No. 20-11179

In the United States Court of Appeals for the Fifth Circuit

DATA MARKETING PARTNERSHIP, L.P.; L.P. MANAGEMENT SERVICES, L.L.C.,

Plaintiffs – Appellees,

v.

UNITED STATES DEPARTMENT OF LABOR; MARTIN WALSH, SECRETARY, U.S. DEPARTMENT OF LABOR; UNITED STATES OF AMERICA,

Defendants – Appellants.

On Appeal from United States District Court
for the Northern District of Texas

BRIEF OF AMICUS CURIAE BLUE CROSS BLUE SHIELD ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLANTS

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SUPPLEMENTAL CERTIFICATE OF INTERESTED PERSONS

Pursuant to Fifth Circuit rules 28.2.1 and 29.2, the undersigned counsel of record for *amicus curiae* provides this supplemental statement of interested parties to fully disclose all those in an interest in the *amicus* brief. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Amicus Curiae on this Brief

Amicus Curiae Blue Cross Blue Shield Association has no parent and no corporation owns stock in it.

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IDENTITY AND INTEREST OF AMICUS CURIAE[1]

The Blue Cross Blue Shield Association ("BCBSA") is the non-profit association that promotes the national interests of thirty-five independent, community-based and locally-operated Blue Cross Blue Shield health insurance companies ("Blue Plans"). Together, the Blue Plans provide health insurance to nearly 106 million people—nearly one-third of all Americans—in every zip code in all fifty states, the District of Columbia, and Puerto Rico. Blue Plans offer a variety of insurance products to all segments of the population, including federal employees, large employer groups, small businesses and individuals. As leaders in the healthcare community for over eighty years, Blue Plans seek to expand access to quality healthcare for all Americans and have extensive knowledge of and experience with the health insurance marketplace.

The district court's decision in this matter makes critical errors in its assessment of Data Marketing's scheme. The decision finds not only that Data Marketing's scheme is a "plan" under ERISA, but also that it constitutes a single employer plan, thus entirely preempting states from regulating this commercial

[1] Pursuant to Federal Rule of Appellate Procedure 29, Blue Cross Blue Shield Association respectfully submits this brief amicus curiae in support of Defendants-Appellants and reversal with an Unopposed Motion for Leave to File an Amicus Curiae Brief. No counsel for a party authored this brief in whole or in part, and no person other than amici curiae or their counsel contributed money that was intended to fund the preparation or submission of this brief.

scheme. Not only are these findings inaccurate—Data Marketing's program does not involve any employment relationships which is at the heart of both errors—they will also likely lead to additional plans utilizing this unintended loophole to avoid regulation to which they would otherwise be subject.

BCBSA and its members are diverse in their offerings, but share a common interest in seeing health insurance regulated in a fair and consistent manner that benefits Americans generally. Moreover, with over eighty years of experience working to deliver affordable health care nationwide, BCBSA has insight and expertise in how insurance markets operate and how damaging certain arrangements have been historically. Accordingly, BCBSA has an interest in explaining how plans that evade oversight, and provide lower-quality healthcare to Americans.

INTRODUCTION AND SUMMARY OF ARGUMENT

The issue in the case is deceptively simple—who is an "employee" for purposes of ERISA? This is a threshold issue for establishing the scope of the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that sets standards for *employer-sponsored* benefits, including group health plans. In order to be an ERISA-covered plan, coverage must be provided to "employees." Here, the issue is whether individuals who download tracking software to their personal electronic devices become "employees" eligible to participate in an "employee welfare benefit plan." If yes, those benefits would be subject to ERISA and—just as critically—***exempt*** from crucial state insurance oversight and federal standards that protect consumers enrolling in individual health insurance coverage.

LP Management Services, LLC ("LP Management") asked the Department of Labor ("DOL") to answer the question of whether the health benefits offered by LP Management to its "limited partners" were subject to ERISA. To become a limited partner, an individual merely needed to agree to download LP Management's tracking software. DOL appropriately concluded that the health benefits offered by LP Management to these limited partners did not qualify as an ERISA-covered group health plan because these limited partners were not true "employees" as required by ERISA. As DOL further concluded, because there was no employment relationship, the health benefits offered through the arrangement

should be treated as coverage subject to state insurance law and regulation, and not subject to ERISA.[2]

Data Marketing Partnership ("DMP")[3] sued, asking for a preliminary injunction and for the advisory opinion to be set aside as an arbitrary and capricious interpretation of ERISA. DMP argued that the limited partners in the Data Marketing Arrangement constituted legitimate "working owners" for ERISA purposes. The district court agreed with DMP and enjoined DOL "from refusing to acknowledge the ERISA-status of the Plan or refusing to recognize the Limited Partners as working owners." *Data Mktg. P'ship*, 2020 WL 5759966, at *14.

