February 19, 2024

*Submitted via http://www.regulations.gov*

Julie Su
Secretary, Department of Labor

Lisa M. Gomez
Assistant Secretary, Employee Benefits Security Administration

U.S. Department of Labor
Attention: Proposed Rescission of AHP Final Rule RIN 1210–AC16
Room N–5655, 200 Constitution Ave. NW
Washington, D.C. 20210

**RE: Definition of "Employer"-Association Health Plans (**RIN 1210–AC16)

Dear Secretary Su and Assistant Secretary Gomez:

We write on behalf of the Credit Union Consortium, Inc. to respond to the Proposed Rule, "Definition of 'Employer'-Association Health Plans," as published in the Federal Register by the Department of Labor ("DOL" or "Department") on December 20, 2023 (88 Fed. Reg. 87968).

The Credit Union Consortium, Inc. (the "Consortium") is an Indiana-based alliance of credit unions. The Consortium was created on September 15, 2017 with five initial credit union members. The Consortium now covers a total of 3,609 employees across 73 credit unions currently participating in an Association Health Plan ("AHP"). The Consortium is governed by nine trustees. The Trustees are nominated and elected by the participating credit unions in accordance with DOL Advisory Opinion 2017-02AC. The Consortium serves as the plan sponsor of the AHP. All participating credit unions must be members of the Indiana Credit Union League, Inc. ("the League").

The League is a trade association that serves credit unions. The League was initially chartered in 1925 and incorporated August 16, 1935 under The Indiana General Not For Profit Corporation Act. It was the first credit union league in the Midwest and the second one in the country. The League is a nonprofit Indiana corporation and has been recognized as exempt from federal and state income taxes as an organization described in Internal Revenue Code Section 501(c)(6). The League assists its members: (a) through advocacy efforts that protect and further credit union interests; (b) by offering consultation, legislative, and regulatory support to credit unions; and (b) by providing public relations, operational and technical assistance, education, and training.

The Consortium seeks to ensure that its members can continue to offer their employees and dependents generous and comprehensive healthcare coverage. The Consortium's AHP offers an efficient pathway for our credit union members to provide their employees affordable and high-

quality healthcare coverage that may otherwise be costly or burdensome to administer under other coverage options. We appreciate the opportunity to respond to the Proposed Rule regarding AHPs and thank the Department for considering our comments in light of our real-world experience operating and participating in an AHP.

We do not object to the DOL's initiative to rescind the 2018 AHP Final Rule ("2018 Final Rule"), 83 Fed. Reg. 28912, published in the Federal Register on June 21, 2018, to better align the AHP regulations with the Employee Retirement Income Security Act's ("ERISA") text, purpose, and policies. Along with providing low-cost and comprehensive healthcare to our members, our primary goal is to ensure our AHP is compliant with ERISA, its implementing regulations, and the Department's subregulatory guidance. To that end, we have carefully designed our AHP to comply with the DOL Advisory Opinion 2017-02AC. We are therefore troubled by the Department's requests for comment regarding whether it should abandon its prior guidance contained in advisory opinions and draft alternative criteria for defining an "employer" for purposes of a sponsoring an AHP. We also strongly disagree with any effort by the Department to add new requirements on the design and structure of AHPs. AHPs have relied on the Department's historical guidance establishing unique pathways for forming a bona fide association for decades. These pathways allow for AHPs to be customized to a particular group of employers' needs and have provided a meaningful source of coverage for employers in the majority of the United States for over three decades.

AHPs offer employers expanded autonomy and opportunity to design healthcare benefits tailored to their employees' needs and their budgetary constraints. Over the past decades, the DOL's flexible AHP framework has increased the availability of coverage to millions of Americans and allowed the AHP and small group markets to not only coexist but thrive, side-by-side. We urge the Department to avoid disrupting the AHP marketplace through regulation in excess of the stringent requirements already imposed by ERISA and state insurance laws. Below, we have provided specific comments in support of the DOL eschewing disruption of the AHP marketplace through deference to its historical guidance. We call for the Department to avoid imposing new and formulaic requirements upon AHPs that will divert employers' resources from employees' and dependents' healthcare coverage to administrative costs without any tangible benefit to employers, employees, or the dependents of employees.

## I. The Department Should Adhere to its Historical View of AHPs that Predates the 2018 Final Rule.

Until the promulgation of the 2018 Final Rule, the Department has maintained and supplemented a substantial body of guidance that establishes the particular pathways available for an AHP to comply with the text and purpose of ERISA, *i.e.*, the requirements that an association must meet to constitute a bona fide association for purposes of sponsoring a single, large employer plan. For nearly thirty years, the reasonable growth in the AHP market has demonstrated that employers value the opportunity to select AHPs both because of the high-quality coverage available, and the fact that they offer a more efficient and cost-effective means to provide coverage to employees through consolidation of healthcare needs with other employers in the same industry. Under this guidance, employers with common economic interests efficiently procure high quality health coverage options for their employees. AHPs have added to the richness in choice for

healthcare coverage products and allowed large and small employers the flexibility to pool resources to offer the highest quality of healthcare possible for their employees at affordable prices.

