IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK, ET AL., Plaintiffs, v. UNITED STATES DEPARTMENT OF LABOR, ET AL., Defendants.	)	No. 18-1747

THE RESTAURANT LAW CENTER'S *AMICUS CURIAE* BRIEF IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS, OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT, AND OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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CORPORATE DISCLOSURE STATEMENT

The Restaurant Law Center is a non-profit, 501(c)(6), tax exempt organization incorporated in the District of Columbia. Pursuant to Fed. R. App. P. 26.1, the Restaurant Law Center states that it has no parent corporation, and no publicly held company has 10% or greater ownership in it.

IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Restaurant Law Center is an independent public policy organization affiliated with the National Restaurant Association, the largest foodservice trade association in the world. The Association supports over 500,000 restaurant businesses including many small businesses. The restaurant industry in the United States includes over one million restaurants and other foodservice outlets employing almost 15 million people – approximately ten percent of the nation's workforce.

Accordingly, the Restaurant Law Center has a profound interest in laws and regulations generally governing the provision of healthcare benefits to restaurant employees throughout the United States, including those laws and regulations designed to enhance the provision of healthcare coverage to the employees of small businesses and to working owners. *Amicus curiae* certifies that no counsel for a party or party authored this brief in whole or in part; no counsel for a party or party made a monetary contribution intended to fund the preparation or submission of this brief; and no persons other than the Restaurant Law Center, its members or their counsel made a monetary contribution to its preparation or submission.

INTRODUCTION AND SUMMARY OF ARGUMENT

It is beyond dispute that the system of providing healthcare in the United States can be improved. This brief focuses on the important role association health plans ("AHPs") play in addressing quality health insurance access for small businesses, and the policy considerations underlying that Final Rule. By expanding the ability of small groups to band together and thereby gain the advantages available to larger groups, the Final Rule enhances the opportunity for many to enjoy quality, affordable health coverage.

The United States spends nearly 20% of its gross domestic product (GDP) on health care—more than any other developed nation. That spending will only increase.[1] Health spending is projected to grow at an average rate of 5.5% per year between 2017 and 2026—one percentage point *faster* than our nation's GDP.[2] Much of that spending pays for health insurance coverage.[3] Increased healthcare spending leads to increases in health insurance premiums. Premiums for individual coverage purchased through the Healthcare Marketplace rose substantially in 2017 and 2018, and premiums for small employer group coverage have risen steadily every year.[4]

These ever-increasing health insurance premiums have hit small businesses and their employees especially hard. Between 2006 and 2016, health insurance costs rose significantly

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[1] National Health Expenditures (NHE) Fact Sheet, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html; Joseph Walker, *Why Americans Spend So Much on Health Care—in 12 Charts*, The Wall Street Journal (July 31, 2018), https://www.wsj.com/articles/why-americans-spend-so-much-on-health-carein-12-charts-1533047243.

[2] *Id.*

[3] *Id.*

[4] U.S. Department of Health and Human Services, *ASPE Research Brief, Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange* (Oct. 30, 2017), https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf; U.S. Department of Health and Human Services, *ASPE Research Brief, Health Plan Choice and Premiums in the 2017 Federal Health Insurance Exchange* (Oct. 24, 2016), https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf.

faster than restaurant sales; employer contributions toward health insurance premiums for family coverage rose 51%, while sales rose only 33%.[5] The average annual premium for family coverage under an employer-provided plan in 2018 was nearly $20,000, with employees paying almost a third of that cost.[6] Such costs are difficult for any business to absorb, but are particularly onerous for small businesses and their employees. Since 2010, the percentage of employees of small businesses with employer-sponsored health coverage declined from 44% to 30% for companies with three to 24 employees, and from 59% to 44% for those companies with 25 to 49 employees.[7] Between 11 and 12 million workers employed by small businesses, and their dependents, lack health insurance.[8]

