**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| STATE OF NEW YORK, ET AL., | ) | |
| | ) | |
| Plaintiffs, | ) | |
| | ) | |
| v. | ) | Case No.: 1:18-cv-01747-JDB |
| | ) | |
| UNITED STATES DEPARTMENT OF LABOR, ET AL., | ) | |
| | ) | |
| Defendants. | ) | |

**BRIEF OF THE COALITION TO PROTECT AND PROMOTE ASSOCIATION HEALTH PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS**

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# CORPORATE DISCLOSURE STATEMENT

The Coalition to Protect and Promote Association Health Plans (the "Coalition") is an *ad hoc* coalition of national and state member-based organizations. It does not have corporate form, and thus has no parent corporation, nor does any publicly held company hold an ownership interest in it.

## IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Coalition comprises 23 member-organizations. Several of these organizations currently sponsor an "association health plan" (or "AHP") through which "group health plan" coverage is actively being provided to employees of the employer-members of these organizations. All of the Coalition's member-organizations are interested in offering group health plan coverage through an AHP in accordance with the rules and requirements set forth in the United States Department of Labor's final regulations under Title I of the Employee Retirement Income Security Act (ERISA) (the "final AHP regulations"). The final AHP regulations establish additional criteria under ERISA section 3(5) for determining when employers may join together in a "group or association of employers" that will be treated as the "employer" sponsor of a single multiple-employer "employee welfare benefit plan" and "group health plan."

The Coalition's member-organizations represent over 1 million small employers and millions more who are employees of these employer-members or who are self-employed, the majority of whom would be eligible to obtain health coverage through an AHP sponsored by Coalition member-organizations in accordance with the final AHP regulations. Thousands of employees are already covered by AHPs sponsored by a number of Coalition members in accordance with the Department of Labor's existing guidance that treat a "group or association of employers" as an "employer" as defined under ERISA section 3(5).

The members of the Coalition therefore have a strong interest in the final AHP regulations, which will enable them to offer comprehensive health coverage to millions of employees and self-employed individuals at an affordable price. Without the rules and requirements set forth under the final AHP regulations, many Coalition members would be unable to provide quality and affordable health coverage to small employers and self-employed individuals who are currently struggling to afford health insurance offered in the existing "small

group" and "individual" health insurance markets. More specifically, if all or a portion of the final AHP regulations are vacated, thousands of employees and self-employed individuals who will be covered by an AHP established exclusively on account of the final AHP regulations – i.e., who are currently enrolling or already have enrolled in AHP coverage that will be effective January 1, 2019 – will lose their health coverage.

Through its members, moreover, the Coalition is especially well-situated to explain the significant benefits of association health plans, to refute the Plaintiffs' one-sided arguments about the supposed risks of such plans, and thus to demonstrate that the final AHP regulations reflect a well-reasoned and considered agency judgment about a matter of social and economic policy that Congress delegated to the Department of Labor.

# ARGUMENT

## I. THE FINAL ASSOCIATION HEALTH PLAN REGULATIONS ARE ENTITLED TO DEFERENCE BECAUSE THEY IMPLEMENT AN AGENCY INTERPRETATION OF AMBIGUOUS STATUTORY TERMS.

The final AHP regulations rest on a solid foundation of administrative law. As a matter of statutory authority, the Department of Labor is empowered to implement regulations that are necessary and appropriate to carry out the provisions of ERISA. 29 U.S.C. §1135. This mandate, of course, includes the authority to give reasonable interpretations to imprecise or ambiguous statutory terms, to which the courts must defer under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

In its administration of ERISA, the Department of Labor has exercised its authority by, among other things, giving content to ERISA's definition of the word "employer," and in particular, to the definitional clause providing that the term "employer," as used in ERISA, "includes a group or association of employers acting for an employer" in relation to an employee benefit plan. 29 U.S.C. §1002(5). Congress' failure to define the term "group or association of employers" "injects ambiguity into [ERISA]." *MDPhysicians & Associates, Inc. v. State Board of Insurance*, 957 F.2d 178, 184 (5th Cir. 1992). The Department of Labor has filled "[t]his void," *id.*, with what the Plaintiffs themselves call "several decades of DOL guidance." Plaintiffs' Memorandum of Law in Support of Motion for Summary Judgment ("Plaintiffs' Br.") at 33.

The courts – in cases cited by the Plaintiffs themselves – have relied on the Department's guidance to determine who qualifies as an "employer" in the specific context of ERISA's administration and enforcement. *See* Plaintiffs' Br. at 33, citing *Gruber v. Hubbard Bert Karle Webber, Inc.*, 159 F.3d 780, 786-7 (3d Cir. 1998) (citing DOL advisory opinions). Indeed, the courts have taken the Department's interpretive opinions into account in ERISA cases even where the courts' decisions could be grounded directly in the statutory language (and *Chevron* deference

therefore was not mandated), because they recognize that DOL opinions always "'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" *MDPhysicians & Associates, Inc.,* 957 F.2d at 186 n. 9, quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944).