As Justice Kennedy recently explained, "ERISA does not guarantee substantive benefits. The statute, instead, seeks to make the benefits *promised by an employer* more secure by mandating certain oversight systems and other standard procedures." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) (emphasis added). If the scheme offered by the Data Marketing Partnership is deemed to be covered by ERISA, then ERISA will have no real boundaries. ERISA was designed to regulate bona fide employment based plans where the

[2] DOL Advisory Op. 2020-01A, January 24, 2020, was filed as Exhibit B to the Amended Complaint in *Data Mktg. P'ship v. DOL*, No. 4:19-cv-800, (N.D. Tex. Feb. 3, 2020), Dkt. 9-2, and referred to in the District Court decision, *Data Mktg. P'ship, LP v. DOL*, No. 4:19-cv-00800, 2020 WL 5759966, (N.D. Tex. Sept. 28, 2020), as the DOL Opinion issued on February 3, 2020.

[3] LP Management is the general partner of DMP.

employer is offering benefits tailored to its employees that it wishes to attract and retain. ERISA was not meant to regulate—and inadvertently shield from federal and state insurance regulation—a thinly-disguised commercial arrangement formed to sell individual insurance. Indeed, the purpose of ERISA is to encourage employers to offer benefits by "assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

As evidenced by its title, ERISA extends only to benefits made available through a bona fide *employment* relationship.[4] *See Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323 (1992). To ensure a uniformity of plan administration and benefits, ERISA generally preempts state laws that regulate so-called "self-insured" employee benefit plans (plans that are not insured by an insurance

[4] Schemes like Data Marketing's should not be conflated with traditional association health plans, which remain tethered to the traditional employment relationship. *See, e.g.*, DOL Adv. Op. 2001-04A (Mar. 22, 2001) (noting that a plan would exist "where a cognizable, bona fide group or association of employers establishes a benefit program for the employees of member employers and exercises control of the amendment process, plan termination, and other similar functions on behalf of these members with respect to a trust established under the program. On the other hand, [however,] where several unrelated employers merely execute participation agreements or similar documents as a means to fund benefits, in the absence of any genuine organizational relationship between the employers, no employer association can be recognized.").

company). But ERISA does not preempt state *insurance* laws that apply to insurance companies and the insurance policies they issue to ERISA plans.

As such, under ERISA, states remain free to regulate their insurance markets in a manner tailored to state needs, *see* 29 U.S.C. § 1144(a) and (b)(2), including by setting solvency standards, examining insurers' accounting and financial statements, administering market conduct examinations, investigating consumer complaints, as well as imposing benefit mandates or other consumer protections, particularly in the individual health insurance market.[5] At the same time, states are generally free to *not* regulate their insurance markets, when circumstances warrant.

Early in the history of ERISA, Congress focused on pension plans, delineating detailed and stringent requirements to protect employee pensions. However, after a series of fraudulent self-insured "trusts" were formed in the 1970s and 1980s to provide health benefits to groups of employers—trusts that left millions of dollars of unpaid health claims in their wake—Congress began more actively regulating employee health benefits. As this Court explained:

> In reaction to the broad range of "persons" claiming "employer" status to gain the protection of ERISA's broad preemption against application of state regulations, Congress evidenced its intent shortly after the

[5] *See, e.g.*, National Association of Insurance Commissioners, *State Insurance Regulation*, https://www.naic.org/documents/consumer_state_reg_brief.pdf (last visited Apr. 5, 2021); National Conference of State Legislatures, *State Insurance Mandates and the ACA Essential Benefits Provisions*, https://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx#Understanding (last visited Apr. 5, 2021).

passage of ERISA. The Activity Report of the Committee on Education and Labor revealed that

> certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that [its] enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation.... [W]e are of the opinion that these programs are not "employee benefit plans".... [T]hese plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction.... They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan. .... [W]e do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the ["employee benefit plan"] definition....

MDPhysicians & Assocs., Inc. v. State Bd. of Ins., 957 F.2d 178, 184 (5th Cir. 1992) (alterations in original) (quoting H.R. Rep. No. 94-1785 (1977)).

Despite this Congressional statement and because of ERISA's broad preemption provision, there was some concern that neither the DOL nor states could act to prevent the formation of these fraudulent trusts, which lacked the traditional employment relationship that undergirded ERISA. As a result, in 1983, Congress amended ERISA to explicitly permit state regulation of these trusts. Following the amendment, states were empowered to exercise oversight and

authority over these groups—now known as multiple-employer welfare arrangements ("MEWAs").