Small businesses and their employees need better options for health coverage. The Labor Department's Final Rule expands access to coverage through AHPs and is a much-needed step in the right direction. The Final Rule, by expanding access to AHPs, allows more small businesses and working owners to band together to obtain health insurance coverage pricing and options on par with large employers. By allowing them to pool their purchasing power and their risks, AHPs created under the Final Rule will enable small businesses and working owners to benefit from the greater negotiating power, more stable risk pools, administrative efficiencies, and economies of

[5] National Restaurant Association, *Employment-based plans are a shrinking share of restaurant employee coverage* (March 8, 2017), https://www.restaurant.org/News-Research/News/Employment-based-plans-are-a-shrinking-share-of-re

[6] *2018 Employer Health Benefits Survey*, Kaiser Family Foundation (Oct. 3, 2018), https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-1-cost-of-health-insurance.

[7] Alexander Acosta, *New Health Options for Small-Business Employees*, The Wall Street Journal, October 22, 2018, https://www.wsj.com/articles/new-health-options-for-small-business-employees-1540249941.

[8] The Editorial Board, *Trump's ObamaCare Lifeboat*, The Wall Street Journal (January 7, 2018), https://www.wsj.com/articles/trumps-obamacare-lifeboat-1515361577?shareToken=stee195a8d7b4b4e5c9d1433fa2b9d4c3f&ref=article_email_share; 83 Fed. Reg. 28912, 28950.

scale that currently benefit only those employers in the large group market. As a result of the Final Rule, it is estimated that 400,000 previously uninsured people will be able to obtain coverage under an AHP, and approximately 3.6 million people will migrate away from their current coverage in favor of AHP coverage that better suits their needs.[9]

Plaintiffs assert that the Final Rule is inconsistent with the Patient Protection and Affordable Care Act ("ACA") (Paragraphs 10 and 11 of complaint) and that it will result in a "flood of inadequate and fraudulent plans newly offered by associations" (Paragraph 14 of complaint). To the contrary, the Final Rule is consistent with, and advances one of the overarching goals of the ACA: to expand access to quality healthcare coverage. Moreover, as ERISA plans, AHP participants enjoy all the protections applicable to ERISA plans. In addition, the Final Rule protects participants' discrimination on the basis of their health status, and the many states also have in place robust measures regulating AHPs, thereby protecting their participants. The Final Rule not only leaves untouched the states' power to regulate these plans, but expressly endorses that power, leaving states free to enact whatever regulation of AHPs they see fit, consistent with ERISA.

In addition to creating a new pathway by which AHPs may be formed, the Final Rule preserves the Labor Department's prior advisory opinions that establish when a bona fide group or association of employers may form an AHP that will be treated as a single ERISA plan. Notwithstanding the ultimate disposition of this case, both as a matter of policy and law, that prior subregulatory guidance and the case law applying that original "pathway" to single ERISA plan status for AHPs should remain intact and unchanged. That pathway was established decades ago, has been affirmed in the courts, and is relied upon by thousands of businesses and current AHP

[9] 83 Fed. Reg. 28912, citing U.S. Congressional Budget Office survey.

participants. The continuing validity of that pre-existing guidance has not been placed in controversy by either party, and there is no reason for it to be addressed by the Court.

For all of the above reasons, discussed in greater detail herein, the Plaintiffs' motion for summary judgment should be denied, and the Defendant-U.S. Department of Labor's ("Department") Motion to Dismiss, or in the Alternative, Cross-Motion for Summary Judgment, and Opposition to Plaintiff's Motion for Summary Judgment, should be granted.

I. THE FINAL RULE WILL EXPAND MUCH-NEEDED ACCESS TO HEALTH COVERAGE FOR SMALL BUSINESSES AND WORKING OWNERS, CONSISTENT WITH THE OVERARCHING POLICY OF THE ACA.

