means to fund benefits); 91-42A, 1991 ERISA LEXIS 49 (Nov. 12, 1991) ("[W]here several unrelated employers merely execute similar documents or otherwise participate in an arrangement as a means to fund benefits, in the absence of any genuine organizational relationship among the employers, no employer association, and consequently no employee welfare benefit plan, can be recognized."); 2008-07 A, 2008 ERISA LEXIS 8 (Sept. 26, 2008) (rejecting local chamber of commerce's request to be an ERISA employee welfare benefit plan); 2017-02 AC, ERISA LEXIS 2 (May 16, 2017) ("The Department has expressed the view that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of ERISA section 3(5).").

employee welfare benefit plan. The courts, congressional committees, and the Secretary uniformly have held they are not.”).

The ACA directly included the phrase “bona fide association” in the components of the statute applicable under the PHSAs and ERISA. As noted above, Congress imported key protections from Title 27 of the PHSAs into ERISA “as if included in” that Act. *See* 29 U.S.C. § 1185d (as amended by § 1563(e) of the ACA). Among the imported provisions is a guaranteed-renewability protection, *see* 42 U.S.C. § 300gg–2, that relies on the phrase “bona fide association,” defined with a series of elements, such as five years of active existence and being “formed and maintained in good faith *for purposes other than obtaining insurance.*” *See* 42 U.S.C. § 300gg–91(d)(3) (emphasis added). As relevant here, the guaranteed-renewability provision requires a health insurance issuer in the large or small group market to “renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable,” except in connection with a series of exceptions, one of which involves when an employer in the small or large group markets ceases to be a member of a “bona fide association.” *Id.* § 300gg–2(b)(6). In short, Congress in the ACA imported into ERISA’s plain text the phrase “bona fide association,” along with its attendant narrow definition, effectively ratifying the DOL’s longstanding interpretation of that term.

Even prior to the ACA’s enactment, Congress had amended ERISA and the interlocking statutes related to health plans in the IRC and PHSAs numerous times based on the DOL’s firmly settled interpretation. *See, e.g.,* Consolidated Omnibus Budget Reconciliation Act (“COBRA”), Pub. L. No. 99-272, § 10001, 100 Stat. 82, at 222-23 (1986) (amending, *inter alia*, 26 U.S.C. § 106(b)); *id.* § 10002, 100 Stat. 82, at 227-31 (codified at 29 U.S.C. §§ 1161-69) (whereby Congress applied the narrow aggregation rules from the IRC, suggesting that Congress foreclosed a broad interpretation of “employer” that would group together many unrelated businesses in a single large group); and Health Insurance Portability and Accountability Act (“HIPAA”), Pub. L. No. 104-191, 110 Stat. 1936, at 1964-66, 1982 (1996) (reflecting continued congressional judgment that unrelated small employers cannot simply be interpreted as one large employer at the DOL’s discretion, including through a definition of “bona fide association”).

Given these key statutory schemes creating health plan protections for consumers, and these statutes’ reliance on DOL definitions, Congress has not left the Department with broad discretion to depart so drastically from a settled understanding of how business entities may be treated as one employer in these interlocking statutes.<sup>36</sup> In short, through a long line of enactments establishing and amending interlocking statutory regimes, Congress long ago ratified the DOL’s narrow conception of “bona fide association” and accordingly barred the Department from so fundamentally altering the established edifice of federal regulation of individual and group health insurance.

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<sup>36</sup> For example, HIPAA enacted Section 2791 of the PHSAs, which defined “large employer” as an employer with an average of at least 51 employees during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. Pub. L. No. 104-191, § 102, 110 Stat. 1936, at 1975-76. That section defined “small employer” as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.” *Id.* at 1976. Like provisions earlier enacted in COBRA, and later enacted in the ACA, this HIPAA provision relied on the IRC’s narrow aggregation rules. *Id.*

## VI. The DOL Should Not Exempt AHPs from State Regulation

The Proposed Rule also invites comment as to whether the DOL should seek to exercise its never-before-used authority to issue regulations that would exempt AHPs from most state insurance regulation and enforcement. 83 Fed. Reg. 614, 625. The history detailed above (in Part II) shows that this would be a tremendous mistake. Exempting AHPs from state insurance laws would allow fraudulent or improperly managed health plans to operate without fear of detection or punishment until after the damage has been done. The result would be policyholders with unpaid medical bills and health care providers who are not paid for their services. Since exercising this authority would require new regulations, if the DOL decides to explore this misguided idea further, it should issue a separate proposed rulemaking with an opportunity for notice and comment regarding the intended use of this exemption. *See* 29 U.S.C. § 1144(b)(6)(B).