If allowed to stand, the *Data Marketing Partnership v. The United States Department of Labor* case will upend this carefully balanced framework. Following that decision, states will be blocked from regulating what are, essentially, unlicensed insurance companies selling *individual, unregulated insurance* to unaware consumers. The design and marketing of products that selectively drain state insurance markets of the healthier, lower-cost individuals needed to keep premiums affordable will result, along with fraud, impacting millions of Americans enrolled in legitimate health care plans regulated by state law and the Affordable Care Act ("ACA"). Consumers, particularly the most vulnerable with preexisting conditions, will be left holding the bag. We have seen this all before—in the wave of fraudulent MEWAs—of which Data Marketing-like schemes are just the latest variation. The district court's decision should be reversed.

ARGUMENT

I. Data Marketing-like Schemes Destroy the Careful Balance of State and Federal Insurance Regulation that Protects Consumers.

Properly characterized, the *Data Marketing* scheme is an unlicensed insurance company offering unregulated, self-insured individual coverage. If allowed to continue, similar schemes will be created without any legitimate

employment-based nexus. Wrongly assuming the preemptive mantle of ERISA, these plans, like others before them, will attempt to elude state regulation. With no legitimate employment basis, federal regulations and regulators cannot provide sufficient oversight. Individuals will be stripped of both federal and state consumer protection. States' ability to regulate insurance will be undermined. And insurance markets will be destabilized, which will cause the cost of coverage to rise.

A. Schemes like Data Marketing's will damage insurance markets, destabilizing the risk pools, and cause spiraling premiums.

The ACA "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 576 U.S. 473, 478–80 (2015). For example, the ACA "addressed the problem of those who cannot obtain insurance coverage because of preexisting conditions or other health issues…[t]hese provisions together prohibit insurance companies from denying coverage to those with such conditions or charging unhealthy individuals higher premiums than healthy individuals." *NFIB v. Sebelius*, 567 U.S. 519, 547–49 (2012).

Critically, while the ACA also imposed requirements on self-funded plans, many powerful provisions protecting consumers—such as the guaranteed issue requirement, a minimum benefit package and limits on how much premiums may

vary based on age, gender and other factors[6]—apply to regulated *insurers and insurance policies*.. Although some of the insurance requirements are federal (enacted in the ACA and other federal statutes), states are the primary regulator for insurance (including with respect to enforcing the ACA individual health insurance consumer protections).[7] Both state and federal regulators have been wary of entities that have tried to avoid these consumer protections ever since, not only out of concern for the consumers directly affected, but also because of the detrimental effect dodging the requirements would have on the insurance markets.

Indeed, the health of the entire insurance pool was key to the ACA and a continuing concern since its passage. Among many provisions designed to keep insurance markets healthy, the ACA required health insurers to "pool" the risks in each state by market (except large group). 42 U.S.C. § 18032(c). The "single risk pool" provision means that the risk associated with individuals with higher health needs or preexisting conditions are pooled with individuals with relatively fewer health needs, so that the costs of services for all individuals covered in a year are spread among every individual that purchases insurance in that market (individual or small group). When individuals that are younger, or healthier, or otherwise have fewer health costs are removed from the pool, the costs of those with greater health

[6] 42 U.S.C. § 300gg; *Id.* at § 300gg-1.
[7] *See* B, *infra.*

needs are spread among fewer individuals. The result is higher premiums and, if the cost increase causes additional healthier individuals to also leave the pool, what actuaries sometimes call a "death spiral" occurs, where increased costs force more individuals out of the market until the market collapses.[8] *King*, 576 U.S. at 476, 481 ("The combination of no tax credits and an ineffective coverage requirement could well push a State's individual insurance market into a death spiral.").

The history of the ACA, and the controversies surrounding it, in many ways can be reduced to disputes over how to address the adverse effects and unintended consequences of policies on the insurance risk pools. For example, in 2012, the Departments of Treasury, Labor and Health and Human Services ("the Departments") requested information on the use of stop loss insurance. The Departments noted that

> It has been suggested that some small employers with healthier employees may self-insure and purchase stop loss insurance policies with relatively low attachment points to avoid being subject to these [insurance] requirements while exposing themselves to little risk. *This practice, if widespread, could worsen the risk pool and increase premiums in the fully insured small group market*…

[8] *See, e.g.*, Milliman, *Has the ACA "death spiral" kicked the bucket?* (July 22, 2019), https://www.milliman.com/-/media/milliman/importedfiles/ektron/aca_death_spiral_20190722.ashx ("In health insurance, death spirals occur when premium rates rise enough to drive out the healthiest enrollees, leaving the risk pool sicker and more expensive. This, in turn, necessitates that insurers increase premium rates, which then drives out the next-healthiest enrollees and reduces new enrollment. This cycle continues until the risk pool contains only the sickest and most expensive enrollees, with premiums unaffordable for most.").

