Appeal No. 19-5125

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

STATE OF NEW YORK, *et al.*,

Plaintiffs/Appellees,

v.

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

Defendants/Appellants.

On Appeal from the U.S. District Court for the District of Columbia
Honorable John D. Bates, District Judge
Case No. 1:18-cv-01747-JDB

BRIEF OF THE RESTAURANT LAW CENTER AS *AMICUS CURIAE* IN SUPPORT OF APPELLANTS U.S. DEPARTMENT OF LABOR ET AL. AND REVERSAL

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CORPORATE DISCLOSURE STATEMENT

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

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STATEMENT REQUIRED BY F.R.A.P 29(2) AND CIR. R. 29(B)

All parties consent to the filing of this brief.

CERTIFICATE OF COUNSEL PURSUANT TO CIR. R. 29(D).

The Restaurant Law Center (RLC) files this separate amicus brief to address an issue that no other amicus discusses: that regardless of the Court's decision as to the validity of the DOL's Final Rule expanding access to association health plans ("AHPs"), the Court should not make any ruling that would affect the ability of AHPs that were in existence prior to the issuance of the Final Rule to continue to operate under the Department's pre-Final Rule advisory opinions.

IDENTITY AND INTEREST OF AMICUS CURIAE AND F.R.A.P. 29(A)(4)(E) STATEMENT

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

RLC thus has a profound interest in laws and regulations generally governing the provision of healthcare benefits to restaurant employees throughout the United States, including laws and regulations designed to enhance the provision of healthcare coverage to employees of small businesses and to working owners.

No party's counsel authored this brief in whole or in part, nor did a party, party's counsel, or person other than the *amicus curiae* contribute money intended to fund preparing or submitting the brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

This brief focuses on the significant policy considerations underlying the DOL's Final Rule and on the important role that association health plans ("AHPs"), including those created pursuant to the Final Rule, play in addressing the lack of access to quality health insurance for thousands of employees of the nation's small businesses. Most importantly this brief asserts that, regardless of the validity of the Final Rule, the court should not upend the decades of settled law that existed prior to the issuance of the Final Rule and that has long defined when a group or association of employees may be deemed a single "employer" that can sponsor a single-employer AHP.

Few would dispute there exists a need to expand access to affordable, comprehensive healthcare coverage options to the nation's small businesses and the self-employed. Health coverage costs are rising, and access to employer-sponsored coverage is narrowing. The United States spends nearly 20% of its gross domestic product (GDP) on health care—more than any other developed nation and that spending is only projected to increase.[1] Healthcare spending is projected to grow at

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

an average rate of 5.5% per year between 2017 and 2026—one percentage point *faster* than our nation's GDP.[2] Much of that spending goes to pay for health insurance coverage.[3] That year-over-year growth in health spending translates into year-over-year increases in health insurance premiums across all markets.

Those ever-increasing health insurance premiums hit small businesses and their employees especially hard. Premium increases have begun to outpace workers' wage growth and inflation.[4] The annual premium for family coverage under an employer-provided health plan in 2018 was nearly $20,000, with employees paying almost a third of that cost.[5] Cost increases of that magnitude are difficult for any business—much less the average worker—to absorb, but they are particularly onerous for small businesses, their employees, and the self-employed. Of those small businesses that continue to offer employer-sponsored medical coverage, annual premium increases are often passed on to employees in the form of higher premium contribution requirements, higher deductibles, and less generous benefits.

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[2] NHE Fact Sheet

[3] Joseph Walker, , *Why Americans Spend So Much on Health Care—in 12 Charts*, The Wall Street Journal, July 31, 2018, https://www.wsj.com/articles/why-americans-spend-so-much-on-health-carein-12-charts-1533047243.

[4] *2018 Employer Health Benefits Survey*, Henry J. Kaiser Family Foundation, Oct. 3, 2018, https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/.

[5] *Id*. at Section 1 of Report.

Tellingly, since 2010, the percentage of small business employees with employer-sponsored health coverage declined from 44% to 30% for companies with three to 24 employees, and from 59% to 44% for those companies with 25 to 49 workers.[6] Workers employed by small businesses, and the dependents of those workers, make up between 11 and 12 million uninsured individuals.[7] Approximately 3 million of the nation's uninsured are self-employed persons and their dependents.[8]

The experience of the membership of RLC is no different. Between 2006 and 2016, health insurance costs rose significantly faster than restaurant sales. Employer contributions toward health insurance premiums for family coverage rose 51%, while sales rose only 33%.[9]

AHPs, established under decades of DOL and court guidance, have long played a key role in giving small businesses access to affordable employment-based health coverage, and have provided such coverage to thousands of small businesses and their employees. Thousands more small businesses, including working owners

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

[7] The Editorial Board, *Trump's ObamaCare Lifeboat*, The Wall Street Journal, Jan. 7, 2018, https://www.wsj.com/articles/trumps-obamacare-lifeboat-1515361577; 83 Fed. Reg. 28912, 28950.