To date, the DOL does not have, and has not sought, the regulatory or enforcement resources to step into the States' shoes and become the primary regulator of AHPs. Furthermore, the Department does not have, and has not proposed, federal financial or other insurance standards to protect beneficiaries from the serious consequences that result when an AHP cannot or does not pay medical claims. Exempting AHPs from state regulation would threaten the health and financial security of individuals and small employers throughout the country.

Indeed, States and State Attorneys General have extensive experience protecting individuals and small employers from predatory entities that seek to defraud or deceive customers through the use of associations. Some examples include:

- In 2007, the operators of an association that deceptively marketed its discount health plan products to Massachusetts residents as “Affordable Healthcare Plans” and “Top Rated Insurance” were ordered to pay restitution to the defrauded consumers, a substantial civil penalty and attorney’s fees, and were permanently enjoined from engaging in various conduct in Massachusetts.<sup>37</sup>
- In 2009, pursuant to a consent judgment following Massachusetts’ consumer protection lawsuit, HealthMarkets, Inc. and its subsidiaries were ordered to pay \$17 million, resulting from unfair and deceptive practices through the sale of insurance products packaged with memberships in three different associations.<sup>38</sup>
- In 2011, the United States Life Insurance Company in the City of New York agreed to pay full restitution to consumers whom it required to join associations and to whom it misrepresented the terms, benefits, and (very limited) coverage

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<sup>37</sup> Compl. at ¶ 19, *Commonwealth of Mass. v. Nat’l Alliance of Assocs. Professional Benefit Consultants, Inc. et al.*, Compl. No. 09-1404B (Mass Super. Ct. Apr. 6, 2009).

<sup>38</sup> *See* Press Release, Att’y Gen. of Mass., *AG Martha Coakley Reaches \$17 Million Settlement with Health Insurers Regarding Unfair and Deceptive Conduct* (Aug. 31, 2009), <http://www.mass.gov/ago/news-and-updates/press-releases/2009/ag-reaches-17-million-settlement-with-health.html>.

provided by its plans, as well as the fact that the policies had not been approved for sale in Massachusetts.<sup>39</sup>

- In 2015, Unified Life Insurance Co., agreed to pay \$2.8 million in restitution and civil penalties as a result of its deceptive and unlawful selling of sold short-term health insurance that was not authorized for sale in Massachusetts, but which it deceptively marketed through a third-party association.<sup>40</sup>
- In 2001, the Maryland Insurance Administration fined and revoked the registration of a MEWA administrator that engaged in “illegal and dishonest practices” such as failing to register as an insurer as required by state law, failing to pay premiums for stop-loss insurance contrary to representations made to employer members (and thereby exposing these employers to unexpected losses), and failing to pay claims for insured employees. *Md. Ins. Admin. v. SAI Med Health Plan, LLC*, No. MIA-6-1/01 (Md. Ins. Admin. Jan. 16, 2001).
- In 2005, the Maryland Insurance Administration fined and revoked the licenses of a MEWA’s administrator for failing to register with the state as required by law and making material misrepresentations regarding the relationship of the MEWA to the insured employees and, overall, engaging in conduct that was “dishonest and lacked ... trustworthiness and competence.” *Md. Ins. Admin. v. Dennis Kelly, et al.*, No. MIA-2005-07-004 (Md. Ins. Admin. Mar. 30, 2007).
- From the 1980s through the early 2000s in California, AHP failures hurt employees across many different industries. For example, thousands of California farm workers suffered when a plan created by Sunkist Growers collapsed, leaving nearly 5,000 medical providers with an estimated \$10 million in unpaid claims. Similarly, when Rubell-Helms Insurance Services went out of business, it reportedly left \$10 million in legitimate medical claims unpaid.<sup>41</sup>

Over many years, state enforcement efforts and oversight have lessened AHP fraud. Since the ACA, this success combined with the development of our state and federally facilitated health exchanges has resulted in consumers having comprehensive and reliable health coverage. Relatedly, our states have made great strides in decreasing the uninsured rate since the ACA. This is largely due to the confluence of a range of affordable plans together with one single risk pool with the same premiums paid by all members of a plan. For example, in New York, the

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<sup>39</sup> See Press Release, Att’y Gen. of Mass., *Health Ins. Co. to Pay \$760,000 for Unlawfully Selling Unauthorized Health Ins. in Mass. and Failing to Cover Mandated Benefits* (Apr. 25, 2011), <http://www.mass.gov/ago/news-and-updates/press-releases/2011/health-insurance-company-to-pay-760000.html>.