Request for Information Regarding Stop Loss Insurance, 77 Fed. Reg. 25,788, 25,789 (May 1, 2012) (emphasis added).

The Departments have implemented policies against practices where an insurer could offer limited coverage only attractive to the healthy, limit eligibility, or otherwise selectively attract and enroll the healthiest individuals out of a market. Because such a plan would likely have fewer claims than others, it would be relatively less expensive. Such selective enrollment of health individuals simultaneously weakens the rest of the market, where the most medically-needy, expensive-to-cover individuals remain. To combat this, the Departments have developed nondiscrimination requirements, rating requirements, minimum service area requirements, and others. *See, e.g.,* Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310-01, 18,410 (Mar. 27, 2012) ("We believe that this provision adequately addresses the underlying causes of 'red-lining,' which is to exclude populations that are high utilizing, high cost, or medically-underserved. In addition, . . . the general service area delineations must be established without regard to a variety of factors that could be used to 'cherry-pick' healthy from unhealthy risk by geography."). Because these rules are designed in large part to protect the insurance market and consumers purchasing individual coverage, the rules generally apply only to

insurers and are enforced by states against licensed health insurers. These rules generally do not apply to self-funded entities.[9]

How are *Data Marketing*-like arrangements initially so attractive, and hence, successful (at least for their organizers)? Typically these arrangements selectively draw the best risks by:

- underwriting at the level of each participant, so that those with preexisting or chronic conditions are charged much higher premiums than others, and
- designing benefits that are not attractive to persons with chronic high cost conditions, like excluding coverage for the drugs that treat high cost conditions, coverage of which is expensive and which would cause premiums to increase and discourage those with preexisting conditions from enrolling.

These are the very methods from which insurers are prohibited in engaging and the very reasons that entities operating these schemes seek to avoid state insurance regulation.

[9] There are some rules, such as the essential health benefit requirements, that Congress also applied to self-funded small group plans, but did not apply to self-funded large group plans. There are also some federal requirements, such as Title VII, which apply to most employers and prevent discrimination in the provision of benefits. It is unclear whether Title VII's protections would extend to Data Marketing's limited partners.

The economic motivation to exclude unhealthy risks can be strong. In the small group market, 5 percent of members account for approximately 57 percent of claims, and only 16 percent of members account for 80 percent of claims.[10] When the DOL proposed expanding the ability of associations to offer group health benefits—association health plans or "AHPs"—two analyses showed that this expansion would result in a rise in premiums in the individual market and an increase in uninsured individuals. AHPs are treated as group health plans (regulated under ERISA) and thus are exempt from many of the ACA's *insurance* rules including essential benefit requirements and more stringent rules regarding preexisting conditions. Both an analysis by Avalere[11] and another by Oliver Wyman[12] for the District of Columbia Health Benefit Exchange Authority found that there would be an increase in premiums in the individual market due to enrollees switching from the individual market to AHPs. Avalere Report at 1. The Avalere Report also found that there would be an increase in uninsured Americans

[10] BCBSA analysis of BCBS companies' 2019 data received from Blue Health Intelligence.

[11] Avalere, *Association Health Plans: Projecting the Impact of the Proposed Rule* (hereinafter "Avalere Report") at 1 (Feb. 28, 2018), https://img04.en25.com/Web/AvalereHealth/%7Be4c8a036-9c6c-4454-8d69-2f5aaa58e58a%7D_Association_Health_Plans_White_Paper.pdf

[12] Letter to Mila Kofman from Oliver Wyman, *Potential Impact of Association Health Plans in the District of Columbia* (hereinafter "Wyman AHP Report") (Feb. 21, 2018), https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Review%20of%20Impact%20of%20AHPs%202.21.2018.pdf.

"largely caused by premium increases in the individual market as healthier enrollees shift into AHPs." *Id.* And Oliver Wyman's AHP analysis concluded generally that claims costs in DC would rise by approximately 10 percent in the small group market and 5 percent in the individual market. Wyman AHP Report at 3. Reports by Oliver Wyman,[13] and the Urban Institute,[14] analyzing a potential expansion of short-term coverage likewise found that allowing less-regulated plans to compete with ACA-compliant individual plans would result in greater premiums for those in the individual market as well as a rise in uninsured individuals.