The Plaintiffs do not contest the ambiguity of the term "group or association of employers," or the Department's authority to clarify its meaning through administrative interpretation. To the contrary, the Plaintiffs themselves rely heavily on the Department's prior interpretive guidance and make much of its supposed inconsistency with the final AHP regulations. Plaintiffs' Br. at 33-35, 38-42. It appears to be undisputed, then, that the term "group or association of employers" *is* ambiguous and that the Department of Labor's interpretations thereof – or, according to the Plaintiffs, at least *some* of its interpretations – are authoritative.

Where the Plaintiffs go wrong, however, is in (i) claiming that the Department has "abandon[ed]" its prior guidance in the final AHP regulations, Plaintiffs' Br. at 34, and (ii) insisting that by giving the statutory definition one interpretation in one context – the administration of ERISA – the Department has fixed the meaning in stone and rendered itself incapable of arriving at a different interpretation that is appropriate to a different context – the classification of employer-provided health plans for purposes of regulation under the Affordable Care Act. In fact, as the Department has pointed out, even when it is operating in a single context, an administrative agency *can* revisit and reconsider its previous interpretations of an enabling statute, as long as the agency does so in a procedurally appropriate fashion. *See* Memorandum of Points and Authorities in Support of Defendants' Motion to Dismiss or, in the Alternative, for Summary Judgment, and Opposition to Plaintiffs' Motion for Summary Judgment ("Defendants' Br.") at 33, citing *Ferring Pharms., Inc. v. Burwell*, 169 F.Supp.3d 199 (D.D.C. 2016).

Here, however, the Department of Labor *hasn't* abandoned its previous guidance, which still pertains in the ERISA-specific settings for which it was developed.[1] The agency, rather, is simply giving meaning to an "old" term that has been assigned a new role in a new setting: that is, it is interpreting a statutory term that happens to be located in ERISA, and that it has previously interpreted for the purpose of administering and enforcing ERISA, but that has now been imported by reference into a new statutory context.

The Department is acting, moreover, in furtherance of Congressional intent. This dispute arose because, when Congress drafted the Affordable Care Act, it designed the new statute in such a way that its impact depended, in significant part, on whether a particular health plan was being offered to an employee of a large employer, an employee of a small employer, or to an individual without regard to his employment status. *See* Plaintiffs' Br. at 5. The meaning of the word "employer," therefore, looms large in the interpretation and administration of the Affordable Care Act.

This is because, as the Plaintiffs point out, the Affordable Care Act regulates the "individual" and "small group" markets differently than the "large group" market. *See* Plaintiffs Br. at 4. It is therefore necessary to determine whether a health plan is considered an "individual," "small group," or "large group" market plan to determine how the health plan should be regulated. This determination, in turn, rests on the "size" of the "employer" sponsoring the health plan, or whether an "employer" is even present.[2]

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[1] For example, the final AHP regulations preserve the Department's previous interpretation of the term "group or association of employers" set forth in what the Plaintiffs themselves call "several decades of DOL guidance," which clearly shows that the Department has not abandoned this previous guidance.

[2] As the Court knows, the Department has determined that the term "employer" may include a self-employed individual with no employees, as long as he or she satisfies the definition of a "working owner" as set forth under the final AHP regulations. In the Department's view, a "working owner"

The definition of "employer" is especially important in this context because the Affordable Care Act amends the Public Health Service Act (PHSA), and the PHSA provides that the "size" of the "employer" sponsoring a health plan under-written by an insurance company (i.e., a "fully-insured health plan") is determined by the number of employees employed by the employer-sponsor. A "small group market" plan is a group health plan sponsored by a "small employer." 42 U.S.C. § 300gg-91(e)(5). A "small employer" is defined as an employer employing between 1 and 50 employees. 42 U.S.C. § 300gg-91(e)(4). A "large group market" plan is a group health plan sponsored by a "large employer." 42 U.S.C. § 300gg-91(e)(3). A "large employer" is defined as an employer employing 51 or more employees. 42 U.S.C. § 300gg-91(e)(2). Meanwhile, the PHSA defines the term "employer" as having "the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974." 42 U.S.C. § 300gg-91(d)(6).

