UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK, et al., Plaintiffs, v. U.S. DEPARTMENT OF LABOR, et al., Defendants.	Civil Action No. 1:18-cv-01747-JDB

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56, Plaintiffs hereby move for summary judgment on the grounds that there is no genuine issue of disputed material fact and that they are entitled to judgment as a matter of law.

In support of this motion, Plaintiffs submit the accompanying (1) memorandum of law; (2) declarations in support; and (3) a proposed order.

Dated: August 23, 2018

Respectfully Submitted,

BARBARA D. UNDERWOOD
Attorney General
State of New York

By: */s/ Sara H. Mark*
Sara H. Mark, Special Counsel
Matthew Colangelo (D.C. Bar No. 997893), Executive Deputy Attorney General
Steven C. Wu (D.C. Bar No. 975434), Deputy Solicitor General
Lisa Landau, Bureau Chief
Eric R. Haren (D.C. Bar No. 985189), Special Counsel & Senior Advisor
Elizabeth Chesler, Assistant Attorney General

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts

By: */s/ Eric M. Gold*
Eric M. Gold, Assistant Attorney General
Stephen B. Vogel, Assistant Attorney General

Health Care Division
Office of the Attorney General
One Ashburton Place
Boston, MA 02108
Phone (617) 727-2200
eric.gold@state.ma.us

Matthew W. Grieco, Assistant Solicitor General
Susan J. Cameron, Deputy Bureau Chief

Office of the New York State Attorney General
Health Care Bureau
28 Liberty St., 19th Floor
New York, NY 10005
Phone: (212) 416-6305
Matthew.Colangelo@ag.ny.gov
stephen.vogel@state.ma.us

KARL A. RACINE
Attorney General
District of Columbia

By: */s/ Robyn R. Bender*
Robyn R. Bender (D.C. Bar No. 465117), Deputy Attorney General
Andrew J. Saindon (D.C. Bar No. 456987), Senior Assistant Attorney General
Valerie M. Nannery (D.C. Bar No. 488529), Assistant Attorney General

Public Advocacy Division
441 4th Street, NW
Suite 630 South
Washington, DC 20001
Phone: (202) 724-6610
Robyn.Bender@dc.gov
Andrew.Saindon@dc.gov
Valerie.Nannery@dc.gov

XAVIER BECERRA
Attorney General
State of California

By: */s/ Julie Weng-Gutierrez*
Julie Weng-Gutierrez, Senior Assistant Attorney General
Kathleen Boergers, Supervising Deputy Attorney General
Nimrod P. Elias, Deputy Attorney General
Karli Eisenberg, Deputy Attorney General

Office of the Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Phone: (916) 210-7913
Julie.Wenggutierrez@doj.ca.gov
Kathleen.Boergers@doj.ca.gov
Nimrod.Elias@doj.ca.gov
Karli.Eisenberg@doj.ca.gov

MATTHEW P. DENN
Attorney General
State of Delaware

By: */s/ Ilona Kirshon*
Ilona Kirshon, Deputy State Solicitor
Jessica M. Willey, Deputy Attorney General

Department of Justice
Carvel State Building, 6th Floor
820 North French Street
Wilmington, DE 19801

ANDY BESHEAR
Attorney General
Commonwealth of Kentucky

By: */s/ J. Michael Brown*
J. Michael Brown, Deputy Attorney General
La Tasha Buckner, Assistant Deputy Attorney General
S. Travis Mayo, Executive Director, Office of Civil and Environmental Law
Taylor Payne, Assistant Attorney General

Phone: (302) 577-8400
Ilona.Kirshon@state.de.us
Jessica.Willey@state.de.us

Office of the Attorney General
700 Capitol Avenue
Capitol Building, Suite 118
Frankfort, Kentucky 40601
Phone: (502) 696-5300
Travis.Mayo@ky.gov
Taylor.Payne@ky.gov

BRIAN E. FROSH
Attorney General
State of Maryland

By: */s/ Steven A. Sullivan*
Steven A. Sullivan, Solicitor General
Kimberly S. Cammarata, Director, Health Education and Advocacy

200 St. Paul Place
Baltimore, MD 21202
Phone: (410) 576-7038
ssullivan@oag.state.md.us
kcammarata@oag.state.md.us

GURBIR S. GREWAL
Attorney General
State of New Jersey

By: */s/ Matthew J. Berns*
Matthew J. Berns (D.C. Bar No. 998094), Assistant Attorney General
Jeffrey S. Posta, Deputy Attorney General

Department of Law and Public Safety
Office of the Attorney General
Richard J. Hughes Justice Complex
25 Market Street, 8th Floor, West Wing
Trenton, NJ 08625-0080
Phone: (609) 376-2965
Matthew.Berns@njoag.gov
Jeffrey.Posta@njoag.gov

ELLEN ROSENBLUM
Attorney General
State of Oregon

By: */s/ Scott J. Kaplan*
Scott J. Kaplan, Senior Assistant Attorney General
Henry Kantor, Trial Attorney
Sarah Weston, Trial Attorney

Oregon Department of Justice
100 Market Street
Portland, OR 97201
Phone: (971) 673-1880
Scott.Kaplan@doj.state.or.us
Henry.Kantor@doj.state.or.us
Sarah.Weston@doj.state.or.us

JOSH SHAPIRO
Attorney General
Commonwealth of Pennsylvania

By: */s/ Michael J. Fischer*
Michael J. Fischer, Chief Deputy Attorney General
Nikole N. Brock, Deputy Attorney General

Office of the Attorney General
Strawberry Square
Harrisburg, PA 17120
Phone: (215) 560-2171
mfischer@attorneygeneral.gov
nbrock@attorneygeneral.gov

MARK R. HERRING
Attorney General
Commonwealth of Virginia

By: */s/ Toby J. Heytens*
Toby J. Heytens, Solicitor General
Matthew R. McGuire, Principal Deputy Solicitor General

Office of the Attorney General
202 North Ninth Street
Richmond, VA 23219
Phone: (804) 786-7773
theytens@oag.state.va.us
mmcguire@oag.state.va.us

BOB FERGUSON
Attorney General
State of Washington

By: */s/ Jeffrey G. Rupert*
Jeffrey G. Rupert, Chief, Complex Litigation Division
Jeffrey T. Sprung, Assistant Attorney General
Marta Deleon, Assistant Attorneys General

Office of the Washington Attorney General
800 Fifth Avenue, Suite 2000
Seattle, WA 98104
Phone: (206) 326-5492
Jeffrey.Rupert@atg.wa.gov
Jeff.Sprung@atg.wa.gov
Marta.Deleon@atg.wa.gov

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747

DECLARATION OF J. MICHAEL BROWN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, J. Michael Brown, Deputy Attorney General of Kentucky, declare as follows:

1. I am the Deputy Attorney General of Kentucky and submit this declaration in support of the Plaintiff States' motion for a summary judgment.

2. Since implementation of the Affordable Care Act (the "ACA"), the Commonwealth of Kentucky experienced the second-largest decline in its uninsured rate (7.5 percentage points) of any state in the country. *See* www.healthy-

ky.org/res/images/resources/Impact-of-the-ACA-in-KY_FINAL-Report.pdf (last visited on Aug. 6, 2018).

3. Employer-sponsored insurance and individual market coverage make up approximately 55% of the insurance coverage Kentuckians receive under the ACA. *Id.*

4. There are 1.8 million people in Kentucky under the age of 65 who have a preexisting condition. *See* kypolicy.org/new-amendment-healthcare-repeal-bill-threatens-kentuckians-pre-existing-conditions/ (last visited on Aug. 6, 2018). Of those individuals, 54% are under the age of 44. *Id.*

5. Prior to implementation of the ACA, 585,000 Kentuckians lacked coverage for substance abuse treatment because they were without any form of health insurance. Another 326,000 Kentuckians were covered through a small employer sponsored plan or through the individual market, which were not required to cover substance abuse services. (*See* www.shadac.org/sites/default/files/publications/SubstanceUseandtheACAIssueBrief.pdf (last visited on Aug. 6, 2018).

6. Since 2006, inpatient substance abuse treatment admissions in Kentucky dropped 33%, which coincided with significant overdose death rates in the state. *Id.*

7. However, since implementation of the ACA, inpatient admissions of substance abuse treatment have risen nearly 15%. *Id.*

8. Further, medication assistance therapy has been dispensed at higher rates. The number of doses of buprenorphine, which can be combined with the medication naloxone to reduce the toxic effects of opioid overdoses, has increased 73% since 2013. *Id.*

9. In Kentucky, the ACA has been a necessary and essential tool to fight the opioid epidemic, both through the expansion of Medicaid and the requirement that small group and

individual market insurance cover 10 essential health benefits, which includes mental health and substance abuse treatment. *Id.*

10. The Department of Labor's Final Rule redefining the use of the term "employer" under ERISA will have a dramatic negative impact on the individual and small group insurance markets in Kentucky. We expect a decrease in enrollment and increase of premiums in the individual and small-group markets because of residents enrolling in unlawful, underfunded and fraudulent Association Health Plans ("AHPs").

11. We expect these residents to have inferior insurance coverage that fails to cover mental health and substance abuse treatment. As a result, we expect a reversal of the post-ACA trend of inpatient substance abuse treatment and medication therapy growth.

12. AHPs will attract a healthier population that will cost less to insure. AHPs will be able to offer limited benefits at lower prices than what is currently available in the small group and individual markets. This will cause those markets to see increased premiums, putting the cost for comprehensive health care coverage out of the financial reach for many Kentuckians.

13. Proliferation of AHPs previously caused substantial harm in Kentucky by damaging the regulated health insurance markets in the 1990s. The AHPs were then exempt from market reforms in Kentucky, and while healthy Kentuckians gained coverage through the AHPs, unhealthy Kentuckians were left to make up the risk pool in the regulated markets. Over 20 insurance carriers left the market; 45 companies withdrew from the individual market, leaving only two companies that experienced financial difficulties, and eight of the 10 companies in the small group market were selling products through associations. As a result, citizens lacked choice in buying insurance and sicker Kentuckians faced premiums that spiraled upwards. The Kentucky Department of Insurance then concluded that, "Kentucky cannot sustain its current

system in the long term." *See* Kentucky's Market Report on Health Insurance, Ky. Dep't of Ins., April 1997 (rev. ed.) https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_blog_2017_ky_market_report_on_health_1997_1.pdf (last visited Aug. 6, 2018); "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." Adele M. Kirk. Journal of Health Politics, Policy and Law, Vol. 25 No. 1. Duke University Press, Feb. 2000.

14. The Final Rule will also cause financial harm to Kentucky. We expect members of AHPs that do not cover the essential health benefits will face denial of claims and lack of coverage that will cause those members financial distress. Members who join underfunded or fraudulent AHPs may be left to pay medical bills for denied or unpaid claims. Furthermore, we expect individuals whose medical history renders them ineligible for coverage under AHPs will face increased insurance premiums. For instance, vulnerable citizens with preexisting conditions will be forced to choose between higher premiums or no health insurance coverage at all. This will result in escalated health care costs to Kentucky citizens and healthcare providers in Kentucky.

Date: 8/13/2018

J. MICHAEL BROWN
DEPUTY ATTORNEY GENERAL

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR, R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF MARLENE CARIDE IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Marlene Caride, declare:

1. I am the Commissioner of the New Jersey Department of Banking and Insurance ("DOBI"). I have served as Commissioner of DOBI since June 2018, after having served as Acting Commissioner since January 16, 2018. I previously served as an Assemblywoman in the New Jersey General Assembly and as an attorney in private practice.

2. The statements in this declaration are based upon information made available to me in my official capacity and upon conclusions and determinations reached and made in accordance therewith.

The New Jersey Department of Banking and Insurance

3. DOBI administers the laws of New Jersey as they pertain to the protection of the insurance consumer through the regulation of the insurance industry. The work of DOBI includes: monitoring financial solvency; licensing insurance companies and producers; reviewing and approving rates and forms; overseeing the takeover and liquidation of insolvent insurance companies and the rehabilitation of financially troubled companies; and investigating and enforcing state laws and regulations pertaining to insurance.

The 1992 New Jersey Legislation

4. In 1992, the New Jersey legislature created two programs (P.L. 1992, c. 161 and 162) to standardize and regulate insurance policies available to individuals (Individual Health Coverage Program, "IHC") and small businesses of 2 to 49 (later extended to 1 to 50) employees (Small Employer Health Benefits Program, "SEH"). The IHC Program was created to address a crisis in the availability of "individual" health coverage and to alleviate the issue of health coverage sought by persons who were not eligible to be insured under a group health insurance policy or Medicare. The SEH Program was created to improve New Jersey's small employer health insurance marketplace.

5. The IHC and SEH laws require that insurance be offered in these markets through standard plans promulgated in regulation by the Programs, guarantee the issuance and renewal of coverage, subject the insurers in those markets to a minimum loss ratio requirement, require insurers to use modified community rating with limited rating factors and tight rating bands, and

permit consumers to easily compare insurers' offerings and premiums currently through use of web sites. The IHC and SEH governing boards function within DOBI and regulate the Programs. It is significant to note that the standard plans provide comprehensive health benefits coverage, including unlimited coverage for services such as maternity, mental illness and substance use disorder, and prescription drugs.

6. "Individual health benefits plan" is defined in the IHC law at N.J.S.A. 17B:27A-2 to include "a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium..." Since the premium for association plans is typically fully paid by the member, the result of this definition is to require that association plans, even when issued outside of New Jersey, comply with the New Jersey IHC law. The policy or contract must be one of the standard plans; comply with a minimum loss ratio requirement; be modified community rated with limited rating factors and narrow rate bands; and not be medically underwritten. The health plans previously offered by associations did not comply with these robust consumer protections. As such, they have been prohibited in New Jersey since 1992.

7. Similarly, N.J.S.A. 17B:27A-19j(1) provides that health benefits plans issued to small employers through associations, multiple employer associations or out-of-state trusts, regardless of the situs of delivery of the health benefits plan, must comply with the guarantee issue, standard plan, guarantee renewal, participation, and rating and minimum loss ratio requirements of the SEH law. Thus, the 1992 law protected New Jersey residents and small businesses by applying extraterritorially to association plans issued outside of New Jersey. If an employer with 50 or fewer employees participates in an association plan, the small employer must comply with the SEH law.

8. The Patient Protection and Affordable Care Act ("ACA") incorporated many of the protections that New Jersey put into place in 1992.

Impact of the Association Health Plan ("AHP") Final Rule on New Jersey

9. The Department of Labor's Final Rule re-interpreting ERISA's definition of employer ("Final Rule") is expected to have a substantial negative impact on the individual and small group insurance markets in New Jersey. In particular, we expect the following: (a) an exponential increase in the marketing and promotion of AHPs that fail to comply with our state laws as detailed above; (b) a decrease in enrollment and an increase in premiums in the individual and small employer markets; and (c) substantial financial and medical risk to our residents who obtain coverage through AHPs.

10. As a result of the Final Rule, DOBI expects that a number of individuals and entities will increase their efforts to market and promote AHPs in New Jersey that comply with the requirements of the Final Rule, but previously would not have been recognized as health plans sponsored by a single "employer" under ERISA. DOBI anticipates that the State will need to expend additional resources and monies to enforce applicable state laws against these AHPs that are fraudulent and/or underfunded.

11. In the past, AHPs have attempted to promote their products in New Jersey in contravention of New Jersey law. DOBI and the New Jersey Office of the Attorney General have resolved several investigations that concerned associations illegally offering health plans to New Jersey residents, including:

- In 2010, CIGNA Healthcare of New Jersey, Inc. and Connecticut General Life Insurance Company, agreed to pay a substantial civil penalty and issue refunds for the improper issuance of group policies to a trust situsued in Delaware that provided health insurance to self-employed members of various guilds and associations affiliated with the entertainment industry. Consent Order No. C10-101.

- In 2013, United States Fire Insurance Company agreed to pay a substantial civil penalty and issue refunds for the improper issuance of policies under an association plan. Consent Order No. E13-87.
- In 2016, Fidelity Security Life Insurance Company agreed to pay a civil penalty of $200,000, and pay over $1 million in refunds, for the improper issuance of group medical indemnity policies to a trust situsedin Illinois that provided individual health benefit plans to 14 employers groups, covering 1,676 persons, located in New Jersey. Consent Order No. E16-15.
- In 2016, Transamerica Premier Life Insurance Company agreed to pay a substantial civil penalty, and $250,000 in refunds, for the improper issuance of purported hospital confinement indemnity coverage to New Jersey residents through out-of-state trust policies. Consent Order No. E16-109.

12. Due to the Final Rule, DOBI expects that it will need to hire additional employees and devote additional funding to ensure that AHPs are not improperly and impermissibly marketed in our State, and ensure that these plans comply with applicable state and federal laws and regulations. I believe that these additional enforcement resources will be necessary to protect both individuals and small employers in New Jersey. This type of case-by-case enforcement is resource intensive, protracted and requires the involvement of multiple state agencies including the State Office of the Attorney General.

13. DOBI expects enrollment in the individual and small employer markets to decrease while healthier small groups and working owners will leave the individual and small employer markets.

14. The small groups and individuals who leave the IHC and SEH markets are expected to have inferior insurance benefits to that which they would have obtained if they had remained in the IHC and SEH markets. For example, AHPs that are marketed and promoted to small groups and individuals, under the Final Rule, will likely not offer the comprehensive and essential benefits that are required of small groups and individual polices pursuant to the ACA and New Jersey law, including coverage for maternity services, mental health and substance use disorder services, and prescription drugs, among other types of benefits. As a result, the members of these small groups

and individuals who leave the individual and small employer markets and purchase inferior AHPs will be at risk of unanticipated health care costs should they or their dependents become pregnant or suffer a sickness or injury that is not covered.

15. A direct financial harm to New Jersey is expected by the implementation of the Final Rule. Currently, in New Jersey, health insurance companies and health service corporations pay a premium tax of 2% on individual health insurance premiums and 1% on group insurance premiums. Health maintenance organizations pay corporate business tax and a 2% assessment on all premiums. As business moves from the individual and small group markets to self-funded association health plans, the taxes paid on premiums from the former markets will decrease. If business moves to insured AHPs under the Final Rule, premium taxes may be paid in the state of issue, instead of New Jersey.

16. The Final Rule will cause an indirect financial harm to New Jersey. Members of AHPs that do not cover essential health benefits will obtain care that puts them in financial distress or unable to pay their bills. New Jersey residents who enroll in AHPs that turn out to be fraudulent or become insolvent may be unable to pay bills when their claims are denied or are not paid. Further, there is expected to be an increase in uncompensated care for hospitals and other providers as well as an increase in charity care expenses for the State.

17. Health care consumers and providers in New Jersey are expected to be put at risk as a result of the Final Rule. Consumers that obtain inadequate health insurance from AHPs that do not cover their health care needs may decide to forego care due to the unexpected and additional cost. Others, who remain in the individual and small employer markets, will likely need to pay higher premiums if they do not receive state and federal subsidies or may be unable to afford insurance if state and federal subsidies do not offset these higher premiums.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Marlene Caride
Commissioner, New Jersey Department of Banking and Insurance

Dated: August 14, 2018

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747

DECLARATION OF PRITIKA DUTT IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Pritika Dutt, hereby declare:

1. I am the Deputy Director for the Office of Financial Review (OFR) at the Department of Managed Health Care (DMHC). I have served in this position for one year, and prior to that, I

managed health care marketplace are actuarially sound and not unreasonable. This is accomplished through the annual rate review process, where health care service plans submit documentation required by law to support their proposed changes in premium rates. As a state regulatory body that reviews rates, the DMHC has deep knowledge about the market forces that influence the premium rates California consumers pay for their health coverage.

3. OFR is responsible for, among other things, reviewing proposed rate increases by health care service plans, and, in certain situations, making findings that certain premium rate increases are unreasonable or unjustified. As Deputy Director, I am responsible for supervising OFR's work and acting as liaison on health plan financial matters to the executive leadership and the administration.

4. On June 21, 2018, U.S. Department of Labor issued the final rule, "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," (DOL final rule), to permit employers to form Association Health Plans (AHPs) and thereby allow those employers to more easily qualify for large group coverage. Specifically, the DOL final rule newly permits sole proprietors and small employers to obtain large group coverage through an AHP, with a looser requirement that AHP members have a commonality of interest than existed under prior law.

5. Expanding access to AHPs will expose more California consumers to unpaid claims when AHPs commit fraud or collapse because of a lack of financial solvency standards. Additionally, the DOL final rule will cause higher premiums and reduce availability of health

Arrangement (MEWA). MEWAs have a troubled history, marked with insolvencies and fraud. Insolvent or malfeasant MEWAs have harmed consumers and providers when claims go unpaid and consumers lose coverage and access to needed health services.

7. Fraudulent MEWAs have harmed California residents. In one significant 2001 case, the operators of Employers Mutual LLC formed 16 different employer associations that claimed to be fully funded. Employers Mutual managed the plans offered through these 16 associations and contracted with legitimate firms to market the plans and process the claims. Licensed agents marketed the 16 plans nationwide. The scheme was in operation for only 10 months, but in that amount of time, Employers Mutual collected $16 million in premiums and defaulted on $24 million of claims. The operators of Employers Mutual were eventually ordered to pay $7.3 million for their breach of fiduciary duty. The operators were criminally prosecuted and convicted in 2007, and one operator was ordered to pay more than $20 million in restitution. Other cases include Rubell-Helm Insurance Services of Irvine, a MEWA that operated in the late 1980s. Rubell-Helm claimed to be self-insured, but instead was found to be operating illegally, and was shut down in California and two other states. Its collapse left $10 million in unpaid medical claims. Further, a 1992 U.S. General Accounting Office report stated that between 1988 and 1990, California estimated that fraudulent or insolvent MEWAs had accumulated $45 million in unpaid claims, affecting 200,000 participants and beneficiaries.

8. Moreover, collapses of financially insolvent MEWAs have left California consumers and health care providers with substantial unpaid claims. For example, in 1989, Building

Market Instability and Segmentation

9. In order to maintain stable premium rates, the small group and individual health care markets require sufficient numbers of healthy consumers to offset the costs incurred by less-healthy consumers. Stable health care markets also require plans that compete for the same consumers to follow the same rules.

10. Allowing AHPs to avoid following Affordable Care Act (ACA) small group and individual market rules by making the large group market available to them would undermine the individual and small group market in two ways. First, it would siphon healthier individuals away from the ACA-compliant market. Second, it would give AHPs a competitive advantage over ACA-compliant individual and small group products by exempting them from important consumer protections.

11. The DMHC expects that as a result of the DOL final rule there will be an increase in the marketing of and enrollment in AHPs to healthier individuals. Expanding access to AHPs in this way will harm the state by segmenting the market and increasing premiums for the state's most vulnerable consumers.

12. AHPs are likely to attract healthier consumers who otherwise would have enrolled in ACA-compliant individual or small group products. Under the DOL final rule, AHPs would be able to lower costs by discouraging less-healthy individuals from enrolling. The DOL final rule would permit an AHP to keep out less healthy consumers by using benefit designs, membership requirements, geography, and other factors that can be proxies for health status. While the DOL

related discrimination. For example, an AHP might choose to operate only in the higher-income part of a metropolitan area, using income as a proxy for health. Such an AHP could pay lower premiums because it would expect fewer claims on account of membership rules designed to attract healthier consumers.

13. The DOL final rule also would give a competitive advantage to AHPs over ACA-compliant individual and small group products. Coverage through AHPs would be able to charge lower premiums because it could omit vital consumer protections and covered benefits, making this coverage even more attractive for the healthier consumers who are able to qualify for it. Consumers who have higher medical expenses—those who need the ACA's protections the most—would be left paying higher premiums because the ACA-compliant market would experience higher average claims. Ultimately, some of these less healthy consumers will lose their health coverage if they are ineligible for premium assistance and cannot afford the higher premiums caused by the segmented risk pool.

14. One recent study[1] estimated that, under the DOL final rule, up to 4.3 million consumers nationwide would shift from ACA-compliant individual and small group products to AHPs, causing an additional premium hike of up to 4% in the small group market and 2% in the individual market. The study noted that the DOL final rule could cause up to 140,000 individuals who would have had health coverage but for the DOL final rule to become uninsured. Because nearly one third of individual market enrollees are self-employed, the DMHC expects the impact of making large group coverage available to self-employed persons through AHPs

15. At some point, everyone receives health care services. When the uninsured rate rises, more people seek these services at safety-net providers and in emergency rooms, leading to higher rates of uncompensated care. In turn, this causes providers to charge higher rates when consumers do have coverage, leading to higher premiums for the whole market. It also directly harms the state, which provides a substantial portion of safety net provider funding through Medi-Cal, California's Medicaid program.

16. Californians who enroll in AHP coverage also are likely to suffer harm. Some will be left with unpaid medical claims when their AHP engages in fraud or becomes insolvent. Because large group coverage obtained through an AHP is not required to cover the state's Essential Health Benefits package, others will enroll in AHP coverage that lacks critical consumer protections and benefits. Some consumers who enroll in AHP coverage will face unexpected medical expenses if they need uncovered treatment as a result of illness, injury, or pregnancy.

Timing and Implementation Concerns

17. The timing of the proposed DOL rule is problematic. In order to meet state and federal deadlines, California health plans are required to submit rates in the individual markets for the 2019 plan year in July 2018, which they have already done. The DMHC will be reviewing updated rates into September, and is required, by law, to determine the reasonableness of rate increases by September 30, 2018. Further, by law, enrollees must receive written notice of any rate increase in October 2018. The DOL final rule was published in late June 2018, at the

they cover potential losses resulting from the market segmentation the DOL final rule promotes.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct, and that this declaration was executed electronically, at my request, on August 16, 2018, in Sacramento, California.

Dated: August 16, 2018

[Pritika Dutt]

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747

DECLARATION OF AUDREY MORSE GASTEIER

I, Audrey Morse Gasteier, declare:

1. I am the Chief of Policy and Strategy for the Massachusetts Health Insurance Connector Authority (the "Health Connector") and submit this declaration in support of the Plaintiff States' Application for Summary Judgment.

The Massachusetts Health Connector

2. The Health Connector is a state-based health insurance marketplace for individuals and small businesses. More than 250,000 Massachusetts residents are covered by

health insurance through the Health Connector. These residents receive high-quality coverage through Qualified Health Plans ("QHPs") certified by the Health Connector.

3. Massachusetts has a "Merged Market" for individuals and small employers with 50 or fewer employees. Massachusetts merged its nongroup and small group markets in 2007, as part of the implementation of our 2006 state health reform ("Chapter 58"). There are approximately 770,000 covered lives in the Merged Market. The Health Connector's enrollment comprises roughly one-third of the overall Merged Market, and its nongroup enrollment is roughly 80% of the Commonwealth's entire nongroup market.

4. Massachusetts has its own individual mandate, enacted as a part of Chapter 58. This mandate requires adults to carry coverage that meets Minimum Creditable Coverage (MCC) standards or else pay a tax penalty. The setting of MCC standards is the responsibility of the Health Connector's Board of Directors. MCC requires that adult residents carry health insurance that covers a range of benefit categories, such as hospitalization, prescription drugs, and mental health care, and also sets limits on out of pocket expenses for consumers.

5. Chapter 58 and the Affordable Care Act (ACA) have provided members of small groups and individuals in Massachusetts with robust protections (*e.g.* maternity services, mental health and substance use disorder services, and prescription drugs) and have prevented insurance policies from excluding individuals based on age, occupation, health status, claims experience, or duration of coverage.

6. Since Chapter 58, the uninsured rate in Massachusetts has declined from 11% to 3%, the lowest in the nation. Owing in part to its success in reaching near-universal coverage, Massachusetts has been ranked the healthiest state in the nation.[1]

[1] https://assets.americashealthrankings.org/app/uploads/2017annualreport.pdf

Impact of the Association Health Plan ("AHP") Final Rule on Massachusetts

7. The Department of Labor's Final Rule re-interpreting ERISA's definition of employer ("Final Rule") is likely to have a negative impact on the merged individual and small group insurance markets in Massachusetts (the "Merged Market"), including the Health Connector and the populations it serves.

8. Although Massachusetts's market rules will continue to be applicable to AHPs comprised of small employer groups, the Final Rule presents the probability that out-of-state actors unfamiliar or unconcerned with existing state law that authorizes the Division of Insurance to regulate AHPs and the Health Connector to implement Minimum Creditable Coverage requirements may attempt to market and sell plans that do not meet these standards. Even with vigorous enforcement of non-compliance and consumer education, an increase in the sale of AHPs that do not meet Massachusetts standards could result in declines in merged market coverage (on and off-Exchange) and increased consumer risk (*e.g.,* exposure to insufficient coverage or unexpected medical bills). Further, consumers who inadvertently purchase AHP coverage that does not meet state Minimum Creditable Coverage standards may face a state tax penalty associated with inadequate coverage. To prevent this harm, the Commonwealth will need to incur new costs and resources, such as additional staff time dedicated to enforcement of Minimum Creditable Coverage standards and M.G.L. c. 176J requirements, as well as distribution of educational materials to consumers.

9. I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on August 9, 2018, in Boston, Massachusetts.

Audrey Morse Gasteier
Chief of Policy and Strategy
Massachusetts Health Insurance Connector Authority

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON,

Plaintiffs,

v.

U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA,

Defendants.

Civ. Action No. 18-1747

DECLARATION OF MYRON BRADFORD "MIKE" KREIDLER IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Myron Bradford "Mike" Kreidler, declare:

1. I am the elected Insurance Commissioner for the State of Washington and head of the Washington State Office of the Insurance Commissioner (OIC).

2. The OIC administers the laws of Washington State as they pertain to the protection of the insurance consumer through the regulation of the insurance industry. Among other work, OIC monitors financial solvency, authorizes insurance companies, licenses

producers, reviews and approves rates and forms, coordinates the takeover and liquidation of insolvent insurance companies and the rehabilitation of financially troubled companies, and investigates and enforces state laws and regulations pertaining to insurance.

3. The Affordable Care Act (ACA) has been very successful in improving quality and access to health care for small employers and individuals in Washington State.

4. Since the implementation of the ACA beginning in 2012, the uninsured rate in Washington State has declined from 13.9% in 2012, to 5.4% in 2016.

5. The ACA has provided members of small groups and individuals in Washington State with robust protections that non-ACA compliant plans often fail to provide. Examples of these protections include coverage for essential health benefits (*e.g.* maternity services, mental health and substance use disorder services, and prescription drugs) and preventing insurance policies from excluding individuals based on age, occupation, health condition, claims experience, duration of coverage, or medical condition.

6. The U.S. Department of Labor's Final Rule re-interpreting ERISA's definition of employer ("Final Rule") will negatively impact the individual and small group insurance markets in Washington State by increasing market segmentation in the individual and small group markets.

7. Prior to the ACA, Washington state law allowed association health plans (AHPs) offered through associations that were formed for the primary purposes of offering health coverage to experience rate individual employers, and allowed sole proprietors to participate in AHPs, very similar to the plans now allowed by the Final Rule.