The lesson is clear: allowing less-regulated plans to drain healthy risk from the pool drives up premiums. This harms everyone who is seeking insurance. Those individuals who shift to the less-regulated plans do not benefit from minimum benefit standards or robust protections from preexisting condition exclusions. Those who must or are able to remain in the individual market endure increased premiums as healthier individuals are drawn to the less-expensive

[13]Letter to Mila Kofman from Oliver Wyman, *Potential Impact of Short-Term Limited Duration Plans* (hereinafter "Wyman Short-Term Report") (Apr. 11, 2018), https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/OWReview%20of%20Impact%20of%20Short%20Term%20Duration%20Plans%204.11.2018%20%28002%29.pdf

[14] Urban Institute, *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (hereinafter "Urban Institute Report") (Feb. 2018), https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf

options. And those unable to absorb the increased premiums and excluded by the less-regulated plans are left uninsured.

This will have a large impact on Americans with preexisting conditions. There are as many as 100 million Americans with preexisting conditions "ranging from life-threatening illnesses like cancer to chronic conditions like diabetes, asthma, or heart disease."[15] Many of these consumers are of limited means[16] and have been severely impacted by the Coronavirus pandemic.[17]

B. This decision undermines the states' authority to regulate the business of insurance.

ERISA preserves states' insurance regulation. And for good reason: States are in the best position to tailor their laws to their markets and their consumers. *See Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747 (1985); *Sec. & Exch. Comm'n v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65, 68–69 (1959) ("When the States speak in the field of insurance, they speak with the authority of

[15] Centers for Medicare & Medicaid Services, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting (last visited Apr. 5, 2021).
[16] Justin McCarthy, *43% of U.S. Households Report Preexisting Conditions*, Gallup (Dec. 6, 2019), https://news.gallup.com/poll/269003/households-report-preexisting-conditions.aspx ("U.S. adults living in low- (26%) and middle-income households (29%) are more likely to report having a preexisting condition than are those in upper-income households (21%).").
[17] Human Rights Watch, *US: Address Impact of Covid-19 on Poor: Virus Outbreak Highlights Structural Inequalities* (Mar. 19, 2020), https://www.hrw.org/news/2020/03/19/us-address-impact-covid-19-poor.

a long tradition. . . . [R]egulation of insurance. . . has traditionally been under the control of the States.") (internal quotation marks and citations omitted); *United States v. S.-E. Underwriters Ass'n*, 322 U.S. 533, 580 (1944) ("[S]tates have developed extensive and effective systems of regulation of the insurance business, often solving regulatory problems of a local character with which it would be impractical or difficult for Congress to deal through the exercise of the commerce power.") (Stone, J. dissenting) (superseded by statute).

Congress has maintained the careful balance between federal regulation of employee benefit plans and state regulation of insurance, even after the ACA. When federal law under the ACA regulates insurance directly, states remain the "primary regulator" and are primarily responsible for enforcing the federal standards. In the enforcement section of the relevant title, Congress said

> [E]ach State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part and part D with respect to such issuers.

42 U.S.C. § 300gg-22(a)(1). Only after a state fails to adequately enforce applicable federal standards will the Department of Health and Human Services begin enforcing the relevant federal standard against health insurers in the state. *Id*.

The Data Marketing scheme upsets this carefully devised regulatory framework by masquerading as a traditional, self-insured employer health plan,

thus invoking its fake ERISA-plan status to preempt states from regulating what is fundamentally an unlicensed health insurance business.

C. The District Court decision circumvents important protections afforded individuals by the Affordable Care Act ("ACA") and may dupe consumers into buying inadequate coverage.

Circumventing insurance regulations can allow an entity to charge individuals more for coverage than would be permitted if the same coverage was offered by a licensed insurer. The ACA requires insurers to limit "age rating," the amount by which premium can vary based on age, to a 3 to 1 ratio. 42 U.S.C. § 300gg(a)(1)(A)(iii). That means that a 65-year-old individual can be charged no more than 3 times the amount an 18 year old is charged. The same ACA provision prohibits women from being charged more than men, or from charging individuals in certain occupations more than others.

But the ACA and state regulatory enforcement also protects consumers in other ways. For example, a licensed insurer must enroll any individual in the state that is eligible for coverage, regardless of that individual's health status or preexisting conditions. 42 U.S.C. § 300gg-1. Licensed insurers must renew coverage, at the option of the individual. 42 U.S.C. § 300gg-2.

Health insurers in the individual and small group markets[18] also must provide the "essential health benefits," or "EHBs," including emergency services, hospitalization, maternity and newborn care, mental health and substance use services, and prescription drugs. EHBs must be included in any "ACA-compliant" plan, including those plans that may be purchased with premium subsidies. 42 U.S.C. § 18022. Further, there are limits on deductibles and cost-sharing for individual and small group plans, so that consumers that purchase such coverage are protected from out-of-pocket expenses that exceed the statutory thresholds. 42 U.S.C. § 300gg-6. Insurers are also required to rebate premiums to individuals when the insurer spends less than a set percentage of premium—80 percent in the individual and small group markets, 85 percent in the large group market—on claims costs. 42 U.S.C. § 300gg-18.