[8] 83 Fed. Reg. 28912, 28947

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

without employees, however, have been unable to access the advantages of AHP participation due to the stringency of the prior guidance in this area. The nation's small businesses and their employees desperately need more and better options for providing health coverage to their employees.

The DOL's Final Rule, which expands access to health coverage through AHPs is a much-needed step in that direction. Prior to the issuance of the District Court's decision in this case, the Final Rule allowed more small businesses and—for the first time—working owners, to band together to gain access to health insurance coverage options, and pricing for those coverage options on par with large employers. By allowing them to pool their purchasing power and their risks, the Final Rule enabled small businesses and working owners to benefit from the greater negotiating power, more stable risk pools, administrative efficiencies, and economies of scale that currently benefit only those employers in the large group market, and it did so with all the same participant protections that apply to large-group ERISA plans.

Importantly, the Final Rule explicitly preserves the guidance set forth in the DOL's prior advisory opinions, establishing the circumstances under which a "bona fide" group or association of employers would be deemed to be a single employer under ERISA Section 3(5) and could establish an AHP that would be a single ERISA plan. Notwithstanding the ultimate disposition of this case, both as a matter of policy

and a matter of law, that prior DOL subregulatory guidance and the case law interpreting and applying the original "pathway" to single ERISA plan status for AHPs, should remain intact and unchanged. That pathway was established decades ago, has been tested in the courts and is relied upon by thousands of businesses and the participants in the AHPs formed under that guidance. Moreover, that pre-existing guidance has not been placed in controversy by either party, making it improper for the Court to express any opinion on it.

Opponents of the Final Rule claim it is inconsistent with the Patient Protection and Affordable Care Act ("ACA")—a mere "end-run" around the ACA—and that it will result in a "flood of inadequate and fraudulent plans newly offered by associations".[10] In fact, the Final Rule is entirely consistent with, and advances one of the overarching goals of the ACA—to expand access to quality healthcare coverage—specifically in this case, employment-based coverage. It is undisputed that AHPs are group health plans subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and, as such, their participants enjoy all the protections applicable to ERISA plans. In addition to the protections of ERISA and other federal laws applicable to ERISA group health plans, the Final Rule builds in nondiscrimination rules to protect participants from being discriminated against on the basis of their health status. Many states have in place

[10] D. Ct. Op.; Complaint, ¶14.

robust measures to regulate AHPs. The Final Rule not only leaves untouched the states' power to regulate these plans, but expressly endorses that power, leaving States free to enact whatever regulation of AHPs they see fit, consistent with ERISA.

ARGUMENT

I. REGARDLESS OF THE OUTCOME OF THE PRESENT CASE, THE DEPARTMENT'S PRE-EXISTING GUIDANCE ON FORMATION OF A SINGLE-EMPLOYER AHP MUST BE PRESERVED.

RLC strongly supports the DOL's Final Rule and believes that the District Court's decision should be reversed. However, no matter the ultimate disposition of this case, the court should expressly limit its decision to the new "pathway" to bona fide AHP status created by the Final Rule, and should express no opinion on the DOL's prior subregulatory guidance on this topic.

Both as a matter of policy and a matter of law, it would be inappropriate for the court to issue any opinion as to the DOL's prior guidance. That guidance has been established and refined over decades of consideration and was expressly preserved in the Final Rule. It has been tested in the courts, is generally regarded as settled law, and is relied upon by thousands of businesses and their employees. Most importantly, the DOL's prior guidance has not been placed into controversy by either party, making it improper for the court to express any opinion as to its legal sufficiency.

A. As a matter of policy, the court should not make any ruling or express any opinion that would interfere with the AHP rules that pre-existed the Final Rule.

Prior to the issuance of the Final Rule, a group or association of employers could only be deemed to be a single employer under ERISA section 3(5), and

therefore sponsoring a single ERISA plan, if it satisfied a three-prong test, which was established and honed over decades of DOL advisory opinions and case law.[11] The facts and circumstances of a given group or association of employers were analyzed to determine: 1) whether the group or association is a bona fide organization, with business or organizational purposes and functions unrelated to the provision of benefits; 2) whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and 3) whether the employers that participate in a benefit program, either directly, or indirectly, exercise control over the program, both in form and substance.[12] If all three of these criteria are satisfied, the group or association of employers is deemed to be a single employer within the meaning of ERISA section 3(5), and therefore the group health plan sponsored by the association for its member employers will be deemed to be a single large ERISA plan, rather than a collection of small plans, each sponsored by a separate member employer.

Of great importance to the DOL and to the courts in making this analysis, was that the entity maintaining the plan and the individuals who benefit from the plan be

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

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

tightly bound by "a common economic or representational interest." As a result, this test was narrowly construed and only a few associations were found to be "bona fide" associations. This original "pathway" to bona fide AHP status, having been settled law for decades, has been relied upon by thousands of businesses and their employees. Indeed, the District Court itself uses the DOL's original three criteria (purpose, commonality, control) and the DOL's interpretation thereof as the foundation upon which it bases its analysis of the Final Rule.