8. In 2011, Mathematica Policy Research published a study, cited by the U.S. Department of Labor in support of the Final Rule, of the Washington AHP and small group

markets as of 2010, prior to the enactment of the ACA. That study noted that market segmentation was an issue in the Washington State small group market because carriers were permitted to use health underwriting and claims experience in setting rates. Specifically, the study noted that, "By rating coverage strategically and denying employers where the associations' own rules may permit, carriers can separate the risk pools for AHPs and other employer groups and can isolate high-cost small groups in community-rated coverage. As a result, premiums in the community-rated small group market might be higher for the same benefit design, discouraging some employers from offering coverage at all and driving others to offer less coverage (with more limited benefits and greater cost sharing) than they might if premiums were lower."

9. With the implementation of the ACA, the AHP market in Washington State was required to change. Sole proprietors, or groups of one, were no longer permitted to participate in AHPs, and all carriers and self-insured multiple employer welfare arrangements (MEWAs) were required to demonstrate that AHPs were only offered to groups that satisfied DOL's guidance concerning what is a bona fide association. As a result, the requirements of the ACA allowed AHPs to continue, but created healthy limitations on access to AHPs. Even with these healthy limits in place, the AHP market in Washington State has continued to thrive, remaining close to the same size as the Washington State small group market. With the ACA limitations in place, Washington State has experienced a fairly stable small group market over the last several years.

10. However, under the new rule, market segmentation noted in the Mathematica study will likely be exacerbated. Particularly under the new pathway described in the Final Rule, more people are likely to be pulled out of both the small group and individual markets. This new pathway would allow "chamber of commerce" type associations to return to the Washington

State market. These large, geographically based associations were allowed in Washington at the time the Mathematica study was published, but were not permitted under the ACA.

11. In addition, the Final Rule gives these new pathway associations more ways to discriminate between their enrollees. By allowing AHPs to divide membership on virtually any basis that is not explicitly a health factor, the Final Rule increases the likelihood that healthier risk will be retained by the AHP, and less healthy risk will be pushed into the community rated markets.

12. The impacts of this market segmentation will be most readily seen in the small group market, where those impacts were already discernable in the 2011 Mathematica study.

13. The Mathematica study also noted that it did not have sufficient information about the sole proprietors and "groups of one" to draw any conclusions about AHP impacts on the individual market. Even so, it is likely that expanding the definition of employer to include sole proprietors will also create a degree of market segmentation in the individual market not present under the previous ACA requirements. This segmentation is likely to result in higher individual premiums, as a result of healthy risk being pulled out of the individual market, and less healthy risk being pushed back into the individual market.

14. The new rule also creates unnecessary confusion concerning cross border sales and what constitutes an appropriate metropolitan area for purposes of the new pathway for AHPs. This vagueness opens the door to legal challenges my office may be forced to use resources to defend or bring, in order to ensure geographically based AHPs still fully comply with state insurance requirements.

15. Although Washington has not seen the proliferation of fraudulent MEWAs that some jurisdictions have seen, the new rule does create an opportunity for the unscrupulous to

exploit Washington small businesses and especially less sophisticated sole proprietors with plans that do not suit their health needs, or that do not actually comply with the law.

16. As a result of the Final Rule, the OIC expects that enrollment in the individual and small group markets will be lower than it would have been if the Final Rule had not been issued.

17. I am also concerned that the small groups and individuals who leave the community rated markets will likely have insurance inferior to that which they would have obtained if they had remained in the individual and small group markets. AHPs are not required to offer comprehensive essential benefits that are required of small groups and individual polices. As a result, the members of these small groups and individuals who leave the individual and small group markets and purchase AHPs will be at risk for unanticipated health care costs in the event that they or their dependents suffer a sickness or injury that is not covered.

18. The Final Rule may also result in indirect financial harm to Washington State, to the extent that enrollees receive health care services that are not covered by their AHP. This could result in increased expenditures to programs and funding designed to assist uninsured and under insured groups within Washington State.

19. Those who remain in the individual or small group market will likely end up paying higher premiums over time.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on August 9, 2018, in Olympia, Washington.

Myron Bradford "Mike" Kreidler
Washington State Insurance Commissioner

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF MILA KOFMAN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to 28 U.S.C. § 1746, I, Mila Kofman, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained herein, and testify based on my personal knowledge and information.

2. I am the Executive Director of the District of Columbia's Health Benefit Exchange Authority (DCHBX). I hold a J.D. from Georgetown University Law Center, and a B.A. in Government and Politics from the University of Maryland. The following is based on my experience as a regulator at the U.S. Department of Labor working on Employee Retirement Income Security Act (ERISA) and association health plan issues, a research faculty member at Georgetown University studying association health plans, Superintendent of Insurance in Maine regulating the insurance industry, and currently as the Executive Director of DCHBX.

3. From 1997 to 2001 I worked at the U.S. Department of Labor in the Pension and Welfare Benefits Administration (PWBA and now called the Employee Benefits Security Administration (EBSA)). I focused on development and implementation of ERISA regulations under the jurisdiction of EBSA. This included implementation of the Health Insurance Portability and Accountability Act (HIPAA) amendments to ERISA and related laws amending ERISA. In addition to other responsibilities, I worked with state insurance regulators on Multiple Employer Welfare Arrangements (MEWA) related issues.

4. From 2001 to 2008 and from 2011 to 2013, I was Project Director and a research faculty member at the Georgetown University Health Policy Institute. From 2001 to 2008, I focused my research on market failures and was the first in the nation to document the third cycle of health insurance scams related to association health plans (AHPs). From 2011 to 2013, I was also a Research Professor. The research informed a Congressional hearing on health insurance scams and a subsequent report from the Government Accountability Office (GAO). The research included a comprehensive study on how all 50 states and the District of Columbia regulate health insurance coverage sold through different types of associations including in-state and out-of-state AHPs/MEWAs, how states regulated self-insured MEWAs (including insolvencies), how EBSA regulated MEWAs, and how states and the federal government were responding to health insurance scams promoted through phony and real associations. The research also included ERISA preemption issues and ERISA-related challenges states faced when trying to shut down scams. In addition to authoring or co-authoring more than 30 publications, I have testified before Congress and numerous state legislatures, including before the U.S. Senate Finance Committee at a hearing on health insurance scams. I also served as an expert witness in MEWA insolvency cases and MEWA scam cases for states and private litigants. Publications related to AHPs/MEWAs include:

- Mila Kofman, Kevin Lucia, Eliza Bangit, and Karen Pollitz, *Association Health Plans: What's All the Fuss About*, Volume 25, Number 6, Health Affairs 1591 (November/December 2006).
- Mila Kofman and Karen Pollitz, *Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change*, Vol. 24, Issue 4 Journal of Insurance Regulation 77 (Summer 2006).
- Mila Kofman, Kevin Lucia, Eliza Bangit, and Karen Pollitz, *Association Health Insurance: Is It Time to Regulate This Product?* Vol. 24, Issue 1 Journal of Insurance Regulation 31 (Fall 2005).
- Mila Kofman, *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Georgetown University Health Policy Institute (July 2005).
- Mila Kofman and Jennifer Libster, *Turbulent Past, Uncertain Future: Is it Time to Reevaluate Regulation of Self-insured Multiple Employer Arrangements?* Vol. 23, Issue 3 Journal of Insurance Regulation 17 (Spring 2005).
- Mila Kofman, Eliza Bangit, and Kevin Lucia, *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of Form M-1 Filings,* Vol. 23, Issue 1 Journal of Insurance Regulation 63 (Fall 2004).

- Mila Kofman and Karl Polzer, *Federal Association Health Plans – Will This Proposal Remedy the Health Insurance Crisis?* 5 Policy, Politics & Nursing Practice 167 (Aug. 2004).
- Mila Kofman, Eliza Bangit, and Kevin Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (Commonwealth Fund March 2004).
- Mila Kofman and Karl Polzer, Opinions Commentary, *Disassociate from this plan*, Modern Healthcare, Feb. 2004 (invited guest column).
- Mila Kofman and Karl Polzer, *What Would Association Health Plans Mean for California?: Full Report* (California HealthCare Foundation Jan. 2004).
- Mila Kofman and Karl Polzer, *Insurance Markets: What Would Association Health Plans Mean for California* (California HealthCare Foundation Jan. 2004).
- Mila Kofman, Kevin Lucia, and Eliza Bangit, *Issue Brief: Health Insurance Scams: How Government Is Responding and What Further Steps Are Necessary* (Commonwealth Fund Aug. 2003).
- Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond* (BNA Plus Fall 2003).
- Mila Kofman, Eliza Bangit, and Kevin Lucia, *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs* (California HealthCare Foundation July 2003).
- Mila Kofman, *Issue Brief: Group Purchasing Arrangements: Issues for States* (State Coverage Initiatives, Vol. IV, No. 3 April 2003).
- Mila Kofman, *Health Insurance Scams Promoted Through Associations: A Primer* (The Insurance Receiver, Vol. 11, No. 3 Sept. 2002).

Congressional Testimony (excludes testimony while Superintendent of Insurance (Maine) and Executive Director DCHBX):

- Invited Testimony before the U.S. Senate Finance Committee, Hearing on Health Insurance Scams, March 2004. *See* U.S. Senate Committee on Finance, "Health Insurance Challenges: Buyer Beware," Mar. 3, 2004, at https://www.finance.senate.gov/imo/media/doc/030304mk.pdf.
- Invited Testimony before the U.S. House of Representatives Committee on Education and the Workforce Subcommittee on Employer-Employee Relations, Hearing: Examining the Impact of State Mandates on Employer-Provided Health Insurance ("The Interplay Between ERISA and State Health Policy Reform Efforts," May 2006).
- Invited Testimony before the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions, Hearing: Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives, May 22, 2007.

5. From 2008 to 2011, I was the Superintendent of Insurance in Maine. I also served on the National Association of Insurance Commissioners' (NAIC) Executive Committee, having been elected Secretary/Treasurer of the Northeast Zone in June 2010. I chaired the Health Insurance Regulatory Framework Task Force (responsible for Affordable Care Act (ACA)

changes to NAIC models), co-chaired the Consumer Information Working Group (statutory working group under ACA), and was a member of the Health Insurance and Managed Care (B) Committee, the Exchanges Working group, the Executive Committee's Professional Health Insurance Advisors Task Force, Anti-Fraud Task Force, and many other task forces and working groups. As Superintendent of Insurance, I was also the hearing officer. I presided over a case involving an AHP health insurance scam and another case that involved AHPs selling limited-benefit plans as comprehensive coverage.

6. Since 2013 I have served as the Executive Director of the DC Health Benefit Exchange Authority, which is responsible for DC Health Link—the online health insurance marketplace for District residents and small businesses.

7. The DC Health Benefit Exchange Authority was established as a requirement of Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011, effective March 3, 2012 (D.C. Law 19-0094). The mission of the DC Health Benefit Exchange Authority is to implement an online health insurance marketplace in the District of Columbia in accordance with the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

8. In the District of Columbia, individual and small group health insurance is sold only through DC Health Link. D.C. Official Code § 31-3171.09a. This policy has helped create market competition, had created lower prices for small businesses, has created transparency, and has ensured strong consumer protections.

9. As of July 15, 2018, DC Health Link covers approximately 66,700 people (excluding Congress) through the small group marketplace and approximately 16,900 residents through the individual marketplace. Including members of Congress and their staff, the small group market covers over 77,000 people, and is growing. Since January 1, 2014, all health insurance sold to District residents and small businesses must cover essential health benefits including primary and specialty care, hospital stays, lab work, prescription drugs, preventive care (with no cost sharing), maternity care, mental health and substance abuse treatment. Annual and lifetime limits on coverage are prohibited. People cannot be denied coverage or charged more because they had a medical condition in the past or currently. Pre-existing medical conditions cannot be excluded from coverage. Rating based on industry or occupation as well as employer size is now prohibited. And, women cannot be charged higher rates than men. There are limits on how much more an insurer can charge someone based on age. The District went beyond minimum federal standards to prohibit insurers from tobacco rating – charging people more because they smoke. The District has the second lowest average individual market premiums in the country (CMS 2018 Marketplace Open Enrollment Period Public Use Files).

10. Currently, small businesses in the District have more than 150 plans from three United Health companies, two Aetna companies, Kaiser, and CareFirst Blue Cross Blue Shield. Like a large company, a small business can pick a level of coverage (called "metal" level, like platinum, gold, silver, and bronze) and their employees can enroll in any of the many insurance companies at that level. The employer pays only one monthly bill no matter how many different insurance companies provide coverage. Small businesses can also choose one insurer and

employees have the option of any coverage level and any plan offered. Or an employer can choose one plan from one insurer. Price points are competitive, with some premiums decreasing the past few years because of this competition. People buying coverage in the individual market have a choice of 26 health plans (including catastrophic) from Kaiser and CareFirst.

11. Because of the ACA and DCHealthLink, the District has cut its uninsured rate (*i.e.*, the number of people without health coverage) in half. Now more than 96% of our population has coverage. Specifically, the District's uninsured rate dropped from 7.6% in 2010 to 3.9% in 2016, with the most dramatic decrease occurring since DC Health Link opened in 2013 — 6.7% to 3.9%. (Source: American Community Survey, United States Census Bureau).

12. I have reviewed both the proposed and final regulations issued by the U.S. Department of Labor (DOL) titled "Definition of 'Employer' Under Section 3(5) of ERISA-Association Health Plans" (AHP regulation), challenged in this lawsuit (the Final Rule).

13. As Executive Director of the DCHBX, I submitted comments to the U.S. Department of Labor on the proposed regulation "Definition of 'Employer' under Section (3) of ERISA- Association Health Plans- RIN 1201-AB85," published January 5, 2018.

14. The Mayor and the Chairman of the Council of the District of Columbia also submitted comments.

15. By exempting AHPs from key requirements under the ACA, the rule will destabilize the private health insurance market for small businesses and individuals in the District. The private ACA health insurance market will shrink and may collapse. Premiums will increase for small businesses and individual market enrollees. Some people will become uninsured. Insurers are likely to leave the market.

16. The key provisions in the final regulation, published on June 21, 2018, that will destabilize the market include the provisions that exempt AHPs selling coverage to self-employed people and/or small businesses from ACA consumer protections that apply in the individual and small group markets, such as rating restrictions, essential benefit requirements, guaranteed issue requirements, single risk pool requirements and risk adjustment requirements.

17. DCHBX commissioned an analysis by Oliver Wyman, a consulting company that provides independent actuarial services to DCHBX, to estimate the potential impact of DOL's proposed rule on the District's small group and individual health insurance markets (Exhibit 1).

18. After the Final Rule was issued, DCHBX commissioned Oliver Wyman to update its analysis to estimate the impact of the Final Rule on the District's small group and individual health insurance markets (Exhibit 2). In part, the update looked at potential impact if DC had a local individual responsibility requirement, and impact assuming there is no individual responsibility requirement.

19. Both the February and July 2018 Oliver Wyman analyses are based on the characteristics of the District's small group and individual health insurance markets. Oliver Wyman estimates that under the Final Rule:

- The District's small group market would shrink by as much as 90% and the individual market would shrink by as much as 25%. See Exhibit 1
- The number of people in the District without health insurance would also increase because of the Final Rule. See Exhibit 1.
- Assuming the worst case—high penetration of AHP coverage—people who stay in ACA plans will see their premiums increase: small group premiums would increase by as much as 23.3% and individual market premiums would increase by as much as 23.0%. These estimates exclude other factors that impact premiums, such as medical trend. See Exhibit 2.
- On an annual basis, a small business would be paying $1,640 per employee (on average) *more* for ACA-compliant health coverage because of the Final Rule. See Exhibit 2.
- A person with individual coverage would be paying $1,307 *more* per year because of the Final Rule. See Exhibit 2.

20. In addition, the uncertainty about the legality of the Final Rule will increase costs to people who enroll in AHPs and/or to people who stay in ACA-compliant policies. Specifically, if a person enrolls in an AHP with a deductible and has medical claims that count toward that deductible, but the Final Rule is later vacated, those enrollees will then lose their coverage and when they enroll in an ACA-compliant plan, they will have a new deductible. Enrollees will not be able to recover the monies they paid toward the AHP deductible, and will be in a worse position than they would have been had they enrolled in an ACA-compliant plan. If, however, the Court allows non-ACA compliant AHP coverage to remain until renewal, that will hurt people in ACA-compliant policies due to cherry picking and market segmentation.

21. The AHP Final Rule will destabilize the District's small group market. If as many as 90% of people now covered through the District's small businesses leave their small group coverage, there would be only about 6,700 people left in the District's small group market covered through small businesses. Currently, members of Congress and their designated staff also receive coverage through DC Health Link, adding approximately 11,000 individuals to the small group risk pool. But even with staff and members of Congress in the small group risk pool, it is unlikely that commercial insurers, as a matter of economic viability, will choose to stay in a market with only 17,700 covered lives compared to approximately 77,000 (and growing) in the current market. The Final Rule will make the insurance market for small businesses in the District extremely unstable, and will likely lead insurance companies to leave the District's small group market. No insurer wants to insure small businesses with only sicker and older employees, and the remaining pool would simply be too small for any insurer to want to make an investment to compete. The individual market would also be destabilized as healthier people move to AHP coverage. There is also substantial risk that a carrier in the individual market could leave.

22. Beginning on September 1, 2018, AHPs will sell cheaper coverage to residents and small businesses. Coverage will be less expensive for two main reasons: 1. It will not be comprehensive coverage; and 2. Even if it is comprehensive coverage, it will be limited to healthy residents and small businesses with healthy and young employees. As AHPs pull

healthy lives out of the insurance markets, the risk pools will be left with sicker and older people and eventually markets will collapse. This means insurers will leave and people will no longer have access to comprehensive private health insurance.

23. Under the Final Rule, an AHP is exempt from providing essential health benefits (EHBs). Consequently, AHPs could offer limited benefits at prices lower than what comprehensive coverage costs. Additionally, using benefit design, an AHP can attract healthier groups and individuals. For example, an AHP could offer coverage without maternity, mental health benefits, and expensive prescriptions. People who need such coverage would not enroll in AHP coverage.

24. Even if an AHP offers comprehensive coverage, it can "cherry pick" the healthiest people and coverage would be less expensive because healthy people don't cost as much as people with medical needs. AHPs can cherry pick because the Final Rule exempts them from rate reforms, guaranteed issue, single-risk-pool, and risk adjustment requirements. Consequently, an AHP can simply avoid covering people and businesses with medical needs. Also, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates without limit. Exemptions from guaranteed issue and single risk pool requirements and rating practices would result in healthier groups and individuals being covered through an AHP. Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could avoid a geographic area where there is a high incidence of cancer, heart disease, and diabetes and thereby avoid covering sicker populations. Inevitably, this will lead to a substantial increase in premiums for those who remain in the traditional insurance markets, putting the cost of comprehensive health insurance out of reach for many people. As a result, the District's uninsured rate will go up.

25. The cost of uncompensated care will also increase as a result of people becoming uninsured and from being underinsured. The Final Rule could result in as much as $26,598,000 (24.6% increase) in additional uncompensated care in the District. (Source: Internal Analysis for DCHBX by Ellen O'Brien, PhD, Department of Health Care Finance)

26. History shows us that wider use of AHPs caused substantial harm to regulated health insurance markets. For example, Kentucky's health insurance market collapsed in the 1990s. Kentucky implemented market reforms, but exempted AHPs from these reforms, including rating reforms. The exemption resulted in healthy people in Kentucky seeking coverage through AHPs, which were not community rated, leaving unhealthy people to seek coverage in the regulated insurance markets. More than 20 insurance carriers left the market, leaving two carriers, one of which experienced millions in losses.

27. Although under the Final Rule self-insured AHPs formed pursuant to the Final Rule will not be eligible to enter the market until 2019, the damage that fully-insured AHPs can do to our insurance markets between September 1, 2018 and January 1, 2019 is substantial. For example, in Kentucky in the 1990s, once AHPs were exempted from insurance market reforms, it took only 90 days for enrollment in AHPs to increase from approximately 91,000 covered lives to over 151,000. ("Health Insurance Reform in the 1990s: A Kentucky Historical Perspective,"

Kentucky Department of Insurance; "Market Report on Health Insurance," Kentucky Department of Insurance, April 1997.)

28. Based on my experience, and knowledge of insurance markets and AHPs, I believe the Final Rule will cause premiums to increase for small businesses and individuals who need comprehensive coverage, including EHB under the ACA, and will cause some small businesses to lose coverage and some District residents to become uninsured. Some insurers will likely leave the District's small group market.

29. The Final Rule opens the door to fraud and insolvencies. The AHP market has a long history of attracting bad actors and being susceptible to fraud. The Final Rule creates opportunities for fly-by-night promoters to set up scams—taking premiums and never paying claims—and to use ERISA as a shield to avoid state enforcement actions.

30. There is a long history of health insurance scams promoted through AHPs. Since the 1970s when ERISA was enacted, promoters of AHPs used ERISA as a shield to evade state oversight and enforcement by arguing that ERISA preempted state regulation. In 1982 ERISA was amended to clarify that states and DOL have authority over AHPs. However, promoters of AHP scams continued to look for ways to evade state oversight, and continued to argue that state regulation was preempted by ERISA. Many associations funneled resources away from paying enrollees' claims and toward fighting oversight. ("Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," Kofman (2005); "Proliferation of Phony Health Insurance: States and Federal Government Respond; Kofman, Lucia and Bangit (2003)).

31. According to the GAO, between 1988 and 1991, operators of multiple employer entities left 400,000 people with medical bills exceeding $123 million; and between 2000 and 2002, 144 entities left 200,000 policyholders with $252 million in unpaid medical bills. ("Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entitles Selling Coverage," GAO-04-312, United State General Accounting Office, February 2004; "Employee Benefits: States Need Labor's Health Regulating Multiple Employer Welfare Arrangements," GAO/HRD-92-40, United States General Accounting Office, March 1992.)

32. Promoters of scams market AHPs to small businesses and self-employed individuals, offering health-insurance premiums at prices below what is generally available. Promoters of scams set up fake associations and also sell through well-established professional and trade associations.

33. The Final Rule adds new ambiguity to ERISA that will be used by promoters to evade state oversight, and overturns decades of ERISA guidance that will make it easier for promoters to set up scams. The Final Rule allows entities to form for the primary purpose of offering health coverage, and does not define the purported "substantial business purpose" that associations must have. This leaves open a gaping loophole that will allow AHPs to operate like commercial insurance companies, without the requirements the ACA applies to commercial insurance carriers. In the past, promoters of phony AHPs purported to have a business purpose other than health insurance even when they did not. Under the Final Rule, they can follow this same old pattern and make it harder for regulators to determine whether an AHP is a scam. Also,

there is no requirement that an entity be in existence for any period of time or have a proven track record. These entities can spring up with ease, and target unsuspecting small businesses and the self-employed.

34. Furthermore, unlike states that license and certify entities to help keep convicted felons and fly-by-night promoters out of the insurance business, DOL does not certify or license ERISA plans. And although AHPs must file a MEWA registration form called M-1 with DOL, there is no evidence that DOL conducts regular reviews or takes actions based on filings. DOL has itself admitted that there is a high M-1 noncompliance rate and estimated that in 2003 fewer than half of existing MEWAs registered with DOL. Furthermore, while there is a fine of $1,000 per day if AHPs do not file or file incomplete information, there is no evidence that DOL has ever used its authority to fine AHPs.

35. States have oversight and enforcement resources that DOL does not have. States have numerous tools that allow them to conduct regular oversight and intervene before consumers are harmed. These tools include background checks for operators of AHPs, financial and market conduct examinations, form reviews, and rate reviews. States also have and use enforcement tools, including cease and-desist authority and state receivership laws. DOL generally investigates plans only after they establish a pattern of failure to pay claims. Thus, by the time DOL acts, consumers have already been harmed. Also, states can act quickly to prevent harm; brokers serve as "eyes and ears" on the ground and help state regulators to identify bad actors who promote fake insurance.

36. While the Final Rule creates new opportunities for promoters of phony coverage to argue ERISA preemption to evade state oversight, it has no standards and no regulatory framework to keep bad actors out.

37. The Final Rule puts thousands of District residents and small businesses at risk of financial harm.

I declare under penalty of perjury that the forgoing is true and correct and of my own personal knowledge.

Executed on August 17, 2018 in Washington, DC.

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747 **DECLARATION OF PAM MACEWAN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

I, Pam MacEwan, declare as follows:

1. I am over the age of 18 years, have personal knowledge of all facts and matters herein, and am competent to testify to the matters below.

2. I am the chief executive officer of the Washington Health Benefit Exchange (WAHBE or the Exchange). I have held this position since 2015. I previously served as chief of staff from 2012 to 2015. I have 24 years of experience in healthcare management.

3. WAHBE is Washington State's health insurance exchange, or insurance marketplace. WAHBE was established in 2011 under the Patient Protection and Affordable Care

Act (ACA) and state legislation, Wash. Rev. Code 43.71. WAHBE is a self-sustaining, public-private partnership governed by an 11-member bipartisan board. WAHBE serves more than 1.7 million Medicaid and commercial insurance customers through its website, www.wahealthplanfinder.org. More than 200,000 Washington residents are covered by individual market health insurance through the Exchange, receiving high-quality coverage through Qualified Health Plans (QHPs) certified by the Exchange. Since implementation of the ACA and formation of the Exchange, the uninsured rate in Washington State has declined from 13.9% in 2012, to 5.8% in 2017.

4. I am submitting this declaration in support of the Plaintiff States' Motion for Summary Judgment following the Department of Labor's final rule re-interpreting the definition of employer under ERISA (Final Rule). 83 Fed. Reg. 28,912 (June 21, 2018).

5. The Final Rule is likely to segment risk and further destabilize the individual and small group insurance markets by undermining the stability that pooling of risk offers to any regulated market. The Final Rule will also harm Washington State consumers by eroding health coverage standards and protections that apply in the individual market under the ACA. Finally, the Final Rule will harm the Exchange by reducing premium assessments and fees on sales of QHPs that the Exchange requires to be a self-sustaining health insurance marketplace.

6. In regard to the market segmentation impacts of the Final Rule, Association Health Plans (AHPs) will be permitted to offer cheaper premiums and cover fewer benefits. This will encourage healthy people to leave regulated individual market and small group coverage, and risk segmentation will follow. In addition, as AHP enrollees develop health conditions and need services not covered by their AHP, they will reenter the regulated markets to obtain those services, further perpetuating segmentation of the risk pool and driving up the cost of coverage in the

regulated market. This phenomenon, also known as "adverse selection", means that remaining or re-entering Exchange enrollees will have more complex medical conditions, and pose greater risk to carriers. Those carriers will likely raise premiums on QHPs to compensate for increased risk. Increased premiums raise the possibility of a "death spiral" in the Exchange market, where more and more enrollees leave the marketplace due to higher costs and fewer carriers participate due to greater risk.

7. The Final Rule allows AHPs to vary rates based on age, gender, geography, and other differences between employer groups. This structure encourages rating based on characteristics that are proxies for health status, allowing "cherry picking" of health risk and further segmenting and destabilizing the individual and small group markets.

8. The Final Rule encourages segmentation of risk within a single employer group into more and less healthy employee sub-groups. The Final Rule incentivizes small employers to offer coverage that is lower than "minimum value" (56% AV), and therefore less expensive for the employer. Healthy employees will have an incentive to take the AHP coverage, as it will be cheaper and provide narrower benefits than individual market coverage. Sicker employees may decline the AHP coverage, apply for individual coverage through an ACA exchange, and be eligible for federal tax credits and cost-sharing reductions. These small groups are able to direct sicker workers and their families to the publicly-subsidized individual market, free from the countervailing influence of the employer shared responsibility payment, which deters larger employers from this practice in the large group market. This practice will further endanger individual market stability as that risk pool becomes less healthy, and negatively impact both individual market and AHP consumers.

9. Finally, the Final Rule encourages market segmentation by expanding the commonality of interest test to include merely having a principle place of business in the same state or, if in different states, in the same metropolitan area. There is not necessarily any employment-related nexus between employers in a given area and an employer-sponsored plan, as exists currently for associations consisting of employers in the same trade, industry, or line of business. Employers in the same trade, industry, or line of business may have similar workforces and employees that have similar health insurance needs; this is not true for all the small employers in a state. The formation of AHPs based on geographic lines is likely to exacerbate risk segmentation issues and encourage the proliferation of AHPs designed to seek only good risk, contributing to the destabilization of non-AHP markets.

10. In regard to harm to consumers, the Final Rule erodes coverage protections, may raise premiums for those left in the individual market, and opens the door to fraud and abuse.

11. By excluding Association Health Plans from the ACA's market rules applicable to the individual and small group insurance markets, including essential health benefits, rating, guaranteed issue, and single risk pool requirements, the Final Rule allows AHPs to tailor their products to attract healthier enrollees and discourage enrollees needing more comprehensive coverage. Consumers may not compare AHPs to QHP products available on the Exchange, and may not be aware that their QHP premiums can be offset by advance premium tax credits and cost sharing reduction benefits. Those consumers choosing AHPs with limited benefits who later develop health issues outside the annual open enrollment period are likely to be harmed when they find themselves with inadequate coverage and facing unanticipated medical bills. Benefits associated with more expensive health conditions, such as cancer care and maternity services, are not required to be covered under AHPs – nor are certain prescription drugs required to be covered

– allowing AHPs to "cherry pick" healthy individuals. This undermines the rules that prohibit discrimination on the basis of health status or condition.

12. The Final Rule also erodes consumer protections by overturning the well-established interpretation of ERISA to require a working owner to have at least one employee to sponsor and participate in an ERISA employee benefit plan. To the extent that AHPs will attract healthier risk through narrower benefits and lower premiums, extending AHPs to working owners with no employees will increase premiums for those who remain in the individual market. Moreover, the reasoning that justifies looser rating and market rules in the large group market does not exist with respect to working owners with no employees. These individuals would receive none of the protections with respect to essential health benefits, rating, and guaranteed issue that apply in the individual market, and would not be able to benefit from the buffering impacts of population variation provided in a large group plan.

13. The Final Rule provides that individuals seeking participation in an AHP shall attest to meeting the "working owner" standard to be eligible. The Rule provides an earned income minimum threshold of the cost of the AHP monthly premium, which could be as low as or lower than $100. This low earned income requirement is likely to result in fraudulent attestation of employer status. The Final Rule's re-interpretation of the long-standing ERISA definition of "working owner" opens the door to fraud and abuse, exacerbated by a federal governance structure that would provide very little oversight.

14. AHPs are exempt from ACA essential health benefits, rating, guaranteed issue, single risk pool, and nondiscrimination rules, and therefore are able to structure association eligibility, plan benefits, and rates in such a way that could result in de facto discrimination based on health status factors. For example, the Final Rule permits AHPs to be available only in

geographic areas that have a history of a low incidence of cancer, or to be unavailable to employers in specific industries that have histories of higher medical claims. AHPs are permitted to offer coverage without maternity care, mental health benefits, or coverage of certain prescriptions. The Rule permits rating to be applied with discriminatory impact, charging women higher rates than men, older individuals higher rates without limit, or individuals in certain industries higher rates than others. Demographic and other factors can be used as proxies to achieve de facto discrimination based on health factors, even if health status is not used explicitly in eligibility or rating decisions.

