NOT YET SCHEDULED FOR ORAL ARGUMENT

No. 19-5125

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IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA

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STATE OF NEW YORK, *et al.*,

Plaintiff-Appellees,

v.

U.S. DEPARTMENT OF LABOR, *et al.*,

Defendant-Appellants.

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On Appeal from the United States District Court
for the District of Columbia

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# BRIEF FOR HEALTH CARE POLICY HISTORY SCHOLARS AS *AMICI CURIAE* SUPPORTING PLAINTIFF-APPELLEES

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## CERTIFICATE AS TO PARTIES, RULINGS, RELATED CASES, FILING OF A SEPARATE BRIEF, AND RULE 26.1 DISCLOSURE

As required by Circuit Rules 26.1, 28(a)(1), and 29(d), and Federal Rule of Appellate Procedure 26.1, counsel for *amici curiae* hereby certify as follows:

### 1. Parties and *Amici*

All parties, interveners, and *amici* appearing in the lower court and this Court are listed in the certificates to the Opening Brief of Appellants U.S. Department of Labor, *et al.*, and the Brief for Appellees New York, *et al.*

*Amici curiae* health policy and economics experts, the filers of this brief, are appearing with the consent of the parties in support of plaintiffs-appellees and affirmance.

### 2. Rulings Under Review

References to the district court decision under review appear in the certificates to the Opening Brief of Appellants U.S. Department of Labor, *et al.*, and the Brief of Appellees New York, *et al.*

### 3. Related Cases

A description of related cases appears in the certificate to the Opening Brief of Appellants U.S. Department of Labor, *et al.*, and the Brief of Appellees New York, *et al.*

### 4. Separate Brief

*Amici* have filed a separate brief from the other *amici* that intend to file briefs supporting plaintiffs-appellees. A single *amicus curiae* brief is not practicable in this case because *amici*'s brief addresses aspects of the issues posed by this appeal that the other *amici* do not comprehensively address. Specifically, *amici*'s brief explains that the district court reached the right result in this case in light of the adverse economic and policy consequences of the final rule. *Amici* understand that other *amici*'s arguments will focus on other aspects of DOL's rule that reflect those other *amici*'s concerns and expertise. *See* D.C. Cir. R. 29(d).

## STATEMENT REGARDING CONSENT TO FILE, SEPARATE BRIEFING, AUTHORSHIP AND MONETARY CONTRIBUTIONS

*Amici* certify that no party or party's counsel authored this brief in whole or in part, or contributed money that was intended to fund the brief's preparation or submission, and further certifies that no person, other than *amici*, contributed money intended to prepare or submit this brief. FED. R. APP. P. 29(c)(5). Pursuant to FED. R. APP. P. 29(a)(2), all parties have consented to the filing of this *amicus* brief.

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# GLOSSARY

**ACA:** Affordable Care Act
**AHP:** Association Health Plan

## STATEMENT OF INTEREST OF *AMICI CURIAE*

The *amici curiae* health policy experts are a group of 36 distinguished professors and researchers from the disciplines of economics, health policy, history, and law, listed in the Appendix, who are experts with respect to the economic and social forces operating in the health care and health insurance markets. *Amici* have closely followed the development, adoption, and implementation of the Affordable Care Act ("ACA") and are intimately familiar with its purpose and structure. They are also familiar with the economics of association health plans and with past experience with the effects of association health plans on health insurance markets.

*Amici* health policy experts submit this brief to assist the Court in assessing the district court's conclusion that the proposed rule is contrary to both the Employee Retirement Income Security Act of 1974 ("ERISA") and the ACA by analyzing how the AHP rule is contrary to the market rules Congress established in enacting the ACA. *Amici* urge the court to affirm the district court's decision partially invalidating the AHP rule.

## INTRODUCTION AND SUMMARY OF THE ARGUMENT

The court below characterized the administration's Association Health Plan ("AHP") rule, 29 C.F.R. § 2510.3-5, as "an end run around the Affordable Care Act." Case 18-1747-JDB, p. 2 (March 28, 2019). This is an accurate description of

both the intention and effect of the challenged AHP rule. The rule allows AHPs to enroll small groups and self-employed individuals (which the rule terms "working owners") in what is considered a large group plan for federal regulatory purposes, thus evading the special regulatory requirements that the ACA imposes on insurers to protect small group and individual enrollees.