The Department of Health and Human Services (HHS) recognizes that "[t]he definitions of employer and employee for purposes of the PHS Act are taken from the definitions of those terms in ERISA." CMS Insurance Standards Bulletin 2002-02 at p. 4. The Obama Administration followed up on this understanding in 2011 when HHS explained:

> The PHS Act derives its definitions of group health plan and employer from the ERISA definitions of employee welfare benefit plan and employer. PHS Act § 2791(a)(1), (d)(6). Under ERISA section 3(5), 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.' Thus, reference to ERISA is needed when establishing the existence of a group health plan and determining the identity of the 'employer' sponsoring the plan.

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is an "employer" that may permissibly be considered a member of a "group or association of employers," which may itself qualify as an "employer" under ERISA section 3(5). Treating a "working owner" as an "employer" for these purposes is consistent with prior Department of Labor guidance, *e.g.*, DOL Adv. Op. 99-04A (Feb. 4, 1999), and Supreme Court precedent, *e.g.*, *Yates v. Hendon*, 541 U.S. 1, 16-17 (2004). Denying "employer" status to working owners, on the other hand, will either relegate them to the "individual" market, or deny them insurance.

CMS Insurance Standards Bulletin, Sept. 1, 2011 at pp. 2-3.

In this same CMS Insurance Standards Bulletin, the Obama Administration further explained that determining whether a fully-insured health plan sponsored by a "group or association of employers" should be regulated as an "individual," "small group," or "large group" market plan is dependent on the "size" of the employer members – or individuals – of the group. For example, in cases where a "group or association of employers" is *not* considered an "employer" under ERISA section 3(5), if an employer-member of the group employs fewer than 50 employees, then the fully-insured health plan meets the definition of a "small group market" plan, and is correspondingly subject to the Affordable Care Act's "small group market" insurance rules. CMS Insurance Bulletin, Sept. 1, 2011. However, in cases where a "group or association of employers" *is* considered an "employer" under ERISA section 3(5) – and thus an "employer" for purposes of the PHSA – all of the employees employed by all of the employer-members are counted together to determine the "size" of this "group or association of employers" (i.e., "employer"), which then determines whether the health plan sponsored by the "group or association of employers" should be regulated in accordance with the Affordable Care Act's "small group" or "large group" market insurance rules. *Id*. In most if not all cases, this "group or association of employers" will employ 51 or more employees – when all of the employees of the employer-members are counted together – and therefore, the fully-insured health plan sponsored by this "group or association of employers"

will meet the definition of a "large group market" plan, and thus be regulated as a "large group market" plan under the Affordable Care Act.[3]

The final AHP regulations did not change the manner in which the Affordable Care Act – through the PHSA – and ERISA work together from a definitional perspective. They merely gave meaning to an ambiguous term – a "group or association of employers" – for purposes of determining whether a "group or association of employers" is an "employer." This means that the manner in which the Affordable Care Act, the PHSA, and ERISA work together from a definitional perspective – as interpreted most recently by the Obama Administration – has *not* changed, and thus the manner in which the "size" of a "group or association of employers" is determined for purposes of applying the Affordable Care Act's insurance rules to an "individual," "small group," and "large group" market plan has *not* changed, either.

The Plaintiffs do not even discuss in their Complaint how the Obama Administration has interpreted how the PHSA and ERISA – and correspondingly the Affordable Care Act – work together from a definitional perspective. Instead, the Plaintiffs argue that the only manner in which employees of multiple employers can be "aggregated" and "counted together" is governed by the Internal Revenue Code's "controlled group" rules. Specifically, the Plaintiffs contend that "Congress delineated very narrow circumstances in which employees could be 'aggregated' across businesses, based on well-established rules under the IRC covering corporate control groups and

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[3] As the Court knows, the Department also interprets the term "employee" to include a "working owner," which is consistent with DOL Adv. Op. 99-04A (Feb. 4, 1999), and with *Yates v. Hendon*, 541 U.S. at 16-17. With respect to a "working owner" participating in an association health plan as an "employee," the Department explains that if the "group or association of employers" to which the "working owner" is a member qualifies as an "employer" under ERISA section 3(5), this "working owner" would be considered an "employee" of the entire "group or association of employers" and aggregated for purposes of determining the "size" of the group, consistent with CMS Insurance Standards Bulletin Sept. 1, 2011. *See* 83 Fed. Reg. 28912, 28931 (June 21, 2018).

the like." Complaint, ¶113. In doing so, they miss or ignore an interpretation of the law that was most recently clarified by the Obama Administration.

Rather than define the term "group or association of employers" directly for purposes of the Affordable Care Act's "small group market" insurance reforms – and also for purposes of distinguishing "individual market" health coverage – Congress did so only by reference to ERISA's definitional provisions. By doing so, Congress made it clear that the word "employer" under the Affordable Care Act includes a "group or association of employers," but it also imported the inherent ambiguity of that term from ERISA to the ACA, and it implicitly, but inescapably, incorporated ERISA's grant of authority to the Department of Labor to sort out the uncertainty and to provide an appropriate measure of clarity. This is what the Department of Labor has done – and it is all that the Department has done.