15. The implications noted above have been discussed nationally in recent publications.[1] [2]

16. Finally, the potential loss of Exchange enrollment due to AHPs threatens the Exchange's sustainability. Any loss of enrollees will lower WAHBE's revenues because WAHBE's operations are mostly financed through fees paid by carriers. Federal and state law authorize user fees on carriers that offer plans on the Exchange. 45 C.F.R. §§ 155.160, 156.50; Wash. Rev. Code 43.71.080, 48.14.020(2)(b), 48.14.0201(5)(b). Carriers are taxed two percent on the value of premiums paid, and also charged a flat per-member per-month assessment for enrollees on the Exchange. These premium taxes and assessments are deposited in the state treasurer's health benefit exchange account. Wash. Rev. Code § 43.71.060(2).

---

[1] Corlette, Sabrina, *What's in the Association Health Plan Final Rule? Implications for States*, Georgetown Center on Health Insurance Reforms, https://www.shvs.org/whats-in-the-association-health-plan-final-rule-implications-for-states/, June 22, 2018.

[2] Cousart, Christina, *The New Association Health Plan Rule: What Are the Issues and Options for States*, National Academy for State Health Policy, https://nashp.org/the-new-association-health-plan-rule-what-are-the-issues-and-options-for-states/, June 26, 2018.

17. For state fiscal year 2018 (July 2017 to June 2018), Exchange revenues related to QHP premiums and assessments were $36.7 million, and projected revenues for state fiscal year 2019 (July 2018 to June 2019) are $ 39.1 million. A 20 percent reduction in QHP enrollment could decrease state fiscal year 2019 revenues by approximately $10 million using 2018 premium tax rates. The exact amount of enrollment loss cannot be precisely calculated, but a*ny* decline in enrollment will reduce the Exchange revenue. Further, if premium tax funds are not available as state Medicaid match, additional state general fund dollars would be needed to replace those premium tax funds to support the Exchange's costs for enrolling Medicaid applicants through the shared on-line portal "Washington Healthplanfinder."

18. In sum, the Final Rule is likely to have a negative impact on the individual and small group markets in Washington State, including WAHBE and the population it serves. AHPs that cover fewer benefits than ACA-compliant plans will encourage healthy people to leave regulated individual market and small group coverage, and risk segmentation will follow. As healthier consumers gravitate toward skimpier AHPs and consumers needing more comprehensive coverage remain in or return to the individual and small group markets, premiums in those markets will rise. Enrollees in individual and small group plans will be harmed as they face higher premiums, and AHP enrollees may face confusion and unanticipated medical costs when they find themselves underinsured and needing benefits that are not covered by their plan. AHPs will have a destabilizing impact on insurance markets and are likely to cause harm to individual and small group consumers in Washington State. Any loss in QHP enrollment due to the AHP rule will also subject the Exchange to lower revenues through reduced revenue generated from carrier premium assessments and fees.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on August 10, 2018, in Olympia, Washington.

Pam MacEwan
Chief Executive Officer
Washington Health Benefit Exchange

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. UNITED STATES DEPARTMENT OF LABOR, R. ALEXANDER ACOSTA, Secretary of the United States Department of Labor, AND UNITED STATES OF AMERICA, Defendants.	Case No. 18-1747-JDB **DECLARATION OF CHRISTOPHER R. MONAHAN**

DECLARATION OF CHRISTOPHER R. MONAHAN

I, Christopher R. Monahan, declare:

1. I am the Deputy Insurance Commissioner for the Office of Market Regulation of the Pennsylvania Insurance Department ("Department"), and submit this declaration in support of Plaintiff States' Motion for Summary Judgment.

The Pennsylvania Insurance Department

2. The Department is the primary regulator for all health insurance products sold in Pennsylvania. As such, the Department:

a. Examines and licenses insurance companies, producers, and administrators who interact with consumers in matters involving financial and health insurance information.

b. Monitors the financial solvency of insurance companies to assure the financial strength and stability of entities that make promises to pay health insurance claims.

c. As specified in law, reviews and approves rates and forms for insurance policies sold in Pennsylvania to assure that the coverage meets the requirements of Pennsylvania law and that rates are not excessive, inadequate or unfairly discriminatory.

d. Coordinates the rehabilitation or liquidation of insolvent insurance companies, including the access to guaranty fund protections due to policyholders of appropriately licensed companies.

e. Researches and resolves consumer complaints regarding insurance coverage.

f. Investigates alleged violations and enforces statutes and regulations pertaining to insurance agents, brokers, companies and other related persons.

3. Health care insurance coverage is a significant piece of Pennsylvania's insurance market, accounting for over $42 billion in direct written premiums in 2016.[1] This includes all

[1] https://www.insurance.pa.gov/Companies/IndustryActivity/BCBS%20Surplus/Commissioners%20Annual%20Statistical%20Report%20period%20ending%202016%20Final.pdf (retrieved 7/30/18).

fully-insured coverage, whether in the individual market, the small group market, or the large group market.

4. Pennsylvania has the fifth largest insurance market in the United States, in terms of premium volume, and the 14th largest insurance market in the world.[2]

Health Care Coverage Jurisdiction

5. The Department has jurisdiction to regulate insured health care coverage provided by an employer to its employees. The Department also has jurisdiction to regulate insured health care coverage sold to individuals, including sole proprietors.

6. Health insurance coverage must be issued by an insurance company licensed by the Department, authorized by the Department to write accident and health insurance, and must offer coverage that complies with Pennsylvania law.

7. However, self-funded health care coverage is not subject to Department oversight and the consumer protections it provides. An employer that self-funds its employees' health care coverage as one aspect of its employee benefit plan is subject to the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA") and regulated by the U.S. Department of Labor ("DOL").

8. Self-funded employer-based coverage may make sense when a single employer is large enough that it can absorb the risk of employees' potentially large medical claims, and, due to influences such as business reputation and shareholder expectations, cannot easily afford to fail its employees.

---

[2] See Pennsylvania Insurance Department. *Meet the Insurance Commissioner* at http://www.insurance.pa.gov/Pages/MeettheCommissioner.aspx (retrieved 7/3/18).

9. Self-funded employer-based coverage raises concerns when an employer is small and does not have the financial capacity to absorb employees' large medical claims; or when an employer does not answer to shareholders or have an ongoing business reputation to maintain.

10. If an employee of an employer with an insured plan complains to the Department, the Department has jurisdiction to require the licensed issuer of the plan to resolve the concern.

11. On the other hand, if an employee of an employer with a legitimate single employer self-funded plan complains to the Department, the Department has no jurisdiction to require the plan to resolve the concern; the federal DOL is the only regulator for that plan.

12. However, if an individual claims to have coverage through a multiple employer welfare arrangement ("MEWA"), and the Department, on investigation, learns that the MEWA is operating in Pennsylvania, the Department may take action against the MEWA for engaging in insurance activity without a license, though the Department does not have the full panoply of regulatory tools to rectify the consumer's harm.

13. DOL's Final Rule, titled "Definition of 'Employer' Under Section 3(5) of ERISA – Association Health Plans" (the "AHP Final Rule"), identifies an association health plan as "a type of MEWA."[3]

[3] *See, e.g.*, 83 Fed. Reg. at 28919 n. 18 ("AHPs are one type of MEWA"); 28959 ("MEWAs, including AHPs (which are a type of MEWA))".

Pennsylvania's Experience with Associations

14. Pennsylvania has extensive experience with associations securing health coverage for their members, including experience with associations that purported to secure coverage for their members where the coverage was illusory or inadequately funded.

15. In the late 1970s through the early 1980s, there were MEWAs in existence that exploited ERISA's federal preemption of state law, and operated sham "employee benefit plans" exempt from state insurance laws. Pennsylvania and other states had the burden of demonstrating that these were not legitimate employee benefit plans.

16. Because of the issues involving sham, self-funding MEWAs avoiding regulation in Pennsylvania and other states, ERISA was amended in 1983 to expressly permit states to apply their insurance laws to MEWAs to allow states to regulate them to the extent state laws are not inconsistent with Title I of ERISA.

17. After joint regulation of MEWAs between the federal DOL and the Department was established, Pennsylvania formulated a dedicated MEWA Task Force in the early 1990s to tackle the issues regarding an uptick in sham MEWAs.

18. On April 24, 1992, the Department and DOL issued a "Joint State/Federal Statement on Regulation of MEWAs." That statement to "all Pennsylvania insurance agents" reminded those agents that MEWAs acting without a certificate of authority were acting in violation of Pennsylvania law. The Statement included DOL's affirmation of the state's authority:

> The U.S. Department of Labor (the Department) joins in this bulletin to notify you that, in general, the federal law regulating employee benefit plans, the Employee Retirement Income Security Act ("ERISA"), will not interfere with the State's authority to enforce its own insurance regulations, including the State's authority to apply insurance licensing requirements to MEWAs under 40 P.S. §46.

The April 24, 1992 Joint State/Federal Statement on Regulation of MEWAs is attached hereto as Exhibit A, and is also published at 22 Pa. B. 3235 (June 27, 1992).

19. Since that time, Pennsylvania has litigated a number of cases, obtaining suspension, seizure and liquidation orders against illegal MEWAs; and revoking the licenses of agents who sold policies for these entities.

20. The consumer harm caused by these MEWAs was significant, leaving many consumers with no coverage and millions of dollars in unpaid claims. This situation was not unique to Pennsylvania. As noted in a 2004 GAO report, small employers were frequent targets of these illegal entities, and states reported that unauthorized entities had at least $252 million in unpaid claims nationwide from 2002-2004. *See* "U.S. Gen. Accounting Office, GAO-04-312, Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage", at 4 (2004).

21. Because of solvency issues and the potential for consumer harm, Pennsylvania still prohibits most self-funded MEWAs. Specifically, under state law, if a group of employers were to join together to self-fund the health care coverage they provide to their employees without first securing a license, it would be considered unlicensed insurance activity and a violation of state law. This regulatory approach is for the benefit of the employees who would purportedly be covered by the self-funded scheme.

The Current Landscape of Health Insurance Coverage in Pennsylvania

22. Pennsylvania has a significant regulatory construct for assuring that health insurance sold in the Commonwealth provides significant benefits, properly discloses to the purchaser and user the coverage provided, and is rated accurately.

23. The Affordable Care Act ("ACA") has improved the quality of and access to health care for small employers and individuals in Pennsylvania.

24. The ACA expanded the protections available to those insured by small group and individual coverage, by requiring that small group and individual insurance coverage includes additional protections, such as coverage for essential health benefits (e.g. maternity services, mental health and substance use disorder services, and prescription drugs) and preventing insurance policies from excluding individuals based on age, occupation, health condition, or claims experience.

25. However, only some of the ACA's consumer protections apply to self-funded group health plans and large group insured plans, leaving employees covered by those plans exposed to the possibility that their plans will not provide coverage for the essential health benefits outlined in the ACA, and therefore may not cover benefits such as maternity services, mental health and substance use disorder services, and prescription drugs.

Impact of the Association Health Plan ("AHPs") Final Rule in Pennsylvania

26. If implementation of the AHP Final Rule is not enjoined, the AHP Final Rule, which reinterprets ERISA's definition of "employer", will jeopardize Pennsylvania's individual and small group insurance markets and negatively impact Pennsylvanian insurance consumers in three key ways.

27. First, if AHPs are permitted to operate as envisioned by the AHP Final Rule, the Department anticipates a substantial increase in the marketing and promotion of association health plans that fail to comply with Pennsylvania laws.

28. The AHP Final Rule allows associations to be formed for the primary purpose of purchasing insurance or providing self-funded coverage, and does not require associations to be in existence for any length of time before offering coverage; both of these provisions are in violation of Pennsylvania law.[4] These requirements are for the protection of persons receiving health care coverage through the association, as they guard against entities that, for example, may be sham organizations or may not have an administrative structure that can properly manage the business of the health care coverage.

29. Moreover, the AHP Final's Rule's metro area commonality requirement allows cross-state insurance sales. This creates an opportunity for Pennsylvania residents to have insurance plans outside of the regulatory reach of the Department. Should problems arise with coverage provided to a Pennsylvania resident through an association formed, marketed and sold in another state, the Department would not have jurisdiction to require the association to remedy its wrongs.

30. Second, if AHPs are permitted to operate as envisioned by the AHP Final Rule, the Department anticipates that enrollment in individual and small group insurance markets will decrease, and premiums in those markets may concomitantly increase.

31. In spite of the uncertainties in the ACA market, the health insurance marketplace has been stabilizing in Pennsylvania. Based on filings made to the Department for the 2019 plan year, it appears that all of the health insurers selling plans in Pennsylvania's individual market in 2018 will stay in the market in 2019, while collectively requesting aggregate statewide increases of a modest 0.7% for 2019. Insurers selling plans in Pennsylvania's small group market filed plans requesting aggregate statewide increases of only 2.9%.

---

[4] *See* 40 P.S. §756.2(a)(2).

32. If healthy sole proprietors and small groups are able to migrate from traditional insurance plans to AHPs as a result of the AHP Final Rule, this may, as explained by the American Academy of Actuaries, "result in market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage."[5]

33. Finally, the Department anticipates that if AHPs are permitted to operate as contemplated by the Final Rule, and if state law is preempted, those AHPs will result in harm to Pennsylvania residents, both financial and health-related, and will require significant enforcement efforts by the Department.

34. Small groups and individuals who leave comprehensive insured coverage as required by the ACA will have inferior insurance to that which they would have obtained if they had remained in the small group and individual markets. AHPs that are marketed and promoted to small groups and individuals likely will not offer the comprehensive and essential benefits that are required of small groups and individual policies pursuant to the ACA and Pennsylvania law, including coverage for pregnancy and mental health treatment. What coverage enrollees do have may also be subject to limitations.

35. Even worse, for some enrollees the premiums they pay to enroll in an AHP will not be there to pay claims if the AHP is fraudulent or becomes insolvent. In those scenarios, the consumers will have illusory benefits, no coverage for claims that they do incur, and potentially significant massive medical debt. That is, the AHPs, as illegal MEWAs, are anticipated to trigger fraudulent or ill-advised arrangements such as those that the Department and the federal DOL

---

[5] American Academy of Actuaries. *Issue Brief: Association Health Plans* (Feb. 2017) at https://www.actuary.org/content/association-health-plans-0 (retrieved 7/5/18).

battled in years past, as described above, and which, as the United States General Accounting Office noted, as referenced above, resulted in significant unpaid claims.

36. Further, if the AHP Final Rule is not immediately halted and AHPs form and operate as contemplated by the AHP Final Rule, the Department anticipates that it will need to expend significant efforts to investigate consumer complaints. This type of case-by-case enforcement is a fact- and labor-intensive investigation that can span several months or even years, exposing consumers to considerable risk during the investigation until the case is resolved, and usually resulting in some unrecompensed harm due to the insolvency of the AHPs, whether from mismanagement or fraud.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

CHRISTOPHER R. MONAHAN

Dated: 8/20/18

EXHIBIT A

U.S. DEPARTMENT OF LABOR
Pension and Welfare Benefits Administration

COMMONWEALTH OF PENNSYLVANIA
Insurance Department

April 24, 1992

INSURANCE DEPARTMENT NOTICE NO. 1992-2

SUBJECT: Joint State/Federal Statement on Regulation of MEWAs

TO: All Pennsylvania Insurance Agents

FROM: U.S. Department of Labor
and
Pennsylvania Department of Insurance
Acting Commissioner Ronald Chronister

The Pennsylvania Department of Insurance has previously warned Pennsylvania agents of the penalties of selling for an unlicensed insurer, including personal liability for unpaid claims, license revocation, and monetary penalties. The Insurance Department has imposed penalties and brought civil litigation against agents for such activities. Despite this, Pennsylvania insurance agents have continued to market insurance products, primarily health benefit programs, on behalf of unauthorized insurers. These unauthorized insurers include operators of certain health benefit programs known as Multiple Employer Welfare Arrangements ("MEWAs") which conduct the business of insurance in Pennsylvania without a certificate of authority, in violation of 40 P.S. §46.

Pennsylvania insurance law, 40 P.S. §46, states that no person shall act as an insurer in Pennsylvania except as authorized by a certificate of authority issued to the insurer by the Pennsylvania Department of Insurance. This includes MEWAs which offer accident and health benefits to Pennsylvania participants.

You should be advised that on many occasions, these unauthorized insurers represent the programs as employee welfare benefit plans subject to only federal regulations, and therefore assert that Pennsylvania has no authority to enforce its insurance regulations.

The U.S. Department of Labor (the Department) joins in this bulletin to notify you that, in general, the federal law regulating employee benefit plans, the Employee Retirement Income Security Act ("ERISA"), will not interfere with the State's authority to enforce its own insurance regulations, including the State's authority to apply insurance licensing requirements to MEWAs under 40 P.S. §46. The Department notes that some operators may refer to a program of health benefits as "collectively-bargained" plans, or "employee-leasing" plans. A determination as to whether these particular programs may be regulated by the State usually may only be made on a case by case basis.

Accordingly, agents that market any insurance products, including any program of health benefits, or sell any such products, should examine carefully whether the insurer has been issued a certificate of authority by the State and whether the product has been approved for use.

For information regarding whether an entity has a Pennsylvania certificate of authority, call the Department of Insurance, 1-717-787-2735.

TAK:jk
K4-6-2

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF TRINIDAD NAVARRO, DELAWARE INSURANCE COMMISSIONER, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Trinidad Navarro, declare and say as follows:

1. I am the elected Insurance Commissioner for the State of Delaware. I have served in this capacity since January 3, 2017. The facts stated herein are of my own personal knowledge or are based on information and belief. If called, I could and would competently testify to them.

2. As the elected Insurance Commissioner for the State of Delaware, I oversee the Delaware Department of Insurance (the "DDOI"). The DDOI is responsible for, among other things, enforcing state laws relative to insurance, licensing insurance companies and producers,

reviewing and approving rates and forms, monitoring the financial solvency of licensed entities and, when necessary, instituting delinquency proceedings against financially impaired or insolvent insurance companies.

3. In Delaware, the Affordable Care Act (the "ACA") has been instrumental in improving quality and access to health care for small employers and individuals.

4. Delaware's uninsured population has decreased from 9.1% in 2013 to 5.7% in 2016. In 2018, approximately 24,500 Delawareans enrolled in the ACA marketplace and obtained coverage containing the ACA's comprehensive benefits.

5. I am familiar with the new Final Rule issued by the Department of Labor that reinterprets ERISA's definition of employer (the "Final Rule"). I anticipate the Final Rule having an adverse impact on Delaware's individual and small group markets.

6. As a result of the Final Rule, I expect to see (a) an increase in the marketing and promotion of association health plans ("AHPs") that fail to comply with Delaware's insurance laws, (b) a decrease in the enrollment, and corresponding increase in premiums, in the individual and small group markets in Delaware, and (c) financial harm to individuals who may lose eligibility for the ACA's tax credit should their small employer opt to provide minimal essential coverage (which is less comprehensive than ACA's essential health benefits) through an AHP.

7. I anticipate a substantial increase in the presence of AHPs marketing in Delaware. Since the Final Rule has been issued, the DDOI has received multiple inquiries seeking information regarding the formation and licensing requirements of AHPs.

8. As a result of the Final Rule, I anticipate market disruption in the individual and small group markets. Delaware's individual market enrollment decreased 11% from 2017 to 2018, which we attribute partly to the uncertain and confusing messages at the federal level regarding the ACA. The Final Rule may result in additional decreased enrollment as healthier "working owners" or smaller employers seek less expensive plans with inferior coverage offered through AHPs. With the exit of healthier individuals from the market, leaving an unhealthier risk pool, I consequently anticipate insurance companies seeking future premium increases to compensate for the additional healthcare costs attendant with insuring such an unhealthier risk pool.

9. The small groups and individuals who leave the individual and small group markets in Delaware will have inferior coverage than had they purchased coverage through the individual and small group markets. AHPs taking advantage of the Final Rule likely will not offer the essential health benefits required of small group and individual policies in

Delaware. This will leave AHP plan members at risk for unanticipated health care costs in the event their less-than-comprehensive coverage fails to cover a suffered injury or illness.

10. The Final Rule will also result in direct financial harm to Delaware. In Delaware, insurance companies are required to pay an annual premium tax based on their net premium income. An increase of coverage through self-insured AHPs, made possible through the Final Rule, will result in a decrease in insurance companies' premium income and, therefore, a decrease in the amount of premium tax collected by the State.

11. In addition to the loss of premium tax revenue, I anticipate having to use additional State resources for the policing of, and enforcement actions taken against, AHPs. DDOI staff members have already had to reassign and reprioritize assignments in order to prepare the DDOI for the September 1, 2018 effective date of the Final Rule for fully-insured AHPs. In addition, following the effective date of Final Rule, I anticipate a 35% increase in work for current DDOI staff specifically related to the licensing, oversight and enforcement actions for AHPs. If AHP activity does increase substantially in Delaware as a result of the Final Rule, I anticipate the DDOI may have to hire additional staff, including at least one full-time position and several part-time positions, to ensure that AHPs comply with applicable state and federal laws and regulations.

12. I also expect that the State will have to use increased resources on educational efforts to inform Delaware consumers of the potential harms in seeking coverage through an AHP. These additional enforcement and educational resources are necessary to protect small employers and individuals in Delaware. These educational efforts will be in the form of a media campaign, which I anticipate will cost the DDOI tens of thousands of dollars to produce. In addition to the financial cost of the production of a media campaign, I also estimate that a minimum of 100 hours will be spent by DDOI staff compiling the information and documentation that will be included in the media campaign. These are costs and additional workplace hours the DDOI would not have incurred if not for the Final Rule.

I declare under penalty of perjury that the foregoing is true and correct and if called as a witness, I would competently testify to the statements above.

By: Trinidad Navarro

Trinidad Navarro
Delaware Insurance Commissioner
Date: August 10, 2018

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR, R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF PATRICIA F O'CONNOR IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Patricia F. O'Connor, declare:

1. I am an Assistant Attorney General and the Deputy Director of the Maryland Attorney General's Health Education and Advocacy Unit (HEAU). I have served in this position for over 4 years. Prior to joining the HEAU, I served as an Assistant Attorney General for the Maryland Department of Health.

2. The HEAU was established to promote the interests of health consumers in the health marketplace, among other purposes. The HEAU assists Maryland residents with health insurance enrollment, enrollment denials, denials of advance premium tax credits, denials of cost-sharing reductions, denials of coverage, and disputes involving medical billing, equipment and records. The HEAU advocates for consumers during federal and state legislative, administrative and rulemaking proceedings.

3. In my role as Deputy Director, I am responsible for written and oral testimony in legislative, administrative and rulemaking proceedings relating to Maryland's health care delivery system, including the regulation of private health insurance.

4. The Affordable Care Act ("ACA"), coupled with the Maryland Health Insurance Reform Act (the "Maryland Act"), has been very successful in improving quality and access to health care for small employers and individuals in Maryland.

5. The ACA, the Maryland Act and other insurance reforms have provided members of small groups and individual plans in Maryland with robust protections that other plans often fail to provide. Members benefit from standard benefit designs, including essential health benefits (e.g. maternity services, mental health and substance use disorder services, prescription drugs), community rating, and guaranteed coverage despite age, occupation, health conditions, or claims experience.

6. The State has made great strides in improving access to health care coverage, with the uninsured rate decreasing from 10.2 percent in 2013 to 6.1 percent in 2016. As of February 1, 2018, 145,109 residents were enrolled in qualified health plans offered through the Maryland Health Benefit Exchange, and over 315,000 were enrolled in the ACA Medicaid expansion. With these coverage expansions, hospital uncompensated care has decreased from

7.2 percent of gross patient revenue in state fiscal year 2013 to 4.6 percent in 2016. This in turn reduced the all-payer costs for uncompensated care built into hospital rates under Maryland's hospital rate-setting system. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html#Section%201332%20State%20Application%20Waiver%20Applications

7. But, over the past several years, a number of carriers have exited the individual health insurance market, resulting in less competition in the market and leaving fewer choices for consumers. In addition, average rates have increased by as much as 53.6 percent between 2017 and 2018 alone. Without further stabilization efforts, premiums are expected to continue to increase at an unsustainable rate, raising concerns about the future viability of the individual market, a loss of access to coverage for consumers, and potential downstream implications for Maryland's hospital all-payer model.
https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html#Section%201332%20State%20Application%20Waiver%20Applications

8. In response, on May 31, 2018, Maryland filed a Section 1332 State Innovation Waiver Application to waive Section 1312(c)(1) of the ACA to implement a state reinsurance program, which, if approved, will allow Maryland to include expected state reinsurance payments when establishing the market wide index rate. This will decrease premiums in the individual market and federal payment of advance premium tax credits.

9. The Department of Labor's Final Rule re-interpreting ERISA's definition of employer will, in my opinion, undermine Maryland's efforts to stabilize the individual market and otherwise negatively impact Maryland's marketplace.

10. In particular, the HEAU expects to see (a) a decrease in enrollment in the individual and small group markets, leading to further premium increases in those markets, (b) an increase in the marketing and promotion of Association Health Plans (AHPs) that fail to comply with our state's laws based on our experience in the past, and (c) medical and financial risk to Maryland residents who enroll in AHPs due to the skimpy benefits that they will likely provide.

11. As a result of the Final Rule, the HEAU expects that individuals and entities will market and promote AHPs in Maryland that do not comply with state laws or that are fraudulent and/or underfunded. Maryland law provides that all small employers and individuals (regardless of their status as "working owners") who join an AHP must comply with state laws regulating the small group market, even if the AHP itself would be recognized as an "employer" under the Final Rule for purposes of ERISA and, thus, due to its total number of enrollees, be categorized as a large group. Md. Code Ann., Ins. § 15-1202(c)(2017 & Supp. 2018). In such situations, each small employer who enrolls in an AHP, regardless of the total size of the AHP, would be regulated at the individual "employer" level and would need to comply with Maryland laws regarding, among other things, standard benefits and rating rules. Further, self-insured multiple employer welfare arrangements (MEWAs) are required to obtain a certificate of authority as an insurer before operating in the State.

12. In prior instances, MEWAs have promoted their products in contravention of Maryland law. By way of example, in 2001, the Maryland Insurance Administration ("MIA") fined and revoked the license of an insurance producer who operated an illegal MEWA and engaged in "illegal and dishonest practices," such as failing to obtain a certificate of authority 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 MIA fined and revoked the license of an insurance producer who operated an illegal MEWA and made material misrepresentations regarding the relationship of the MEWA to the insured employees and, overall, engaged 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).

13. As a result of the Final Rule, the HEAU expects that the MIA and the Attorney General's Consumer Protection Division will need to devote additional resources to ensure that AHPs will comply with applicable state and federal laws and regulations as necessary to protect Marylanders.

14. As a further result of the Final Rule, the HEAU expects that small groups and "working owners," who are generally healthier and have more attractive risk profiles, will be swayed by the marketing and promotion of less expensive AHPs that do not comply with state laws, and will leave Maryland's individual and small group markets. The exit of these members from Maryland's marketplaces will further destabilize those markets.

15. The HEAU also expects that enrollment in the individual market will be lower than it would have been if the Final Rule had not issued. The expansion of the footprint of AHPs, allowing individuals ("working owners") to group together with others as an association in order to exit the individual market and seek lower premiums in the small group market, will further erode Maryland's efforts to stabilize the individual market.

16. The Final Rule will also result in direct and indirect financial harm to the State of Maryland. The individuals and small groups who leave Maryland's marketplace to purchase AHPs that are not compliant with Maryland law will have inferior insurance compared to that which they would have obtained if they had remained in Maryland's market. As a result, members who experience pregnancy or suffer a sickness or injury that is not covered, are at risk for unexpected healthcare costs and may forego necessary care, face financial distress, or require additional expenditures through the Maryland Medicaid program or other state programs.

I declare under penalty of perjury that the foregoing facts are true and correct based on my knowledge, information and belief.

Executed on August 14, 2018, in Baltimore, Maryland.

Patricia F. O'Connor

Patricia F. O'Connor

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747

DECLARATION OF ANDREW STOLFI

Pursuant to 28 U.S.C. § 1746, I, Andrew Stolfi, declare and state as follows:

1. I am over the age of 18 and competent to testify.

2. I am the Oregon Insurance Commissioner and the Administrator for the Division of Financial Regulation of the Oregon Department of Consumer and Business Services ("DCBS"). As such, I am responsible for enforcement of the Oregon Insurance Code, including regulation of insurance carrier licensing, solvency, and product offerings, review

Oregon Department Justice
100 SW Market Street
Portland, OR 97201
(971) 673-1880 / Fax: (971) 673-5000

and approval of rates and forms used by insurance carriers, and ensuring a fair insurance marketplace for Oregon consumers. These duties encompass the area of health insurance subject to regulation by the State of Oregon. I have personal knowledge ofthe matters stated herein.

3. The Affordable Care Act (ACA) increased access to affordable health insurance coverage in Oregon. Overall the number of individuals with insurance has increased. In Oregon, in 2017, 3,747,500 people had health insurance coverage (93.8%). In 2013 before ACA, 3,236,200 people in Oregon had health insurance coverage (85.5%). Approximately 500,000 people gained health coverage in Oregon between 2013 and 2017. The rate of uninsured in the state is now 6.2%. This is a decrease from 2013 when 14.5% of Oregonians were uninsured. DCBS is therefore very concerned about any action by the federal government that will

of

contribute to undermining the ACA.

4. The Department of Labor's Final Rule reinterpreting ERISA's definition of "employer" ("Rule") to expand the availability of association health plans (AHPs) will have a negative impact on the Oregon individual and small group markets. This is because the Rule creates additional consumer confusion in the market as to the health coverages available under state law, particularly after the federal government has already, among other things, removed the individual mandate penalty, eliminated cost-sharing reduction payments to carriers, and expanded the benefit period on short-term, limited duration insurance. The consumer confusion caused by this Rule, along with the additional activities of the federal government to undermine the ACA, is likely to cause some individuals to forego insurance coverage altogether and others to purchase AHPs that violate Oregon law.

Oregon Department Justice
100 SW Market Street
Portland, OR 97201
(971) 673-1880 / Fax: (971) 673-5000

5. Coverage offered to individuals and small employers through an Al-IP may be less comprehensive than what would be required for those groups under the ACA. The Rule allows an Al-IP to be treated as a single (large) employer that sponsors a group health plan under

ERISA. Importantly, coverage offered to large employers is not subject to essential health benefits (EHB) requirements under the ACA. Consequently, coverage offered to individuals and small employers through an Al-IP may be less comprehensive (and thus less expensive) than what must be offered under the ACA. Moreover, the ability for an AHP to exclude certain categories of coverage that are required under El-IB may allow an Al-IP to attract healthier groups and individuals. For example, an Al-IP could potentially exclude coverage of maternity services and expensive prescription drugs.