Specifically, AHPs regulated under the challenged federal rule as large groups are allowed to skimp on benefits that the ACA requires small group and individual market insurers to cover. More importantly, AHPs can offer lower premiums by attracting low-risk consumers. This will leave the ACA regulated small group and individual markets with higher cost enrollees and higher premiums. States may address this regulatory imbalance at their own cost but are limited in their ability to do so.

The court properly partially vacated the AHP rule as violating both the ACA and ERISA. The decision below reflects an accurate understanding of not only the law but also of relevant health policy and economics issues. Amici health policy experts submit this brief explaining why this ruling should be affirmed.

## ARGUMENT

### I. The Affordable Care Act Recognizes Separate Large Group, Small Group, and Individual Insurance Markets and Includes Special Protections for Consumers in the Small Group and Individual Markets

The ACA was the most dramatic expansion of federal authority over health care financing since ERISA established health coverage as a federal concern 36 years earlier. While the ACA was an omnibus bill addressing a broad range of problems of our health care system, a primary concern of the legislation was the reform of health insurance markets to expand access to coverage. *King v. Burwell*, 135 S.Ct. 2480, 2496 (2015).

The ACA addresses three health insurance markets—the large group, small group, and individual markets—each with its own specific problems and concerns. (See, 42 U.S.C. 18024(a); Allison K. Hoffman, Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act, 159 U.Pa.L.Rev. 1873, 1884-1887 (2011); Timothy Stoltzfus Jost, Loopholes in the ACA: Regulatory Gaps and Border Crossing Techniques and How to Address Them, 5 St.L.J. Health L. & Pol'y 27, 28-30 (2011). Congress considered the large group market to be essentially stable. Large employers were able to hold their own in negotiating with insurers to purchase insured coverage while self-insured employer plans had large and diverse enough memberships to be able to offer attractive coverage to their employees. Large group coverage was not perfect: the ACA

included a number of targeted reforms that applied to all group health plans and health insurers in all markets, including the large group market. These reforms limited out-of-pocket expenses, 42 U.S.C. §' 300gg-6(b),18022(c), eliminated lifetime and dollar limits, 42 U.S.C. § 300gg-11, prohibited rescissions except for fraud or material misrepresentations, 42 U.S.C. § 300gg-12, required coverage of adult children up to age 26, 42 U.S.C. § 300gg-14, mandated coverage of preventive services without cost-sharing requirements, 42 U.S.C. § 300gg-13, and imposed mandatory minimum loss ratios on insured plans, 42 U.S.C. § 300gg-18. The ACA continued preexisting legal requirements that large group insurers guarantee issue and renewal of coverage to all applicants and enrollees, 42 U.S.C. § 300gg-1, 42 U.S.C. § 300gg-2, as well as prohibitions against group health plans or insurers discriminating against individuals with pre-existing conditions by denying coverage, charging more, or excluding benefits, 42 U.S.C. § 300gg-4, 42 U.S.C. § 300gg-3. Finally, the ACA included a large employer mandate, imposing one set of tax obligations on employers with more than 50 employees who failed to offer their full-time employees health coverage and another set of tax obligations on employers with more than 50 employees who offered coverage that was not affordable or did not cover at least 60 percent of medical costs. 26 U.S.C. § 4980H. Otherwise, however, large employers and their insurers were left free to provide health benefits

on terms and conditions that were most beneficial to themselves and their employees.

Congress was more concerned with the small group and individual markets and enacted more sweeping changes to protect access to affordable and adequate health coverage in those markets. Small employers—those with fewer than 50 employees—had been dropping coverage for years as health care costs and premiums had increased. Stacey McMorrow, Linda Blumberg, Matthew Buettgens. The Effects of Health Reform on Small businesses and Their Workers. Urban Institute, at 2-3 (June 1, 2011) *available at* https://www.rwjf.org/en/library/research/2011/06/the-effects-of-health-reform-on-small-businesses-and-their-worke.html. Small employers were customarily underwritten by insurers based on the potential claims of their employees, making it difficult for small groups with older or sicker employees to purchase coverage.