Individuals that enroll in plans designed to avoid insurance regulations receive none of these protections. These entities, with Data Marketing-like arrangements, are free to refuse to cover high-cost individuals. These arrangements would also be free to drop coverage if the individual becomes sick; they are not required to, and generally do not, provide robust benefits, as EHBs require; and, they are not required to rebate premium to enrollees if claims costs paid are lower

[18] Small group health plans that are not insured are also subject to the essential health benefit requirements.

than 80 percent of the premium collected. Perhaps most importantly, many consumers that enroll in these kinds of arrangements are unlikely to know that they do not receive the benefit of these kinds of regulatory oversight and protections.

II. There is a long history that should not be repeated, of Congress, the Department of Labor, and states chasing after abusive arrangements just like the *Data Marketing* scheme.

Early in ERISA's history entrepreneurs sought to use ERISA preemption to avoid state regulations. These fraudulent MEWA schemes were devastating for consumers. *Legislative Hearing on Pension Issues, Hearing Before the Subcomm. on Labor–Management Relations of the House Comm. on Educ. and Labor*, 97th Cong., 2d Sess. at 1–2 (1982) (statement of Rep. Burton) ("Although…[ERISA] was enacted to protect workers, some individuals have used ERISA as a smokescreen to conceal fraudulent activities….[the MEWA amendment to ERISA] clarifies and strengthens the ability of the States to protect their citizens from such unscrupulous individuals by giving the States clear authority to establish and enforce standards for [MEWAs]" and "[i]f problems in delivery of health insurance arise, the States must be able to step in immediately to protect consumers."). Unscrupulous actors set up trusts that were marketed to multiple employers to allow them to self-insure health care benefits for their employees. Employers joined MEWAs believing that they would save money, while providing promised health care coverage to employees. In reality, many MEWAs were underfunded

and could not make necessary payments. At the same time, both DOL and the states were handicapped on their ability to oversee, investigate or regulate these trusts.

As a result, in 1983 Congress amended ERISA to allow states to regulate so-called MEWAs. This ensured that states could adopt their own rules to regulate local insurance markets. *See* DOL MEWAs Guide at 3 (2013), https://www.dol.gov/sites/dolgov/ files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf ("Prior to 1983, a number of States attempted to subject MEWAs to State insurance law requirements, but were frustrated in their regulatory and enforcement efforts by MEWA-promoter claims of ERISA-plan status and Federal preemption.").[19]

Congressional action was only the beginning. To address the fallout from the fraudulent health coverage arrangements, the DOL and states have worked cooperatively to address MEWA fraud. DOL has issued guidance to states,

[19] Congress further bolstered DOL authority to directly regulate and shutdown MEWA fraud in ERISA amendments in the ACA. 29 U.S.C. § 1149 (prohibiting false statements by MEWAs); 29 U.S.C. § 1150 (allowing the adoption of regulatory standards or specific orders identifying MEWAs).

clarifying their authority and bringing its own enforcement actions—civil and criminal—against fraudulent MEWA operators.[20]

For example, guidance has been issued to states in the Fifth Circuit, including the Texas Department of Insurance[21] facilitating their ability to regulate and close down abusive arrangements similar to the one in *Data Marketing*. DOL and several states have entered into memoranda of understanding to promote cooperative federal-state enforcement efforts. *See, e.g.*, DOL EBSA Enforcement Manual, *Investigative Authority*, ¶13, https://www.dol.gov/sites/dolgov/file

[20] U.S. Gen. Acct. Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, H.R. Doc. No 92-40, at 3, 12 (1992) ("Protecting MEWA participants and their beneficiaries is a joint federal and state responsibility…" and "[t]he [DOL] … generally agreed that MEWAs have proven to be a source of regulatory and enforcement problems…[DOL] said it has devoted a substantial portion of available resources to deal with the problem."); DOL MEWAs Guide at 4 (stating it intended to "provide a clear understanding of ERISA's MEWA provisions, and the effect of those provisions on the respective regulatory and enforcement roles of the Department of Labor and the States in the MEWA area…[to] not only facilitate State regulation of MEWAs, but…also enhance Federal-State coordination efforts with respect to MEWAs").

[21] DOL Advisory Op. 90-18A (July 2, 1990), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/advisory-opinions/1990-18a.pdf.

s/ebsa/about-ebsa/our-activities/enforcement/oe-manual/investigative-authority.pdf (last visited Apr. 5, 2021) (noting agreements with state insurance agencies and state attorneys general).[22] And states have been active in regulating MEWAs. *See, e.g.* Tex. Ins. Code § 846.001 *et seq.* (specifying regulations specific to MEWAs); Fla. Stat. § 624.436 *et seq.* (same); Ga. Code § 33-50-1 *et seq.* (same).