A. Overview of the Final Rule

Private, employer-sponsored health insurance coverage is generally purchased in one of three ways: through the large group market for employers with 50 or more employees (or in some states, 100 or more employees); through the small group market for employers with between 2 and 49 employees (or in some states, between 2 and 99 employees), and, for working owners without common law employees, through the individual market. Small employers and large employers do not play on a level field when it comes to negotiating costs, benefits, and options for purchasing health coverage. According to the National Conference of State Legislatures, on average, small businesses pay about 8% to 18% more than large businesses for the same health insurance policy.[10] Those purchasing coverage on the individual market are, in essence, faced with a take-it-or-leave it "choice" in coverage.

Some of that inequity between small and large group purchasers of health insurance is due to market changes made by the ACA. The ACA imposed certain requirements on the individual and small group markets that were not imposed on the large group market (Complaint, paragraphs

[10] National Conference of State Legislatures, Research, http://www.ncsl.org/research/small-business-health-insruance.aspx

3 and 4, page 3). It changed the way coverage for small groups and individuals is priced (or "rated"), mandating that carriers rate those groups using single risk pools (such that an insurance carrier must calculate premiums of all its enrollees in all its health plans issued in a particular state, instead of on an employer-by-employer basis). The ACA also required coverage of an "essential health benefits" package by all plans sold in the ACA Marketplace. Those mandates had the effect of making coverage in the individual and small group markets increasingly costly, and therefore increasingly out of reach of many Americans. In addition, financial losses incurred by insurance carriers as a result of the ACA reforms, as well as regulatory uncertainty, has, in past years, resulted in some insurance carriers leaving ACA Marketplaces altogether, leaving consumers with fewer and fewer choices in health insurance coverage, particularly in rural areas.[11] In 2019, twenty-one states will have only one or two insurers participating in their ACA exchanges.[12] Moreover, small groups have little to no bargaining power when negotiating with insurance carriers.

The Final Rule does not seek to undermine the ACA's protections in the individual and small group markets. Rather, it seeks to allow small businesses, including working owners without employees, to band together to form a single, large-group ERISA plan and thereby enjoy the same advantages as large employers when it comes to buying health insurance coverage. In the large group market, insurance carriers can rate each employer based on its own claims experience. Furthermore, plans maintained by large employers have a larger pool of participants over which to spread the risk of high-cost claims, making the overall risk of the pool more predictable. The

[11] Rachel Fehr, Cynthia Cox, and Larry Levitt, *Insurer Participation on ACA Marketplaces, 2014-2019*, Kaiser Family Foundation (Nov. 14, 2018), https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/#; Olga Khazan, *Why So Many Insurers Are Leaving Obamacare*, The Atlantic (May 11, 2017), https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/

[12] *Id.*

stability of larger risk pools also means self-insuring the plan's benefits is often more financially feasible and cost-effective than purchasing an insurance policy. Large groups also have greater clout when negotiating with insurance carriers over rates and plan options, and can spread administrative costs out over a larger population, resulting in lower per-capita administrative expenses incurred in providing health coverage to their employees.

Before the Final Rule, only under very narrow circumstances could employers form a group or association that would be deemed to be a single employer, sponsoring a single ERISA group health plan. In most cases, these groups and the health plans they sponsored would be treated and regulated as a collection of single-employer ERISA group health plans. And, the Department's past interpretations of section 3(5) of ERISA[13] did not allow working owners without common law employees to participate in AHPs. As a result, the advantages of participation in an AHP were out of reach of most businesses and all self-employed persons. In response to these significant obstacles, the President issued Executive Order 13813 directing the Department to issue rules to make AHPs more broadly available.

As explained below, the Final Rule gives small businesses and the self-employed many of the same advantages enjoyed by large employers when it comes to securing health coverage. It does so in a manner consistent with the intent of the ACA and while maintaining safeguards against discrimination, fraud, and abuse.

[13] 29 U.S.C. § 1002(5).