The individual market was even more problematic, with insurers denying coverage or charging very high rates for individuals with preexisting conditions or refusing to cover costs related to those conditions. Gary Claxton, et al., Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA, Kaiser Family Foundation, at 4-8 (Dec. 12, 2016), *available at* https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-

underwriting-in-the-individual-insurance-market-prior-to-the-aca. Individual and small group insurers also often failed to cover essential benefits such as mental health and substance abuse treatment, prescription drugs, or maternity care—benefits much more common in large employer coverage because large groups offered more enrollees over which to spread the cost of high-cost claims of a few employees.

The ACA's individual and small group market reforms are very similar to each other. The ACA requires insurers in both markets to cover ten essential health benefits, including mental health and substance abuse, habilitative and rehabilitative care, prescription drugs, pediatric dental and vision services, and maternity care. 42 U.S.C. § 300gg-6(a), 42 U.S.C. § 18022(b). Although denial of coverage for preexisting conditions and health status underwriting for individual enrollees are prohibited in all markets (including large employer plans), the ACA goes further in regulating the individual and small group markets, permitting premium variation only for age (maximum 3 to 1 ratio), tobacco use (maximum 1.5 to 1 ratio), geographic location, and family size. 42 U.S.C. § 300gg. It also requires all insurers in the individual and small group markets (but not the large group market) to consider all their enrollees in a state to be part of a single small group or individual risk pool, 42 U.S.C. § 18032(c), and creates a market-wide risk adjustment program in each market under which insurers with low cost enrollees compensate those with

higher cost enrollees, 42 U.S.C. § 18063. This program was designed to discourage some insurers from cherry picking low-risk enrollees and thereby putting other insurers with a disproportionate number of high-cost enrollees at a competitive price disadvantage. The ACA provided premium tax credits both for individuals and for small groups, 26 U.S.C. §§ 36B, 45R, and created separate exchanges (also known as marketplaces) for individuals and small employers, 42 U.S.C. § 18031(b)(1).

## II. Association Health Plans Under the Affordable Care Act

The ACA did not eliminate association health plans, which had existed for decades in the individual, small group, and large group markets. It did, however, continue the "look though rule" established under the Health Insurance Portability and Accountability Act, Center for Medicare and Medicaid Services, Insurance Standards Bulletin, Transmittal 02-02, at 2 (Aug. 2002). Under this standard, association plans are regulated under the market rules that ordinarily would apply to each purchaser. As explained in a 2011 guidance from the Centers for Medicare and Medicaid Services (CMS), association coverage sold to large groups is regulated under the large group market rules; association coverage sold to small groups is regulated under the small group market rules, and association coverage sold to individuals is regulated under the individual market rules. CMS, Application of Individual and Group Market Requirements under Title XXVII of the Public Health

Service Act when Insurance Coverage Is Sold to, or through, Associations, at 2-3. (Sept. 1, 2011), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf. If an association offers coverage to multiple types of consumers (*e.g.*, large and small groups) then the coverage sold to each kind of enrollee must generally comply with the rules applying to that type of consumer.

However, interpretations of ERISA that preceded the ACA did provide that in "extremely rare instances" an association itself could be considered to be the "employer" and ERISA plan sponsor, and thus all coverage would be regulated as a single large group. CMS Insurance Standards Bulletin, Transmittal 02-03, p. 1 (Aug. 2002). This exception was grounded in the definition of "employer" found in ERISA 3(5) 29 U.S.C. § 1002(5) which includes as an employer, "a group or association of employers" "acting directly as an employer, or indirectly in the interest of an employer."