The resources an AHP would be required to employ to comply with new administrative requirements will directly undermine the efficiencies in resource allocation gained by providing innovative and comprehensive healthcare coverage to employers' employees and dependents through the association model, with robust controls in place to ensure that the core protections of ERISA remain intact. Of course, as multiple employer welfare arrangements ("MEWAs"), AHPs are subject not only to the requirements of ERISA, but also to state law insurance regulations either through the regulation of the MEWA itself (if self-funded) or through state regulation of the insurance policy (if insured). Indiana state law already requires self-funded MEWAs to fund one hundred percent (100%) of the aggregate retention plus all costs of the MEWA. 760 Ind. Admin. Code 1-68-2. Implementing new or differing formulaic criteria for AHPs to fulfill would undermine the best practices built by employers over decades under the DOL's advisory opinions and create a challenging and expensive process that produces limited to no tangible benefit for enrollees.

The Department avails itself of significant benefits by deferring to its prior guidance. A key benefit of the Department's approach prior to 2018 enabled the DOL to avoid rigid tests and deploy a fact- and circumstance-specific approach for determining whether an AHP was properly considered a bona fide employer group or association. *See* Advisory Opinion 2003-13A. The DOL's historical approach to regulation of AHPs has generally supported employers' efforts to provide healthcare benefits by permitting different pathways for AHP formation that account for employers' unique needs, which may differ depending on their industry and finances, among other factors. *See, e.g.*, Adv. Op. 2019-01A (July 8, 2019); Adv. Op. 2005-20A (Aug. 31, 2005). These distinct pathways to compliance would be extremely challenging to distill into a single regulation, and likely disrupt the coverage currently being offered through AHPs, notwithstanding the fact that this coverage currently complies with the requirements of ERISA, state insurance law, and the Affordable Care Act. Moreover, the lengthy formal rulemaking process would hinder the DOL from contemporaneously responding to industry trends while also restricting industry exploration of new arrangements that could pool employers' resources more efficiently to maximize the healthcare benefits available to employees and their dependents.

The Department's three criteria (the business purpose standard, commonality standard, and control standard) and the many factors it evaluates already serve to screen out bona fide associations from those that fail to meet the definition of an employer under ERISA. *See, e.g.*, Adv. Op. (February 13, 1995); Adv. Op. 88-07A (March 28, 1988). If the DOL moved to create a new and separate requirement around rating practices within the AHP, the Department would be reaching beyond its statutory authority rooted in ERISA section 3(5) and replacing Congress' definition of "employer" with its own construction of how associations act indirectly on behalf of the employer, disregarding the fact that such definition has not been annunciated by courts or previously by the Department. Importantly, the Department's historical and current regulatory guidance requires a genuine organizational relationship between the employers in a bona fide AHP for purposes of ERISA section 3(5). This well-understood element of being a bona fide association ensures that the association, as the plan sponsor, remains accountable to and serves in the interest of both the plan and the participating employees of the relevant employers who offer

coverage through the AHP. In this capacity, AHPs under the pre-2018 guidance closely balance the need to ensure the ongoing viability of the AHP and the economic and rating needs of individual employers.

The Department acknowledges in the preamble to the Proposed Rule that guidance pre-dating the 2018 Final Rule has been consistent with caselaw interpreting ERISA. Specifically, the Department stated its guidance is "consistent with the criteria articulated and applied by *every* appellate court, in addition to several federal district courts, that considered whether an organization was acting in the interests of employer-members." 88 Fed. Reg. at 87969 (citing, in part, *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 786–87 (3d Cir. 1998); *MD Physicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 185–86 (5th Cir. 1992); *Wisconsin Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1062–65 (8th Cir. 1986)) (emphasis added). A new rule altering the design of AHPs would face the scrutiny of the courts and invite a deluge of litigation from regulated entities and stakeholders, diverting resources away from healthcare coverage. By adhering to established ERISA caselaw precedent, the DOL would avoid displacing carefully crafted and cognizable standards for AHPs and unwarranted disruption to the AHP marketplace.

We request the DOL preserve its functioning body of guidance that AHPs have depended upon for decades and invested significant resources into complying with. The existing fact-specific framework enables the Department to create tailored advisory opinions for regulated entities and align its guidance with industry developments, which helps promote stability in an important sector of the healthcare delivery system in this country. If the DOL believes additional regulatory oversight is needed, we encourage the Department to collaborate with the industry to address the continuously evolving and novel issues that impact the provision of healthcare coverage. In particular, we strongly encourage the DOL to resume issuing advisory opinions to MEWAs, as to whether the MEWA meets the Department's interpretation of ERISA's "employer" definition. As MEWAs face significant compliance obligations federally and at the state-level, advice and support from the Department in overcoming regulatory challenges would be most welcome.

## II. The Department Should Preserve its Existing Health Insurance Portability and Accountability Act Nondiscrimination Policy.