B. The Final Rule is Consistent with the Overarching Policy of the ACA.

The Final Rule advances the overarching goals of the ACA: to achieve "near-universal" health coverage, to "add millions of new consumers to the health insurance market," and to "increase the number and share of Americans who are insured."[14]

Some of the mandates brought about by the ACA had the unintended effect of making health coverage less accessible due to the associated higher costs, and risk-averse insurance carriers pulling out of ACA Health Insurance Marketplaces.[15] Some individuals purchasing coverage on the Marketplace are eligible for federal premium tax credits, which shift some of the cost onto taxpayers. But for many others who do not qualify for premium tax credits, or who get their coverage from their employer, the coverage is simply out of their financial reach.[16]

Seeking to reverse that trend, the Final Rule was born out of Executive Order 13813 and its directive that the Department issue rules expanding access to health coverage.[17] As a result of the Final Rule, it is estimated that 400,000 previously uninsured people will be able to obtain coverage under an AHP, and approximately 3.6 million people will migrate away from their current coverage in favor of AHP coverage that better suits their needs.[18] Moreover, the Final Rule does not undermine ACA protections. It simply enhances an employer's access to purchase coverage in the large group market – coverage that can fit that particular business's employees and that can be scaled to the needs of that particular workforce. The Plaintiff States' concerns over the competitive pressure that the Final Rule might place on their small group and individual markets

[14] 42 U.S.C. § 18091(2)(C) and (2)(D).
[15] Executive Order 13813, October 12, 2017; Khazan, *supra* n. 111.
[16] *Trump's ObamaCare Lifeboat* , *supra* n. 8.
[17] Executive Order 13813, October 12, 2017; 82 Fed. Reg. 48385 (October 17, 2017).
[18] 83 Fed. Reg. 28912, citing U.S. Congressional Budget Office survey.

are no justification for dismantling the Final Rule and shutting small businesses out of the opportunity to obtain quality and comprehensive coverage that does not require federal subsidies.

II. AHPS ARE SUBJECT TO SUBSTANTIAL SAFEGUARDS TO PREVENT DISCRIMINATION, FRAUD, AND ABUSE, BOTH THROUGH THE FINAL RULE AND THROUGH EXISTING LAW.

The Plaintiff States and their amici suggest the Final Rule will result in a "flood of inadequate or fraudulent plans newly offered by associations" (complaint paragraph 15, page 8) and that a rise in "insolvent and sham AHPs" and an "explosion of inadequate health insurance policies" lies just over the horizon (AMA Amicus brief pages 22 and 23). These concerns are unwarranted.

As an initial matter, the vast majority of associations, as a matter of sound business practice and self-preservation, will not risk their goodwill with their membership by selling "junk" insurance plans. Businesses that defraud or disappoint customers simply do not stay in business long. Indeed, in the Final Rule, the Labor Department placed great weight on the need to distinguish between "bona fide" associations and commercial insurance-type arrangements to ensure that the interests of the AHP sponsor closely align with its membership.[19] Under the Final Rule, in order to constitute a "bona fide association" and be deemed a single "employer" under ERISA, the group or association of employers must have some substantial business purpose other than providing health care coverage to its members. As in any business relationship, client satisfaction—or in an association's case, member satisfaction—with the value of association membership is critical to the success of the association. And to be successful, associations must offer health plans at price points and benefit levels that are of value to their members and meet members' expectations. To do otherwise, to "make a quick buck" off of the membership by

[19] 83 Fed. Reg. 28912, 28928.

offering thinly funded plans with poor benefits, or to mislead the membership as to the benefits being purchased, would be fruitless and self-destructive.

Second, implied in the distinction between small and large group health insurance markets, is the belief that those businesses purchasing coverage in the large group market can be trusted to offer sufficiently comprehensive coverage to their employees, and not to defraud them or leave them underinsured. The large group market was not made subject to the same increased regulation by the ACA as the individual and small group markets because the large group market was seen to be functioning sufficiently well with respect to benefits offered and rating methodologies.[20] The goal of the Final Rule is to allow small businesses and the self-employed to participate in that well-functioning large group market. There is no reason to believe that small businesses and the self-employed cannot be trusted to purchase appropriate coverage for their employees or themselves, just as large businesses are given the latitude to do.