Even with cooperative federal and state action, there are numerous examples of underfunded, and even outright fraudulent, MEWAs occurring notwithstanding the more-stringent regulatory environment.[23] In just one example, three individuals were arrested in 2004 for defrauding employers and their employees and leaving more than $20 million dollars in health claims unpaid.[24] Operating as "Employers

[22] *See also* Memorandum of Understanding Between The United States Department of Labor, Employee Benefits Security Administration and The New Your State Office of the Attorney General, Health Care Bureau (Aug. 2015), https://ag.ny.gov/pdfs/MOU_btw_USDOL_EBSA_and_NYSOAG.PDF.

[23] *See, e.g., United States v. Hogge*, No. 2:07-CR-46, 2013 WL 4782261, at *1 (N.D. Ind. Sept. 5, 2013) (denying appeal of 84 month sentence for MEWA operator who fraudulently failed to segregate funds for different employers, deducted excessive administrative fees, and failed to maintain appropriate stop-loss insurance coverage which resulted the MEWA not having sufficient funds to pay claims); *Solis v. Palombo*, No. 1:08-CV-2017-BBM, 2009 WL 10698739, at *2 (N.D. Ga. June 9, 2009) (granting in part a motion for default judgment against an underfunded MEWA that had "benefit claims pending against it in the amount of $3,467,710—which have not been processed or paid."), *amended*, No. 1:08-CV-2017-BBM, 2009 WL 10698740 (N.D. Ga. Oct. 8, 2009).

[24] News Release, *Three Affiliated with Employers Mutual Arrested for Operating Bogus Health Insurance Provider*, U.S. Attorney Cent. Dist. of Ca. (May 10, 2004), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/newsroom/criminal-releases/05-10-2004.pdf.

Mutual LLC," the defendants misappropriated premiums and failed to pay most of the health claims incurred. Employers Mutual LLC claimed to be offering ERISA-covered benefits, "shield[ing] the scheme from the scrutiny of the California Department of Insurance." *Id*. Litigation surrounding Employers Mutual LLC extended for years, as did the devastation Employers Mutual LLC wreaked on its victims, as the Ninth Circuit (when reviewing one conviction) explained,

> During its year of operation, Employers Mutual collected about $14 million in payments from individuals and employers for medical coverage. Of that amount, only $1,749,725.63 was used to pay medical providers who treated patients covered by the Plans. The amount of unpaid claims as of December 10, 2001, was a little over $20 million.
>
> That $20 million represents thousands of victims whose medical bills were not paid by Employers Mutual. People who had purchased health insurance expecting to receive benefits instead received collection notices. A kidney dialysis patient was unable to receive a kidney transplant because Employers Mutual refused to process the request or even pay for his required dialysis. A woman suffering from breast cancer almost had her life-saving chemotherapy cancelled, and her reconstructive surgery was postponed for over a year due to Employers Mutual's failure to pay her medical bills. Several victims testified that they were unable to receive health care from their regular doctors because of thousands of dollars in unpaid medical bills. Others had trouble renting homes because of their ruined credit.

United States v. Graf, 610 F.3d 1148, 1154 (9th Cir. 2010) (affirming Graf's convictions).

Unfortunately, Employers Mutual LLC was not an isolated incident. The Governmental Accountability Office, in a 1992 report on MEWAs, said that

> 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. . . .
>
> [W]hen 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. . . .
>
> States sometimes questioned whether the entities were contrived solely to qualify for exemption from state regulation. . . .

Employee Benefits, H.R. Doc. No 92-40, at 2–3, 8. Between 2001 and 2003, four fraudulent health insurance companies, run through associations, "left nearly 100,000 people with approximately $85 million in unpaid medical claims and without health coverage."[25] In Tennessee, two fraudulent associations operated from 2008–10 before being shut down by the Department of Commerce and Insurance. Reports estimate that victims incurred losses of over $7 million.[26] In 2014, South Carolina shut down a self-insured, fraudulent MEWA after it became

[25] Mila Kofman, Kevin Lucia & Eliza Bangit, *Health Insurance Scams: How Government is Responding and What Further Steps are Needed*, The Commonwealth Fund (Aug. 2003), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2003/aug/health-insurance-scams--how-government-is-responding-and-what-further-steps-are-needed/kofman_insurancescams_ib_665-pdf.pdf.