Thus, when the Plaintiffs complain that "DOL does not even apply its new interpretation to anything governed by ERISA *other than* AHPs," Complaint, ¶134 (emphasis in original), they are putting their finger on a strength, not a weakness, in the Department's position. Congress didn't instruct the Department to come up with an interpretation of "group or association of employers" for purposes "other than AHPs" – it didn't need to because, for those non-AHP purposes, the Department (and the courts) had already done so, and the Department's interpretation in this context remains largely unchanged under the final AHP regulations. However, by incorporating an ambiguous term into the Affordable Care Act, Congress effectively instructed the Department to do exactly what it did: come up with an interpretation that could reasonably be applied in the new context, e.g., determining whether a particular health plan is sponsored by a "small employer" or "large employer" – or whether an "employer" is even present – for purposes of determining

whether the Affordable Care Act's "individual," "small group," or "large group" market plan insurance rules apply.[4]

The fact that the new interpretation of whether and when a "group or association of employers" is considered an "employer" under ERISA section 3(5) differs from previous guidance is of no consequence – or, to be more precise, it is a consequence of the fact that the Department has now been instructed to construe the same term for application in different statutes. "In law as in life … the same words, placed in different contexts, sometimes mean different things." *Yates v. United States*, 135 S.Ct. 1074, 1082 (2015). With respect to the current dispute, when it enacted the Affordable Care Act, Congress took the ambiguous phrase "group or association of employers" out of one context, placed it into a new and different context, and – because it adopted the term by reference to ERISA – delegated to the Department of Labor the obligation and authority to determine whether the same words, when read in the new setting, mean a different thing. The Department has determined that they do, and its determination is entitled to deference under *Chevron*.

## II. THE FINAL ASSOCIATION HEALTH PLAN REGULATIONS REFLECT A CONSIDERED AND REASONABLE AGENCY JUDGMENT ABOUT A MATTER OF SOCIAL AND ECONOMIC POLICY.

Substantial judicial deference is due here for another reason. When it establishes an administrative agency, the legislature "delegate[s] the primary authority of implementing policy in a specialized area to governmental bodies with the staff, resources, and expertise to understand

[4] The Department *has*, moreover, applied its new interpretation to something governed by ERISA "*other than AHPs*." Subsequent to the issuance of the final AHP regulations, the Department released proposed regulations applying its same interpretation of whether and when a "group or association of employers" may be considered an "employer" under ERISA section 3(5) for purposes of sponsoring an "employee pension benefit plan" for employees of the employer members of the group, along with "working owners" who may permissibly participate in this new "association retirement plan." *See* 83 Fed. Reg. 53534 et. seq. (Oct. 23, 2018).

and solve those specialized problems." *Communications Workers of Am. v. New Jersey Civ. Serv. Comm'n (In re Job Banding for Software Dev. Specialist 1 & 2)*, 234 N.J. 483, 514, 191 A.3d 643, 661 (2018), quoting *Bergen Pines Cty. Hosp. v. Dep't of Human Servs.*, 96 N.J. 456, 474, 476 A.2d 784 (1984).

Thus, when it enacted the Administrative Procedure Act to govern judicial review of federal agency decision-making, Congress "understood that administrative agencies were more competent than the courts in many specialized areas of fact determination, and particularly in making quasi-legislative judgments about matters of social and economic policy. It recognized this in the APA by requiring the courts to exercise considerable deference in their review of such issues" – i.e., by subjecting administrative rule-making to review under the highly deferential "arbitrary and capricious" and "substantial evidence" standards. *Natural Resources Defense Council, Inc. v. SEC*, 606 F.2d 1031, 1048 (D.C.Cir. 1979), citing 5 U.S.C. §§706(2)(A), (E). *See also Environmental Defense Fund, Inc. v. Costle*, 657 F.2d 275, 283 (D.C.Cir. 1981) (arbitrary and capricious standard is "a highly deferential one … which presumes the agency's action to be valid"); *Humane Society of the United States v. Zinke*, 865 F.3d 585, 609 (D.C.Cir. 2017) (substantial-evidence review "is highly deferential to the agency fact-finder, requiring only such relevant evidence as a reasonable mind might accept as adequate to support a conclusion") (internal citations omitted).