A. AHPs are subject to all the protections of ERISA and its associated laws.

The Plaintiff States' concerns over fraud and abuse are also overstated because nothing in the Final Rule changes the fact that AHPs are group health plans subject to ERISA[21] and other federal laws that apply to large group health plans. ERISA protects the interests of employee benefit plan participants and their beneficiaries through a broad range of protections. One of the most fundamental of ERISA's protections is its requirement that fiduciaries of ERISA plans (including the association sponsor of an AHP) must act for the exclusive benefit of the plan's participants and beneficiaries, and be subject to civil and criminal penalties for failure to do so. ERISA also: imposes bonding requirements on those who handle ERISA plan assets; requires

[20] *See* Congressional Amicus Brief at p. 7.
[21] 29 U.S.C. § 1001, *et seq.*

annual reports containing detailed plan, financial, and service provider information to be filed with the Labor Department; and provides enforcement mechanisms through the Labor Department, the Internal Revenue Service, and through civil lawsuits. In addition, ERISA's comprehensive participant disclosure rules require group health plans to notify plan participants and beneficiaries of the plan's terms regarding eligibility, benefits, claim and appeal procedures, and any exclusions from coverage. Furthermore, ERISA plan sponsors must maintain and distribute summary plan descriptions ("SPDs") and Summaries of Benefits and Coverage ("SBCs") so that participants are informed of the terms, conditions, and limitations of their coverage. As ERISA group health plans, AHPs are also subject to the nondiscrimination rules of the Health Insurance Portability and Affordability Act of 1996, as amended ("HIPAA"),[22] which nondiscrimination rules prohibit plans and insurers from discriminating against participants and beneficiaries on the basis of their health status. Specifically, AHPs, as ERISA plans, cannot refuse to cover an individual because of a preexisting condition. AHPs are also subject to the federal Mental Health Parity Act of 1996[23] and Mental Health Parity and Addiction Equity Act of 2008,[24] which require group health plans that provide benefits for mental health and substance use disorders to provide those benefits on equal footing with the plan's medical and surgical benefits. Federal law also requires ERISA group health plans to cover certain pediatric vaccines,[25] mastectomy reconstruction and related services,[26] and minimum hospital stays for childbirth and newborns.[27] The Pregnancy

[22] Pub. L. 104-191 (1996).
[23] Pub. L. No. 104-204 (1996);29 U.S.C. § 1185(a).
[24] Pub. L. No. 110-343 (2008), as amended by Pub. L. No. 110-460 (Dec. 23, 2008), amending 29 U.S.C. § 1185(a).
[25] Pub. L. No. 103-66 (1993); 29 U.S.C. § 1169(d).
[26] Women's Health and Cancer Rights Act, Pub. L. 105-277 (1998), 29 U.S.C. § 1185b.
[27] Newborns and Mothers Health Protection Act, 29 U.S.C. § 1185.

Discrimination Act, an amendment to Title VII of the Civil Rights Act of 1964,[28] requires AHPs to cover pregnancy and pregnancy-related conditions on the same basis as other medical conditions. Finally, many of the ACA's participant protections also apply to AHPs under the Final Rule, including required coverage of dependents to age 26, the ban on retroactive cancellations of coverage (called "rescissions") except in cases of fraud, the prohibition on lifetime dollar limits on coverage, the prohibition on annual dollar limits on the essential health benefits covered under the plan, the complete elimination of preexisting condition exclusions, elimination of eligibility waiting periods exceeding 60 days, annual limitation on out-of-pocket maximums, required first-dollar coverage of certain preventive services, patient protections regarding coverage of emergency services, enhanced claim and appeals procedures, and coverage of approved clinical trials.