Established Department of Labor guidance specified when this limited exception applied. Under this guidance, an association could be considered a "bona fide group or association of employers" when the association members had a commonality of "economic or representational interest," the association had a substantial business purpose other than the providing of insurance, and the

members of the association controlled the association. *See, e.g.*, DOL Op. No. 1996-25A (Oct. 31, 1996); DOL Op. No. 1994-07A (March 14, 1994). Associations based on geographic proximity, such as chambers of commerce, did not qualify for the exception. DOL Op. No. 2008-07A (Sept. 26, 2008). Neither did associations that allowed sole proprietors without employees other than the owner and the owner' spouse to join. DOL Op. No. 2007-06A (Aug. 16, 2007). The courts have consistently held that organizations that do not meet ERISA requirements as employer or employee organizations cannot sponsor employee benefit plans. *See, e.g.*, *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1998); *MDPhysicians v. State Bd. of Ins.*, 957 F.2d 178, 185-186 & n.9 (5th Cir. 1992).

## III. The Challenged Rule Is Inconsistent with the Policy Goals of the ACA

Small business insurance has fared relatively well under the ACA. Mark A. Hall and Michael J. McCue, The Health of the Small Group Market, Commonwealth Fund, (Oct. 26, 2018), *available at* https://www.commonwealthfund.org/publications/issue-briefs/2018/oct/health-small-group-insurance-market. Although premium rates for small group coverage have continued to climb since 2010, they have grown at a slower rate than they did in the 1990s or early 2000s. Kaiser Family Foundation, 2018 Employer Health Benefits Survey, at 39 (Oct. 3, 2018), *available at* https://www.kff.org/health-

costs/report/2018-employer-health-benefits-survey. Indeed, small group premiums have grown at approximately the same rate as have premiums for large group coverage. *Ibid.*; *see also* Sabrina Corlette, *et al.*, Small Business Health Insurance and the ACA: Views from the Market 2017, Robert Wood Johnson Foundation and Urban Institute, at 5 (July 2017), *available at* https://www.urban.org/sites/default/files/publication/92291/2001459_small_business_health_insurance_and_the_aca_views_from_the_market_2017_0.pdf. Offers of coverage by small businesses to their employees have continued a long-term downward trend but seem to have increased slightly in the recent past. Paul Fronstin, After Years of Erosion, More Employers Are Offering Health Coverage; Worker Eligibility Higher, EBRI 2018, (Aug. 6, 2018), *available at* https://www.ebri.org/content/after-years-of-erosion-more-employers-are-offering-health-coverage-worker-eligibility-higher; Kaiser Family Foundation, 2018 Employer Health Benefits Survey 2018, *supra*, at 47. More importantly, however, 5.7 million small business owners and employees and self-employed individuals have obtained coverage through the individual marketplaces. Small Business Majority, Number of Small Business Owners, Self-Employed People and Small Business Employees in the ACA Marketplaces, *available at* https://smallbusinessmajority.org/sites/default/files/052918-ACA-Impact-on-Smll-

Biz-Appendix-A.pdf. Indeed, an analysis by the U.S. Department of the Treasury found that in the first year of operations, about one fifth of the individual market Marketplace enrollees were self-employed or small business owners. Adam Looney and Kathryn Martin, One in Five 2014 Marketplace Consumers was a Small Business Owner or Self-Employed (Jan. 12, 2017), *available at* https://www.treasury.gov/connect/blog/Pages/One-in-Five-2014-Marketplace-Consumers-was-a-Small-Business-Owner-or-Self-Employed.aspx. As an apparent result, the rate of uninsured small business employees dropped by 8 percentage points from 2013 to 2016. Hall & McCue, *supra*, at 2.

The challenged AHP rule threatens to upend this progress. The new rule dramatically expands the exception established in prior guidance allowing associations to serve as employer plan sponsors. First, it defines "commonality of interest" to include geographic proximity, permitting chambers of commerce or other geographically based sponsors covering an entire state or metropolitan area spanning more than one state to be considered an "employer." 29 C.F.R. § 2510.3-5(c)(1)(ii). Second, it allows entities whose primary purpose is offering insurance coverage to serve as employer plan sponsors as long as they serve at least one other substantial business purpose. 29 C.F.R. § 2510-3-5(b)(1). Third, it allows such

associations to enroll "working owners," sole proprietors with no employees other than the owner and spouse. 29 C.F.R. § 2510.3-5(e).