[26] Nicole Young, *More guilty pleas, death in Springfield-based, multi-million dollar fraud case*, The Tennessean (Jan. 19, 2018), https://www.tennessean.com/story/news/local/robertson/2018/01/19/more-guilty-pleas-death-springfield-based-multi-million-dollar-fraud-case/1049596001/.

clear it was not financially solvent. Ultimately over 500 small businesses were left liable for medical claims incurred by their employees.[27]

At bottom, the Data Marketing plan is just the latest Employers Mutual LLC variation. With nearly 50,000 individuals eligible,[28] it is certain that it covers individuals that are employees of two or more employers and as such it is a MEWA. But under the district court decision, which found that Data Marketing's plan constituted an employment relationship itself, states will be blocked from regulating what are, essentially, unlicensed insurance companies selling unregulated individual insurance to unaware consumers. Without appropriate state oversight, the schemes are ripe for misappropriation, mismanagement and abuse. Health-based discrimination—drawing the healthy individuals needed to keep premiums affordable out of the market—will occur, impacting millions of Americans enrolled in legitimate health care plans regulated by states and the ACA. And individual participants will be left holding the bag after the schemes are exposed, including leaving claims unpaid, medical treatments delayed or denied, and consumers' lives in disarray.

[27] Liv Osby, *State Takes over South Carolina Health Co-Op*, Greenville News (Nov. 25, 2014), https://www.greenvilleonline.com/story/news/health/2014/11/25/state-takes-south-carolina-health-co-op/70117286/. *See also*, S.C. Dept. of Ins., *South Carolina Health Cooperative, Inc., a Multi-Employer Self-Insured Health Plan, In Rehabilitation*, http://www.doi.sc.gov/840/SCHC (last visited Apr. 5, 2021).

[28] *Data Mktg. P'ship, LP*, 2020 WL 5759966, at *2.

III. Who are "employees" for ERISA group health plan purposes?

The error in this case and the resulting adverse consequences that follow result from improperly defining who is considered an "employee" for purposes of ERISA. Data Marketing, and the District Court, avoided state regulation of what is actually individual insurance by draining the word "employee" of all meaning. In *Darden*, the Supreme Court held that whether an individual is an "employee" for purposes of ERISA generally must be determined by applying common law principles; specifically,

> In determining whether a hired party is an employee under the general common law of agency, we consider the hiring party's right to control the manner and means by which the product is accomplished. . . . [O]ther factors relevant to this inquiry are the skill required; the source of the instrumentalities and tools; the location of the work; the duration of the relationship between the parties; whether the hiring party has the right to assign additional projects to the hired party; the extent of the hired party's discretion over when and how long to work; the method of payment; the hired party's role in hiring and paying assistants; whether the work is part of the regular business of the hiring party; whether the hiring party is in business; the provision of employee benefits; and the tax treatment of the hired party.

Darden, 503 U.S. at 323–24. Following the District Court's decision, downloading tracking software is sufficient to establish an employer-employee relationship. Under that decision it is difficult to understand how anyone who owns a cell phone with a single application installed is not an employee of that application developer.

This is an absurd result given the proliferation of, and privacy concerns about,[29] cell phone applications tracking individuals' locations, searches, purchases, emails and other habits.

Like the *MDPhysicians* case, Data Marketing-like "plans are established and maintained by entrepreneurs for the purpose of marketing insurance products…. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction. . . . They are no more ERISA plans than is any other insurance policy sold . . . ." *MDPhysicians*, 957 F.2d at 184. Unlike the MEWA in *MDPhysicians*, however, Data Marketing is targeting individuals, not forging a mutually-beneficial employment relationship, and thus the arrangement is arguably all the more dangerous to consumers as a result.

If Data Marketing-type plans are determined to be subject to ERISA, their marketers will hide behind ERISA preemption to avoid state regulation of essentially unlawful individual insurance arrangements. This will undercut the ability of states to adopt rules specific to their consumers and markets. They will also use ERISA to avoid the consumer protections established under the ACA.

[29] *See, e.g.*, Geoffrey Fowler, *Is that app spying on you? Here's how to read iPhone privacy labels*, Washington Post (Jan. 29, 2021), https://www.washingtonpost.com/technology/2021/01/29/how-to-read-iphone-privacy-labels/.

CONCLUSION

For the reasons above, the district court's decision should be reversed.

Dated: April 7, 2021

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), undersigned counsel certifies that this brief:

(i) complies with the type-volume limitation of Rule 29(a)(5) because it contains 6,412 words, including footnotes and excluding the parts of the brief exempted by Rule 32(f); and

(ii) complies with the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared using Microsoft Office Word 2016 and is set in Times New Roman font in a size equivalent to 14 points or larger.

Dated: April 7, 2021

s/ Jon W. Breyfogle
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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system on April 7, 2021. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ Jon W. Breyfogle
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