B. The Final Rule incorporates rules to protect consumers against discrimination on the basis of health conditions.

The Final Rule ensures that expanded access to AHPs will not result in the very kind of adverse risk selection that Amici in support of Plaintiffs are concerned about. To address this concern, and to further "distinguish genuine employment-based plans from commercial enterprises that claim to be AHPs but that are more akin to traditional insurers selling insurance in the employer marketplace," the Labor Department included in the Final Rule a set of nondiscrimination rules designed to ensure that associations do not restrict membership in the association—and therefore in the AHP—based on participants' health factors.[29]

These nondiscrimination rules build upon the existing HIPAA nondiscrimination rules, which, as noted above, apply to AHPs. HIPAA prohibits all group health plans, when setting

[28] 42 U.S.C. § 2000e *et seq.*
[29] Preamble to Proposed Rule, 83 Fed. Reg 614, 623 (January 5, 2018).

premiums and eligibility for benefits, from discriminating on the basis of a health factor *within* groups of similarly situated individuals. Health factors include health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability. As a result, plans may not, for example, charge higher premiums to, or restrict eligibility for coverage for, individuals based on their past claims experience. Group health plans may, however, discriminate *across* groups of similarly situated individuals, as long as those groups are defined by reference to bona fide employment classifications consistent with the employer's usual business practice—such as full-time or part-time status, geographic location, date of hire, membership in a collective bargaining unit, length of service, current versus former employee status, and different occupations. So, for example, individuals at different geographic locations may be charged different premiums or be subject to differing eligibility criteria. These distinctions are not permitted, however, if the creation or modification of a coverage classification is directed at individual participants or beneficiaries, based on any health factor. With or without the Final Rule, AHPs are subject to these nondiscrimination rules, to the same extent as any other group health.

The Final Rule, however, goes one-step further by also restricting AHPs from treating member employers as distinct groups of similarly situated individuals if they wish to be deemed a single employer sponsoring a single ERISA plan. This means that the AHP cannot charge each member employer different premiums based on the claims experience or other health factors of its employees and their beneficiaries. The Department specifically designed this rule to distinguish "bona fide" AHPs from commercial insurance arrangements, which are permitted to "experience-rate" employer groups (*i.e.*, to set premiums based on the group's past claims experience) in the

large group market.[30] As noted by the Labor Department, if a group or association seeks treatment as an 'employer' under ERISA section 3(5) for purposes of sponsoring a single ERISA group health plan, it "cannot simultaneously undermine that status by treating different employers as different groups based on health factor of an individual or individuals within an employer member."[31] In other words, the Labor Department prohibits associations from having their cake and eating it too: if the association is "bona fide" under the Final Rule, established to act in the interests of its members, then it cannot simultaneously act like a commercial insurance arrangement when it comes to setting rates. The Labor Department appropriately recognized that it would be inconsistent for a group of employers to be treated as a single "employer" for some purposes, but to then treat each employer member separately for purposes of applying the nondiscrimination rules. Accordingly, the Department structured the Final Rule's nondiscrimination provisions to further emphasize the commonality that must exist across the employer members of the association, which in turn ensures that the association safeguards the interests of its members and their employees.

C. AHPs created under the Final Rule are subject to robust state regulation.

In 1983, Congress enacted Section 514(b)(6)[32] of ERISA, which created an exception to ERISA's broad preemption provision to allow states regulatory authority over Multiple Employer Welfare Arrangements ("MEWAs"), of which AHPs are one type. Accordingly, a fully-insured AHP is subject to state laws and enforcement mechanisms relating to maintenance of specified contribution and reserve levels. And, of course, the insurance contract that funds benefits under a fully-insured AHP is also subject to state laws regulating insurance. States' power to regulate

[30] 83 Fed. Reg. 28912, 28928
[31] *Id.*
[32] 29 U.S.C. § 1144(b)(6).

insurance contracts means that States can require AHPs to cover state-mandated benefits. If the AHP is not fully insured, States have authority to apply any State law that regulates insurance, to the extent the law is not inconsistent with ERISA. Such laws include, for example, those regulating solvency, benefit levels, or rating methods. States also routinely require AHPs to be registered or licensed as insurers with the state insurance department, to meet the state's individual and small group market rules, to engage in market conduct and financial examinations, to contribute to state guaranty funds, and to be placed into receivership, if needed.[33] As of 2016, the majority of states had enacted laws specifically regulating MEWAs.[34] Moreover, *all* states have the authority to do so, should they want to impose more significant restrictions on AHPs than the robust protections provided under existing federal law.