The effect of this rule, as discerned by the court below, is to permit associations to aggregate small groups or individuals to be treated as large groups for federal regulatory purposes – even though the underlying economic incentives facing the small employers, individuals, and insurers are not meaningfully different if they participate in associations than they would be absent having joined the association. Although associations so formed remain subject to the relatively modest large group reforms, listed above, their members are no longer protected by the ACA's much more substantial individual and small group reforms, which as noted above, provide broader consumer protections and take additional steps to establish a unified market for applicable coverage.

## IV. Associations Formed Under the New Rule Are Able to Offer Lower Premiums to Some Enrollees Because They Can Offer Less Comprehensive Benefits and Because They Can "Cherry Pick" Low Cost Small Groups and Individuals

The defendant's amici claim that in some situations the new rules enable associations to offer lower premiums, broader networks, or lower cost sharing than are available in the ACA compliant small group market. Amicus Brief of the Chamber of Commerce of the United States, State and Local Chambers of Commerce, the National Federation of Independent Business, The Texas

Association of Business, and the United Service Association for Health Care at 9-12 (June 7, 2019), *available at* https://affordablecareactlitigation.files.wordpress.com/2019/06/dcc-chamber-of-commerce-amicus.pdf; *Amicus Curiae* Brief of the Coalition to Protect and Promote Association Health Plans Jointed with Associationhealthplans.com, in Support of Appellant United States Department of Labor at 17-19 (June 7, 2019) *available at* https://affordablecareactlitigation.files.wordpress.com/2019/06/coalition-to-protect-and-promote-amicus.pdf. These are, of course, only anecdotes representing the experience of particular employers or individuals—there is no assurance that they are representative of the experience of other employers or individuals.

It is undoubtedly true that some AHP enrollees will be able to get coverage on better terms than are available in the ACA-compliant small group or individual market. It is likely, however, that lower premiums are possible because associations can evade regulatory requirements that the ACA applies to the small group and individual markets. The Congressional Budget Office's analysis of association health plans offers two very plausible reasons why association health plans can offer lower premiums to some enrollees in the individual and small group market than are available in the small group or individual market: 1) covering less comprehensive benefits or 2) selecting the best health care risks. Congressional Budget Office, How

CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans, at 5 (January 2019), *available at* https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

First, an association that has at least 51 enrollees is not required by federal law to offer the ten essential health benefits. 42 U.S.C. § 300gg-6(a), 42 U.S.C. § 18022(b). By offering skimpier benefits, associations can, of course, offer lower premiums or cost-sharing requirements. And unlike large employers – who generally face pressure to offer a wide range of benefits because they have employees that face many different health needs and are required by the ACA to offer minimum coverage or pay a tax – AHPs can find buyers for their skimpier benefits. Of course, when these buyers must use their benefits to cover health care claims, they may well be surprised as to how skimpy the benefits are and what they do not cover.

Defendant's *amici* protest that the AHPs they represent offer all ten of the essential health benefits. Chamber of Commerce *Amicus* Brief, *supra*, at 19; Coalition to Protect and Promote *Amicus* Brief, *supra*, at 17-18. It is not clear, however, whether they simply offer coverage for some services under each of the ten categories, or whether they offer the full benchmark "essential health benefits package" of the state in which they are located. Under federal regulations, each state

defines such a benchmark package, which specifies essential services and drugs. 45 C.F.R. §§ 156.100, 156.110, 156.111. Small group and individual insurers must cover those items and services or a "substantially equal" package of services. 45 C.F.R. ' 156.115(a)(1). Associations are not bound by this rule. Indeed, associations that span several states would be expected to offer a benefit package that did not necessarily fully cover all the services or drugs included in any single state's essential health benefits package.