6. The premiums charged for Al-IP coverage may be discriminatory and predatory. Health insurance coverage offered to large employers is not subject to ACA rating restrictions such as the single risk pool and allowed rating factors. This means that the rates charged for AHP coverage may be set in ways that would not be permitted, and that may be considered discriminatory, under the standards applicable to the ACA individual and small employer

of

markets. In particular, nothing in the Rule prevents an Al-IP from offering premium rates to individuals and small employers that are specifically designed to undercut the rates that must be charged to younger enrollees under the ACA requirements.

7. The Rule allows some AHPs to begin offering coverage under the new standards as soon as September l, 2018. As described above, that is the earliest date when AHPs could begin offering leaner, cheaper coverage to individuals and small employers under

Oregon Department Justice
100 SW Market Street
Portland, OR 97201
(971) 673-1880 / Fax: (971) 673-5000

the Rule. While this coverage may be less comprehensive, our experience has shown that many insurance purchasers will seek out the lowest cost coverage that is available to them.

8. To the extent that the Rule causes enrollees to move from ACA compliant coverage to Al-IP coverage, enrollment in the private ACA health insurance markets will shrink. The remaining enrollees in the ACA markets will likely have relatively higher average medical expenses than is the case today. This will cause premiums to rise in the ACA markets, meaning that fewer Oregonians will be expected to enroll. In the worst case scenario, the Rule could drive Oregon's ACA markets into a death spiral of ever-rising premiums and decreasing enrollment, eventually forcing insurers to stop offering products. The ACA markets, which remain available to everyone, could eventually collapse.

9. Consumer confusion created by the Rule will be amplified as insurance carriers, agents, and associations, unfamiliar or unconcerned with Oregon state law, offer Al-IP coverage to Oregon consumers. Although Oregon's strict regulation of AHPs may remain unchanged by the Rule, Oregon anticipates dedicating significant resources to ensuring that all health coverages are compliant with state law. Oregon expects to expend considerable enforcement resources due to Al-IP offerings that do not meet state law requirements. To date, DCBS has received a significant number of inquiries from carriers and fellow regulators regarding the formation of Al-IPs based upon the Rule. From these inquiries it is reasonable to conclude that carriers are currently planning product offerings based upon the Rule that will be introduced into the Oregon market in the near future, and that these offerings may not comply with state law.

of

Oregon Department Justice
100 SW Market Street
Portland, OR 97201
(971) 673-1880 / Fax: (971) 673-5000

10. In addition, the Rule opens the door to fraud and insolvencies. The Al-IP market has a long history of attracting bad actors and being susceptible to fraud. DCBS will have to expend scarce state resources to try to police Al-IPs to protect the public from fraudulent promoters.

Executed on August 10, 2018 in Salem, Oregon.

Andrew Stolfi

Oregon Insurance Commissioner

Oregon Department Justice
100 SW Market Street
Portland, OR 97201
(971) 673-1880 / Fax: (971) 673-5000

-

of

Oregon Department Justice
100 SW Market Street
Portland, OR 97201
(971) 673-1880 / Fax: (971) 673-5000

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF STEPHEN C. TAYLOR IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to 28 U.S.C. § 1746, I, Stephen C. Taylor, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained herein, and testify based on my personal knowledge and information.

2. I am the Commissioner of the District of Columbia Department of Insurance, Securities and Banking ("DISB"). I have served in this position since November 2015, and I was Acting Commissioner from June through November 2015. In this role, I serve as the chief

regulator of the District of Columbia's financial-services industries, including insurance companies and their representatives and captive insurance companies. As part of my responsibilities, I am a Member of the Executive Board of the District of Columbia Health Benefit Exchange ("HBX"), and a Member of the Board of Directors of the Washington DC Economic Partnership.

3. I have over 15 years of experience in financial services regulation and finance and fiscal affairs. I have served in various leadership roles including General Counsel and Acting Deputy Commissioner with DISB, and General Counsel with the former Department of Banking and Financial Institutions. In those roles, I directed legislative and regulatory drafting programs, assisted in implementing the Patient Protection and Affordable Care Act ("ACA"). Previously, I served as Assistant Attorney General with the Office of the Attorney General for the District of Columbia, where I provided legal counsel to the District Department of Health Care Finance.

4. I serve as the Secretary of the Northeast Zone of the National Association of Insurance Commissioners ("NAIC"). Also, I am a member of the NAIC's Executive Committee. I also serve as a member of the Life Insurance and Annuities and International Insurance Relations Committees. I am Chair of the Consumer Liaison Committee and the Consumer Participation Board of Trustees, and serve as Vice Chair of the Receivership and Insolvency Task Force and the Risk Retention Group Task Force.

5. I hold a Juris Doctor and Master of Laws from Georgetown University Law Center, and a Bachelor of Arts from Fordham University.

6. DISB regulates financial-service businesses in the District. DISB's primary goal is to ensure residents of the District of Columbia have access to a wide choice of insurance, securities and banking products and services, and that they are treated fairly by the companies

and individuals that provide these services. Specifically, DISB protects the interests of District consumers by ensuring that insurers and individuals presenting insurance products in the District are qualified, appropriately licensed, and meet and act in accordance with all requirements of the insurance laws of the District of Columbia. The Insurance Bureau monitors the financial condition and marketing activities of insurers and producers, and reviews insurance policies and rates to ensure compliance with applicable laws.

7. The Health Insurance Actuarial Division of DISB reviews health insurance rate filings for individual, small and large group plans and recommends whether such rates should be approved or disapproved. The Department reviews rates based on rating factors to generate premiums that are fairly priced considering the benefits provided. Reasonable rates are usually adequate to cover the costs of paying for medical services claims and for operating the company. Also, rates cannot be excessive or unfairly discriminatory. DISB also reviews policies to ensure compliance with District and federal laws. This review ensures that health plans cover all required benefits at the appropriate cost-sharing levels (*e.g.*, copays, deductibles, maximum out of pocket limits). The benefits review includes essential health benefits, mental health parity, non-discriminatory benefit design, as well as other District of Columbia mandated benefits.

8. The ACA has been very successful in improving quality and access to health care for small employers and individuals in the District of Columbia.

9. Since the ACA went into effect, the rate of people without health insurance in the District of Columbia has been reduced by almost 50%—declining from almost 7% to less than 4%—and the number of uninsured has declined to 26,000.

10. Currently, under the ACA, the health insurance market is very competitive in the District of Columbia. Health insurance plans for individuals, families and small employers are

sold through DC Health Link, the District of Columbia's health insurance exchange marketplace. Small businesses in the District now have robust coverage options. The District has three United Healthcare companies, two Aetna companies, Kaiser Permanente, and two CareFirst Blue Cross Blue Shield companies in the small group market, offering more than 150 qualified health plan options. Price points are competitive with some premiums remaining at previous levels or even decreasing because of competition. For the 2019 plan year, DISB is reviewing proposed rates from four major insurance companies—Aetna, CareFirst BlueCross BlueShield, Kaiser Permanente and UnitedHealthcare—who have proposed health plan offerings for individuals, families and small businesses. Overall, 180 plans were filed for 2019, compared to 177 last year. The number of small group plans increased from 151 to 155, and individual plans decreased from 26 to 25.

11. The Final Rule of the Department of Labor ("DOL") redefining the definition of "employer" under section 3(5) of the Employee Retirement Income Security Act of 1974 ("ERISA") will have a *substantial negative impact* on the individual and small group insurance markets in the District of Columbia. In particular, we expect to see (1) a substantial decrease in enrollment and a substantial increase in premiums in the individual and small group markets; (2) financial and medical risk to our residents who enroll in Association Health Plans ("AHPs") due to the *skimpy* benefits that they will likely provide; and (3) a substantial increase in the marketing and promotion of AHPs that fail to comply with our laws, as has been our experience in the past.

12. As a result of the Final Rule, DISB expects a substantial increase in the marketing and promotion of AHPs in the District of Columbia that comply with the requirements of the Final Rule, but previously would not have been recognized as health plans sponsored by a single

"employer" under ERISA. The increased availability and use of such AHPs is the express intent of the Final Rule as stated by DOL.

13. The Final Rule likely will cause risk segmentation. A recent analysis performed by Oliver Wyman, an actuarial consulting firm, estimated the potential impact of DOL's proposed rule (not substantially different than the Final Rule) on the District's small group and individual health insurance markets, as follows:

- AHPs would enroll as much as 90% of people now in the small group market and as much as 25% of people now in the individual market.
- As many as 2.4% of people currently with small group coverage and 2.94% of people with individual coverage would become uninsured in the District.
- People who stay in the individual and small group markets will see premiums increase: small group claims costs would increase by as much as 25.8% and individual market claims costs would increase by as much as 10.9%. These estimates exclude other factors that impact premiums.

14. If the analysis is correct that 90% of the small group market will move to AHPs, the District's small group market will have fewer than 10,000 people left. In that event, it is likely that insurers will leave the small group market to avoid being left with only the sicker and older employees and their families. In that event, the remaining risk pool would simply be too small for any insurer to want to make an investment to compete.

15. Additionally, there are many other ways AHPs can segment insurance markets. One possible way is through "redlining," another long-discredited practice. Redlining is the pejorative term applied to techniques by which insurers illegally refuse to sell, or selectively market, in certain locations based on the economic or racial profile of the population. The Final

Rule allows geographic (and thus possibly socioeconomic) redlining, by allowing AHPs to form merely based on geographic units of whatever size and proximity they choose. Thus, the Final Rule could allow AHPs to "cherry-pick" the particular micro-areas that have the population features considered most desirable, without even needing, necessarily, for the covered areas to be contiguous. In addition, AHPs can use rating practices as well as marketing to attract desirable populations and to avoid groups and individuals expected to have higher claims.

16. We expect greater expenditures and staff time will be required for DISB to effectively regulate an expansion of AHPs. Over the last 2 years, DISB received 19 complaints related to 6 licensed insurers. DISB's consumer services division, licensing division, financial examination division, enforcement division, and legal services division can all expect to see a higher volume of cases related to:

- lack of clarity on eligibility of a group or person for association coverage,
- lack of clarity around agent and broker activities, offering exchange plans vs. AHPs,
- lack of clarity around what benefits must be covered or not,
- lack of clarity around which jurisdiction should regulate (*e.g.*, a District resident enrolled in a Florida based AHP, or a Montana resident enrolled in an AHP based in the District), and
- lack of clarity around geographic flexibility for AHPs, and competing regulations when AHPs are offered in the metropolitan region, which includes Maryland, Virginia, West Virginia, and Delaware.

I anticipate having to use additional District resources for the oversight of AHPs. I also expect that the District will have to use increased resources on educational efforts to inform District

consumers of the potential harms in seeking coverage through AHPs. The additional oversight and resources will be necessary to protect small employers and individuals in the District.

17. The District of Columbia likely will need to issue additional regulatory guidance, or perhaps enact new statutes or regulations, to address the many issues facing it, its small businesses, and individual policyholders in the wake of the Final Rule. Any measures the District might need to take could not be put in place before the effective date of the Final Rule or before the first date on which AHPs may be marketed in the District under the Final Rule. Thus, under the Final Rule, "associations" will be able to market AHPs in the District before the District can effectively put in place procedures and regulations to protect enrollees.

18. As a result of the Final Rule, DISB expects a substantial increase in the number of "associations" that market or will market AHPs under the Final Rule to establish themselves or incorporate in the District of Columbia. In our experience, "associations" that market AHPs prefer to operate from, incorporate in, or list their primary business address in, the District of Columbia even if they do not market AHPs plans in the District of Columbia. Having an address in "Washington, DC" may be thought to lend additional credibility to these associations and the plans they offer.

19. The filings for 2019 individual and small group insurance plans were filed prior to the issuance of the Final Rule. Thus, the insurers were unable to fully contemplate any shift in the marketplace to occur. Moreover, the District of Columbia recently enacted the Fiscal Year 2019 Budget Support Act of 2018 which establishes an individual shared-responsibility requirement ("ISRR") for District of Columbia residents. Under the ISRR, persons enrolled in an AHP that is multiple employer welfare arrangement ("MEWA") formed after December 15, 2017 which does not comply with federal law and regulations applicable to MEWAs that were in

place as of December 15, 2017 would not have the minimum essential coverage required. As a result, those persons would be required to pay the penalty under the ISRR unless exempt.

20. The small groups and individuals who leave the DC Health Link likely will have inferior insurance to that which they would have obtained if they had remained in the individual and small group markets. For example, AHPs that are marketed and promoted to small groups and individuals likely will not offer the comprehensive and essential benefits that are required of small groups and individual polices pursuant to the ACA, including coverage for pregnancy and prescription drugs, among other types of benefits. Although District law mandates coverage for certain specific types of health benefits, it does not mandate coverage in large group plans of all ten categories of essential health benefits that the ACA mandates for individual and small group plans. As a result, the members of these small groups and individuals who leave the small group and individual markets and purchase AHPs will be at risk for unanticipated health care costs in the event that they or their dependents become pregnant or suffer a sickness or injury that is not covered. AHPs will offer "cheaper" plans, but at the cost of reduced coverage and greater exclusions. AHPs' "cheaper" plans will be more expensive to the District and its residents in the long run.

21. The Final Rule will result in indirect financial harm to the District of Columbia. For example, members of AHPs that do not cover essential health benefits will obtain care that puts them in financial distress or unable to pay their bills. And, District residents who enroll in AHPs that turn out to be fraudulent or that become insolvent may be unable to pay bills when their claims are denied or are not paid. In both of these situations, additional expenditures will have to be made through the District's Medicaid program, *e.g.*, Disproportionate Share Hospital (DSH) payments made with Federal Financial Participation funds by States to hospitals

providing uncompensated care, or other District programs that provide care for such individuals, *e.g.*, the District's Medicaid and Alliance programs.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on August 21st, 2018, in Washington, District of Columbia.

Stephen C. Taylor
Commissioner
District of Columbia Department of Insurance,
Securities, and Banking

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF MARIA T. VULLO IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

MARIA T. VULLO, declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am the Superintendent of the New York State Department of Financial Services ("DFS"), and submit this Declaration in support of the States' Motion for Summary Judgment.

2. I was confirmed as Superintendent on June 15, 2016 and served in an acting role before that beginning February 22, 2016. Prior to this role, I was a litigation partner at a large law firm

for over 20 years. I also previously served as Executive Deputy Attorney General for Economic Justice in the Office of the New York State Attorney General. I hold a J.D. from New York University School of Law, an MPA from the NYU Wagner Graduate School of Public Service and a B.A. and honorary Ph.D. from the College of Mount Saint Vincent.

3. As Superintendent of DFS, I am charged with protecting the viability of the health insurance markets in New York State and ensuring that residents of the State of New York have continued access to comprehensive and affordable health insurance.

4. DFS, among other responsibilities, regulates commercial accident and health issuers, non-profit health services corporations, and health maintenance organizations (collectively referred to as "Health Plans") and ensures their compliance with New York law and applicable federal law including the applicable provisions of the Patient Protection and Affordable Care Act ("ACA"). Some of DFS's most important responsibilities include overseeing the solvency of Health Plans, reviewing and approving health insurance policies and contracts, reviewing and approving health insurance plan premium rates and adjustments, and ensuring that Health Plans pay consumer claims for covered benefits as they become due. In addition, DFS acts to ensure that New Yorkers have access to high quality healthcare, which means ensuring that commercial health insurance policies sold in New York provide coverage for essential health benefits and do not discriminate based on age, gender, or pre-existing conditions.

5. Health Plans offer a variety of products in New York including Qualified Health Plans ("QHPs") through the New York State of Health ("NYSOH" or "Marketplace"), New York State's Official Health Plan Marketplace established pursuant to the ACA. On the NYSOH, individual and small group plans are sold to consumers and small businesses. Under New York law, small groups are those employers with 1-100 employees. In just six years, through the

establishment of products such as QHPs and the Marketplace, the ACA has succeeded in providing lower cost, higher quality coverage to millions of individuals and small businesses in New York. Since the ACA's implementation, New York's uninsured rate has dropped by approximately 50%, reducing the number of uninsured New Yorkers from approximately 10% to 5%. Under the ACA, approximately 4 million New Yorkers have received new coverage through our Marketplace – 227,796 of these enrollees are in QHPs in the individual market. In addition, commercial health insurance premiums for individuals remained over 50% less costly in 2017 than they would have been without the ACA. New York's healthcare market is robust, with 14 issuers offering individual coverage, 19 issuers offering small group coverage, and consumers in every county having a choice of coverage. As of March 31, 2018, there were 328,784 enrollees in the individual market and 1,076,361 enrollees in the small group market.

History of MEWAs in New York State

6. As initially enacted, ERISA created an exception to state regulation for employee benefit plans, including health care plans established or maintained by an employer. That was done through ERISA's preemption provision. Soon after ERISA's enactment, multiple-employer trusts and similar entities sought to take advantage of ERISA's preemption provision to claim ERISA status for entities that—like insurance companies—were marketing insurance policies to a range of small employers.

7. However, such arrangements were plagued with problems. For instance, it was reported that multiple employer arrangements were rife with fraud, fiscal mismanagement and insolvency. It was further reported that various third-party promoters viewed multiple employer arrangements as profit-making opportunities, claiming ERISA preemption of state laws, whether or not the arrangement was a legitimate ERISA plan. In short, multiple employer arrangements

promoters took advantage of the regulatory void and made money at the expense of their participants. Many such arrangements became insolvent, resulting in significant sums of unpaid claims and the loss of health insurance for many participants.

8. To remedy these problems, in 1983, Congress enacted the Erlenborn-Burton Amendment to add a new section 3(40) to ERISA to ensure states retain full authority under state insurance law to regulate associations and trusts of multiple employers. These were defined in section 3(40) as multiple employer welfare arrangements, or MEWAs. With the Erlenborn-Burton Amendment, Congress recognized that states are in the best position to use their insurance laws to protect their citizens and thus expressly authorized states to regulate these types of arrangements under those laws.

9. Despite that congressional action, fraud reportedly persisted. I am aware of several government agency reports and enforcement actions documenting the fraud and abuse committed by MEWAs and stating that such entities often left consumers without critical coverage or with unpaid claims. For example, the U.S. Government Accounting Office (GAO) noted in 1992: "Between January 1988 and June 1991, MEWAs left at least 398,000 participants and their beneficiaries with over $123 million in unpaid claims and many other participants without insurance. More than 600 MEWAs failed to comply with state insurance laws, and some violated criminal statutes. Moreover, MEWA problems increased in many states during this period. State efforts to regulate MEWAs, enforce state laws, and recover unpaid claims were hindered because the states could not identify MEWAs operating within their boundaries. Further, when states learned about problems, usually through complaints, many of their efforts to enforce compliance and collect unpaid claims were slowed because MEWAs asserted that they

were exempt from state regulation under ERISA."[1] That report also noted that "[t]he inability to identify MEWAs until after problems occur is at the heart of enforcement problems. Thirty-eight states said they were unable to proactively apply established standards-such as reporting and disclosure, as well as funding-because states were unable to identify MEWAS until complaints were received. For example, New York and Ohio officials said they could not enforce state-licensing requirements until the states had identified MEWAS through complaints from participants and others."[2]

10. In a 1995 report, the Department of Labor noted a case from New York in which the "First Class Health Plan, a MEWA which operated out of Buffalo, New York from 1988 until 1990, . . . collapsed, leaving $2 million in unpaid claims." The Department of Labor filed complaints charging "David Balzer and John Dunham, the MEWA administrators, with fiduciary breaches arising from their failure to place welfare plan assets in trust, causing participating plans to pay excessive administrative fees, failing to price premiums properly, failing to obtain appropriate actuarial studies, and using plan assets to satisfy their personal liability in a related New York State Insurance Division action."[3] The State of New York investigated and otherwise took action against such entities.[4]

---

[1] U.S. Gen. Accounting Office (GAO), Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements 2, GAO/HRD-92-40 (1992), at https://www.gao.gov/assets/220/215647.pdf.

[2] *Id.* at 7.

[3] U.S. Department of Labor, Labor Department Participation in ERISA Litigation and Significant Issues in Litigation, available on Westlaw at CA44 ALI-ABA 835, *884 (1995).

[4] *Id.*; *see also* New York State Department of Insurance, General Counsel Opinion No. 12-23-93, 1993 WL 13482549 (noting that two entities, including a trust and association, "are currently being investigated" and providing general guidance on treatment of MEWAs under ERISA).

11. Since the enactment of the Erlenborn-Burton Amendment in 1983, New York has adopted insurance laws designed to correct these problems and protect the integrity of its small group and individual health insurance markets, as well as consumers, that would otherwise be adversely affected by unregulated MEWAs.

12. Specifically, New York insurance law allows coverage to be issued to MEWAs for member employers only in certain carefully-defined circumstances. *See* New York Insurance Law § 4235(c)(1). New York generally regulates coverage issued to MEWAs at the employer-level, based on the size of each component employer. As many of these component employers have fewer than 100 employees, most employers receiving coverage through MEWAs in New York are issued small group coverage, which are therefore subject to DFS regulations to protect markets and consumers.

13. In particular, small groups are subject to "community rating," and large groups, with the exception of HMOs, are subject to "experience rating." Utilizing "community rating" to calculate premiums prevents issuers from varying premiums within a geographic area based on age, gender, health status, or other factors. "Community rating" contrasts with "experience rating" for large group plans, which rating allows premiums to be based on the group's claim history and the issuer's past experiences of providing health care coverage to the group during a given period of time, and is not subject to DFS's determination. This practice often results in groups whose members have increased health risks paying higher premiums. Community rating is considered a hallmark of the ACA as well as New York law, and its requirement in the small group market is fundamental to providing affordable coverage to all consumers. Moreover, New York law generally requires that coverage issued to a MEWA be based on its underlying member employers and not based on the size of the MEWA. Large employer members must be issued

large group coverage, small employer members must be issued small group coverage and individuals must be issued individual coverage. *See* New York Insurance Law §§ 3231(g) and 4317(d). These requirements protect the small group market in New York from higher premiums and adverse selection.

14. New York law also requires that individual and small group plans cover the essential health benefits package established under the ACA. *See* N.Y. Ins. Law § 3221(h).

15. If small employers were allowed to join together and be covered under a large group plan with out-of-state coverage, it would result in the loss of critical consumer protections that ensure consumers have adequate and affordable coverage.

The AHP Rule

16. Notwithstanding the AHP Rule, New York will continue to vigorously enforce its insurance laws, including those regarding community-rating and essential health benefits and those generally regulating insurance provided through an association at the level of the component employer. The AHP Rule expressly does not preempt state insurance law and makes clear that state insurance regulators, including DFS, maintain their full authority under state insurance law and regulations to enforce state law and regulate their state insurance markets. The AHP Rule further states that it "depends on state insurance regulators for oversight and enforcement to, among other things, prevent fraud, abuse, incompetence and mismanagement, and unpaid claims," 83 Fed. Reg. at 28,960, and that states will have to build and implement robust supervisory structures to prevent those outcomes from taking place, *id.*

17. Given the long and troubled history of MEWAs offering fraudulent plans, discriminating against consumers, and leaving consumers with unpaid claims, DFS already has taken action to prevent a potential influx of plans that purport to be authorized by the AHP Rule and ERISA but

would violate New York legal requirements and/or defraud New Yorkers. DFS will continue to take such actions to enforce New York laws to protect our markets and consumers.

18. New York will continue to regulate AHPs at the employer level, consistent with the State's small group and individual market requirements, and AHPs that do not comply with the State's laws and regulations will be prohibited from being sold to New Yorkers. DFS already has devoted staff time to analyzing the AHP Rule, both for associations based in New York and those that are based or may be formed in other States seeking to take advantage of the AHP Rule. DFS has used staff time to examine these issues, to advise insurers and other licensees of New York requirements, and to be prepared to enforce state protections notwithstanding the AHP Rule.

19. DFS is undertaking the additional regulatory burden to prevent harms from occurring in New York. DFS plans to devote additional staff resources and time to policing any such plans' attempts to sell such policies to New York consumers and to ensure that all applicable New York insurance laws are enforced against AHPs that may impact the State—as well as associated conduct of any broker or other agent in the State attempting to assist in such conduct. Further, DFS will take action against any issuer, agent or broker for any failure to comply with or attempt to circumvent New York statutory or regulatory requirements with respect to accident and health insurance coverage, employee welfare benefit plans or association health plans, including New York's requirements regarding the establishment of such groups, the provision of essential health benefits and other consumer protections. DFS also is prepared to undertake all additional enforcement actions necessary to protect New Yorkers from the AHP Rule.

20. Although the AHP Rule does not preempt state insurance law and does not impair DFS insurance regulation of AHPs, the AHP Rule creates confusion and will require DFS to expend

resources to ensure full enforcement of New York insurance law. For example, there may be AHPs that do not comply with New York's insurance requirements, but comport with other states' less stringent requirements, which may attempt to be sold to consumers in our State. As a result, DFS will need to deploy additional resources to enforce New York law against such plans being sold to New Yorkers, which will require additional expenditures of time and money by the State. These efforts will require the expenditure of significant staff time, expenses for current and additional staff, diversion of staff from other priorities, budgetary planning, and travel and other expenses for investigative and visitorial activities. These costs will grow even more with respect to any out-of-state AHP that attempts to sell into the New York market. DFS's enforcement efforts are needed to ensure that AHPs do not cross our borders in violation of New York law, and offer coverage with less comprehensive benefit packages than required under New York law. Moreover, as contemplated by the AHP Rule itself, those steps are also needed to prevent fraud and abuse of these plans that would harm consumers and markets.

21. It is important to view the impact of the AHP Rule as a matter of scale. As compared to prior ERISA law, the AHP Rule would authorize thousands (and likely many more) associations to provide association health plans under federal law. Whereas prior federal rules for the formation of a "bona fide association" under federal ERISA law were narrow and permitted that formation only rarely, the AHP Rule purports to authorize a vast expansion of such associations, to include, but not be limited to, any chamber of commerce in a geographic area up to the size of a State or metropolitan area. That change alone could allow for many additional entities to seek to qualify, under the federal AHP Rule, as "bona fide associations."[5] The AHP Rule would

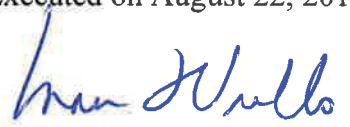
[5] U.S. Chamber of Commerce, Accreditation (noting that there are "approximately 7,000 chambers in the United States"), *at* https://www.uschamber.com/members/chambers/accreditation.

authorize a much broader scope of associations or groups (existing and new) to qualify; it is not limited to chambers of commerce, and can cover trade or business associations unlimited by geography. As noted above, these efforts are contrary to New York law and thus will require the expenditure of DFS time and resources.

22. DFS will expend these additional resources to ensure that any association health plans impacting New York comply with New York State Insurance Law and protect New York's market. DFS must ensure that insurers and brokers do not seek to violate New York law and cause harm to consumers and the individual and small group markets that are under DFS supervision. DFS will not permit sub-standard products that negatively impact New York's insurance markets and thus will take on the additional regulatory and enforcement burden necessary to protect New York's consumers and markets from adverse selection and other risk segmentation.

23. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on August 22, 2018



Maria T. Vullo
Superintendent of Financial Services

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR, R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF MASSEY S. J. WHORLEY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Massey S. J. Whorley, offer this Declaration in support of the Plaintiffs' motion for summary judgment. In doing so, I declare that the following facts are true to the best of my knowledge, information, and belief:

1. I am a Senior Advisor with the Virginia Department of Social Services. Before assuming my current position, I served as the Senior Policy Advisor to Secretary of Health and Human Resources, Dr. Daniel Carey, and to former Governor Terence R. McAuliffe. Prior to that, I was a Senior Policy Analyst at the Commonwealth Institute for Fiscal Analysis, a

nonpartisan organization that provides analyses of fiscal and economic policies and their implications for Virginians, especially low- and middle-income residents, where I managed the Health Care and Tax portfolios.

2. The Affordable Care Act (ACA) has been successful in improving quality and access to health care in Virginia. Since the ACA was enacted, the percent and number of individuals without insurance in Virginia has decreased. In 2009, prior to the implementation of the ACA, Virginia's uninsured rate for non-elderly adults (age 19-64) was 16.4%, representing 779,000 non-elderly adults in Virginia who lacked health insurance. By 2016, after the ACA was in effect, Virginia's uninsured rate for non-elderly adults dropped to 12.4%, representing 621,000 non-elderly adults in Virginia who lacked health insurance. A significant part of the ACA's success in reducing Virginia's uninsured rate was the federal health subsidies that enabled individuals with moderate incomes to purchase health insurance in the Exchanges. In 2017, 410,726 Virginians purchased health insurance on the Federally Facilitated Marketplace. In 2018, Virginia expanded Medicaid, which will lower Marketplace premiums while further expanding access to health insurance that covers all of the ACA's essential health benefits.

3. The Department of Labor's Final Rule re-interpreting ERISA's definition of employer (Final Rule) will have a substantial negative impact on Virginia's market for insurance. In particular, we anticipate a substantial decrease in enrollment and a substantial increase in premiums for individuals acquiring ACA-compliant health insurance through the Marketplace. The Final Rule will generally result in small groups and "working owners" who are healthier and have more attractive risk profiles leaving the Marketplace. One study estimated that, conservatively, more than two million people will leave the individual and small group markets for Association Health Plans, and that the average individual premium on the Marketplace would

be almost $15,000 by 2022, while the average Association Health Plan premium would be $6,200. The inevitable result of higher premiums is that some people will be unable to afford insurance. The study projected that the proposed rule would lead to 130,000 – 140,000 additional individuals in the United States becoming uninsured.

4. The Final Rule also will increase the financial and medical risk to our residents who enroll in Association Health Plans due to the limited plans that they may provide. The small groups and individuals who leave the insurance exchanges in favor of an Association Health Plan will have inferior coverage to that which they would have had if they remained in the Marketplace. Association Health Plans likely will not offer (because they are not required to offer) the comprehensive and essential benefits that are required of small groups and individual policies under the ACA, including coverage for pregnancy, substance abuse treatment, mental health treatment, and prescription drugs. Consequently, members of small groups and individuals who opt for an Association Health Plan will be at risk for unanticipated health care costs in the event they or their dependents become pregnant or suffer a sickness or injury that is not covered.

5. The Final Rule will result in financial harm to Virginia because the Commonwealth will be required to expend funds through its public hospitals and other state programs to provide care for these individuals in situations that would have been covered if they had obtained insurance through the Marketplace. For example, if members of an Association Health Plan are forced to obtain care at a public hospital for an essential health benefit that is not covered by their less comprehensive plan, then Virginia would incur a portion of the costs of providing that care if the individual cannot pay out of pocket. Moreover, there is a long history of Association Health Plans being underfunded, and the Commonwealth will be responsible for a

portion of the cost of providing care to these individuals when their claims are denied or cannot be paid because the plan is insolvent.

6. These well-known concerns about the effect Association Health Plans will have on the Marketplace and the people who count on it is why the Governor of Virginia vetoed state legislation that would have authorized Association Health Plans as a matter of state law. The Final Rule, like Virginia Senate Bills 934 and 935, undermines efforts to make sure all Virginians have access to quality, affordable health care. The Final Rule will increase the costs to the Commonwealth as people with minimal current health care needs purchase Association Health Plans that provide limited coverage, and people with more significant health care needs are forced to purchase ACA-compliant plans on the increasingly expensive Marketplace.