A key component of an AHP's value proposition to employers is the ability to offer comprehensive medical care as financially efficiently as possible. As the Department knows, employers large and small have the choice to offer their employees and their dependents medical care – and small employers are under no legal mandate to do so. The success of the AHP market within the last decade indicates that employers value the opportunity to pool their resources to access healthcare plans that meet their employees' unique needs. Employers are more than capable of examining an AHP to determine if a given plan is within their budget, if the coverage is best suited for their employees' health care needs, and if the AHP meets their overall service expectations. For nearly thirty years, the Department has issued guidance and regulations that support the ability of employers to make informed choices about their health insurance coverage and have the flexibility to choose AHPs amongst other forms of coverage under certain conditions.

A key to this dynamic is the flexibility for AHPs to develop premium rates on an employer-by-employer basis, which limits cross-subsidization between participating employers, and ensures that the AHP offers affordable coverage that meets the needs of the relevant group of employees. While weighing whether to pursue additional regulatory action, we ask the Department to preserve the ability of AHPs that meet the pre-2018 guidance to experience rate consistent with state insurance law, as it is an essential feature these plans depend upon to offer affordable and comprehensive coverage.

Notably, some, if not most, of the employers that participate in AHPs would not offer coverage at all but for the existence of the AHP. Accordingly, any additional regulatory effort that limits the financial benefits of offering coverage through an AHP could create significant disruption in the coverage currently in place for millions of Americans.

The experience rating techniques employed by the Consortium, and many other AHPs, comply with ERISA and the Health Insurance Portability and Accountability Act's ("HIPAA") nondiscrimination rules. Importantly, individual employees (and their dependents) are not singled out based on their claims experience. ERISA § 702(b). Like single employer plans, AHPs may not discriminate (including in premium rates) with respect to eligibility for a "similarly situated individual" on the basis of a health-status factor. Under HIPAA, an AHP is only permitted to consider health factors to determine aggregate premiums. With respect to treating separate employers' employee populations as separate similarly situated groups (the basis for AHPs to currently rate different member employers separately), protections are already in place for determining whether an employer member is its own similarly situated group. Such a distinction must be based on a "bona fide employment-based classification consistent with the employer's usual business practices." 29 CFR § 2590.702(d)(1). The Department has provided clarification on what constitutes a bona fide classification, such as distinguishing employer members based on their full-time versus part-time status, geographic locations, dates of hire, lengths of service, or occupations. The regulations further provide that a classification based on a health factor would not be "bona fide" distinction if it is intended to target an individual based on a health factor (such as for filing an expensive claim). 29 CFR § 2590.702(d)(3). Under existing law, individual employees as well as employer members are adequately protected from discrimination by AHPs based on health status and other inappropriate criteria, so that employer-by-employer rating does not directly relate back to an individual's health status.

The Department should also recognize that the relaxed standards included in the 2018 Final Rule necessitate greater non-discrimination protections with respect to setting of premium rates. This is so because AHPs under the 2018 Final Rule lacked the same level of commonality of economic interest than under the pre-2018 guidance. So, for example, an AHP offered pursuant to the 2018 Final Rule might include an employer with a higher-risk profile as a matter of the nature of the employer's business, like coal mining, and a lower risk employer, like a yoga studio. Allowing rating by group in that situation would more clearly base rating on an individual or individuals health status. Whereas, under the pre-2018 guidance, commonality of trade, occupation, or profession, effectively prevents against that type of discriminatory rating practice.

Employers are free to choose to both offer healthcare coverage and offer the coverage through an AHP. Other alternative forms of coverage also remain an attractive option for some

employers. For example, community-rated plans remain a competitive option for small employers and may better match the healthcare needs of employees of many small employers over an AHP option. If the DOL revisited the nondiscrimination rules for AHPs by eliminating or undercutting the ability of AHPs to price the cost of coverage on an employer-by-employer basis, many employers may drop coverage altogether or pursue less comprehensive plans because the AHP is no longer capable of offering cost effective coverage. Accordingly, we urge the Department to refrain from altering the substantive requirements that apply with respect to AHPs established under the DOL's decades of guidance and to continue to partner with the industry through continued publication of advisory opinions for AHPs and by providing additional regulatory supports and insights to MEWAs.[1]

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We thank the Department for considering our comments regarding the important role of AHPs in promoting employers' access to efficient, high quality, and affordable healthcare. We urge the Department to adhere to its historical guidance and avoid disruption of the AHP market through imposition of new or formulaic requirements upon AHPs. We further ask the Department to promote employers' ability to choose a health plan best suited for their employees' health needs and their financial wellbeing by preserving the ability of AHPs to continue to provide experience rated comprehensive healthcare coverage.

We welcome the opportunity to further collaborate with the Department or share additional information. Please do not hesitate to contact us with any questions about this comment or for additional information.

Sincerely,

*/s/ Ryan C. Temme*
Ryan C. Temme

[1] We note that, in our view, the request for comments included in the Proposed Rule addresses only the threshold question of whether the Department should engage in a separate rulemaking process codifying existing subregulatory guidance, and not whether the Department should codify that guidance in the process of finalizing the Proposed Rule. We would not view any rulemaking outside the scope of the 2018 Final Rule as being a logical outgrowth of the Proposed Rule on which we comment today.