By covering fewer services or drugs or placing quantitative or non-quantitative limits (such as prior approval requirements) on services or drugs not permitted for small group or individual coverage in the states in which they offer coverage, associations could reduce their costs, and thus their premiums, significantly—and deter enrollment of those who need the full range of benefits offered within a category. Further, the rule creates a new regulatory loophole for AHPs: because the new AHPs are considered large group plans, they can also offer plans with an actuarial value of less than 60 percent (which is the minimum percent of medical expenses covered by individual and small group plans under the ACA) or with provider networks that do not meet ACA adequacy standards. *See* American Academy of Actuaries, Comment on Considerations Relating to Modeling the Impact of Potential of Association Health Plans at 5 (February 9, 2018), a*vailable at*

https://www.actuary.org/sites/default/files/files/publications/AHP_modeling_considerations_02092018.pdf. But, because they are not themselves the common law employer for tax purposes, the "large" AHP is not subject to the "play or pay" taxes that would apply to large employers who fail to achieve a 60 percent benefit adequacy standard. Moreover, even if AHPs are initially offering rich benefit packages, that does not mean they always will. There are no legal constraints prohibiting AHPs that initially offer a rich benefit package from cutting back benefits after their first plan year to cut costs or attract healthier purchasers.

A second related, and more important, way in which AHPs can substantially reduce premiums is through risk selection. If a plan can enroll a population with lower average health care needs, it will have lower claims costs and can charge lower premiums than can an insurer enrolling a more representative population. The challenged rule prohibits explicit underwriting based on health status. 29 C.F.R. § 2510-3.5(d). It allows, however, underwriting based on other factors that can serve as substitutes for health status. Department of Labor, Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912, 28946, June 21, 2018. AHPs can, for example, charge higher premiums based on age with a disparity beyond the 3 to 1 ratio allowed by the ACA, thus siphoning off

younger enrollees from the ACA-compliant small group market and individual market. Academy of Actuaries, Comment, *supra*, at 2.

An AHP can reduce premiums for some small groups or working owners and raise premiums for others based on group size, marital status of members, occupational status, industry, duration of coverage, or geography. For example, young women cost more to insure than young men. AHPs can charge lower premiums to groups composed predominantly of young men, but leave to the ACA-compliant market groups composed predominantly of young women. American Academy of Actuaries, Comment, *supra*, at 3. Indeed, any criteria other than health status can be used to vary premiums, and many such factors can serve as effective proxies for health status. ACA compliant insurers in the individual and small group markets are prohibited from this type of price differentiation. 42 U.S.C. § 300gg. AHP price discrimination will encourage healthy groups to enroll in AHPs and discourage less healthy groups from doing so. Defendants admit in the preface to the challenged final rule that AHPs will risk select to the disadvantage of ACA compliant insurers. 83 Fed. Reg. *supra*, at 28944.

As noted earlier, unlike insurers in the small group and individual market, AHPs are not required to consider their enrollees as part of a single risk pool or participate in the ACA's risk adjustment program. The ACA's single risk pool

requirement and risk adjustment programs are vital checks for ensuring that insurers are not charging higher rates to individuals with higher risks. Because they are exempt from these programs, AHPs can reap the full financial advantage of enrolling healthier than average people, leaving those purchasing ACA compliant coverage with the full costs of a worsened risk pool. Christina Lechner Goe, Non-ACA-Compliant Plans and the Risk of Market Segmentation: Considerations for State Insurance Regulators, at 10 (March 26, 2018), *available at* http://healthyfuturega.org/ghf_resource/non-aca-compliant-plans-risk-market-segmentation/.

To the extent AHPs offer comprehensive benefits, they can afford to do so because they can use risk selection to avoid high cost consumers. But, as noted above, they can also shape their benefit packages to avoid consumers who need high cost services, by not offering mental health or maternity coverage, for example, and to attract healthy consumers, offering "wellness" incentives that the ACA does not otherwise allow.

A final reason why some AHPs may be currently offering lower premiums to some small groups or working owners is that their initial premiums may in fact be "teaser premium rates." Kevin Lucia and Sabrina Corlette, It's All About the Rating: Touted "Benefits" of Association Health Plans Ignore Key Facts (Feb. 4,

2019), *available at* CHIRblog, http://chirblog.org/its-all-about-the-rating . First year rates may be reduced below costs to attract business from healthier than average groups or individuals with the intention to raise the rates significantly in the second or subsequent years—if the AHP remains solvent. Indeed, the tendency for coverage to become costlier over time as underwritten groups incur greater claims costs is a well-recognized actuarial phenomenon and could explain low initial premiums in some cases. American Academy of Actuaries, Draft Health Practice Note 2004-1, Small Group Medical Business, at 6, 8 (Dec. 2004), *available at* https://www.actuary.org/sites/default/files/pdf/practnotes/health_small.pdf. As premiums increase over time, however, groups with higher claims costs are likely to return to the ACA-compliant market, raising premiums for all in that market.