Pursuant to 28 U.S.C. § 1746, I declare under the penalty of perjury that the foregoing is true and correct.

Executed on August 8, 2018.

MASSEY S. J. WHORLEY

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

STATE OF NEW YORK, COMMONWEALTH OF MASSACHUSETTS, DISTRICT OF COLUMBIA, STATE OF CALIFORNIA, STATE OF DELAWARE, COMMONWEALTH OF KENTUCKY, STATE OF MARYLAND, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, COMMONWEALTH OF VIRGINIA, and STATE OF WASHINGTON, Plaintiffs, v. U.S. DEPARTMENT OF LABOR; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor, and UNITED STATES OF AMERICA, Defendants.	Civ. Action No. 18-1747-JDB

DECLARATION OF KEVIN LUCIA IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Kevin Lucia, declare:

1. I am a Research Professor at the Center on Health Insurance Reforms ("CHIR"), a research center which is part of the Health Policy Institute ("HPI") within the McCourt School of Public Policy at Georgetown University. As part of a specialized research team, I study and analyze how states and the federal government regulate private health insurance with a focus on access, affordability, and adequacy of coverage. My research includes analysis of state and federal laws, pending legislation and regulations, and current market practices related to private

health insurance. For many years, one focus of my research and that of HPI has been the regulation of health insurance sold through association health plans ("AHPs"), a type of multiple employer welfare arrangement ("MEWA").

2. Before co-founding CHIR in 2011, I directed the State Compliance Division within the Office of Oversight, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. From 2012-2016, I served as an Executive Board Member and Chair of the Insurance Market Committee of the Health Benefit Exchange Authority for the District of Columbia.

3. I have authored or co-authored many papers concerning AHPs and other MEWAs: *President Trump's Executive Order: Can Association Health Plans Accomplish What Congress Could Not?* Kevin Lucia and Sabrina Corlette, To the Point, The Commonwealth Fund, Oct. 10, 2017.; *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability,* Kevin Lucia and Sabrina Corlette, To the Point, The Commonwealth Fund, Jan. 24, 2018; *Federal and State Policy Towards Association Health Plans in Oregon,* Kevin Lucia, Sandy Ahn and Sabrina Corlette, Urban Institute and Robert Wood Johnson Foundation, October 2014; *Association Health Plans: What's All the Fuss About*, Mila Kofman, Kevin Lucia, Eliza Bangit and Karen Pollitz, Health Affairs, November/December 2006; *Association Health Insurance: Is It Time to Regulate This Product?* Mila Kofman, Kevin Lucia, Eliza Bangit and Karen Pollitz, Journal of Insurance Regulation, Fall 2005; *MEWAs: The Threat of Plan Insolvency and Other Challenges*, Mila Kofman, Eliza Bangit and Kevin Lucia, The Commonwealth Fund, March 2004; *Health Insurance Scams: How Government Is Responding and What Further Steps Are Necessary,* Mila Kofman, Kevin Lucia and Eliza Bangit, The Commonwealth Fund, August 2003; *Proliferation of Phony Health Insurance:*

States and the Federal Government Respond, Mila Kofman, Kevin Lucia and Eliza Bangit, Bureau of National Affairs, August 2003; *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs,* Mila Kofman, Eliza Bangit and Kevin Lucia, California Health Care Foundation, July 2003.

4. As part of my academic research, I have closely read and analyzed the Department of Labor's ("DOL") recent rulemaking effort pursuant to which DOL has sought to redefine the term "employer" under Section 3(5) of ERISA for the purpose of encouraging the formation and enrollment in AHPs and which resulted in the release of a final rule on June 21, 2018. 83 Fed. Reg. 28912 (June 21, 2018) (the "Final Rule").

5. My curriculum vitae is attached to this Declaration as Exhibit A.

Background – History and Regulation of AHPs

6. The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to reform employee pensions and other employee benefit programs, including employee welfare benefit plans. ERISA federalized regulation and oversight of employee benefit plans. Title I of ERISA, which governs employee benefit plans including group health plans, was adopted by Congress in 1974, among other reasons, to remedy the abuses that existed in the handling and management of welfare and pension plan assets. ERISA also preempted many state laws that related to employee benefit plans.

7. Since ERISA's enactment, there has been an extensive history of scams connected to the federal framework under which MEWAs are regulated. Promoters of phony or deceptively-marketed multiple employer benefit plans have used the federal law in an attempt to avoid scrutiny by state regulators and law enforcement. When states sought to enforce their own insurance laws to regulate MEWAs prior to a 1983 amendment to ERISA, the entities sponsoring

and promoting these plans argued that ERISA preempted state law, in many cases hindering efforts to stop fraudulent and illegal activity. At the same time, DOL claimed to lack authority over these insurance arrangements because the vast majority were not, in fact, ERISA plans. To help address these concerns, a 1983 amendment to ERISA explicitly allowed for state insurance regulation of self-insured and fully-insured AHPs. Also, because fully-insured AHPs obtain insurance from state-licensed carriers, states have always retained authority to regulate products these AHPs offer. This means that states may apply and enforce their insurance laws with respect to self-insured and fully-insured AHPs.

8. Both before and after the 1983 amendment to ERISA, AHPs and other types of MEWAs have been rife with fraud, insolvency, gross mismanagement, and deceptive conduct. For example, in the late 1980s, one MEWA, purporting to be a union plan, reportedly left 3,600 people in 32 states with some $25 million in unpaid claims, according to a DOL report. A 1992 Government Accounting Office ("GAO") report found that from 1988 to 1991, failed MEWAs, such as AHPs, phony unions, and employee leasing firms, left thousands of people in dozens of states without health insurance and nearly 400,000 patients with medical bills exceeding $123 million.

9. Similarly, 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." In total, GAO identified 144 unauthorized entities that covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002. These entities failed to pay at least $252 million in medical claims and, at the time of the report, federal regulators were able to recover less than a quarter of this amount.

10. Employers Mutual LLC is an example of a scam perpetrated through AHPs. This entity – using a name similar to a legitimate Iowa-based insurance company – sold unauthorized health insurance across the United States through existing associations such as the National Writers Union – a professional association for journalists – and sixteen associations that Employers Mutual established. By the time regulators intervened in 2001, over 30,000 people nationwide were left without coverage and these individuals had at least $27 million in unpaid claims. Employers Mutual's operators were eventually indicted, but not until thousands of individuals were severely harmed by their fraud.

11. Similarly, in 2002, American Benefit Plans ("ABP"), a nationwide scam, left over 40,000 people without health insurance and with over $28 million in unpaid medical bills when it failed due to widespread fraud. ABP sold coverage through four associations it created, such as the National Association for Working Americans and the United Employer Voluntary Employee Beneficiary Association.

12. Prior to the enactment of the Patient Protection and Affordable Care Act ("ACA"), millions of individuals and small employers bought health insurance through associations. Business and trade associations often offered coverage as part of their broader mission to serve the professional needs of their members. Some associations catered primarily to individuals, including the self-employed, while others catered to employer groups. Some associations focused on a population within a specific state, such as those operated by a state medical association or a local chamber of commerce. Others were domiciled in one state but marketed AHP coverage in multiple states.

13. The regulation of AHPs has been a combined federal and state endeavor. In general, states are the primary regulators of health insurance and health insurance issuers. Prior

to the ACA, states sometimes exempted AHPs from state rules and standards that applied to commercial insurers, such as filing requirements, underwriting restrictions, benefit mandates, and solvency standards. Additionally, AHPs would sometimes set up headquarters in one state with limited regulatory oversight and then market policies to businesses and consumers in other states with more robust regulation of rating and plan benefits.

14. The federal government, through DOL, is responsible for the enforcement of federal law with respect to employee benefit plans subject to ERISA. Thus, to the extent an AHP constitutes an ERISA employee welfare benefit plan, states and DOL have concurrent oversight responsibility. Until issuance of the Final Rule, however, DOL has not considered an AHP offered by an association to member employers to be an employer benefit plan subject to ERISA (called a "bona fide" employer group or association) except under rare conditions, discussed in more detail below.

15. For decades, DOL has interpreted ERISA to provide that a MEWA consisting of self-employed members is not a bona fide employer group or association because self-employed persons are not employers of common-law employees.

16. Historically, the lower premiums frequently associated with AHPs derive from their ability to attract healthier enrollees and deter those with higher health care costs. One method AHPs used to attract healthier enrollees is to exclude benefits that appealed to employers and individuals with higher health risks. As a result, absent the ACA's protections, AHPs would siphon healthy small groups and individuals away from ACA-compliant plans, leaving a smaller and sicker risk pool for the traditional insurance market and fewer plan options and higher prices for the small businesses and individuals that remain in that market.

17. The ACA was enacted to expand access to health insurance and make insurance more affordable. The ACA included reforms designed to help curb past abuses and solvency concerns raised by AHPs. These included greater enforcement authority for DOL, criminal penalties for false statements to state or federal officials, federal registration, and additional reporting requirements.

18. More broadly, the ACA ushered in a suite of market reforms and consumer protections that apply to commercial insurance. Different protections apply to the individual, small employer, and large employer markets. Among the reforms that apply to the small group market (defined as fewer than 50 full-time equivalent employees) but not to the large group market (defined as 50 or more full-time equivalent employees), are the following: (a) required coverage of "Essential Health Benefits;" (b) the application of adjusted community rating rules; (c) the creation of a single risk pool for all of an insurer's market participants; and (d) participation in the risk adjustment program.

19. For example, plans offered in the individual and small employer market must cover the ACA's ten Essential Health Benefits, which include, among other services, mental health and substance use disorders, prescription drugs, and rehabilitative and habilitative services and devices. Plans offered in the large employer market are not required to cover these benefits.

20. The Essential Health Benefits also requires maternity and newborn care to be included in all plans offered in the individual and small employer market. While the Pregnancy Discrimination Act ("PDA") requires employers with 15 or more employees to provide maternity care benefits on the same basis as other health benefits to employees and their spouses, plans in the large employer market sometimes exclude maternity care for other dependents. In addition, the PDA is an employer requirement and not a requirement on the plan, so employers with less

than 15 employees that are able to offer a plan that does not need to comply with the Essential Health Benefits could exclude maternity if not otherwise required by state law.

21. Similarly, the individual and small employer markets have premium rating rules that prohibit insurers from adjusting premiums based on an individual's occupation, health status, and gender, among other factors. Under the ACA, insurers may only adjust premiums based on the number of family members enrolled in the plan; geography; tobacco use (insurers may charge those that use tobacco more than those that do not if the state allows; however, the variation in premiums is limited to 1.5 to 1); and age (insurers may charge older adults more than younger adults; however, the variation in premiums is limited to 3 to 1). These rules do not apply to the large employer market.

22. The creation of a single risk pool for each of the individual and small employer markets requires insurers offering products in those markets to set rates using a single risk pool that includes all enrollees across their individual plans and across their small group plans in the state. This requirement does not apply to the large employer market.

23. Finally, the ACA established a risk adjustment program. The risk adjustment program transfers funds from insurers in the individual and small employer markets with lower risk enrollees to plans in these markets with higher risk enrollees. This program does not apply to the large employer market.

24. Together, the ACA's reforms to the individual and small employer market were designed to ensure that health insurance is more readily available, affordable, and provides comprehensive coverage to small employers, their employees, and individuals – a demographic that historically faced significant challenges obtaining and/or affording quality health insurance.

25. The ACA enacted more limited reforms to the large group market through new requirements on large employers, who historically have provided their employees with far more comprehensive coverage than was available in the small group market. For example, the ACA requires large employers to offer health coverage to their full-time employees or face the possibility of paying a tax penalty. If a large employer offers coverage but that coverage is not considered "minimum essential coverage" that is "affordable" and meets "minimum value" standards pursuant to the ACA's provisions, then the employer may be assessed a tax penalty. The tax penalty discourages, but does not prohibit, large group plans that do not meet these standards or that do not otherwise offer "minimum essential coverage." In addition, Congress extended certain reforms that apply in the small group and individual markets to the large group market: small and large group plans cannot deny coverage to eligible enrollees based on pre-existing conditions; must cover certain benefits such as preventive care and screenings for women, without cost-sharing; and, for those health plans that offer dependent coverage, must cover dependents up to their twenty-sixth birthday.

26. Certain states have in the past structured their health insurance markets so that different rules apply to the small group and/or individual markets, on the one hand, and to AHPs, on the other. The results of such experiments have resulted in significant market dysfunction and, in some cases, market failure.

27. For example, in the mid-1990s, Kentucky enacted health insurance reforms for the individual and small group markets that were, in many ways, similar to the ACA in that they required insurers to accept all applicants regardless of health status and adjusted community rating in setting premiums and prohibited excluding applicants with pre-existing conditions. A few years later, Kentucky exempted associations of employers or individuals from various

requirements of the law, allowing them to sell insurance with less stringent requirements than applied to the small group and individual markets. For the reasons discussed above (*see* ¶ 16), healthy Kentucky residents enrolled in AHPs, resulting in increasing premiums for the sicker enrollees in the traditional markets. Post-reform, nearly all insurers stopped selling policies in the traditional individual market or declined to sell new policies leading to a collapse of the individual insurance market. The AHP exemption likely contributed, at least in part, to what the Kentucky Department of Insurance referred to as the start of a death spiral in the insured market. Ultimately, the Kentucky legislature repealed most of the market reforms and created a high-risk pool for those that were denied coverage based on their health status.

28. Similarly, Tennessee currently has a fragile individual insurance market in large part due to a large AHP – the Tennessee Farm Bureau – that is open to all Tennessee residents who pay a fee and can pass the AHP's medical underwriting standards. In particular, the Farm Bureau screens members for high-cost medical conditions. The Farm Bureau is not considered a health insurer subject to the Tennessee insurance code, but nevertheless provides health coverage that is not ACA complaint to as many as 73,000 people. As a result, the Society of Actuaries found in 2015 that the population enrolled in individual ACA-compliant plans in Tennessee had the worst overall health risk score in the country. If the healthy people insured by the Farm Bureau were included in the individual market, it would very likely improve the overall balance of healthy and sick in the Tennessee individual marketplace.

DOL Guidance Regarding AHPs and ERISA Before the Final Rule

29. Prior to its 2018 rulemaking, when DOL assessed whether an association or group of employers could be considered a bona fide single employer group under ERISA, it generally focused on three issues: (a) whether the association is a bona fide organization with a purpose

and function other than the provision of benefits; (b) whether the employers in the association share some commonality unrelated to the provision of benefits; and (c) whether the employers that participate in the benefit program exercise control over the program.

30. DOL considers the following factors as part of an evaluation of all facts and circumstances in determining whether a bona fide group or association of employers exists for purposes of ERISA: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed; the purposes for which it was formed and what, if any, were the pre-existing relationships of its members; the powers, rights, and privileges of employer-members; and who actually controls and directs the activities and operations of the benefit program. In addition, employer-members of the group or association that participate in the AHP must, either directly or indirectly, exercise control over that program, both in form and substance, to act as a bona fide employer group or association with respect to the benefit program. To be recognized as an employer by ERISA, the association must be acting in the interest of its employer-members to provide benefits to their employees and there must be a genuine organizational relationship among the employers. Finally, where membership in an association is open to anyone engaged in a particular trade or profession regardless of their status as employers or where control of the association is not vested solely in employer members, the association is not a bona fide employer group or association under ERISA.

31. DOL has issued guidance, including multiple advisory opinions and the 2013 publication "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation," stating that associations with self-employed members are not eligible for bona fide employer group or association of

employers status within the meaning of ERISA § 3(5) because they are not treated as employers for this purpose, since self-employed members may not have common-law employees. Pursuant to DOL regulations dating to the implementation of ERISA, individual working owners without separate employees are not considered "employers" under ERISA and any AHP that offers coverage only to such individuals is not a group health plan under ERISA.

The Final Rule

32. On June 21, 2018, DOL released the Final Rule. As noted above, I have closely read and analyzed DOL's Final Rule related to AHPs. To analyze its impact on the private health insurance markets, I have completed a comprehensive review of research and analysis related to AHPs conducted by HPI faculty before and after the ACA, along with more recently published quantitative analysis. My analysis was informed by discussions with former DOL officials, current and former state regulators, and stakeholders such as AHPs, consumer groups, insurers, and brokers.

33. Under the Final Rule, existing AHPs can continue to operate under previous DOL regulations and guidance. However, DOL also authorized the sale of new AHPs that need only comply with the new standards under the Final Rule. As discussed below, these new standards mark a dramatic shift away from previous DOL regulations and guidance and are expected to result in the proliferation of AHPs in many states across the country.

34. Under the Final Rule, AHPs can qualify as a bona fide ERISA association even if they form an association primarily to provide insurance benefits, in addition to one other business purpose, and gain the regulatory advantages of being treated as a large group. Additionally, DOL expanded what it means for employers to "share some commonality." To be considered a single-employer AHP under the Final Rule, employer-members could either: (a) be

in the same trade, industry, line of business, or profession; or (b) have their principal place of business in the same geographic region, either within a state or metropolitan area that includes more than one state. If the former, the AHP could sell coverage nationwide, so long as its members are in the same trade, industry, line of business, or profession. If the latter, an AHP could enroll all businesses in a State, or all businesses in a metropolitan area that crosses state lines.

35. The Final Rule would allow self-employed individuals to be treated as "employers" to join an association and at the same time be treated as their own "employees" to be covered under the benefit plan. The Final Rule would require these "worker-owners" to earn a minimum income or work a minimum number of hours. However, the Rule's income standard is vague and low, providing minimal guidance to AHPs on how to enforce the requirement. The Final Rule permits the AHP to rely on "the accuracy of the information in written documentation or a sworn statement submitted by a working owner, without independent verification." The Final Rule would also allow AHPs to cover individuals by allowing them to maintain coverage for former employees and family members.

Impact of Final Rule on National Small Group and Individual Markets

36. Based on my extensive study of AHPs and my knowledge of state and national small group and individual health insurance markets, it is my expectation that the Final Rule will lead to a proliferation in the marketing and promotion of, and enrollment in, AHPs throughout the United States.

37. The Final Rule will cause a very significant increase in the number of AHPs recognized as employee welfare benefit plans under ERISA and, as a result of this recognition, these AHPs will not be required to abide by the ACA's rules governing the individual and small

group markets. Because the ACA's more robust protections will not apply to these AHPs, it is to be expected that the results of prior experiences with AHPs will repeat themselves. In particular, AHPs will likely attract younger and healthier individuals because they are not required to offer the same comprehensive set of benefits required of ACA-compliant plans and they are allowed to use additional rating factors based on age, gender, industry, and other non-health related factors. For example, an ACA-compliant plan in the individual market is limited to charging an older person no more than three times the premium charged to a younger person. Under the new Federal Rule, AHPs will not have to comply with this requirement, which would allow AHPs to increase premiums for older members, while offering lower premiums to younger individuals, who generally have lower health costs than older individuals. This premium differential is expected to encourage younger, healthier individuals to migrate from the individual insurance market to AHPs.

38. Healthy small groups and individuals can be expected to leave ACA-compliant plans for AHPs that provide skimpier benefits and fewer consumer protections because they are lower cost, leaving a smaller and sicker risk pool for the traditional insurance market. Over time, this loss of healthy risk will likely result in fewer plan options and higher prices for the most vulnerable small businesses and individuals that remain in the traditional markets because they need access to the comprehensive benefits and consumer protections in those markets.

39. In addition, in the past fraudsters and other bad actors often used periods of regulatory uncertainty – such as will result from the Final Rule – to market and promote fraudulent, abusive, and deceptive health coverage. There is a long history of this sort of conduct being committed through AHPs. Because the Final Rule will create confusion among market actors – especially as to the continued applicability of state insurance laws concerning

AHPs – we are very likely to see an increase in fraud and deception as has been the historical practice with MEWAs and AHPs. As a result, many small employers and individuals may find that they do not in fact have the insurance coverage that they had been led to believe and will find themselves unable to receive needed medical care or stuck with very large medical bills.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on August 17, 2018, in Washington, D.C.

Kevin Lucia
Research Professor and Project Director
Center on Health Insurance Reforms
Georgetown University

EXHIBIT A

KEVIN LUCIA, J.D., M.H.P.

Center on Health Insurance Reforms
McCourt School of Public Policy
Georgetown University
3300 Whitehaven Street, NW Suite 5000
Washington, DC 20007
202-687-4928
kwl@georgetown.edu

Health Policy Researcher

Kevin Lucia is a Research Professor and Project Director at the Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy. Mr. Lucia currently directs policy research and analysis of federal and state law related to access, affordability and adequacy of private health insurance. He provides expertise, training and strategic advice and prepares resources to inform regulators, policymakers, stakeholders organizations and the media. He speaks regularly on status of federal health coverage reform. His research has been funded by government, private foundations and various stakeholder organizations.

Prior to CHIR, Mr. Lucia led the State Compliance Division within the Office of Oversight, Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS).

Mr. Lucia holds his J.D. from The George Washington University Law School and an M.H.P. from Northeastern University.

Education

The George Washington University Law School, George Washington University
Juris Doctor — Jan. 2005

Bouve College of Health Sciences, Northeastern University
Master of Health Professions — June 1995
Major: Health Policy

Bouve College of Health Sciences, Northeastern University
Bachelor of Science — June 1994
Major: Physical Therapy

Health Policy Experience

Center on Health Insurance Reforms, Health Policy Institute, Georgetown University, Washington DC
Co-founder; Research Professor; Project Director — June 2011 – Present

Office of Oversight, CCIIO, CMS, Washington DC
Director State Compliance Division — May 2010 – May 2011

Health Policy Institute, Georgetown University, Washington DC
Assistant Research Professor — June 2006 – Apr. 2010

Health Policy Institute, Georgetown University, Washington DC
Health Policy Researcher June 2001 – June 2006

United States Department of Defense, Army
Captain, Medical Specialty Corps Sept. 1995 – Sept. 1999
Multiple Duty Stations:
-West Point: United States Military Academy
-Pentagon: Department of Defense
-WRAMC: Walter Reed Army Medical Center

Teaching Experience

1. Adjunct Professor of Law, Georgetown University Law Center, Georgetown University, *The Affordable Care Act: Law and Policy Governing Private Health Insurance*, 3 Credit Course, Spring 2015.

2. Co-Director, *O'Neill Summer Program on Health Reform-The Affordable Care Act*, O'Neill Institute For National & Global Health Law, Georgetown University Law Center, Georgetown University, Summer 2014.

3. Assistant Professorial Lecturer, School of Public Health and Health Services, George Washington University, *Private Health Insurance: Building Blocks For Reform*, 2 Credit Course, Summer 2007-2009.

Appointments

1. Board Member, Health Benefit Exchange Authority, District of Columbia, Appointed by Mayor Vincent C. Grey, 3 year term, July 2012-2016.

2. Consumer Liaison Representative, National Association of Insurance Commissioners, 2008-2010.

Selective Publications*

1. State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market, The Commonwealth Fund, March 2018.

2. Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018, Kevin Lucia, Jack Hoadley, Sabrina Corlette, Dania Palanker, Olivia Hoppe, the Robert Wood Johnson Foundation, November 2017

3. Balance Billing by Health Care Providers: Assessing Consumer Protections Across States, Kevin Lucia, Jack Hoadley and Ashley Williams, The Commonwealth Fund, June 2017.

4. Post–Affordable Care Act Trends in Health Coverage for Small Businesses: Views From the Market, Kevin Lucia, Sabrina Corlette and Sandy Ahn, Urban Institute and Robert Wood Johnson Foundation, September 2015

*For a compreheisve list of publication, see https://chir.georgetown.edu/publications.html

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK, et al., Plaintiffs, v. U.S. DEPARTMENT OF LABOR, et al., Defendants.	Civil Action No. 1:18-cv-01747-JDB

[PROPOSED] ORDER FOR SUMMARY JUDGMENT

Upon consideration of Plaintiffs' Motion for Summary Judgment, the memoranda in support thereof and in opposition thereto, and the entire record in this case, it is hereby

ORDERED that Plaintiffs' Motion is **GRANTED**; and it is further

ORDERED that Defendants are enjoined to vacate and set aside the Department of Labor's June 21, 2018 final rule entitled "Definition of 'Employer' Under Section 3(5) of ERISA – Association Health Plans" (Final Rule); and it is further

DECLARED that the Final Rule is arbitrary, capricious, or otherwise contrary to law within the meaning of 5 U.S.C. § 706(2)(A); and it is further

DECLARED that the Final Rule was promulgated by the Defendants in excess of statutory jurisdiction, authority, or limitations within the meaning of 5 U.S.C. § 706(2)(C); and it is further

ORDERED that Defendants take all other necessary steps to ensure full vacatur of the Final Rule.

SO ORDERED.

Dated: _____, 2018

_____
John D. Bates
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK, et al., Plaintiffs, v. U.S. DEPARTMENT OF LABOR, et al., Defendants.	Civ. Action No. 18-1747-JDB

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

FEDERAL STATUTES

AGENCY GUIDANCE

LEGISLATIVE MATERIALS

OTHER AUTHORITIES

INTRODUCTION

This lawsuit challenges a Final Rule issued by the U.S. Department of Labor that departs from decades of settled practice and authorizes a dramatic expansion of the circumstances under which employers may join together in an association to offer health insurance coverage exempt from critical consumer protections. The Final Rule authorizes the expansion of association health plans ("AHPs") for the express purpose of overriding the Patient Protection and Affordable Care Act ("ACA") and exempting a significant portion of the health insurance market from the ACA's core protections. When announcing the Final Rule, the President proclaimed that the Rule was another "truly historic step in our efforts to rescue Americans from ObamaCare and the ObamaCare nightmare" and would "escape some of ObamaCare's most burdensome mandates."[1] The Final Rule seeks to further this goal by redefining the term "employer" in Section 3(5) of the Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. ("ERISA") to allow individuals and small employers to join "associations" that can offer large group health plans not subject to the ACA's principal safeguards. 83 Fed. Reg. 28,912 (June 21, 2018) (to be codified at 29 C.F.R. pt. 2510) (hereinafter the "Final Rule"). Simply put, the Final Rule seeks to expand AHPs in order to undermine the ACA.

Plaintiffs—eleven States and the District of Columbia that are harmed by the Final Rule—ask this Court to vacate and set aside the Final Rule under the Administrative Procedure Act ("APA") on the ground that it is arbitrary, capricious, not in accordance with law, and in excess of statutory jurisdiction. 5 U.S.C. §§ 706(2)(A), (C).

[1] President Donald Trump, Remarks at the National Federation of Independent Businesses 75th Anniversary Celebration (June 19, 2018), at https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-federationindependent-businesses-75th-anniversary-celebration/. *See also* Compl. ¶ 6 (ECF No. 1).

The Final Rule violates the ACA by seeking to overturn Congress's reforms of the individual and small group markets—reforms that were intended to ensure that individuals and employees of small employers could purchase or maintain comprehensive health insurance coverage. To accomplish that goal in those markets, the ACA curtails discrimination in premiums based on factors including health, gender, age, region, and occupation. The ACA also requires coverage of ten "essential health benefits" and further requires that insurers treat all enrollees in each of the individual and the small group markets—healthy or sick—as part of unified insurance pools. Because of these reforms, the States have made enormous progress in decreasing uninsured rates, ensuring comprehensive coverage, and achieving market stabilization in the individual and small group markets. If the Final Rule takes effect as the Department of Labor ("DOL") intends, the result will be a vast expansion of associations that qualify as single, large employers that evade core ACA protections and that will result in millions of people exiting the unified risk pools for the individual and small group markets in many states—destabilizing and potentially destroying those markets.

The Final Rule also violates ERISA and unlawfully upends nearly forty years of ERISA precedent. For the first time in ERISA's history, the Final Rule deems sole proprietors with no employees (called "working owners") to be eligible to form associations under ERISA. And in a dramatic departure from well-settled precedent and DOL's own longstanding practice, the Final Rule allows entirely unrelated and separate employers in a state or metropolitan area to form associations, including associations created for the primary purpose of selling insurance for profit. Because the States are entitled to judgment as a matter of law that the Final Rule is unlawful, arbitrary, and capricious under the APA, Plaintiffs respectfully request that this Court grant their motion for summary judgment and vacate the Rule.

STATEMENT OF FACTS

I. STATUTORY AND REGULATORY FRAMEWORK

A. The ACA Adopted Fundamental Reforms for the Individual and Small Group Insurance Markets.

In a series of enactments culminating in the ACA in 2010, Congress created a statutory scheme of several interlocking and interdependent Acts governing health insurance at the national level. *See* Pub. L. No. 111-148, 124 Stat. 119 (2010). The core reforms of the ACA focused on health insurance provided to individuals and to employees of small businesses (defined as businesses employing fifty or fewer employees). Because the risk pools in these markets prior to the ACA had been fragmented into multiple segments—thus pooling risk only across small slices of the relevant population—premiums were volatile, benefits often were inadequate, and people experienced severe discrimination based on health status and other factors.[2] Risk segmentation, in particular, led to wide and unsustainable fluctuations in costs for individuals and small businesses. *See, e.g.,* Cong. Research Serv., R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act 5* (Jan. 29, 2010).

The ACA's comprehensive reform of health insurance directly addressed these problems in several ways. With respect to risk segmentation within the individual and small group market, the ACA required insurers to treat all enrollees in each of those markets as "members of a *single risk pool*." 42 U.S.C. § 18032(c) (emphasis added). To ensure more uniform and robust health coverage, the ACA required that all individual and small group plans provide a "comprehensive" benefits package known as the "essential health benefits package" ("EHBs"). 42 U.S.C. § 300gg-

[2] *See* Declaration of Kevin Lucia ("Lucia Dec.") ¶ 16; *see also* Compl. ¶¶ 3, 52 (ECF No.1).

6(a).[3] This package also has financial protections for enrollees.[4] And, rather than permitting wide variations in premiums that previously had priced out many consumers, the ACA severely limited premium variation in the individual and small group markets. This provision, known as the "community rating" provision, forbids premium variation except based on certain narrow factors. 42 U.S.C. § 300gg.

In addition, the ACA provided tax credits to subsidize individuals' purchase of health insurance, *see* 26 U.S.C. § 36B; credits to encourage small businesses to provide health coverage, *see id.* § 45R; and exchanges to enable marketplace shopping for individual and small group coverage, *see* 42 U.S.C. § 18031. *See generally King v. Burwell*, 135 S. Ct. 2480 (2015).

In contrast to its treatment of the individual and small group markets, the ACA adopted different reforms for the large group market, which generally serves employers that employ more than fifty employees. Because most large employers already offered comprehensive health insurance to their employees, the ACA did not impose the same array of reforms on the large group market. For example, broader variation in premiums is allowed. While Congress mandated that large employers provide health coverage or pay a tax penalty, *see* 26 U.S.C. § 4980H, the mandated coverage need not meet the standards of comprehensiveness set for the individual and small group markets. A large employer pays this tax penalty only if the coverage the employer provides is either unaffordable or does not provide "minimum value," in the sense that it covers

[3] The package must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services, substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. 42 U.S.C. § 18022(b).