The Department engaged in just such a quasi-legislative project when it carried out the particular definitional task that Congress delegated to it in the Affordable Care Act, and decided how to interpret "employer" and "group or association of employers" in this new context. Employing its resources and expertise to understand the problem before it published a proposed rule, it solicited and responded to public comments, weighed competing interests and concerns,

and assessed relative costs and benefits, all in an effort to "solve [a] specialized problem" by reaching a considered judgment about what is indisputably a matter of social and economic policy. *See generally* 83 Fed. Reg. 28912 *et seq.* (June 21, 2018). Congress could have used its own resources to conduct this sort of fact-finding and policy-balancing, but instead it left the matter to the Department's resources and to the exercise of the Department's administrative experience and expertise.

In these circumstances, therefore, considerable judicial deference is due to the agency's interpretation for not one but two reasons: (i) under *Chevron*, because the agency has interpreted a statutory term that is undeniably ambiguous, and (ii) under the APA, because the agency has responded to a legislative delegation of responsibility by using its resources and employing its expertise.

Perhaps recognizing this additional, independent obstacle to their claims, the Plaintiffs have attacked the Department's determination as "arbitrary and capricious" on a number of grounds, which the Plaintiffs seem to summarize in their attempt to describe the purpose of the final AHP regulations:

> The Final Rule's purpose and effect are simple: To shift, through manipulation of the Employment Retirement Income Security Act (ERISA), a large number of small employers and individuals into the large group market because the ACA's core protections do not apply to that market. Worse yet, health plans created under the Final Rule would lack basic market incentives and statutory protections under federal law that apply to plans from true large employers. The results will be adults and children with less coverage and fewer benefits than Congress intended in all three markets (individual, small group, and large group), and a destabilized individual and small group market with premiums that may be unaffordable for people with pre-existing conditions who need the ACA's core protections.

Complaint, ¶7.

The Plaintiffs also contend that "the Final Rule would return the country to the pre-ACA world where people with pre-existing conditions will lack federal protections that enable them to obtain quality, affordable health insurance." *Id.* at ¶8.

### A. The Final AHP Regulations Will *Not* Return the Health Care Market to a "Pre-ACA World."

The Coalition is uniquely well-situated to respond and add a "market" perspective on the issues raised by the Plaintiffs. First, though, it must respond to the Plaintiffs' hyperbolic claim that the final AHP regulations will somehow return the country to a "pre-ACA world," and particularly to a world where people with pre-existing conditions will be unprotected by federal law.

In fact, every association health plan is a "group health plan" subject to consumer protections under a panoply of federal laws: (1) ERISA, (2) the Health Insurance Portability and Accountability Act (HIPAA), with its prohibition against varying premiums based on the health status of a plan participant, (3) the Consolidated Omnibus Budget Reconciliation Act (COBRA), which confers the right to continuation of coverage in certain circumstances, along with (4) the Affordable Care Act's "coverage requirements," specifically including its prohibition against denying coverage based on a pre-existing condition, as well as the prohibition against imposing annual and lifetime limits on the "essential health benefits" covered under the plan. Thus, in *no* case will the final AHP regulations erode the Affordable Care Act's pre-existing condition protections or in any way "return the country to the pre-ACA world," nor will association health plans – as "group health plans" governed by ERISA, HIPAA, COBRA, and the Affordable Care Act – evade "the statutory protections under federal law that apply to plans from true large employers." In effect, an association health plan is the same type of health plan that a large employer offers, subject to the same rules and requirements applicable to a large employer plan.

### B. The Plaintiffs Fail to Recognize that Association Health Plans Will Provide Comprehensive Health Coverage.

Indeed, that is precisely the point of the final AHP regulations: to give small businesses an opportunity to stand on the same footing as large employers with respect to the provision of employee health benefits. Large employers voluntarily offer health benefits to their employees to attract and retain talented workers, and to keep their employees healthy and productive. They have historically offered comprehensive benefits because the labor market traditionally demands such quality health coverage. The Plaintiffs acknowledge this when they explain that the Affordable Care Act requirements for plans sponsored by large employers differ from "small group" or "individual" market plans "[b]ecause most large employers already offered comprehensive health insurance to their employees…." Plaintiffs Br. at 4.

When it comes to these concerns, however, small employers are really no different from large ones. Small employers – just like large employers – want to attract and retain talented workers and to keep their employees healthy and productive. As a result, small employers – just like large employers – *want* to offer comprehensive health coverage. Because they lack the resources and bargaining power of big employers, however, the majority of small employers are unable to offer comprehensive coverage at an affordable price. This is where association health plans can play such an important and socially-beneficial role. By obtaining health coverage through an association health plan – which effectively will be treated as a health plan sponsored by a large employer – small employers will be able to compete with large employers and offer comprehensive benefits at affordable prices.