In the preamble to the Final Rule, the Labor Department sided with those commenters who urged the Department to "make it clear that the final rule in no way limits the ability of States under State insurance laws to regulate AHPs, health insurance issuers offering coverage through AHPs, and insurance producers marketing that coverage to employees."[35] The Department agreed that the Final Rule "does not modify or otherwise limit existing State authority as established under section 514 of ERISA."[36] Indeed, the Department declined to entertain suggestions by commenters arguing for increased federal regulation of MEWAs, and who contended that the Department

[33] Kevin Lucia and Sabrina Corlette, *Association Health Plans: Maintaining State Authority is Critical to Avoid Fraud, Insolvency, and Market Instability*, The Commonwealth Fund (January 24, 2018), https://www.commonwealthfund.org/blog/2018/association-health-plans-maintaining-state-authority-critical-avoid-fraud-insolvency-and

[34] *NAIC Compendium of State Laws on Insurance Topics: Multiple Employer Welfare Arrangements (MEWA) and Multiemployer (MET) Provisions* (November 2016), https://nahu.org/media/3623/naic-chart-of-state-mewa-laws-2016.pdf.

[35] 83 Fed. Reg. 28912, 28936.

[36] *Id.*

should use the Final Rule to exempt AHPs from State insurance laws.[37] In response to the Final Rule, at least eighteen states have already made legislative changes, engaged in rulemaking, or issued subregulatory guidance on how AHPs will be regulated under state law.[38] In fact, some States have already effectively nullified certain portions of the Final Rule as applied within their jurisdictions—for example, by requiring that sole proprietors without common law employees cannot be covered under group policies, but instead must be issued policies from the individual market,[39] or restricting AHPs to those whose association has been in existence for some minimum number of years.[40] Existing State regulation, and the capacity for further State regulation, provides yet another layer of protection to participants of AHPs. The Final Rule does nothing to change that, and in fact, it expressly preserves States' authority to do so.

III. REGARDLESS OF THE OUTCOME OF THE PRESENT CASE, THE DEPARTMENT'S PRE-EXISTING PATHWAY FOR FORMATION OF ASSOCIATION HEALTH PLANS SHOULD BE PRESERVED.

As set forth above, Amicus supports the Labor Department's Final Rule and believes that it should be upheld by the Court. What is not at issue in this case is the Labor Department's pre-existing guidance on the "pathway" to bona fide AHP status. Thus, no matter the disposition of this case, the Court should expressly limit its decision to the new pathway to bona fide AHP status created by the Final Rule, and should not opine on the Department's prior subregulatory guidance on this topic. That guidance has been established and refined over decades of consideration and was expressly preserved in the Final Rule. It has been tested in the courts, is generally regarded as settled law, and is relied upon by thousands of businesses and their employees. Most

[37] 83 Fed. Reg. 28912, 28937.
[38] AL, CA, CT, DE, IL, IN, IA, LA, MA, MD, MI, MO, NH, NJ, NY, OR, UT, WA
[39] CA, CT, PA
[40] IA, MD, MA, NY, OR, PA, VT

importantly, the Department's prior guidance has not been placed into controversy by either party, making it improper for the court to express any opinion as to its legal sufficiency.

Before the issuance of the Final Rule, a group or association of employers could only be deemed a single employer under ERISA section 3(5), and therefore sponsoring a single ERISA plan, if it satisfied a three-prong test established and honed over decades of Labor Department advisory opinions and case law.[41] Under that guidance, the facts and circumstances of a given group or association of employers are analyzed to determine: 1) whether the group or association is a bona fide organization, with business or organizational purposes and functions unrelated to the provision of benefits; 2) whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and 3) whether the employers that participate in a benefit program, either directly, or indirectly, exercise control over the program, both in form and substance.[42] If all three of these criteria are satisfied, the group or association of employers is deemed to be a single employer within the meaning of ERISA section 3(5), and therefore, the group health plan it sponsors will be deemed a single ERISA plan, rather than a collection of plans, each sponsored by a member employer.