[4] *See* 42 U.S.C. § 18022(a), (c) (limitations on cost-sharing); *id.* § 18022(d) (minimum actuarial value).

sixty percent of essential health benefit costs on an actuarial basis, *id.* § 4980H(b)(1)(B).[5] Although not an essential health benefits requirement, that tax penalty provides some protection for employees to ensure that relatively comprehensive benefits are provided by large employers.[6]

In short, whether the ACA's core protections apply to a particular type of coverage depends on whether the coverage is individual, small group, or large group. The ACA supplies essentially identical definitions of these terms at 42 U.S.C. § 300gg-91 and § 18024.[7] Under each, a "small employer" is an "employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees [sic] on the first day of the plan year," and a "large employer" is an "employer who employed" more than fifty employees. 42 U.S.C. §§ 300gg-91(e), 18024(b)(1)–(2). These same sections define "employer" by reference to Section 3(5) of ERISA, 29 U.S.C. § 1002(5), "*except that such term shall include only employers of two or more employees*," thus excluding sole proprietors with no other employees. 42 U.S.C. §§ 300gg-91(d)(6) (emphasis added).[8]

---

[5] Under 26 U.S.C. § 4980H(b), an employer who provides health coverage in the large group market can be subject to the provision's $3,000 penalty only if an employee buys a different policy on an exchange using a premium tax credit under the ACA. The employee can be *eligible* for such a credit only if the employer's coverage does not provide "minimum value," defined as at least sixty percent of the "total allowed costs of benefits provided under the plan." 26 U.S.C. § 36B(c)(2)(C)(ii).

[6] Some of the ACA's reforms applied to all three markets (individual, small group, and large group). For example, Congress forbade exclusions based on pre-existing conditions in all three markets, *see* 42 U.S.C. § 300gg-3; required that all group health plans, including large group plans, cover certain benefits, such as preventive care and screenings for women, without cost-sharing, *see* 42 U.S.C. § 300gg-13(a); and required that such plans cover an insured's "adult child until the child turns 26 years of age," 42 U.S.C. § 300gg-14(a).

[7] Two sets of definitions apply because ACA provisions are codified in different parts of Title 42.

[8] 42 U.S.C. § 18024 does not have its own definition of "employer," but the definition contained in 42 U.S.C. §300gg-91(d)(6) applies. *See* 42 U.S.C. § 18111 ("Unless specifically provided for otherwise, the definitions contained in section 300gg–91 of this title shall apply with respect to this title," referring to Title I of the ACA, where 42 U.S.C. § 18024 was enacted).

B. ERISA's Definitions of "Employer" and "Bona Fide Association."

Congress enacted ERISA in 1974 principally to protect employees, pensioners, and their employee pension and welfare benefits. ERISA imposed fiduciary obligations on plan administrators and implemented disclosure requirements and other safeguards. Title I of ERISA —which governs employee benefit plans, including group health plans—"was adopted [in part] to remedy the abuses that existed in the handling and management of welfare and pension plan assets[.] Workers in such traditional employer-employee relationships are more vulnerable than self-employed individuals to abuses because the workers usually lack the control and understanding required to manage pension funds created for their benefit[.]" *Schwartz v. Gordon*, 761 F.2d 864, 868 (2d Cir. 1985).

Under ERISA, an "employer" is "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's definition of employer includes the employer who acts *directly* as an employer, and can include an entity, like an association, that acts indirectly in the direct employer's interest.

Because ERISA's definition of "employer" refers to "a group or association of employers," entities began abusing that definition to offer health insurance plans through purported groups known as multi-employer welfare arrangements ("MEWAs," of which AHPs are one type). Those entities engaged in widespread fraud and abuse.[9] In response to such abuses, DOL and the courts crafted a narrow interpretation of when an "association of employers" can be deemed an "employer" under ERISA. First, the employer-members of the association must be

[9] *See* Lucia Dec. ¶¶ 8-11; 83 Fed. Reg. at 28,954 n. 142 (acknowledging history of fraud and abuse).

tied by a common economic or representational interest, unrelated to the provision of benefits. Because of this requirement, associations formed to make money by selling insurance do not qualify—a principle Congress reaffirmed shortly after passing ERISA. *See Bell v. Emp. Sec. Benefit Ass'n*, 437 F. Supp. 382, 392 (D. Kan. 1977) (quoting Activity Report of the Committee on Education and Labor of the U. S. House of Representatives, H.R. Rep. No. 94-1785, at 48 (1977)).[10] Second, the association's employer-members must have meaningful control over, and direct involvement in, the establishment or maintenance of the plan and the association. *See*, *e.g.*, *Gruber v. Hubbard Bert Karle Weber, Inc.,* 159 F.3d 780, 787 (3d Cir. 1998); *Matthew 25 Ministries, Inc. v. Corcoran*, 771 F.2d 21, 22 (2d Cir. 1985).

Over the last several decades, DOL has established well-settled criteria to determine whether an association is a "bona fide association" that qualifies as an "employer" under ERISA Section 3(5). These criteria include: (1) the process by which the association was formed and the purposes for which it was formed; (2) the existence, if any, of pre-existing relationships among employer members; (3) whether employer members were solicited; (4) who is entitled to participate and who actually participates in the association; (5) the powers, rights, and privileges of employer members; and (6) whether employer members actually control and direct the activities of the benefit plan. *See, e.g.*, DOL Op. No. 2007-06A (Aug. 16, 2007); DOL Op., 1992 ERISA LEXIS 45 (Oct. 30, 1992) (Op. No. Not Assigned); DOL Op. No. 91-42A (Nov. 12, 1991). Associations that fail to satisfy these criteria cannot offer plans that would qualify as ERISA plans. Thus, for example, when so-called "multiple employer trusts" formed as entrepreneurial "associations" for profit-making purposes soon after ERISA's enactment, DOL

[10] *See also* Compl. ¶ 45 (noting that this House report has been described as "virtually conclusive as to legislative intent" by a host of federal courts).

testified before Congress that they were not ERISA plans, and argued in the courts that ERISA's statutory language precluded recognizing them as such. *See Bell*, 437 F. Supp. at 392 (quoting H.R. Rep. No. 94-1785, at 48).[11]

It likewise has been settled for decades that an individual with no employees cannot be both an "employer" and "employee" under ERISA. DOL has adhered to this interpretation since 1975, when the agency first implemented ERISA. *See* Coverage; Reporting and Disclosure Requirements, 40 Fed. Reg. at 34,526, 34,533 (Aug. 15, 1975).

Congress expressly provided that ERISA does not "alter, amend, modify, invalidate, impair, or supersede any law of the United States," and restricted DOL's authority to construe the statute to do so. 29 U.S.C. § 1144(d).

II. SUMMARY OF THE FINAL RULE

President Trump signed Executive Order 13813 on October 12, 2017, directing his administration to look for ways to expand AHPs. In January 2018, DOL published a notice of proposed rulemaking in response to the President's order. *See* Proposed Rule, 83 Fed. Reg. at 614 (Jan. 5, 2018). DOL received more than 900 comments on the Proposed Rule. *See* Final Rule, 83 Fed. Reg. at 28,914. DOL released the Final Rule at issue in this case, "Definition of 'Employer' under Section 3(5) of ERISA – Association Health Plans," on June 19, 2018, and published it in the Federal Register on June 21, 2018. *See id.* at 28,912. With the purpose of undermining core ACA protections, the Final Rule redefines the term "employer" in Section 3(5)

[11] *See also*, *e.g.*, Br. for Appellant DOL, at *7, *Donovan v. Dillingham*, 668 F.2d 1196 (11th Cir. 1982) (No. 80-7879), 1980 WL 340211; 128 Cong. Rec. H1,1084 at 11395 (daily ed. May 21, 1982) (statement of Sen. Erlenborn) (describing DOL congressional testimony); *see infra* at 39–40 (describing congressional testimony of Administrator for Pension and Welfare Benefits Jeffrey Clayton).

of ERISA to expand what may qualify as an "association of employers" under ERISA. The intended effect of this redefinition is to allow these associations to qualify as large employers subject to the ACA's more limited protections for large group plans and to shift millions of the States' residents out of the ACA's individual and small group markets, thereby causing them to lose the ACA's most robust protections and destabilizing those markets.

The Final Rule accomplishes this goal through two primary changes. First, reversing DOL's longstanding reliance on the "bona fide association" test, the Final Rule enables numerous unrelated employers to join an "association" formed primarily to offer insurance, and then permits that association to include employers that are merely in the "same trade, industry, line of business, or profession" *or* "have a principal place of business within a region that does not exceed the same State or the same metropolitan area (even if the metropolitan area includes more than one State)." *Id*. at 28,922. The result would be that associations (1) newly formed (2) primarily to sell insurance (3) for profit (4) to all employers in the same industry or geographic area (an undefined term that could include a whole state or an area that crosses many states' borders) will qualify as "employers" under ERISA for the purpose of creating AHPs.[12]

Second, for the first time in ERISA's history, the Final Rule deems self-employed individuals with no other employees to be "employers" under ERISA, thus enabling them to form and/or join employer associations. The test under the Final Rule for an individual to be considered self-employed is minimal. Under the Final Rule, to qualify as a so-called "working owner," an individual must merely "[w]ork[] on average at least 20 hours per week or at least 80

[12] The Final Rule does not define "geographic area." DOL makes clear that an area could be *as large as* a state or metropolitan area (undefined), but "nothing in the final rule requires [] that a group or association or their AHP cover the entire State or an entire metropolitan area in order for the group or association to qualify as bona fide." 83 Fed. Reg. at 28,925.

hours per month providing personal services to the working owner's trade or business," or must have "wages or self-employment income from such trade or business that at least equals the working owner's cost of coverage for participation by the working owner and any covered beneficiaries in the group health plan sponsored by the group or association in which the individual is participating." *Id*. at 28,964.

In addition, the preamble to the Final Rule purports to expand the number of AHPs that will be deemed large group plans for the purposes of the ACA, by aggregating "the total number of employees of all the employer-members participating in the AHP." *Id*. at 28,915. Thus, which ACA protections are applicable will be determined by counting the number of employees in the entire association, rather than the number of employees of each direct employer.

The Final Rule became effective on August 20, 2018. *Id.* at 28,912. The Final Rule allows "fully insured plans"—i.e., plans that purchase insurance from third-party insurance companies—"to begin operating under the new rule on September 1, 2018," *id.* at 28,953, thus enabling such AHPs to begin operating within weeks, free from federal ACA protections not otherwise duplicated under state law. In addition, "[e]xisting self-insured AHPs"—that directly offer insurance themselves—"can begin operating under the new rule on January 1, 2019, and new self-insured AHPs can begin on April 1, 2019." *Id.* The Final Rule states that this "modest" delay will allow DOL and states to prepare for the anticipated need to increase investigatory and enforcement resources to prevent AHPs from engaging in fraud and abuse. *Id*. at 28,912, 28,954.[13]

[13] Plaintiffs are not at this point seeking preliminary injunctive relief, but are carefully monitoring the phased implementation of the Final Rule and may seek a preliminary injunction in the future if circumstances warrant.

ARGUMENT

Defendants promulgated the Final Rule for the express purpose of undermining the ACA and to avoid the heightened protections established by that Act for individuals and employees of small employers. Those protections include a guarantee that premiums for the individual and small group markets will not vary based on a wide range of factors such as gender or health status[14]; the requirement that health plans in these markets cover ten essential health benefits[15]; and the requirement that all enrollees in a given State's individual and small group markets, respectively, be placed in a common risk pool.[16] By contrast, health plans offered by large employers are not subject to the same consumer protections.

The Final Rule explicitly seeks to overturn this congressional judgment. In the notice of adoption, DOL acknowledged that its permissive rules for AHPs are intended to "level[] the playing field between small employers in AHPs, on the one hand, and large employers, on the other, who generally are not subject" to the ACA's consumer protections. 83 Fed. Reg. at 28,933. Defendant Acosta, the Secretary of Labor, publicly stated that the purpose of the Final Rule is to exempt small employers from the ACA's "benefit mandates and rating restrictions." Alexander Acosta, *A Health Fix For Mom and Pop Shops*, Wall St. J. (June 18, 2018). As Secretary Acosta admitted, the purpose of the Final Rule is to override Congress's intent—he declared that Congress's judgment in the ACA was "backward" because "[s]mall businesses should face the same regulatory burden as large companies, if not a lighter one." *Id.*

---

[14] *See* 42 U.S.C. § 300gg-91(a)(1); *see also* Compl. ¶¶ 4, 56 (describing other factors the ACA does not permit to influence premiums).

[15] *See* 42 U.S.C. §§ 300gg-6(a), 18022(a)(1), (b)(1).

[16] *See* 42 U.S.C. § 18032(c).

The Final Rule is unlawful under both the ACA and ERISA, and is arbitrary and capricious as well. First, by allowing millions of unrelated individuals and small employers to count as if they all worked for one large employer—for the express purpose of negating the ACA's most important consumer protections—the Final Rule conflicts with the health insurance market structure at the heart of the ACA. Second, by allowing individuals with no employees to be treated as "employers" for purposes of forming large group health plans, the Final Rule violates the plain language of ERISA and the ACA. Moreover, the Final Rule violates the decades-old, settled understanding of when an "association" can qualify as an "employer" under ERISA. Third, the Final Rule is arbitrary and capricious because it departs from longstanding agency practice without sufficient explanation, is counter to the evidence in the record before the agency, relies on factors Congress did not intend DOL to consider, and is predicated on mutually inconsistent statutory interpretations.

States will suffer significant harm as a result of the Final Rule. Many states have relied on the ACA's individual and small market protections as intended by Congress,[17] but have not enacted similar protections in their own laws.[18] When AHPs authorized under the Final Rule infiltrate those states' markets with skimpy coverage that will no longer adhere to ACA coverage requirements, the result, borne out by history, will be serious harm to those markets and the individuals who rely on them to obtain quality, affordable health coverage.[19]

---

[17] Congress empowered the states to enforce core ACA provisions, with the Department of Health and Human Services ("HHS") stepping in only if a state substantially failed to do so. *See* 42 U.S.C. § 300gg-22.

[18] *See, e.g.*, Declaration of Stephen C. Taylor ("Taylor Dec.") ¶ 20.

[19] *See, e.g.*, Declaration of J. Michael Brown ("Brown Dec.") ¶ 13; Declaration of Pritika Dutt ("Dutt Declaration") ¶¶ 6–8; Declaration of Kevin Lucia ("Lucia Dec.") ¶¶ 7–11; Declaration of Mila Kofman ("Kofman Dec.") ¶¶ 26–27, 30–31; Declaration of Christopher R. Monahan

Many of the states' most vulnerable residents in need of comprehensive health coverage will remain in the individual and small group markets as they destabilize and shrink, and will experience significant premium increases, potentially resulting in the loss of coverage entirely. At the same time, the individuals who leave those markets—healthier individuals who may join AHPs—will have substandard coverage that may not cover vital services (such as hospitalization, maternity and newborn care, and prescription drugs) and will be denied access to ACA subsidies that would enable them to acquire coverage for those services.[20]

Where, as here, final agency action is challenged under the APA, "[s]ummary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the APA standard of review." *Stewart v. Azar*, 2018 WL 3203384, *6 (D.D.C. June 29, 2018) (quoting *Loma Linda Univ. Med. Ctr. v. Sebelius*, 684 F. Supp. 2d 42, 52 (D.D.C. 2010) (citation omitted). "[T]he Court's role is limited to reviewing the administrative record, so the standard set forth in Rule 56(c) does not apply." *Sierra Club v. Jackson*, 833 F. Supp. 2d 11, 18 (D.D.C. 2012) (quoting *Air Transport Ass'n of Am., Inc. v. Nat'l Mediation Bd.*, 719 F. Supp. 2d 26, 32 (D.D.C. 2010); *see also Stewart v. Azar*, 2018 WL 3203384, at *6 (D.D.C. Jun. 29, 2018) ("The summary-judgment standard set forth in Federal Rule of Civil Procedure 56(c), therefore, 'does not apply because of the limited role of a

("Monahan Dec.") ¶¶ 14–20; Declaration of Patricia F. O'Connor ("O'Connor Dec.") ¶ 12; Declaration of Maria T. Vullo ("Vullo Dec.") ¶¶ 6–10.

[20] *See* Brown Dec. ¶¶ 10–12, 14; Declaration of Marlene Caride ¶¶ 13–14, 16–17; Dutt Declaration ¶¶ 9–16; Declaration of Audrey Gasteier ¶¶ 7–8; Declaration of Myron Bradford "Mike" Kreidler ¶¶ 6–13, 16–17, 19; Kofman Dec. ¶¶ 15–25, 28–29, 33–34, 36–37; Lucia Dec. ¶¶ 36–39; Declaration of Pam MacEwan ¶¶ 5–15, 18; Monahan Dec. ¶¶ 26–35; Declaration of Trinidad Navarro ¶¶ 6–9; O'Connor Dec. ¶¶ 9–11, 14–16; Declaration of Andrew Stolfi ¶¶ 4–8; Taylor Dec. ¶¶ 12–15, 20; Declaration of Massey S.J. Whorley ¶¶ 3–6.

court in reviewing the administrative record.'") (quoting *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 89 (D.D.C. 2006)).[21]

The Final Rule violates the Administrative Procedure Act ("APA"), as it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). The States thus respectfully request that this Court grant Plaintiff States summary judgment and vacate the Final Rule.

I. The Final Rule Unlawfully Seeks To Override the Affordable Care Act's Market Structure.

Under the Administrative Procedure Act, courts "shall" "hold unlawful and set aside" agency regulatory action that is "not in accordance with law" or "in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. §§ 706(2)(A), (C). In promulgating the Final Rule, DOL improperly seeks to override the ACA's market structures in a manner that is not in accordance with the ACA, and is in excess of DOL's authority.

A. The ACA Requires That an Employer's Market Size Be Determined by Counting the Employees at the Individual Employer Level and Not at the Association-of-Employers Level.

A key component of the ACA is its robust consumer protections for health plans in the markets for individuals and small groups—*i.e.*, small employers and their employees. Congress focused on the individual and small group markets because those markets have historically had worse coverage and were more volatile than the large group market. *See* Compl. ¶¶ 3–4, 52, 54–58. In the ACA, Congress made a legislative judgment that individuals and employees of small employers require more robust consumer protections than employees of large employers.

[21] Plaintiffs intend to file a proposed scheduling order with the Court that addresses the filing of the administrative record, consistent with Local Civil Rules 7(h)(2) and 7(n). Plaintiffs' citations to the rulemaking record in this memorandum will, pending the Court's approval of the proposed scheduling order, be included in a joint appendix to be filed with the Court.

The stated intent of the Final Rule is to undo that legislative judgment based on Defendants' belief that Congress made the wrong policy choice. The Final Rule dramatically expands the number of health benefit plans exempt from the ACA's strict protections for individual and small group plans by allowing the package of consumer protections applicable to AHPs to be determined by aggregating "the total number of employees of all the employer-members participating in the AHP." 83 Fed. Reg. at 28,912, 28,915. In other words, under the Final Rule, an association whose employer-members *collectively* have more than fifty employees would be able to offer health plans exempt from the ACA's individual and small group protections—even if those plans are being provided exclusively to individuals or employees of small employers.

The ACA forecloses the aggregation principle that is relied on by the Final Rule. The plain language of the ACA requires that the relevant consumer protections applicable to an employee's group health plan depend on the size of that employee's employer—not on the size of an association or other group of which the employer is a member. The ACA defines a "large employer" as "an employer who employed an average of at least 51 employees" during the preceding year, and a "small employer" as "an employer who employed an average of at least 1 but not more than 50 employees" in the preceding year. 42 U.S.C. §§ 300gg-91(e); 18024(b)(1)–(2).[22] Under analogous statutes defining the reach of a federal law based on the size of an employer, the Supreme Court has made clear that the operative inquiry is the number of employees who work for the employer—*i.e.*, who have a common-law master-servant relationship with the employer.

[22] Because the ACA amended multiple existing statutes, including the Public Health Service Act ("PHSA"), the Internal Revenue Code ("IRC"), and ERISA, the market-size definitions are codified in multiple sections, but do not differ in their operative language.

For example, the Americans with Disabilities Act applies to an employer who "has 15 or more employees for each working day in each of 20 or more calendar weeks in the preceding calendar year." 42 U.S.C. § 12111. The Supreme Court has interpreted that language to refer to traditional, common-law employers—*i.e.*, "the person, or group of persons, who owns and manages the enterprise . . . can hire and fire employees, can assign tasks to employees and supervise their performance, and can decide how the profits and losses of the business are to be distributed." *Clackamas Gastroenterology Assocs., P.C. v. Wells*, 538 U.S. 440, 449–50 (2003). The Age Discrimination in Employment Act similarly applies to an employer who "has twenty or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year." 29 U.S.C. § 630(b). Courts have applied the common-law test to that definition as well. *See Weary v. Cochran*, 377 F.3d 522, 525 (6th Cir. 2004). These decisions reflect the general principle that, when Congress uses terms such as "employer" or "employee" that have "accumulated settled meaning under . . . the common law, a court must infer, unless the statute otherwise dictates, that Congress means to incorporate the established meaning of these terms." *Cmty. for Creative Non-Violence v. Reid*, 490 U.S. 730, 739 (1989) (interpreting "employee" in the Copyright Act).

Indeed, DOL has adopted the common-law understanding of the employer-employee relationship to determine whether benefit plans offered by associations qualify as MEWAs under ERISA. Such benefit plans are MEWAs if they are offered "to the employees of two or more employers." 29 U.S.C. § 1002(40)(A). The dispositive question under this language is whether the individuals covered by the plan are employees of one employer (such as an association) or instead multiple employers (such as the association's employer-members). DOL has expressly relied on the common law to make that determination, concluding that the common-law master-

servant test not only determines who is an employee, but also "determin[es] *by whom* an individual is employed" for purposes of ERISA's MEWA provision. DOL Op. No. 93-29A n.2 (emphasis added); *see also Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323–24 (1992) (applying common-law test to definition of "employee" under ERISA). In other words, common law principles determine whether an employee is employed by an association or by one of its employer-members for purposes of the MEWA statute.[23]

The same interpretive principles apply to the ACA's textually analogous definitions of large and small employers. Congress specified that a "large employer" is an "employer *who employed*" more than fifty employees. 42 U.S.C. § 300gg-91(e)(2) (emphasis added). As with the other statutory sections discussed above, an employer (including an association) satisfies this definition only if it exercises sufficient control and supervision to satisfy the common-law test for an employer-employee relationship for more than fifty employees. Thus, even if an association were to qualify as an "employer" under the ACA's cross-reference to the definition of "employer" in ERISA § 3(5), *see* 42 U.S.C. § 300gg-91(d)(6), it would not be the "employer *who employed*" its members' employees absent a common law relationship, and accordingly could not aggregate those employees for purposes of being deemed a "*large* employer." *Id.* § 300gg-91(e)(2) (emphases added). The Final Rule contravenes this plain reading of the ACA by allowing an association to aggregate its employer-members' employees to qualify as a large employer, even when those employees do not have a common law master-servant relationship with the association.

[23] The same principles apply under ERISA provisions governing when a plan must provide continuation coverage. *See* 29 U.S.C. § 1161(a). Those provisions contain an exemption for employers that employ fewer than twenty employees. *See id.* § 1161(b). Only "common law employees of an employer are taken into account in determining whether" this exemption applies. 26 C.F.R. § 54.4980B-2.

The ACA's own statutory aggregation rules also foreclose the Final Rule's treatment of associations. For purposes of qualifying as a large employer, the ACA allows multiple employers to aggregate their employees in specific, statutorily enumerated circumstances—but those circumstances do not include associations. Specifically, in a provision entitled "Rules for determining employer size," 42 U.S.C. § 18024(b)(4), the ACA sets out an "aggregation rule for employers" that provides, in full: "All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of Title 26 shall be treated as 1 employer," *id.* § 18024(b)(4)(A). The cross-referenced subsections are clauses in the Internal Revenue Code ("IRC") that allow employees of multiple entities to be "treated as employed by a single employer" under specific circumstances, none of which are applicable here. *Id.* [24] The existence of this section demonstrates that, in enacting the ACA, Congress specifically defined the circumstances under which employees of separate employers could be "treated as employed by a single employer" for purposes of "determining employer size" under the ACA, and thus necessarily intended to exclude other circumstances—including aggregation by an association. *See John Wiley & Sons, Inc. v. DRK Photo*, 882 F.3d 394, 405 (2d Cir. 2018) (describing "interpretive canon of *expressio unius est exclusio alterius*").

Finally, the Final Rule contravenes Congress's intent to apply these principles across all of the different statues amended by the ACA, including the IRC. The Final Rule states that its re-definition of "employer" does not extend to the IRC. *See* 83 Fed. Reg. at 28,915. But in enacting

[24] Specifically, aggregation of employees is permitted when: several corporations have a common parent corporation that owns eighty percent of the stock in all of the corporations, *see* 26 U.S.C. § 414(b); a group of partnerships or proprietorships are under "common control," *id.* § 414(c); arrangements in which one organization holds shares in another and performs services for that organization, *id.* § 414(m); and certain arrangements intended to avoid employee benefit requirements, *id.* § 414(o).

the ACA, Congress applied core ACA provisions dependent on the term "employer" not only in the Public Health Service Act ("PHSA"), but also in the IRC (and ERISA). *See* Compl. ¶ 58 (quoting 29 U.S.C. § 1185d and 26 U.S.C. § 9815). Congress's simultaneous adoption of substantively identical provisions across all of these statutes unambiguously expressed its intent to apply the same market-size rules across the board.[25] The Final Rule ignores that requirement.

The most egregious disparity introduced by the Final Rule's disregard of the uniform definitions mandated by Congress is its refusal to extend the ACA's employer mandate (which is contained in the IRC) to associations offering AHPs. The employer mandate is a tax added by the ACA to the IRC that is imposed on any large employer that fails to offer its employees affordable coverage that meets certain minimum standards. *See* 26 U.S.C. §§ 36B(c)(2)(C), 4980H. Congress plainly intended the large employer mandate generally to apply to the same employers as the ACA's more lenient consumer protections for large employer plans: the two statutes use the same "employer who employed" language to define the size of the employer, and further contain the same statutory aggregation rules and the same rules for treatment of predecessor employers and employers not in existence in the previous year. *Compare* 42 U.S.C. § 300gg-91(e)(2), *with* 26 U.S.C. § 4980H(c)(2)(A). Congress also specified that any term appearing in the IRC's statutory provision imposing the employer mandate "shall have the same

[25] Making doubly clear Congress's intent that these substantively identical provisions across the PHSA, ERISA, and IRC must be construed the same way is a separate provision instructing the pertinent agencies to administer these statutes "so as to have the same effect at all times." Health Insurance Portability and Accountability Act ("HIPAA"), Pub. L. No. 104-191, § 104. That provision, which remains on the books, was enacted when Congress in 1996 enacted the portions of ERISA (Part 7), the PHSA (Part A of Title 27), and the IRC (Chapter 100) later amended by the ACA. The Final Rule acknowledges that this provision applies but omits that it imposes an obligation to construe these statutory provisions the same way. 83 Fed. Reg. at 28,915 n.9 ("The Departments of Labor, HHS, and the Treasury operate under a Memorandum of Understanding that implements section 104 of [HIPAA] and subsequent amendments, including certain sections of the Affordable Care Act, and provides for coordination and consultation.").

meaning" as the same term in the ACA, 26 U.S.C. § 4980H(c)(6), meaning that any entity that qualifies as an employer under the ACA must also qualify as an employer for purposes of the employer mandate.

The Final Rule disregards the statutorily mandated parallel between the meaning of "large employer" in the IRC and the ACA. For purposes of the employer mandate, the preamble to the Final Rule asserts that the employer mandate will *not* apply to the association, but only to a member employer of the association that independently satisfies the definition of an "applicable large employer." 83 Fed. Reg. at 28,933 & n.54. In other words, while the Final Rule declares that a group of employers that band together to form an AHP will be treated as a single large employer for purposes of evading the ACA's protections for small group plans, *see* 83 Fed. Reg. at 28,912, it provides that the same group will *not* be considered a large employer for purposes of the employer mandate, *see id.* at 28,915, 28,933. DOL does not explain—nor could it—how an association could qualify as a "large employer" within the meaning of the market-size definitions but not as an "applicable large employer" within the meaning of the employer mandate. Such a disparity contravenes Congress's intent by purporting to exempt associations from the protections for small group plans *and* from the employer mandate applicable to large group plans.[26]

Finally, DOL misplaces its reliance on a 2011 bulletin issued by the Centers for Medicare & Medicaid Services ("CMS") that provided guidance on how to determine whether associations are large or small employers. *See* CMS Ins. Stds. Bulletin Series (Sept. 1, 2011) ("CMS

[26] DOL has represented that the Department of the Treasury—the agency that administers the IRC—offered "consultation" on the Final Rule. 83 Fed. Reg. at 28,915. This token invocation of another agency's assent cannot permit DOL to divorce statutory provisions that Congress meant as complementary—particularly in the absence of even an attempt to address the plain language of the employer mandate.

Bulletin"); *see also* 83 Proposed Rule, 83 Fed. Reg. at 618 & n.12 (quoting CMS Bulletin). The CMS Bulletin supports Plaintiffs' position by stating that in most cases a "group health plan exists at the individual employer level and not at the association-of-employers level," meaning that "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." CMS Bulletin at 3; *see also* Proposed Rule, 83 Fed. Reg. at 618 (quoting CMS Bulletin). While DOL relies on a statement in the CMS Bulletin that there are "rare" exceptions to this rule (CMS Bulletin at 3), that statement did not analyze the provisions of the ACA discussed above, see *supra* at 15–20, and was incorrect because the ACA does not contain any exception that would allow associations to aggregate their employer-members' employees for purposes of calculating market size. In any event, the Final Rule here sweeps well beyond what CMS could possibly have intended in its 2011 Bulletin. At that time, as the Bulletin acknowledged, only a very narrow class of "bona fide associations" could be considered "employers" under ERISA; as a result, allowing this limited number of associations to qualify as large employers was sufficiently "rare" to not materially affect the character of the small group and individual markets. DOL's dramatic expansion of the class of associations that may now qualify as "employers" under ERISA (and "large employers" under the ACA) will have a far more than *de minimis* effect—indeed, it will enable an association of virtually all employers in a state to qualify as a "large employer."

B. Nothing in ERISA Authorizes DOL To Evade the Plain Meaning of "Large Employer" Under the ACA.

DOL's authority to interpret the term "employer" under ERISA cannot justify its subversion of the ACA's statutory market-size definitions. To be sure, the ACA cross-references the definition of "employer" in ERISA § 3(5), 42 U.S.C. 300gg-91(d)(6), and the ERISA

definition includes a "group or association of employers" that is acting "indirectly in the interest of an employer, in relation to an employee benefit plan," 29 U.S.C. § 1002(5). But that cross-reference at most establishes that an association of employers may be an "employer." It does not establish—nor does anything in ERISA determine—whether such an employer is a "large" or "small" employer under the ACA, which turns instead on whether the employer *employs* a threshold number of employees under the common-law master-servant standard.