The association health plans themselves have similar incentives. The type of "groups or association of employers" interested in sponsoring an association health plan are member-based organizations. These organizations want to offer association health plan coverage – which again,

is effectively a large employer plan – to their employer-members, not only to help the employer-members attract and retain talented to workers, but as a member benefit to attract new members and retain their current members. An offer of less comprehensive, sub-standard health coverage will actually be detrimental to these organizations (i.e., their current members will leave the organization and they will be unable to attract any new employer-members).

This is not just theory, but practice. For example, Land O'Lakes, Inc. – which is a member-owned cooperative in the agricultural industry and also considered a "group or association of employers" and an "employer" under ERISA section 3(5) – is currently enrolling self-employed farmers in a self-insured association health plan established in accordance with the final AHP regulations. (It should be noted that Land O'Lakes, Inc. is able to offer self-insured association health plan coverage to their self-employed farmers only because of the existence of the final AHP regulations, and that if all or a portion of the final AHP regulations are vacated – especially the portion of the regulations that allow "working owners" to participate in an AHP – these self-employed farmers will *lose* their health coverage.)

The Land O'Lakes association health plan offers its members eight different plan designs, and while this self-insured association health plan is not *required* to cover the Affordable Care Act's "essential health benefits" (EHBs), all of these plans *voluntarily* cover the ten statutory EHB categories mandated by the Affordable Care Act, along with all of the services that fall into the EHB categories that are medically necessary. The health coverage Land O'Lakes offers to its farmer-members is therefore "comprehensive," and it is also superior in price – 15 to 25 percent more affordable than "individual market" rates in Nebraska, and 10 percent more affordable than "individual market" rates in Minnesota.

### C. A Regulatory Framework Has Been Put In Place Over Time to Combat Fraud and Abuse.

The Plaintiffs devote a significant portion of their Complaint and brief to arguing that fraud and abuse is sure to occur if the final AHP regulations are upheld. The Plaintiffs presumably hope to convince the Court that future fraud and abuse is inevitable based on a past history of misconduct and insolvencies associated with association health plans and other multiple employer welfare arrangements (MEWAs). Historical allegations that some AHPs or MEWAs had fraud or abuse problems in the past, however, are not descriptive of the current state of the market, much less predictive of its future operation under the final AHP regulations, for several reasons.

First, the Plaintiffs fail to acknowledge that an association health plan can take the form of either a fully-insured or a self-insured arrangement. This is a crucial distinction when it comes to the issue of fraud and abuse. Fully-insured association health plans are under-written by insurance companies, which are themselves subject to significant State regulation. Even as a historical matter, therefore, there have been very few cases of fraud and abuse in fully-insured association health plans. Nevertheless, the Plaintiffs paint with a broad brush, calling on the court to invalidate the final AHP regulations in their entirety, and to block the ability of a "group or association of employers" to sponsor even a fully-insured association health plan.

Second, while self-insured association health plans have in the past been more vulnerable to fraud and abuse, this history long ago prompted Congress to act. Before 1983, self-insured AHPs resisted efforts at State regulation by arguing that such regulation was pre-empted by ERISA. That year, however, Congress amended ERISA to give States the exclusive authority to regulate self-insured association health plans and other self-insured MEWAs.

Since 1983, therefore, the States have been free to regulate self-insured AHPs as they see fit, and they have exercised that authority through the enactment of State multiple employer

welfare arrangement (MEWA) laws. Currently, a number of States – including California, Illinois, South Dakota, and Wisconsin – flatly prohibit the establishment of any new self-insured association health plans. Other States – such as Indiana, Michigan, Nebraska, and Ohio – have enacted MEWA laws that set forth comprehensive certification and approval processes that an organization seeking to operate a self-insured association health plan in the respective State must satisfy. Any such certification/approval must come directly from the State's Insurance Commissioner, and any such certification/approval will only be provided by the Commissioner if all of the State's MEWA law requirements are satisfied.

More extensive oversight has also come at the Federal level. With the enactment of the Affordable Care Act, Congress both expanded and strengthened the Department of Labor's authority over MEWAs and thus over AHPs. As the Department put it in 2013, soon after those reforms were implemented:

> The Patient Protection and Affordable Care Act (ACA) established a multipronged approach to MEWA abuses. Improvements in reporting, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration with the Department of Labor prior to operating in a State. The additional information provided will enhance the State and Federal governments' joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a financially hazardous condition.

U.S. Dep't of Labor, *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* (August 2013), at p. 4.