## V. Lower AHP Premiums Are Unlikely to be Explained by Lower Administrative Costs or Lower Provider Rates

Appellants' *amici* contend that AHPs formed under the new rule are able to offer lower rates or more advantageous coverage because they have lower administrative costs or can negotiate lower provider rates than insurers in the ACA-compliant small group or individual market. Chamber of Commerce *Amicus*, *supra*, at 12-13, 15-16. AHPs may be able to avoid some of the administrative costs incurred by ACA compliant plans because they have a lighter regulatory load and insure a healthier population. 83 Fed. Reg., *supra*, at 28943. Enrollees in insured

AHPs, however, must bear the administrative and marketing costs of both the AHP and the insurer. It is hard to see how this would lower total administrative costs. Moreover, AHPs underwrite their enrollee small groups and working owner members individually for non-health status factors, adding a not insignificant expense absent from the ACA-compliant markets. Indeed, the defendants admit in the preface to the challenged regulation that savings AHPs might achieve through administrative efficiencies are likely to be less than the savings AHPs can achieve by offering less comprehensive benefits or through risk selection. 83 Fed. Reg., *supra*, at 28943.

AHPs will generally have fewer enrollees than insurers in the state-wide small group or individual market and thus have less bargaining power in dealing with insurers and health care providers. They will also have smaller enrollee populations over which to spread administrative costs. The defendants acknowledge in the preface to the final rule that only very large AHPs will be able to secure provider discounts comparable to those obtained by insurers in the ACA-compliant market, which can often aggregate their purchasing power not just for enrollees in the individual and small group markets, but also in large groups, Medicare Advantage, and Medicaid plans that they offer. 83 Fed. Reg., *supra*, at 28942. For example, Nebraska's' farm bureau plan offered in conjunction with Medica offers premiums

for self-employed individuals 25% lower than premiums in the individual market, but it only covers about 700 enrollees in its AHP, whereas Medica has 80,000 insured members in the ACA-compliant market. Kevin Lucia and Sabrina Corlette, *supra*. It strains credulity to assert that this AHP or AHPs in general will have greater economies of scale to reduce administrative costs or market power to negotiate provider rates below those available in the small group markets.

## VI. AHP Risk Selection Will Harm the ACA-Compliant Small Group and Individual Markets

The likely effect of the AHP rule will be to undermine the individual and small group markets-the markets that Congress was most concerned to protect by adopting the ACA. As AHPs siphon off healthier and younger enrollees, those left behind in the individual and small group markets will be older and sicker enrollees. The Congressional Budget Office estimates that 3 million people will move from the small group market to AHPs, along with 1 million from the individual market. CBO, *supra,* at 6. The CBO projects this will raise premiums by 3 percent in the ACA compliant small group market. *Ibid.* at 5. An analysis by Avalere projects that the AHP rule will increase individual market premiums by 3.5 percent. Dan Mendelson, Chris Sloan, and Chad Booker, Association Health Plans Projected to Enroll 3.2 Million Individuals (February 28, 2019), *available at* https://avalere.com/press-releases/association-health-plans-projected-to-enroll-3-2m-

individuals. Yet another study concluded that somewhere between 3 and 10 percent of individual market enrollees could move from individual plans to AHPs, increasing average claims costs from 1.4 to 4.4 percent, since the movers would be healthier than those left behind. Sabrina Corlette, Josh Hammerquist and Pete Nakahata, New Rules to Expand Association Health Plans: How Will They Affect the Individual Market? The Actuary (May 2018), *available at* https://theactuarymagazine.org/new-rules-to-expand-association-health-plans/