Indeed, as explained above (see *supra* at 16–17), in interpreting ERISA's MEWA statute DOL has explained that although an "association of employers may constitute an 'employer' within the meaning of ERISA Section 3(5)," that classification does not itself determine whether the association's employer-members can be treated in the aggregate as a single employer.[27] To the contrary, as DOL explained in 2013 guidance (that has not been rescinded):

> the individuals typically covered by the group or association-sponsored plan are not "employed" by the group or association and, therefore, are not "employees" of the group or association. Rather, the covered individuals are "employees" of the employer-members of the group or association.

Id. Under the principles stated in this interpretation, DOL's classification of an association as an "employer" under ERISA would not by itself permit the association to count its employer-members' employees as the association's own employees for purposes of qualifying as a "large employer" under the ACA. The preamble to the Final Rule does not even acknowledge, let alone distinguish, this recent pronouncement from DOL regarding the limited implications of qualifying as an "employer" under ERISA.

[27] U.S. Dep't of Labor, MEWAs: *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal & State Regulation* 22 (2013), at 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.

In any event, because the ACA is both "later-enacted" and a "more specific, comprehensive statute that targets the specific subject matter at issue," it prevails if there is any "potential conflict or discrepancy." *Nutritional Health All. v. FDA,* 318 F.3d 92, 102 (2d Cir. 2003) (citing *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 143 (2000)). ERISA's definitional section allows an association, in some circumstances, to be an "employer," but nothing in that section—which defines scores of terms—has anything to do with market sizes or the distinction between large and small employers for purposes of triggering the ACA's consumer protections. *See generally* 29 U.S.C. § 1002.

Finally, ERISA in particular is a statute that should not be read to change the meaning of any other federal statute absent a clear congressional directive. ERISA contains an express non-impairment clause providing that "[n]othing in [ERISA] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States." *Id*. at § 1144(d). As the D.C. Circuit has observed, this language is "expansive" and "unequivocal" and thus deserves "broad application." *Oakey v. U.S. Airways Pilots Disability Income Plan*, 723 F.3d 227, 233 (D.C. Cir. 2013). This non-impairment clause further undermines DOL's attempt to leverage the definition of "employer" in ERISA to alter the protections offered by the ACA.

C. Congress Did Not Delegate to DOL the Authority To Issue Regulations Eliminating Consumer Protections or Substantially Impacting the Health Insurance Market.

"It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). DOL here exceeded its authority by attempting to override Congress's judgment. While the Final Rule ostensibly seeks only to clarify the meaning of "employer" under ERISA, the purpose and effect of this purported definitional clarification is to

dramatically alter the health insurance market structures established under the ACA. This is not "carrying out" a provision of ERISA—it is regulatory hijacking.

The Final Rule identifies no statutory authority authorizing any agency—let alone DOL—to abrogate by ERISA regulation the ACA's critical consumer protections for the individual and small group markets. Nor can such authority be inferred in the face of Congress's silence. The ACA's protections for the individual and small group markets were some of the statute's "key reforms," affecting "millions of people" previously subject to inadequate or discriminatory health plans. *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). Whether and how those protections apply is thus "a question of deep 'economic and political significance' that is central to this statutory scheme; had Congress wished to assign that question to an agency, it surely would have done so expressly." *Id*. No provision of the ACA provides such express authority.

It is especially unlikely that Congress would have left *to DOL* the fundamental policy choice of whether individuals and small employers may, by forming or joining associations, evade the ACA's consumer protection and rating requirements. Not only does this policy determination undermine Congress's specific legislative goal of ensuring comprehensive health benefits and consumer protections for individuals and small employers' employees, but it could undermine the shared risk pools Congress created to stabilize the individual and small group markets. The Final Rule's express purpose is to siphon people out of the individual and small group markets—and thus out of these shared risk pools—by authorizing a new breed of AHPs that will qualify as large group plans. *See, e.g.*, 83 Fed. Reg. at 28,938–39.

Nothing in the ACA or ERISA suggests—let alone expressly provides—that DOL can regulate to reverse the deliberate design of the ACA, which reflected Congress's intent to

consolidate rather than balkanize the risk pools for the individual and small group markets. Indeed, DOL does not have expertise regulating healthcare or health insurance marketplaces, and yet DOL's justification for the Final Rule rested heavily on findings about how the health care and health insurance markets function, including the risks and benefits of exempting small employers from the ACA's essential health benefit requirements; the possibility of adverse selection and increased consumer out-of-pocket health care expenses in AHPs; and the effects of siphoning individuals and small businesses out of the individual and small-group markets through the expansion of AHPs. *See, e.g.*, 83 Fed. Reg. at 28,912 (analyzing the economic impact of the Final Rule, including the purported need for regulation). Congress typically delegates this type of analysis not to DOL, but to HHS, which has general authority to carry out the terms of the ACA, including the creation, operation, and oversight of health insurance marketplaces.[28] It is implausible that Congress would have silently delegated to DOL the authority to make fundamental choices about the scope of a statute that a different agency would typically administer. *See Chamber of Commerce v. DOL*, 885 F. 3d 360, 386 (5th Cir. 2018).

Even before the legislative process that led to the ACA's enactment, Congress repeatedly considered and rejected legislation to expand AHPs in precisely the ways that the Final Rule attempts to pursue.[29] Where Congress has repeatedly rejected legislation to amend a statute to achieve a significant policy change (such as an expansion of AHPs under ERISA) and instead

[28] *See, e.g.*, 42 U.S.C. § 18041(a); *see also* ACA, Pub. L. No. 111-148, § 1254 (ordering HHS to "conduct a study of the fully-insured and self-insured group health plan markets" to "compare the characteristics of employers" and "determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure."). To be clear: the Final Rule would not be valid if it were promulgated by HHS instead, in light of its other defects.

[29] *See, e.g., Small Business Health Fairness Act of 2005*, H.R. Rep. No. 109-41, at 1–5 (describing Congress's failure pass legislation expanding AHPs in 1995, 1996, 1997, 1998, 1999, 2001, 2002, and 2003).

has enacted different reforms, an agency may not seize upon general language in the existing statute to find an implied delegation to achieve the rejected ends through regulation. *See INS v. Cardoza-Fonseca*, 480 U.S. 421, 442 ("Few principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language.").

During debate on the ACA, and continuing in the years since enactment, members of Congress proposed bills that would more freely allow small employers to band together into large employers. None of those bills have passed, and many were rejected. *See, e.g.*, S. 2818, 110th Cong., § 802 (Small Business Health Plans Act of 2008); S. 1818, 115th Cong. (Small Business Health Plans Act of 2017); *see also* Compl. ¶¶ 64–72 (describing decades of rejected legislation). Indeed, many opponents of the ACA bill expressly argued that it *did not* create a way for small employers to band together to qualify for the large group market, and cited this as an important reason for their opposition.[30] Their efforts to add AHP legislation to the ACA, or to substitute AHP legislation for the ACA, were rejected. *See* Compl. ¶ 71 (describing rejections in committee and on the floor of the House of Representatives). At the same time, members of Congress who supported the ACA bill explicitly recognized the market pressures affecting smaller employers and explained that the bill contained a specific, different solution to that issue. As Senator Baucus, a principal architect of the ACA, explained, "small businesses lack the buying power larger companies have to negotiate affordable group rates," and therefore "[t]he Senate bill creates small business insurance exchanges . . . where small businesses can band

[30] *See, e.g.,* 155 Cong. Rec. S13,563-64 (daily ed. Dec. 20, 2009) (statement of Sen. Isakson); 115 Cong. Rec. S13,681 (daily ed. Dec. 21, 2009) (statement of Sen. Enzi); 115 Cong. Rec. S13,829 (daily ed. Dec. 23, 2009) (statement of Sen. Kyl); *id.* S14,126 (daily ed. Dec. 24, 2009) (statement of Sen. Ensign); 156 Cong. Rec. H1,919 (daily ed. Mar. 21, 2010) (statement of Rep. Frelinghuysen).

together and pool their risks." 155 Cong. Rec. S13,573 (daily ed. 2009); *see also id.* S13,864 (daily ed. Dec. 23, 2009) (statement of Sen. Klobuchar) ("small businesses can finally pool their numbers and do what big businesses do"). DOL cannot substitute its judgment for Congress's, and it certainly may not negate the requirements Congress chose to apply.

Finally, whatever authority Congress may have delegated to clarify the precise definitions of large and small employers under the ACA, Congress could not have authorized an agency to entirely subvert the ACA's statutory goals. *See Brown & Williamson*, 529 U.S. at 133 (a court "must be guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency."). But the Final Rule expressly and deliberately seeks to overturn Congress's judgment that individuals and small employers receive key consumer guarantees. And DOL's attempt to substitute its policy views for those of Congress is all the more remarkable because the agency explicitly concedes that an association of "working owners" or small employers will not have the same incentive to provide quality coverage that large employers do. *See* 83 Fed. Reg. at 28,944. A true large employer has economic incentives to provide comprehensive coverage, whereas DOL admits that AHPs will favor "risk differences between, for example, genders, age groups, and industries, and more tailored, often less comprehensive benefits." *Id.* DOL thus concedes both (1) that it is attempting to reverse policies set by Congress, and (2) that it will not even be able to provide an alternative route to the same quality of coverage Congress required.

"What we have here, in reality, is a fundamental revision of the statute." MCI *Telecommunications Corp. v. AT&T*, 512 U.S. 218, 231 (1994). Given the "enormous importance to the statutory scheme" of the ACA's reforms to the individual and small group markets, *id.*, a regulation that makes those reforms inapplicable to a wide swath of individuals

and employers does not merely adjust the scope of the ACA, but utterly transforms it—changing it from a scheme with a principal goal of protecting individuals and small employers' employees into a scheme that gives them fewer protections than the employees of large employers. Whatever the merits of that idea as a policy matter, "it was not the idea Congress enacted into law." *Id.* at 232. By seeking to leverage its regulatory authority to effect changes to the ACA, a law duly enacted by Congress, DOL has acted in excess of its statutory authority. *See Bowen*, 488 U.S. at 208; *Am. Library Ass'n. v. FCC*, 406 F.3d 689, 691 (D.C. Cir. 2005). The Final Rule is also "not in accordance with law." *Atl. City Elec. Co. v. FERC*, 295 F.3d 1, 14 (D.C. Cir. 2002) (citing 5 U.S.C. § 706(2)(A)). Therefore, as required by the APA, the Final Rule must be set aside. 5 U.S.C. §§ 706(2)(A), (C).

II. The Final Rule Unlawfully Expands the Definition of "Employer" in the ACA and ERISA.

The Final Rule also seeks to undermine the ACA by expanding those individuals and associations that can qualify as "employers" in two ways that break sharply with judicial interpretations of ERISA and DOL's longstanding interpretations. First, the Final Rule redefines a "working owner" with no other employees as an "employer" under ERISA. Second, the Final Rule upends DOL's decades-long requirement that a group of employers be a "bona fide association" to qualify as an "employer" under ERISA. Both changes are unlawful.

A. The Final Rule's Redefinition of a "Working Owner" with No Employees as an "Employer" Is Contrary to Both ERISA and the ACA.

ERISA precludes DOL from redefining a "working owner" without any employees as an "employer." The Supreme Court spoke directly to this issue in *Yates v. Hendon*, 541 U.S. 1 (2004), stating that "[p]lans that cover *only* sole owners or partners and their spouses . . . fall outside [ERISA] Title I's domain." *Id.* at 21 (emphasis added); *see also id.* at 21 n.6 ("Courts

agree that if a benefit plan covers *only working owners*, it is *not* covered by Title I [of ERISA]") (emphasis added). The Second Circuit has likewise squarely held that a "sole proprietorship[] without employees" cannot "logically be considered an 'employer'" because it has no employees. *Marcella v. Capital Dist. Physicians' Health Plan, Inc.*, 293 F.3d 42, 48 (2d Cir. 2002). As a result, the "plain language of the [ERISA] statute would . . . seem to preclude finding" that an association that includes such sole proprietors qualifies as an "association of *employers*" under ERISA's definition. *Id.*; *see also Schwartz*, 761 F.2d at 867 (holding that self-employed individual was not a participant in an ERISA plan where he was the only contributor to the plan). Many courts of appeals have reached the same result.[31]

DOL's own rule on this question has consistently defined a "working owner" without employees as outside of ERISA's scope. A DOL regulation promulgated almost immediately after ERISA's enactment, 29 C.F.R. § 2510.3-3(b),[32] expressly excludes sole proprietors from the definition of an "employee benefit plan," stating that a plan under which "only partners or only a sole proprietor are participants covered under the plan will not be covered" by Title I of ERISA. Likewise, "[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." *Id.* at § 2510.3-3(c)(1).[33]

---

[31] *See, e.g.*, *Dahl v. Charles F. Dahl, M.D., P.C. Defined Benefit Pension Tr.*, 744 F.3d 623, 629 (10th Cir. 2014); *House v. Am. United Life Ins. Co.*, 499 F.3d 443, 450 (5th Cir. 2007); *Provident Life & Acc. Ins. Co. v. Sharpless*, 364 F.3d 634, 639 (5th Cir. 2004); *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102, 1105 (11th Cir. 1999); *In re Watson*, 161 F.3d 593, 597 (9th Cir. 1998); *SEC v. Johnston*, 143 F.3d 260, 262–263 (6th Cir. 1998).

[32] *See* 40 Fed. Reg. at 34,526, 34,533 (1975).

[33] For this reason, the Final Rule also amends 29 C.F.R. § 2510.3-3 for the sole purpose of defining "working owners" as ERISA "employees."

Indeed, DOL's interpretation of ERISA as excluding "working owners" without employees from the definition of "employer" has been consistent for many decades. DOL Op. No. 07-06A (Aug. 16, 2007) ("[T]he Department has previously concluded that sole proprietors without common-law employees are not eligible to be treated as 'employers' for purposes of participating in a bona fide group or association of employers within the meaning of ERISA section 3(5)."); *see also* DOL Op. No. 03-13A (Sept. 20, 2003); DOL Op. No. 95-01A (Feb. 13, 1995); DOL Op. No. 94-07A (Mar. 14, 1994); DOL Op. No. 77-75A (Sept. 21, 1977); DOL Op. No. 75-19 (Oct. 10, 1975). DOL's abrupt reversal in course is thus not only contrary to ERISA, but also inconsistent with the agency's own longstanding interpretation dating to immediately after that statute's enactment.[34]

The Final Rule's classification of "working owners" as "employers" also conflicts with the ACA's statutory text. While the ACA largely incorporates ERISA § 3(5)'s definition of "employer," it further provides that "employer" under the ACA "shall include only employers of two or more employees." 42 U.S.C. § 300gg-91(d)(6). Even if ERISA allowed for a "working owner" without employees to be an "employer," that "working owner" would not be an "employer" under the ACA because she would have only one employee—herself.

DOL cannot circumvent the ACA's unambiguous language by declaring that an *association* of "working owners" has two or more employees in the aggregate. As the Final Rule acknowledges, an association can qualify as an "employer" under the ACA only if it is a "group or association *of employers*"—the same requirement as for ERISA. 83 Fed. Reg. at 28,912 (emphasis added). Thus, in order to form or join an association that itself is considered an

[34] As explained below, see *infra* at 38–41, DOL's largely unexplained reversal of its longstanding interpretation also violates the APA because it is arbitrary and capricious.

employer, the component members must be employers themselves. Non-employers cannot join together and form an association that is then considered an employer. Yet, the Final Rule seeks to do just that: it takes "working owners"—who would not be considered "employers" under the ACA—and deems an association of such "working owners" to be "employers." That result is simply an unlawful end run around the ACA and ERISA.

The Final Rule's treatment of "working owners" as "employers" further conflicts with the ACA's structuring of the health insurance market. Federal agencies have consistently held that sole proprietors are individuals under the ACA subject to the individual market.[35] That position is consistent with the text of the ACA, which defines the "individual market" as "the market for health insurance coverage offered to individuals other than in connection with a group health plan," and defines group health plan as those offered by small employers and large employers. 42 U.S.C. §§ 300gg-91(a)(1), (e)(1)(A). Because, for the reasons already given, neither "working owners" nor associations of "working owners" qualify as employers (whether small or large) under the ACA, "working owners" are necessarily part of the individual market. That result is consistent with a separate provision of the ACA setting forth the "[t]reatment of very small groups," which provides that the individual market "includes coverage offered in connection

[35] *See* CMS Center for Consumer Information and Insurance Oversight, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/SHOP.html ("If you're a sole proprietor or self-employed with no employees, you can get *individual* coverage through the Health Insurance Marketplace.") (emphasis added); *Health coverage if you're self-employed*, HealthCare.gov, https://www.healthcare.gov/self-employed/coverage/#self-employedorsmallemployer ("If you're self-employed, you can use the individual Health Insurance Marketplace to enroll in flexible, high-quality health coverage that works well for people who run their own businesses. You can enroll through the Marketplace if you're a freelancer, consultant, independent contractor, or other self-employed worker who doesn't have any employees. You're considered self-employed if you have a business that takes in income but doesn't have any employees.").

with a group health plan that has *fewer than two participants as current employees* on the first day of the plan year"—language that would cover "working owners" that have no other employees. 42 U.S.C. § 300gg-91(e)(1)(B)(i) (emphasis added).

The Final Rule thus defies Congress's intent to provide "working owners" with the ACA's protections for the individual market. *See supra* at 23–28. Before the ACA, individual premiums were unaffordable because they were "typically based on the risk of the applicant, such as an individual or family." *America's Healthy Future Act of 2009*, S. Rept. 111-89, at 31. "[H]ealth insurers—particularly in the individual market—ha[d] adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy." H.R. Rept. 111-299, pt. 3, at 146. Congress adopted robust protections in the individual market to respond to these discriminatory practices. DOL's attempt to shift "working owners" from the individual market, in which they are afforded the panoply of ACA protections, to the large group market is simply an end run around congressional intent. Indeed, beyond just losing the ACA's protections for the individual market, many "working owners" will also be worse off than other employees in the large group market because, unlike traditional large employers, AHPs will not have the same incentives to provide quality coverage that large employers do. *See supra* at 23–28.

B. The Final Rule's Abandonment of DOL's Longstanding Interpretation of "Bona Fide Association" Conflicts with ERISA.

Over the last several decades, the criteria to determine whether an association is a "bona fide association" under ERISA Section 3(5) have been well-settled. Courts interpreting that provision, and Congress's intent, agree that for an association to be deemed an "employer" under the statute, the association maintaining an employee benefit plan under ERISA must be tied to the contributing employers by *common* economic or representational interests *unrelated* to the

provision of health insurance benefits; and that employer members participating in an employee benefit program must exercise actual *control* over the program. *E.g.*, *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 & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 186 n.9 (5th Cir. 1992) (the "statutory language of ERISA and the intent of Congress" made clear that a plan marketed to all employers in the Texas Panhandle could not be an ERISA plan as there was no "protective nexus" between the MEWA and the employer-members); *Wisconsin Educ. Assoc. Ins. Trust v. Iowa State Bd.,* 804 F.2d 1059, 1063, 1065 (8th Cir. 1986) (interpreting "ERISA's language and Congress' intent" and holding 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*.") (emphasis added); *Matthew 25 Ministries, Inc. v. Corcoran*, 771 F.2d 21, 22 (2d Cir. 1985) (trust that solicited "disparate and unaffiliated" employer-enrollees that played no role in management of the trust was not "established or maintained" by an "employer" under ERISA).

In addition, several decades of DOL guidance have clearly established that the employer-members of a "bona fide association" must share a commonality of interest unrelated to the provision of health care. *See* DOL Op. No. 08-07A (Sept. 26, 2008) (rejecting chamber of commerce's attempt to become AHP); DOL Op. No. 94-07A (Mar. 14, 1994) ("None of the information furnished points to a common economic or representation interest linking employees of [association's] members to [the association] that is unrelated to their obtaining benefits.").

In a sharp reversal of this longstanding precedent, and in disregard of independent statutory interpretation by multiple federal courts, the Final Rule now provides that employer-

members have a sufficient commonality of interest if they merely "have a principal place of business within a region that does not exceed the same State or the same metropolitan area (even if the metropolitan area includes more than one State)" or are in the "same trade, industry, line of business, or profession." 83 Fed. Reg. at 28,923, 28,925. The breadth of DOL's new interpretation is staggering: for example, *all* employers in a state joining *one* association could qualify. The Rule also allows an association to form with the "primary purpose" of offering health insurance, if the association has another—undefined—"substantial business purpose." *Id*. at 28,918. Under DOL's interpretation, a single association could exist to sell insurance products for profit to *all* employers in a state, and even to many individuals. Absent state law protections, DOL's new interpretation would allow one association to subsume a state's group insurance markets.

These dramatic departures from longstanding interpretations of ERISA render the Final Rule an unreasonable interpretation of ERISA's definition of "employer." The Final Rule "flatly contradicts the position which the agency had enunciated at an earlier date, closer to the enactment of the governing statute." *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125, 142 (1976). DOL's abrupt reversal of its longstanding criteria for bona fide associations "alone gives [this Court] reason to withhold approval or at least deference for the Rule." *Chamber of Commerce*, 885 F.3d at 381.

The Final Rule's abandonment of the well-established "bona fide association" test is also unreasonable because it conflicts with ERISA's foundational purpose. As courts have repeatedly recognized, Congress intended to exclude from ERISA's coverage plans "established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others." *MDPhysicians & Assocs., Inc.*, 957 F.2d at 184 (quoting H.R. Rep. No. 94-1785, at

48).[36] The purpose of this exclusion was to ensure that "employers" under ERISA—including any "association of employers"—would have the type of "protective nexus" with their direct employees that is missing from commercial insurance. Contravening Congress's intent, the Final Rule would sweep within ERISA's definition of "employer" associations that are (1) newly formed (2) primarily to sell insurance (3) for profit (4) to all employers in the same industry or geographic area (an undefined term that could include a whole state or an area that crosses many states' borders). Little would distinguish these entities from health insurance companies or insurance brokers seeking to develop and market plans for their own profit. By abandoning the requirements that ensured that an association's employer-members have a substantial "commonality of interest," the Rule unreasonably disregards Congress's intent that an association must "act[] indirectly in the interest of" its employer-members, instead of acting as a commercial insurance provider, in order to qualify as an "employer" under ERISA. *See Public Citizen, Inc. v. Mineta*, 340 F.3d 39, 55 (2d Cir. 2003) (vacating agency rule because it contravened the "unambiguously expressed intent of Congress").[37]

[36] *See also* Compl. ¶ 45 (noting that this House report has been described as "virtually conclusive as to legislative intent" by a host of federal courts).

[37] Moreover, past enactments by Congress also demonstrate its awareness of the "bona fide association" concept; when it enacted HIPAA in 1996, Congress adopted a definition of that term that is specifically applicable to the PHSA's guaranteed issue and guaranteed renewability requirements. *See* 42 U.S.C. § 300gg-91(d)(3). But Congress has never created a separate definition of that term for ERISA, suggesting that it agreed with DOL's existing interpretation and intended it to remain unaltered. *See* CMS Bulletin at 2 n.4 (noting that the PHSA's definition of "bona fide association" applies "only for purposes of providing limited exceptions from its guaranteed issue and guaranteed renewability requirements").

C. DOL's Novel Expansion of the Definition of "Employer" Conflicts with Congress's Intent To Incorporate DOL's Longstanding Understanding of That Term into the ACA.

Even if DOL could abandon its longstanding interpretation of "employer" under ERISA, it could not thereby alter the meaning of that term in the ACA. Congress considered and enacted the ACA against the backdrop of consistent agency and judicial interpretations of ERISA, including settled understandings of the term "employer" as excluding sole proprietors without employees and including only "bona fide associations" with a true commonality of interest. Having enacted multiple rounds of health care reform during the decades in which both Republican and Democratic administrations reaffirmed DOL's longstanding interpretation of "employer," in enacting the ACA, Congress would not have intended to deviate from those settled principles without expressly saying so.

That backdrop necessarily informs the meaning of Congress's incorporation of ERISA's definition of "employer" into the PHSA after the enactment of the ACA. 42 U.S.C. § 300gg-91(d)(6). When Congress has enacted statutes "against the background of [an agency] repeatedly and consistently asserting" a specific interpretation of a statute the agency administers, it "has effectively ratified the [agency]'s previous position." *Brown & Williamson*, 529 U.S. at 156. Moreover, "[t]he consistency of the [agency]'s prior position . . . provides important context" for Congress's subsequent enactments. *Id.* at 157. When the agency has maintained an interpretation for "decades without any action from Congress suggesting disapproval," and where "Congress's inaction cannot be ascribed to lack of interest or knowledge" because it has "frequently tinkered with the statutory scheme in question," then Congress must be deemed to have "acquiesce[ed] in the agency's interpretation." *Bellevue Hosp. Ctr. v. Leavitt*, 443 F.3d 163, 176 (2d Cir. 2006). And once Congress has ratified an agency's prior interpretation, "[t]he consistency of the

[agency]'s prior position . . . provides important context" for Congress's subsequent enactments. *Brown & Williamson*, 529 U.S. at 157.

Here, as explained above, DOL has taken the position since ERISA's enactment that the definition of "employer" in ERISA excludes "working owners" without employees, and includes only "bona fide associations" that satisfy certain well-established criteria. These interpretations have been strikingly consistent for decades. Regulated entities have relied upon these interpretations, and courts have consistently affirmed them. And although Congress has repeatedly amended ERISA—including through the ACA—in the decades since its enactment, it has never sought to disturb DOL's well-settled positions about the limitations of the term "employer" intended by Congress.

It is against this backdrop that Congress incorporated the ERISA definition of "employer" into the ACA. Given the striking consistency and vintage of DOL's interpretation of that term, Congress's cross-reference to ERISA in the ACA necessarily reflected Congressional intent to ratify DOL's longstanding interpretations of "employer." *See Chamber of Commerce*, 885 F.3d at 370 (use of a particular term "triggers the settled principle of interpretation that, absent other indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses.") (quotation marks omitted). In the Final Rule, DOL impermissibly seeks to abandon its previously "unwavering position[s]" after Congress already relied upon them in enacting the ACA. *See Brown & Williamson*, 529 U.S. at 157.

Because the Final Rule is not in accordance with either ERISA or the ACA, this Court should hold the Rule unlawful and set it aside as required by the APA. *See* 5 U.S.C. § 706(2)(A).

III. The Final Rule Is Arbitrary and Capricious.

The Final Rule should be vacated for the independent reason that it is arbitrary and capricious. Under the APA, "agencies are required to engage in 'reasoned decisionmaking.'" *Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015) (citation omitted). "The requirement that agency action not be arbitrary or capricious includes a requirement that the agency adequately explain its result . . . ." *Public Citizen, Inc. v. FAA*, 988 F.2d 186, 197 (D.C. Cir. 1993). Agencies must "adequately analyze . . . the consequences" of their actions. *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017). Here, DOL: (1) failed to provide adequate justification for changing its longstanding definition of "employer"; (2) ignored extensive evidence of MEWAs engaging in fraud and abuse; (3) relied on factors that Congress did not intend it to consider; and (4) created flatly inconsistent statutory interpretations. Therefore, the Final Rule should be set aside as arbitrary and capricious.

A. The Final Rule Is a Substantial Departure from DOL's Longstanding Interpretation of "Employer" without Adequate Justification.

"A central principle of administrative law is that, when an agency decides to depart from decades-long past practices and official policies, the agency must at a minimum acknowledge the change and offer a reasoned explanation for it." *Id*. at 923; *see also Good Fortune Shipping SA v. Comm'r of IRS*, 2018 WL 3595945, at *5 (D.C. Cir. July 27, 2018). Moreover, if a "new policy rests upon factual findings that contradict those which underlay [an agency's] prior policy" or "when [an agency's] prior policy has engendered serious reliance interests that must be taken into account," agencies must provide a reasoned explanation for disregarding facts and circumstances that underlay that long-held policy. *FCC v. Fox Television Stations, Inc.*, 556 U.S. at 502, 515 (2009).

Here, in promulgating the Final Rule, DOL has not justified the agency's dramatic departure from decades of consistent interpretation of "employer" under Section 3(5) of ERISA. The Rule fails to provide a reasoned explanation for abandoning the long-held agency interpretation of "employer" and insufficiently justifies its dramatic change in course.

DOL adopted its well-established interpretations of "employer" nearly contemporaneously with ERISA's original enactment to promote the core purposes of that statute. *See supra* at 7–8, 34. In reversing course now, the Final Rule says that its radically revised definition of "employer" will allow AHPs to "tailor health coverage to better meet the needs of their members at lower and more actuarially fair prices"—specifically, by allowing AHPs to discriminate in premiums more than otherwise would be allowed by the ACA, and to offer less comprehensive benefits than otherwise would be required by the ACA. 83 Fed. Reg. at 28,939.

By focusing solely on DOL's effort to subvert the ACA, this explanation does not acknowledge, let alone explain the basis for departing from, the compelling reasons that led DOL to adopt and then adhere to its original understanding of "employer" under ERISA itself. That original understanding was formed in response to a wave of fraud and abuse by MEWAs and multiple employer trusts ("METs") in the mid-to-late 1970s and early 1980s. *See, e.g.,* H.R. Rep. No. 94-1785, at 48. DOL's Administrator of Pension and Welfare Benefits, Jeffrey N. Clayton, appeared before Congress in 1982 to describe the "MET Problem":

> While these entities may vary in form, they usually involve a trust fund, which is formed by a promoter who usually has experience in the insurance business. The promoter actively solicits small employers and individuals offering to provide health and other benefits for relatively low rates; people who want to sign up for these benefits become subscribers to the trust and pay their premiums to the trust. The promoter naturally is interested in making a profit through this enterprise which he does either through receiving "sales commissions" for signing up new subscribers to the trust or by charging administrative fees to the trust. Sometimes, these MET arrangements are able to deliver

> the benefits they have promised. All too often, however, the METs have become insolvent usually because the promoter has taken excessive fees from the trust or the rates charged were simply too low to pay for all the benefits promised. When these METs collapse, and some very large ones have done so, thousands of individuals are stranded with large unpaid medical bills.[38]

Administrator Clayton expressed "concern for what has happened to the many unfortunate people who have become innocent victims of the MET arrangements,"[39] and explained that because of DOL's construction of ERISA "it has rarely been the case that METs qualify as employee benefit plans."[40] Administrator Clayton likewise testified that "ERISA METs are very rare, as a matter of fact. And the fact that someone waves a flag and says, 'I am an ERISA MET,' . . . in almost all instances is a subterfuge."[41]

The lack of adequate explanation for DOL's fundamental divergence from ERISA's foundational principles renders the Rule arbitrary and capricious.[42] DOL's reasoning further underscores the conflict between the Final Rule's objectives and Congress's design in the ACA.

---

[38] *Oversight Investigation of Certain Multiple Employer Health Insurance Trusts (METs), Evading State and Federal Regulation, Hrg. Before the Subcomm. on Labor-Management Relations of the H. Comm. on Education and Labor*, 97th Cong., Mar. 5, 1982, at 42.

[39] *Id.* at 38.

[40] *Id.* at 39, 42.

[41] *Id.* at 45.