The Coalition submits that this detailed State and Federal regulatory framework – which was not in place at all prior to 1983, and which has been built up over the years – provides safeguards that will largely prevent fraud and abuse, and, where misconduct does occur, will

significantly mitigate its effects. The Coalition has, moreover, pledged to the National Association of Insurance Commissioners generally, and to certain State Insurance Commissioners specifically, that it is ready, willing, and able to work with the States to build on the current regulatory framework. In addition, the Coalition intends to work with members of Congress to provide additional funding for the DOL's enforcement activities – as established under the Affordable Care Act – as well as State enforcement efforts.

Finally, and just as important, there is no factual basis for concluding that past is prologue here because the nature of the market itself has changed, in a way that strongly incentivizes current and future association health plans *not* to engage in the kinds of "fraud" and "abuse" that their predecessors committed. This is no longer a "make a buck" market that attracts fly-by-night operators. To the contrary, "groups or association of employers" are now seeking to offer health coverage through association health plans to fill a significant, legitimate, and long-term need, i.e., because the existing "small group" and "individual" markets are too expensive and inflexible, and thus are not adequately serving their customers.

In addition, the Plaintiffs appear to miss the impact of the very statute they are purporting to defend. The Affordable Care Act didn't just enhance regulatory oversight of MEWAs and AHPs. It also worked a distinct change in the landscape of the health-insurance market. Before the ACA was enacted, "working owners" and small employers had few alternatives when it came to health plan options, and even fewer good alternatives since – in comparison to the market for health insurance provided by large employers, who enjoy the kind of buying power and leverage that individuals and small employers inherently lack – "health insurance markets for individuals and small businesses were much more prone to abuse, including discrimination in pricing and benefits." Complaint, ¶52. Unable to obtain the kinds of prices and benefits that large employers

could get, "far fewer small employers offered health insurance to their employees," and many individuals were just priced out of the market. *Id.*

The Affordable Care Act was designed to rectify that imbalance by "specifically targeting [its] most comprehensive reforms to the individual and small group markets." Complaint, ¶52. It is not necessary to catalog those reforms here. What matters, for present purposes, is that the ACA gives "working owners" and small businesses an alternative – however imperfect – for obtaining comprehensive health benefits.

Because that alternative now exists, and because participation in an AHP is always *voluntary*, the Affordable Care Act itself – simply by virtue of its existence and operation – will regulate any tendencies that AHPs *might* still have for fraud or abuse. In order to thrive, the AHPs must compete, and in order to compete effectively, they must operate in a manner that customers will find attractive. For example, if an association health plan cannot offer comprehensive coverage at a price point that is more affordable than the same type of comprehensive health plans that are offered in the "small group" or "individual" markets, employees and "working owners" will not enroll in association health plan coverage. As a result, the demand for comprehensive coverage at a reasonable price will drive the type of health coverage association health plans offer, and these market forces will significantly limit any abusive activity.

### D. Predictions of Market Segmentation Are Speculative and Over-Stated.

The Plaintiffs argue that the final AHP regulations will somehow destabilize the "individual" and "small group" markets. Complaint, ¶7. This argument, however, is mostly theoretical. The Plaintiffs certainly have not quantified the impact of the predicted destabilization of the markets, and thus nothing they say on this subject should displace the Department of Labor's informed judgment – which Congress entrusted to the agency's resources and expertise – about

how employers, employees, and "working owners" will behave if the final AHP regulations are upheld.

The Plaintiffs' predictions of market segmentation, moreover, are at the very least overstated. For one thing, the Plaintiffs have overlooked the likelihood – substantiated above in Section II.B. – that association health plans will offer comprehensive coverage at lower cost than "individual" and "small group" market plans. In the Coalition's experience, employees and individuals shop for health insurance based on price, as well as the comprehensiveness of the health coverage. The health status of a particular employee or individual also drives their behavior. In cases where an employee or individual is healthy, they will most likely gravitate toward health coverage with a lower cost. If, however, an employee or individual is less healthy (and thus a "high-medical utilizer"), they are more likely to seek out comprehensive coverage, although price remains an important factor as well.

The plaintiffs are wrong, therefore, when they predict that association health plans will draw healthy people out of the ACA markets. Because association health plan coverage is proving to be as comprehensive as – if not more comprehensive than – existing "small group" or "individual" market coverage, while still being offered at a more affordable price, both healthy people *and* less healthy/high-medical utilizers are going to be attracted to association health plan coverage. And insofar as less healthy/high-medical utilizers exit the "small group" or "individual" markets to enroll in an association health plan (because such plans will offer comprehensive benefits at a lower cost), the expanded availability of AHP coverage will *benefit* the "small group" and "individual" markets from a health risk perspective, drawing less healthy/high-medical utilizers out of the current risk pool. At the very least, this beneficial effect should offset any

"destabilizing" effect that will result when healthy employees and "working owners" also leave the "small group" and "individual" markets for superior association health plan coverage.