The impact of AHPs on some markets could, however, be much greater than these national projections. Mark Hall, States Have Already Tried Trump's Health Care Order. It Went Badly, (Oct. 13, 2017), *available at* https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/10/13/states-have-already-tried-trumps-health-care-order-it-went-badly. Impacts will be driven by important variations in market conditions in different locations. For instance, an analysis of the likely effect of the challenged rule on the District of Columbia market concluded that the District's small group market could shrink by 90 percent with premiums for groups left behind increasing 23.3 percent and the individual market by 25 percent with premiums increasing 23 percent. Plaintiff's Motion for Summary Judgment, Declaration of Mila Kofman, (Aug. 23, 2018). The Massachusetts Department of Insurance estimated that the AHP rule

would increase premiums in Massachusetts' ACA compliant market by 10 percent. Comment letter from the Massachusetts Division of Insurance and Massachusetts's State-Based Marketplace (March 6, 2018) Comment #600 on Association Health Plan proposed rule. These projections are not merely speculative—when AHPs were introduced into Kentucky in the 1990s in competition with tightly-regulated plans, the market collapsed with over 20 carriers leaving the market. Adele Kirk, Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts, 25 J. Health Pol, Pol'y & L 133, 151-154 (2000).

Whatever, the exact number, however, it is safe to assume that the AHP rule will increase premiums in the ACA-compliant markets. As premiums increase in those markets as a result, there is potential that coverage with comprehensive consumer protections will be priced out of reach for some consumers, thus undermining protections for individuals with preexisting health problems that Congress intended to address by clearly defining and separating out the individual and small group markets under the ACA. The AHP rule is clearly an "end run" around the protections Congress specifically created for people relying upon these markets.

## VI. State Regulation Can Address AHP Abuses in Some Circumstances, but will Substantially Burden the States that Choose to Fill the Federal Regulatory Void

Federal law allows states to regulate self-insured AHPs and certain aspects of insured AHPs. 29 U.S.C. § 1144(b)(6)(A). Because of the deficiencies in the federal AHP rule described above, small businesses or individuals who sign up for AHP coverage are largely dependent on state regulation for protection. The federal rule imposes on AHPs none of the regulatory requirements that states customary impose on licensed insurers, including form and rate review or solvency or market conduct standards. Indeed, the preface to defendant's final rule concedes that the job of AHP regulation will be largely left to the states. 83 Fed. Reg., *supra*, at 28925, 28928, 29833, 28936, 28953-54, 28460. The impact of this final rule on State individual and small group risk pools will be highly dependent on State regulatory practices.

Some states are stepping up to this regulatory task, but others have not. Kevin Lucia, *et al.*, In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets (Nov. 27, 2018), *available at* https://www.commonwealthfund.org/blog/2018/initial-state-approaches-association-health-plans. States that choose to do so will bear a significant additional regulatory burden in identifying and monitoring AHPs and in enforcing market rules. Moreover, state regulation is complicated because AHPs

can, and do, market across state lines. There is not only confusion, therefore, as to, overlapping state and federal jurisdiction but also as to which state or states are responsible for regulation. Christina Goe, *supra*, at 11, 14; Plaintiff's Motion for Summary Judgment, Declaration of Maria T. Vullo, at 8-10. It is inappropriate for the federal defendants to create this regulatory morass and then look to the states, including the plaintiffs, to clean it up at their own expense.

## CONCLUSION

For all these reasons, this court should sustain the judgment of the lower court invalidating the challenged AHP rule.

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## CERTIFICATE OF COMPLIANCE WITH RULE 32(A)

1. This brief complies with the type-volume limitation of FED. R. APP. P. 32(a)(7) and Circuit Rule 32(a)(2) because: this brief contains 5159 words, (excluding the parts of the brief exempted by FED. R. APP. P. 32(a)(7)(B)(iii)) as determined by the word counting feature of Microsoft Office Word 2010).

2. This brief complies with the typeface requirements of FED. R. APP. P. 32(a)(5) and the type style requirements of FED. R. APP. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Office Word 2010 14-point Goudy Old Style font.

Dated: July 22, 2019

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## CERTIFICATE OF SERVICE

I hereby certify that on July 22, 2019, the foregoing Brief was electronically filed with the Clerk of the Court for the United States Court of Appeals for the DC Circuit using the appellate CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: July 22, 2019

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