<sup>40</sup> See Press Release, Att’y Gen. of Mass., *Ins. Co. to Pay \$2.8 Million to Resolve Claims of Unlawful, Deceptive Sales of Health Ins. Sold Across State Lines* (Apr. 4, 2017), <http://www.mass.gov/ago/news-and-updates/press-releases/2017/2017-04-04-insurance-company-to-pay-2-8-million.html>.

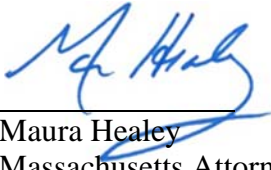
<sup>41</sup> See Melinda Fulmer & Ronald D. White, *Sunkist’s Health Plan Collapses*, L.A. Times, Jan. 4, 2002, available at <http://articles.latimes.com/2002/jan/04/business/fi-sunkist4>; Robert L. Jackson, *Health Insurance ‘Pyramid’ Scams Examined: Hearing: Authorities Tell a Senate Panel That Irvine-Based Rubell-Helm Insurance Services Is among Firms under Scrutiny for Allegedly Taking Premiums and Not Paying Large, Legitimate Claims*, L.A. Times, May 16, 1990, available at [http://articles.latimes.com/1990-05-16/business/fi-362\\_1\\_health-insurance](http://articles.latimes.com/1990-05-16/business/fi-362_1_health-insurance).

uninsured rate dropped from 10% to 5%; in California, it dropped from 17% to 7%; in Illinois, from 14% to 6.5%; in Maryland, from 10% to 6%; and in Delaware, from 9% to 6%. In Massachusetts, the uninsured rate has dropped from more than 10% before it enacted health reform in 2006 to less than 4% today. The success of our state and federally facilitated exchanges, and our future success in decreasing the rates of uninsureds is likely to be impacted by any exemption from state regulations that govern the types of AHPs that are envisioned in the Proposed Rule.

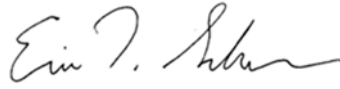
## VII. Conclusion

For the reasons set forth above, the States strongly oppose the Proposed Rule and urge that it be withdrawn.

Sincerely,



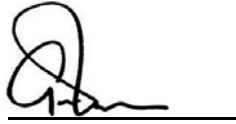
Maura Healey  
Massachusetts Attorney General



Eric T. Schneiderman  
New York Attorney General



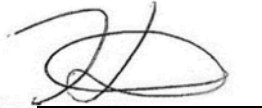
Xavier Becerra  
California Attorney General



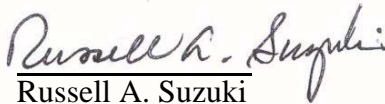
George Jepsen  
Connecticut Attorney General



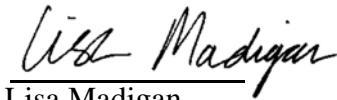
Matthew P. Denn  
Delaware Attorney General



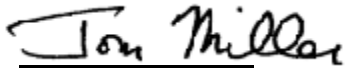
Karl A. Racine  
Attorney General for the District of Columbia



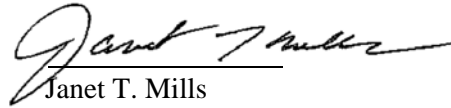
Russell A. Suzuki  
Acting Attorney General, State of Hawai'i



Lisa Madigan  
Illinois Attorney General



Tom Miller  
Iowa Attorney General



Janet T. Mills  
Maine Attorney General



Brian E. Frosh  
Maryland Attorney General



Gurbir S. Grewal  
New Jersey Attorney General



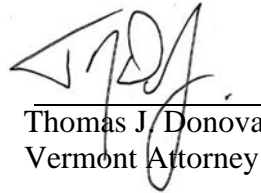
Hector Balderas  
New Mexico Attorney General



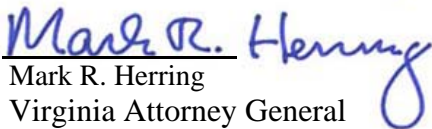
Ellen F. Rosenblum  
Oregon Attorney General



Josh Shapiro  
Pennsylvania Attorney General



Thomas J. Donovan Jr.  
Vermont Attorney General



Mark R. Herring  
Virginia Attorney General