[42] In another example, DOL did not grapple with the textual limit at 42 U.S.C. § 300gg-91(d)(6) that plainly excludes sole proprietors from the definition of "employer" under the ACA's market definitions. In response to comments, DOL claimed only that HHS had agreed with DOL's view (83 Fed. Reg. at 28,931), and stated that the PHSA incorporates the ERISA § 3(5) definition of "employer" without noting the crucial textual distinction that § 300gg-91(d)(6) "shall include only employers of two or more employees." DOL's response fails to satisfy the agency's duty to "make a reasonable attempt to grapple with" the statutory text and thus is arbitrary and capricious. *BP Energy Co. v. FERC*, 828 F.3d 959, 965–66 (D.C. Cir. 2016).

In addition, the Final Rule does not provide a reasoned justification for ignoring the serious reliance interests of the states.[43] The states are the primary regulators of insurance markets, as reflected in a variety of federal statutes. *See, e.g.*, 15 U.S.C. § 1011–15. The ACA places states at the front line of enforcement—states operate health insurance exchanges, *see* 42 U.S.C. § 18031, and states enforce the ACA's key reforms, *see, e.g.*, 42 U.S.C. § 300gg-22. Thus, for decades, the states have legislated on the subjects of insurance and health care, and state officials have overseen insurance companies and other businesses, with DOL's prior interpretation of Section 3(5) as a settled background principle of law. As the front-line regulators, the states have fundamental reliance interests in ensuring the stability of insurance markets for the protection of our residents. *See supra* at 12–13 (discussing states' reliance on existing market structures and the harm that would result from their destabilization). Yet the Final Rule makes no effort to address these serious reliance interests—instead suggesting that the states will simply have to bear any additional burdens to police the new AHPs. *See, e.g.*, *Encino*

[43] Worse, the Final Rule ignores the reliance interests of the thousands of Americans who were finally able to obtain affordable, quality health insurance under the ACA. "The Supreme Court has set aside changes in agency policy for failure to consider reliance interests that pale in comparison to the ones at stake here." *NAACP v. Trump*, 298 F. Supp. 3d at 240 (citing *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016)); *see also NAACP v. Trump*, 2018 WL 3702588, at *12 (D.D.C. Aug. 3, 2018) (The agency decision "demonstrates no true cognizance of the serious reliance interests at issue here—indeed, it does not even identify what those interests are. 'It would be arbitrary and capricious to ignore such matters,' and it is so here.") (quoting *Perez v. Mortg. Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015)). *See, e.g.*, American Medical Association, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00378.pdf; National Governors Association, Comment Letter on Proposed Rule (Mar. 6, 201[8]), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00695.pdf; Coalition Against Insurance Fraud, Comment Letter on Proposed Rule (Jan. 10, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00041.pdf; American Association of Retired Persons, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00595.pdf.

Motorcars, LLC v. Navarro, 136 S. Ct. 2117, 2125–27 (2016) (finding DOL's explanation insufficient in view of the "significant reliance interests involved" in prior law); *Util. Air Regulatory Group v. EPA*, 134 S. Ct. 2427, 2444 (2014) ("The fact that the [agency rule] would place plainly excessive demands on limited governmental resources is alone a good reason for rejecting it").

B. The Final Rule Is Counter to the Evidence Before the Agency.

The Final Rule is also arbitrary and capricious because DOL has "offered an explanation for its decision that runs counter to the evidence before [it]." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Numerous health care industry stakeholders and patient groups vigorously opposed the Final Rule as proposed, but DOL wholly failed to address the serious issues raised by the public comments.[44]

More than 95 percent of the health-care-related organizations that filed comments—266 out of 279—opposed the Proposed Rule or expressed "serious concern." Noam N. Levey, *Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments*, L.A. Times, May 30, 2018. Of the groups that represented patients, physicians, nurses, or hospitals, not a single one supported the Department's proposal. *Id.* In the words of a former president of the National Association of Insurance Commissioners who had served as a Republican insurance regulator in Kansas: "Basically anybody who knows anything about healthcare is opposed to these proposals." *Id.* Among the many organizations whose comment

[44] All public comments on the Proposed Rule are available on DOL's website at https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85. Individual comments will be incorporated into the appendix containing cited portions of the administrative record that Plaintiffs anticipate filing at the conclusion of briefing on this motion.

letters expressly called on DOL to completely withdraw the Proposed Rule were the American Academy of Family Physicians, the American Medical Association, the American Heart Association, the American College of Obstetrician and Gynecologists, the American College of Physicians, the American Hospital Association, the American Lung Association, and others.[45]

These groups with expertise in health care identified an array of flaws in the Proposed Rule that needed correction, but two problems in particular were mentioned by the vast majority of these comments: (1) the demonstrated tendency of AHPs to succumb to fraud, abuse, and insolvency; and (2) the damage that would be done to the ACA marketplace if AHPs are not required to cover essential health benefits ("EHBs") or follow community-rating requirements. DOL's decision to press ahead with the Final Rule despite these glaring flaws in its proposal unreasonably disregarded these well-supported comments.

[45] *See, e.g.*, American Academy of Family Physicians, Comment Letter on Proposed Rule (Mar. 5, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00350.pdf; American Medical Association, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00378.pdf; American Heart Association and American Stroke Association, Comment Letter on Proposed Rule (Mar. 5, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00416.pdf; American College of Obstetricians and Gynecologists, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00585.pdf; American College of Physicians, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00596.pdf; American Hospital Association, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00620.pdf; American Lung Association, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00624.pdf.

First, the long and troubled history of fraud, abuse and insolvency by MEWAs is uncontested. DOL itself acknowledges this past, 83 Fed. Reg. at 28,952, and a wide range of commenters expressed significant concerns about AHPs given their fraudulent and abusive practices.[46] Yet, in direct conflict with this evidence, the Final Rule seeks to vastly expand AHPs. *Int'l Union, United Mine Workers of Am. v. Mine Safety & Health Admin.*, 626 F.3d 84, 93 (D.C. Cir. 2010) (finding rule arbitrary and capricious where "it defie[d] the expert record evidence and is unexplained."); *see also Morall v. DEA.*, 412 F.3d 165, 167 (D.C. Cir. 2005) (striking down rule as arbitrary and capricious for "fail[ure] to consider contradictory record evidence where such evidence is precisely on point").

Indeed, a core predicate for DOL's long-held interpretation of ERISA Section 3(5) was that a narrow understanding of what constitutes an "association of employers" was necessary to limit fraud and abuse. DOL fleshed out that construction when MEWAs in the 1970s, proffering their own flawed interpretation of ERISA, invoked preemption to defraud consumers and avoid state regulation. DOL's answer to Congress and in court was simple: in almost all instances, those MEWAs were not ERISA plans at all, because of DOL's construction of ERISA.[47]

---

[46] *See, e.g.*, American Medical Association, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00378.pdf; American Academy of Pediatrics, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00637.pdf; American Cancer Society Cancer Action Network, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00539.pdf; Robert Wood Johnson Foundation, Comment Letter on Proposed Rule (Mar. 3, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00334.pdf.

[47] *See* H.R. Rep. No. 94-1785, at 48; Br. for Appellant DOL, at *7, *Donovan v. Dillingham*, 668 F.2d 1196 (11th Cir. 1982) (No. 80-7879), 1980 WL 340211; 128 Cong. Rec. H1,1084 at 11395 (daily ed. May 21, 1982) (statement of Sen. Erlenborn) (describing DOL congressional testimony); *see infra* at 39– 40 (describing congressional testimony of Administrator for Pension and Welfare Benefits Jeffrey Clayton).

DOL offers little explanation for how abandoning this evidence-based construction will safeguard members of AHPs from fraud and abuse. DOL cannot claim that these problems no longer exist, or that they will not surge if this Court permits DOL to reverse its decades-old interpretations. *See* Compl. ¶¶ 44–50 (describing fraud and abuse documented in government reports). The agency itself admits that the Final Rule will exacerbate these problems. 83 Fed. Reg. at 28,953 (AHPs "will introduce increased opportunities for mismanagement or abuse, in turn increasing oversight demands on the Department and State regulators"); *id.* at 28,928 (noting that Final Rule's relaxation of legal requirements would, without safeguards, create "cause for concern about fraud"). Moreover, DOL admits that its own past "enforcement efforts often were too late to prevent or fully recover major financial losses." *Id.* at 28,952.

Instead of offering a reasoned explanation for disregarding these facts, DOL outsources the problem to the states. DOL has acknowledged the burden on state government regulators, *see id.* at 28960, but declined to make any changes in response to that burden. DOL also notes that Congress would need to "appropriate additional funding" to increase DOL's own enforcement resources. *Id.* at 28,954, 28,960. But Congress may never do that, and DOL declined to wait for such funding. *Id.* at 28,960. DOL's speculation about future funding and resources that may never exist do not constitute a reasonable response to the serious problems the Final Rule will facilitate. The lack of reasoned, and reasonable, explanation for promoting the expansion of AHPs in disregard of well-established evidence renders the Rule arbitrary and capricious.

Second, commenters showed that failure to require AHPs to cover essential health benefits ("EHBs") would harm both currently healthy individuals and those individuals who are already sicker, older, or in need of special care. As commenters persuasively showed, currently healthy individuals—and their employers—cannot reliably predict what benefits they and their

dependents will need, and thus will tend to forgo insurance coverage of health benefits if given the choice. For example, the American Heart Association pointed out that until the ACA mandated coverage for EHBs, patients would regularly discover that their coverage did not include emergency, life-saving heart care—and that if AHPs are not required to cover EHBs, approximately 27 percent of Americans have conditions that would be denied coverage.[48] A nationwide group of psychiatrists who treat children and adolescents likewise pointed out that when employers do not provide coverage for mental health treatment for their children, there will is a significant coverage gap given that the rate of serious mental illness increases from 13 percent among children and young teenagers to 21 percent in older teenagers.[49] The psychiatrists urged that AHPs be required to provide the EHBs required by the ACA, including mental health coverage, because young patients in particular have far better outcomes if treated when their symptoms first appear.[50] The American College of Obstetricians and Gynecologists similarly noted that before the ACA imposed the EHB requirement, only *12 percent* of plans in the individual market covered maternity care—and those plans were often unaffordable or imposed a waiting period before providing that coverage.[51] Commenters made similar points about the consequences of declining to impose community-rating requirements; for example, the American

[48] American Heart Association and American Stroke Association, Comment Letter on Proposed Rule (Mar. 5, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00416.pdf.

[49] American Academy of Child & Adolescent Psychiatry, Comment Letter on Proposed Rule (Mar. 5, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00382.pdf.

[50] *Id.*

[51] American College of Obstetricians and Gynecologists, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00585.pdf.

Heart Association explained that failure to require community-rating would leave the ACA-abiding markets "to fail as the risk pool worsens and premiums spiral out of control."[52]

Making matters worse, commenters emphasized that the absence of an EHB requirement would trigger an adverse selection cycle that segments the market. As the American Medical Association explained, AHPs would have an economic incentive to carefully target their narrower benefit packages to people who are—for the time being, at least—outwardly healthy and without other specific needs, such as maternity care.[53] Even though an AHP could not expressly deny coverage for a specific patient's pre-existing condition, it could achieve the same result by choosing not to cover certain costly conditions for anyone. Before long, "an uneven playing field" would develop between AHPs and the ACA-abiding plans that remain subject to the EHB mandate, because AHPs would "siphon off small businesses with healthier employees."[54] The inevitable consequence of that segmentation would be a rise in premiums for those people whose current conditions cause them to remain in ACA-abiding plans with the mandatory EHBs—premium increases that would be allowed because DOL *also* declined to apply community-rating principles to AHPs. At the same time, those individuals who signed on to skimpier AHP plans because their current needs did not require certain benefits would later find themselves without adequate coverage if their health needs change.[55]

---

[52] American Heart Association and American Stroke Association, *supra* at n.48.

[53] American Medical Association, Comment Letter on Proposed Rule (Mar. 6, 2018), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB85/00378.pdf.

[54] *Id.*

[55] *Id.*

Despite the overwhelming evidence of the damage that will ensue from exempting AHPs from the EHB protections, DOL refused to include EHB or community-rating requirements for AHPs in the Final Rule. The agency made no serious effort to dispute the harmful consequences of exempting AHPs from the ACA's EHB mandate. To the contrary, DOL acknowledged the health care groups' comments that such an exemption would damage risk pools, harm "populations with specific needs," and lead to "cascading effects" on the markets.[56] 83 Fed. Reg. at 28,933. Moreover, the Final Rule identifies no record evidence of any offsetting benefits that consumers will experience to justify these severe harms.

Instead, the Final Rule makes clear that these adverse effects on the health care market are the intended purpose of DOL's radical shift. As the Final Rule explained, DOL declined to adopt commenters' suggestion to require AHPs to provide EHBs because "[s]uch a mandate would run contrary to the goal of leveling the playing field between small employers in AHPs, on the one hand, and large employers, on the other . . . ." *Id.* at 28,933. In other words, DOL intended to substantially eliminate any differences between the small group and large group markets. *Id*. But this rationale is not only contrary to law because it directly opposes Congress's judgment in enacting ACA, as discussed (*see supra* at 23–28); it is also arbitrary and capricious. An agency acts irrationally when, in purporting to balance competing policy costs and benefits, it

[56] To the limited extent that DOL disputed the commenters' evidence at all, its reasoning was incomplete or self-contradictory. While DOL pointed to comments arguing that AHPs, like large employers, would not risk their "goodwill and reputation" to offer substandard plans lacking EHBs, 83 Fed. Reg. at 28,933, the Final Rule itself later rejected those very comments, finding that "AHPs and large employers *differ* with respect to their economic incentives, and the Department does not expect that their behavior will be the same," precisely because AHPs "will have incentives to tailor benefits to appeal to lower-risk groups"—in other words, they will offer skimpier plans to attract healthier beneficiaries. 83 Fed. Reg. at 28,941 (emphasis added). DOL also suggested that "State benefit mandates" could take the place of the ACA's EHB mandate, *id.* at 28,934, but it did not at all address the fact that many states do not have such state law mandates.

ignores a cost-benefit judgment that Congress itself performed when it enacted the statutory scheme. *Nat'l Ass'n of Regulatory Util. Comm'rs v. ICC*, 41 F.3d 721, 726–28 (D.C. Cir. 1994); *see also Chamber of Commerce v. FEC*, 76 F.3d 1234, 1235–36 (D.C. Cir. 1996) (arbitrary and capricious test overlaps with statutory construction, and agency action is irrational if it unreasonably applies the statutory scheme). Here, one of the driving purposes behind the ACA was to apply different and stricter rules to small employers than to large employers. *See supra* at 3–5. Whatever room there may be for DOL to give "weight to the goal of easing the [employer] administrative burdens," it cannot justify that course based on an analysis that discards the "statutory objective" that Congress has chosen. *Nat'l Ass'n of Regulatory Util. Comm'rs*, 41 F.3d at 728.

It is no answer, as DOL asserts, that AHPs will face other forms of regulation, such as the employer mandate or state law benefit mandates. *See* 83 Fed. Reg. at 28,933–34. The reliance on the employer mandate is arbitrary and capricious because, as discussed above (see *supra* at 4–5), the Final Rule does not require AHPs to abide by the employer mandate, except to the limited extent that their employer-members are large employers in their own right. And although the Plaintiff States stand ready to fully enforce their own laws, including those that would require AHPs to provide certain minimum health benefits, it is arbitrary and capricious for DOL to abandon the "congressionally approved" method of protecting individuals and employees of small employers—namely, the ACA's federal EHB requirement. *Nat'l Ass'n of Regulatory Util. Comm'rs*, 41 F.3d at 728. In light of Congress's choice, DOL's belief that the states will pick up the slack is "not so much a balance of conflicting policy goals as the acceptance of one without any real consideration of the other." *Id.*

C. DOL Relied on Factors Congress Did Not Intend it To Consider.

An agency's action is arbitrary and capricious when the agency has "relied on factors which Congress has not intended it to consider." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43; *see also Midwater Trawlers Coop. v. Dep't of Commerce*, 282 F. 3d 710, 720 (9th Cir. 2002) (requiring the agency to either promulgate a new rule or provide further justification where the rule's history demonstrated that it "was a product of pure political compromise, not reasoned scientific endeavor"). In promulgating the Final Rule, DOL was motivated by a single goal: to open the floodgates for ACA-exempt AHPs pursuant to the President's Executive Order. In its efforts to achieve that goal, DOL relied heavily on factors Congress did not intend for it to consider when promulgating regulations under ERISA.

Congress passed ERISA to impose minimum fiduciary standards, disclosure requirements, and other safeguards to protect employees against abusive and unfair plan administration practices. "The principal object of the statute is to protect plan participants and beneficiaries," *Boggs v. Boggs*, 520 U.S. 833, 845 (1997), and "Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Mass. v. Morash*, 490 U.S. 107, 115 (1989).

Here, DOL has ignored these goals and instead pursued an unrelated goal: to "facilitate the creation and maintenance of AHPs" in order to undermine the ACA's market structures. 83 Fed. Reg. at 28,938. In particular, in promulgating the Final Rule, DOL relied upon, *inter alia*, the following factors: (1) the purported concern that "[t]oo many have unaffordable options for health insurance or lack insurance altogether"; (2) that under the Final Rule, "AHPs will be able to offer many small businesses more attractive and affordable health coverage options than are currently available to them in the ACA-compliant individual and small group markets"; (3) the

ability of ACA-exempt AHPs to offer health coverage at "actuarially fair" premiums because of this more "tailored" coverage, i.e., coverage that could charge certain people more in premiums or offer them fewer benefits; (4) the supposed likelihood of AHPs achieving improved economies of scale; and (5) the possibility that small employers "may use some of the economic gains that they will reap from affordable AHP health coverage to raise pay, hire more employees," and otherwise "contribute[] to economic growth." *See* 83 Fed. Reg. at 28,938–41; *see generally id.* at 28,939–59 (economic impact analysis discussing the purported benefits of not requiring insurers to comply with all of the ACA's consumer protections for the small group markets). Nothing in ERISA suggests Congress intended DOL to rely upon such factors[57] in using its general ERISA regulatory power.

[57] Many of these factors are illusory or premised on incorrect information. *Cf. Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 841 (D.C. Cir. 2006) (holding a rule arbitrary and capricious where agency lacked evidence to support key factual conclusion). For example, while touting supposed administrative savings, DOL stated that self-insured AHPs would be exempt from the ACA provisions limiting administrative costs, *see* Proposed Rule, 83 Fed. Reg. at 618. But did not explain how an AHP would enjoy a greater administrative advantage over an insurance company, and only postulated a narrow setting where an AHP even theoretically could secure better provider discounts than an insurer, *see* Final Rule, 83 Fed. Reg. at 28,942. DOL ultimately conceded that AHPs may involve greater administrative costs. *Id.* at 28,943. In another example, DOL asserts that the number of small businesses offering coverage experienced a steep decline in recent years "from 47 percent of establishments in 2000 to 29 percent in 2016." *Id.* at 28,947. Yet the source on which DOL relied, the Agency for Healthcare Research and Quality, actually concluded that the number was 47.7 percent—nearly double DOL's claimed figure—and not meaningfully different from the figure in 2014, when the ACA's exchanges came online. Agency for Healthcare Research and Quality, MEPS Insurance Chartbook 23 (2016) ("Overall, 47.7 percent of workers in establishments that were part of firms with fewer than 50 workers were offered coverage in 2016."), https://www.meps.ahrq.gov/data_files/publications/cb21/cb21a.pdf.); *see also id.* at 26. That data also showed that small business offer rates rose in some small business categories. *See id.* at 27 (offer rates rose from 52.6 percent to 54 percent among small businesses with between 10 and 24 employees from 2015 to 2016, and from 77.3 percent to 80.1 percent among businesses with between 25 and 99 employees in that period).

Worse yet, DOL pursued these extraneous goals at the expense of ERISA's primary purposes. As noted above, and as DOL acknowledges, AHPs and other MEWAs have a history of fraud, abuse, and insolvency that jeopardized enrollees. DOL admits that the Final Rule will exacerbate these problems, and that in the past, enforcement efforts came too late to protect people or recover financial losses. See *supra* at 44–45.

DOL's determination to rely on factors Congress did not intend it to consider, at the acknowledged expense of factors that are ERISA's core purpose, was arbitrary and capricious. *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 49 (noting, under statutory mandate to achieve traffic safety using "practicable and appropriate" standards, an agency could not defer to current technology when Congress intended the statute to be "'technology-forcing' in the sense of inducing the development of superior safety design.").

D. The Final Rule Is Predicated on Plainly Inconsistent Statutory Interpretations.

The Final Rule also attempts to interpret the term "employer" in ERISA in a cherry-picked fashion, creating inconsistencies both within ERISA and across other statutes. "That is the very meaning of the arbitrary and capricious standard." *Indep. Petroleum Ass'n of Am. v. Babbitt*, 92 F.3d 1248, 1260 (D.C. Cir. 1996) (holding that an agency that adopted a court decision as its construction of a statute cannot "treat[] type A cases differently from similarly situated type B cases . . . where the rationale of the court decision applies to both.").

In particular, DOL says its new interpretation of ERISA's definition of "employer" will not apply "in any context other than as applied to an employer group or association sponsoring an AHP." 83 Fed. Reg. at 28,915 n.10. Under ERISA, benefit plans provide a broad range of benefits other than health benefits, such as life insurance and disability, as well as pensions. Yet DOL interprets "employer" expansively for only one benefit (health care) in one context (AHPs),

but not for any other welfare or benefit plan or any other context that ERISA covers. That selective application of this new definition creates a stark, unexplained inconsistency across ERISA's statutory scheme.

Another notable inconsistency is DOL's conclusion that the common law master-servant relationship governs whom an individual is an "employee of" under ERISA's MEWA definition, but does not likewise control who is the "employer who employed" that same individual under the ACA's market definitions. The Final Rule is clear that "AHPs are MEWAs." *Id.* at 28,938. The MEWA definition asks whether a plan provides benefits "to the *employees of* two or more employers," or instead to those of a "single employer." 29 U.S.C. § 1002(40) (emphasis added). To determine whether there is more than one employer, DOL looks to whom the employees are "employees of" and applies the common law master-servant test, which is "equally applicable to determining *by whom an individual is employed*." *See* DOL Op. No. 1993-29A (emphasis added) (citing *Prof'l & Exec. Leasing, Inc. v. Comm'r*, 89 T.C. 225 (1987), *aff'd*, 862 F.2d 751 (9th Cir. 1988)); *see also supra* at 22 (quoting 2013 DOL MEWA guide). Thus, if an employee leasing company leases employees to clients and offers associated health benefits, those employees are "employees of" any client who has a master-servant relationship with the leased employees, and the benefit arrangement would be a MEWA. *See* DOL Op. No. 93-29A. But under the ACA's market definitions, *see, e.g.*, 42 U.S.C. § 300gg-91(e), DOL concludes that the common law test does not control who is the "employer who employed" particular employees—such that a statewide chamber of commerce is transformed into the "employer who employed" all of its members' employees. Nothing explains why DOL ascribes such starkly different meanings to "employee of" and "employer who employed" in such closely related provisions.

The Final Rule also creates significant inconsistencies between ERISA and the IRC. DOL disclaims any effect of its revamped definition of "employer" on tax provisions that are the same, word for word, as those that govern group health plans under ERISA and the PHSA. 83 Fed. Reg. at 28,915. Several key ACA provisions apply verbatim not only under the PHSA and ERISA, but also in Chapter 100 of the IRC, where they are enforced via an excise tax. Compl. ¶ 58 (citing 29 U.S.C. § 1185d and 26 U.S.C. § 9815); *see also* 26 U.S.C. § 4980D (enforcement via excise tax). DOL offers no justification for limiting its new interpretation of "employer" only to the statutory provisions that it chooses, and not to identically worded provisions in the IRC. Nor is it likely that DOL would be able to offer such a justification, given that Congress enacted this identical language across these various statutes *in the same legislation*. *Cf. Smith v. City of Jackson*, 544 U.S. 228, 233 (2005) ("[W]hen Congress uses the same language in two statutes having similar purposes, particularly when one is enacted shortly after the other, it is appropriate to presume that Congress intended that text to have the same meaning in both statutes.").

DOL also inexplicably fails to apply its new interpretation to the ACA's employer mandate under the IRC (also known as the "shared responsibility provision"), which would require an AHP (as an "applicable large employer") to offer meaningful coverage or pay a tax penalty. *See supra* at 4–5. DOL offers no explanation for why, if the Final Rule's interpretation of "employer" governs under the ACA, it would not govern under the shared responsibility provision as well. *See Util. Air Regulatory Group*, 134 S. Ct. at 2441 (an agency "must ground its reasons for action or inaction in the statute . . . rather than on reasoning divorced from the statutory text.") (emphasis omitted) (internal citation and quotation omitted).

For the reasons above, the Final Rule is arbitrary and capricious in violation of the APA, and should be set aside. 5 U.S.C. §§ 706(2)(A).

CONCLUSION

The Court should grant summary judgment to the Plaintiff States, declare that the Final Rule is illegal, and vacate the Rule in its entirety.

Dated: August 23, 2018

Respectfully Submitted,

BARBARA D. UNDERWOOD
Attorney General
State of New York

By: */s/ Sara H. Mark*
Sara H. Mark, Special Counsel
Matthew Colangelo (D.C. Bar No. 997893), Executive Deputy Attorney General
Steven C. Wu (D.C. Bar No. 975434), Deputy Solicitor General
Lisa Landau, Bureau Chief
Eric R. Haren (D.C. Bar No. 985189), Special Counsel & Senior Advisor
Elizabeth Chesler, Assistant Attorney General
Matthew W. Grieco, Assistant Solicitor General
Susan J. Cameron, Deputy Bureau Chief

Office of the New York State Attorney General
Health Care Bureau
28 Liberty St., 19th Floor
New York, NY 10005
Phone: (212) 416-6305
Matthew.Colangelo@ag.ny.gov

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts

By: */s/ Eric M. Gold*
Eric M. Gold, Assistant Attorney General
Stephen B. Vogel, Assistant Attorney General

Health Care Division
Office of the Attorney General
One Ashburton Place
Boston, MA 02108
Phone (617) 727-2200
eric.gold@state.ma.us
stephen.vogel@state.ma.us

KARL A. RACINE
Attorney General
District of Columbia

By: */s/ Robyn R. Bender*
Robyn R. Bender (D.C. Bar No. 465117),
Deputy Attorney General
Andrew J. Saindon (D.C. Bar No. 456987),
Senior Assistant Attorney General
Valerie M. Nannery (D.C. Bar No. 488529),
Assistant Attorney General

Public Advocacy Division
441 4th Street, NW
Suite 630 South
Washington, DC 20001
Phone: (202) 724-6610
Robyn.Bender@dc.gov
Andrew.Saindon@dc.gov
Valerie.Nannery@dc.gov

XAVIER BECERRA
Attorney General
State of California

By: */s/ Julie Weng-Gutierrez*
Julie Weng-Gutierrez, Senior Assistant
Attorney General
Kathleen Boergers, Supervising Deputy
Attorney General
Nimrod P. Elias, Deputy Attorney General
Karli Eisenberg, Deputy Attorney General

Office of the Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Phone: (916) 210-7913
Julie.Wenggutierrez@doj.ca.gov
Kathleen.Boergers@doj.ca.gov
Nimrod.Elias@doj.ca.gov
Karli.Eisenberg@doj.ca.gov

MATTHEW P. DENN
Attorney General
State of Delaware

By: */s/ Ilona Kirshon*
Ilona Kirshon, Deputy State Solicitor
Jessica M. Willey, Deputy Attorney General

Department of Justice
Carvel State Building, 6th Floor
820 North French Street
Wilmington, DE 19801
Phone: (302) 577-8400
Ilona.Kirshon@state.de.us
Jessica.Willey@state.de.us

ANDY BESHEAR
Attorney General
Commonwealth of Kentucky

By: */s/ J. Michael Brown*
J. Michael Brown, Deputy Attorney General
La Tasha Buckner, Assistant Deputy Attorney
General
S. Travis Mayo, Executive Director, Office of
Civil and Environmental Law
Taylor Payne, Assistant Attorney General

Office of the Attorney General
700 Capitol Avenue
Capitol Building, Suite 118
Frankfort, Kentucky 40601
Phone: (502) 696-5300
Travis.Mayo@ky.gov
Taylor.Payne@ky.gov

BRIAN E. FROSH
Attorney General
State of Maryland

By: */s/ Steven A. Sullivan*
Steven A. Sullivan, Solicitor General
Kimberly S. Cammarata, Director, Health Education and Advocacy

200 St. Paul Place
Baltimore, MD 21202
Phone: (410) 576-7038
ssullivan@oag.state.md.us
kcammarata@oag.state.md.us

GURBIR S. GREWAL
Attorney General
State of New Jersey

By: */s/ Matthew J. Berns*
Matthew J. Berns (D.C. Bar No. 998094),
Assistant Attorney General
Jeffrey S. Posta, Deputy Attorney General

Department of Law and Public Safety
Office of the Attorney General
Richard J. Hughes Justice Complex
25 Market Street, 8th Floor, West Wing
Trenton, NJ 08625-0080
Phone: (609) 376-2965
Matthew.Berns@njoag.gov
Jeffrey.Posta@njoag.gov

ELLEN ROSENBLUM
Attorney General
State of Oregon

By: */s/ Scott J. Kaplan*
Scott J. Kaplan, Senior Assistant Attorney General
Henry Kantor, Trial Attorney
Sarah Weston, Trial Attorney

Oregon Department of Justice
100 Market Street
Portland, OR 97201
Phone: (971) 673-1880
Scott.Kaplan@doj.state.or.us
Henry.Kantor@doj.state.or.us
Sarah.Weston@doj.state.or.us

JOSH SHAPIRO
Attorney General
Commonwealth of Pennsylvania

By: */s/ Michael J. Fischer*
Michael J. Fischer, Chief Deputy Attorney General
Nikole N. Brock, Deputy Attorney General

Office of the Attorney General
Strawberry Square
Harrisburg, PA 17120
Phone: (215) 560-2171
mfischer@attorneygeneral.gov
nbrock@attorneygeneral.gov

MARK R. HERRING
Attorney General
Commonwealth of Virginia

By: */s/ Toby J. Heytens*
Toby J. Heytens, Solicitor General
Matthew R. McGuire, Principal Deputy Solicitor General

BOB FERGUSON
Attorney General
State of Washington

By: */s/ Jeffrey G. Rupert*
Jeffrey G. Rupert, Chief, Complex Litigation Division
Jeffrey T. Sprung, Assistant Attorney General
Marta Deleon, Assistant Attorneys General

Office of the Attorney General
202 North Ninth Street
Richmond, VA 23219
Phone: (804) 786-7773
theytens@oag.state.va.us
mmcguire@oag.state.va.us

Office of the Washington Attorney General
800 Fifth Avenue, Suite 2000
Seattle, WA 98104
Phone: (206) 326-5492
Jeffrey.Rupert@atg.wa.gov
Jeff.Sprung@atg.wa.gov
Marta.Deleon@atg.wa.gov