Second, the Plaintiffs' predictions of market destabilization are not just speculative, but also incomplete because they fail to account for the numbers of small employers – as well as "working owners" in the "unsubsidized" individual market – who are currently *not* covered by an ACA-compliant plan. If the employees of these small employers – along with these working owners – choose to enroll in an association health plan, the current Affordable Care Act's reformed "small group" or "individual" markets will *not* be affected because these insured "lives" were never in those markets and never affected the composition of their risk pools in the first place.

Again, this is not a theoretical consideration. Since the enactment of the Affordable Care Act in 2010, health coverage offered by small employers with fewer than 50 employees has declined by about 20 percent. *See Employer Health Benefits: 2018 Annual Survey* (Kaiser Family Foundation 2018) at pp. 15 (Figure G), 45, 47. Only 54 percent of small employers with fewer than 50 employees actually offer health coverage, as compared to 96 percent of large employers with 50 to 199 employees. *Id*. Importantly, 47 percent of small employers identify the high cost of health insurance as the primary reason for not offering coverage. *Id.* at p. 58.

A similar phenomenon exists in the "unsubsidized" individual market. Since 2015, about 3 million individuals have exited the Affordable Care Act's reformed "individual" market. *See* Semanskee, Cox, and Levitt, *Data Note: Changes in Enrollment in the Individual Health Insurance Market* (Kaiser Family Foundation, July 2018) at p.1. This amounts to a loss of about 17 percent of the "individual" market from its peak. *Id*. It is reasonable to infer that many, if not most, of these individuals exited the "individual" market due to significant premium increases following the enactment of the Affordable Care Act. It is also reasonable to infer that many of

these individuals will be attracted to an association health plan that offers comprehensive coverage, additional flexibility, and lower prices. In any event, the undeniable fact is that these "lives" are currently *not* a part of the Affordable Care Act's reformed "individual" market, which therefore cannot be affected by their migration from uninsured status to an association health plan.[5]

## CONCLUSION

In all of these ways and for all of these reasons, the specter of "fraud and abuse" raised by the Plaintiffs is more shadow than substance, and the putative risks of the final AHP rules are substantially outweighed by the benefits they will provide. The Coalition expects that the operations of its members will fully bear out (i) the Department of Labor's characterization of AHPs as "an innovative option for expanding access to employer-sponsored coverage (especially for small businesses)," 83 Fed. Reg. 28912 (June 21, 2018), (ii) the agency's determination that "[t]he expansion of AHPs under this final rule will provide small businesses, including working employers … with additional and more affordable health insurance options that will more closely match their preferences," *id.* at 28957, and (iii) its conclusion that the final AHP regulation "delivers social benefits that justify any attendant costs." *Id.* Of course, the Court does not have to agree with the Department of Labor about the balance it struck on this policy issue. What matters is that it was perfectly rational (and therefore neither arbitrary nor capricious) for the Department

[5] In 2013, the Obama Administration announced what is referred to as its "transitional policy," which authorized States to allow insurance companies to continue to sell non-ACA-compliant health plans to small employers and individuals. This "transitional policy" has been extended multiple times, most recently through December 31, 2019. Although this market has been shrinking, a good number of small employers – as well as individuals – are still enrolled in these non-ACA-compliant plans. Because these non-ACA-compliant plans are subject to different rules than ACA-compliant "small group" and "individual" market plans, these "lives" are in a separate risk pool and not a part of the existing "small group" and "individual" market risk pools. If the small employers and individuals that currently get coverage under these non-ACA-compliant "transitional" plans are attracted to an association health plan, their enrollment in the association health plan will likewise have zero impact on the Affordable Care Act's reformed "small group" and "individual" markets.

to strike such a balance, and that no basis for judicial intervention exists here. *See, e.g.*, *Apotex, Inc. v. Food and Drug Administration*, 414 F.Supp.2d 61, 66 (D.D.C. 2006) ("it is not enough for the agency decision to be incorrect – as long as the agency decision has some rational basis, the court is bound to uphold it"). The Court should therefore grant the Department of Labor's motion and dismiss the Plaintiffs' claims.

Respectfully submitted,

**THE COALITION TO PROTECT AND PROMOTE ASSOCIATION HEALTH PLANS**

By its attorneys,

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Date: December 19, 2018

**CERTIFICATE OF SERVICE**

I hereby certify that on this 19th day of December, 2018, I caused to be electronically filed and served via CMF/ECF, the foregoing Brief of the Coalition to Protect and Promote Association Health Plans as *Amicus Curiae* Brief in Support of Defendants, upon all counsel of record.

/s/ Jennifer R. Budoff
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