In evaluating AHPs prior to the Final Rule, the Department and courts focused on whether the entity maintaining the plan and the individuals who benefit from the plan be tightly bound by "a common economic or representational interest."[43] As a result, the test was narrowly-construed

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[41] *See, e.g.*, DOL Advisory Opinion 97-07A; Advisory Opinion 2001-04A; *Wisconsin Education Assn. Ins. Trust v. Iowa State Bd. of Public Instruction*, 804 F.2d 1059, 1064 (8th Cir. 1986) *rehearing denied* (8th Cir. February 10, 1987).; *MD Physicians & Associates, Inc. v. State Bd. of Ins.*, 957 F.2d 178 (5th Cir. 1992), *cert. denied*, 506 U.S. 861 (1992); *National Business Assn. Trust v. Morgan*, 770 F. Supp. 1169 (W.D. Ky. 1991).

[42] Preamble to Department's Proposed Rule, 83 Fed. Reg. 53534, 53537 (October 23, 2018).

[43] *Wisconsin Education Association Insurance Trust v. Iowa State Board of Public Instruction*, 804 F.2d 1059, 1063 (9th Cir. 1986), *rehearing denied* (8th Cir. February 10, 1987).

and very few associations qualified as "bona fide" associations. Thus, the Final Rule intends to build-upon this original means of establishing AHP status. At the same time, this original "pathway" to bona fide AHP status, having been settled law for decades, has been relied upon by thousands of businesses and their employees. Recognizing this fact, in the preamble to the Final Rule, the Labor Department stated that the Final Rule does not supplant its previously issued guidance. Rather, the Final Rule provides a new, alternative pathway for employer groups to be treated as a single employer under ERISA section 3(5).[44] The Final Rule makes clear that existing AHPs, formed under the Department's prior guidance, may continue to operate under that prior guidance. If the Department had abrogated its earlier guidance, this would have led to a massive and unwarranted disruption of the existing AHP market.

In this case, the Plaintiff States have not expressed any concern about the pre-Final Rule rules or market. Indeed, neither the Plaintiffs nor the Defendant have, in any respect, put the original pathway to bona fide AHP status in controversy in this case. The legality of the original pathway to bona fide AHP status is not briefed, presented, or otherwise ripe for consideration by the Court. Like the Department, the Court should not disrupt that existing market. Indeed, it would be improper as a matter of law for the Court to make any ruling or to express any opinion on it. Article III of the U.S. Constitution limits the power of federal courts to "cases" and "controversies," and federal courts refrain from issuing advisory opinions and routinely decline to consider arguments or rule on issues not properly raised by the parties.[45]

[44] 83 Fed. Reg. 28912, 28955.

[45] *See, e.g., United States v. Fruehof*, 365 U.S. 146, 157 (1961) (declining to consider question the Court regards as a request for an advisory opinion); *Turner Broadcasting System, Inc. v. FCC*, 520 U.S. 180, 223–224 (1997) (declining to decide question that received only "scant argumentation"); *Decker v. Northwest Environmental Defense Center*, 598 U.S. 597, 615-16 (2013) (Roberts, C.J., concurring) ("Respondent suggested reconsidering *Auer*, in one sentence in a footnote, with no

CONCLUSION

For the foregoing reasons, Plaintiffs' motion for summary judgement should be denied, and Defendant's motion to dismiss, or in the alternative, for summary judgment, should be granted.

argument. . . . Petitioners said don't do it, again in a footnote. . . . I would await a case in which the issue is properly raised and argued.").

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 18th day of December, 2018, I caused a copy of the foregoing to be filed with the Clerk of the Court using the ECF system, which will send notification of such filing to all ECF registered counsel.

/s/ *Jaclyn L. West Hamlin*
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