Recognizing the importance of preserving its original pathway to single-employer AHP status, in the preamble to the Final Rule, the DOL expressly stated that the Final Rule does not supplant its previously-issued guidance. Instead, it creates a second, independent "pathway" to single-employer AHP statues. The DOL also recently re-emphasized that point in guidance issued after the District Court's decision, stating that its "pre-rule guidance remains in effect and employer groups and associations that meet that criteria continue to be able to act as an 'employer' for purposes of sponsoring an ERISA-covered AHP."[13] The intent of the Final Rule was strictly limited to providing a new, *alternative* pathway for employer groups to be treated as a single employer under ERISA section 3(5).[14] It was DOL's intent

[13] Federal District Court Ruling in *State of New York v. United States Department of Labor* Concerning Departmet nt of Labor's Final Rule on Association Health Plans, Questions and Answers – Part Two (May 13, 2019).
[14] 83 Fed. Reg. 28912, 28955.

then and now that existing AHPs, formed under the DOL's prior guidance, may continue to operate under that prior guidance without regard to the new pathway established by the Final Rule. For DOL to have done otherwise—or for the Court to now do otherwise—would cause a massive, unnecessary, and unwarranted disruption of the existing AHP market, over which even the Plaintiff States have not, in this case, expressed concern.

B. The court should not make any ruling on the AHP rules that pre-existed the Final Rule.

No party to this case has, in any respect, put the original pathway to bona fide AHP status in controversy in this case. As such, it would be improper as a matter of law for the Court to make any ruling or express any opinion on it. It is well settled that Article III of the U.S. Constitution limits the power of federal courts to "cases" and "controversies" and, as such, federal courts are prohibited from issuing advisory opinions. Courts routinely decline to consider arguments or rule on issues not properly raised by the parties.[15] Any discussion of the parameters or the legality of

[15] *See, e.g.*, *United States v. Fruehof*, 365 U.S. 146, 157 (1961) (declining to consider question the Court regards as a request for an advisory opinion); *Turner Broadcasting System, Inc. v. FCC*, 520 U.S. 180, 223–224 (1997) (declining to decide question that received only "scant argumentation"); and *Decker v. Northwest Environmental Defense Center*, 598 U.S. 597, 615-16 (2013) (Roberts, C.J., concurring) ("Respondent suggested reconsidering Auer, in one sentence in a footnote, with no argument. . . . Petitioners said don't do it, again in a footnote. . . . I would await a case in which the issue is properly raised and argued.")

the original pathway to bona fide AHP status is even less ripe for consideration than the issues the Supreme Court declined to review in *Fruehof*, *Turner* and *Decker*.

II. THE FINAL RULE EXPANDS MUCH-NEEDED ACCESS TO EMPLOYMENT-BASED HEALTH COVERAGE, CONSISTENT WITH THE OVERARCHING POLICY OF THE ACA.

A. Overview of the Final Rule

Private, employer-sponsored health insurance coverage is generally purchased in one of three ways: through the large group market for employers with 50 or more employees (or in some states, 100 or more employees); through the small group market for employers with between 2 and 49 employees (or in some states, between two and 99 employees), and, for working owners without common law employees, through the individual market. Small employers and large employers do not play on a level field when it comes to their ability to negotiate costs, benefits, and options when purchasing health coverage. According to the National Conference of State Legislatures, on average, small businesses paid about eight to 18% more than large businesses for the same health insurance policy.[16] Those purchasing coverage on the individual market are, in essence, faced with a take-it-or-leave it "choice" in coverage.

Seeking to address past perceived abuses by insurance carriers in selecting and rating health insurance risks, the ACA imposed certain requirements on the

[16] http://www.ncsl.org/research/small-business-health-insurance.aspx

individual and small group markets, which were not imposed on the large group market.[17] Those requirements include restrictions on the way coverage for small groups and individuals is priced (or "rated"), mandated coverage of an "essential health benefits" package by all plans sold in the ACA Marketplace, and providing for single risk pools in the individual and small group markets. (A single risk pool means that an insurance carrier must consider all of its enrollees in all its health plans issued in a particular state when calculating premiums, instead of—in the case of small groups—rating them on an employer-by-employer basis.)

Although well-intentioned, those ACA mandates had the effect of making coverage in the individual and small group markets increasingly costly, and therefore increasingly out of reach of many Americans. In addition, financial losses incurred by insurance carriers as a result of the ACA reforms, as well as regulatory uncertainty, has, in past years, resulted in some insurance carriers leaving ACA Marketplaces altogether, leaving consumers with fewer and fewer choices in health insurance coverage, particularly in rural areas.[18] In 2019, twenty-one states have

[17] Complaint, ¶¶ 3-4, p. 3.

[18] Kaiser Family Foundation, Insurer Participation on ACA Marketplaces, 2014-2019, https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/#; Olga Khazan, The Atlantic, "Why So Many Insurers Are Leaving Obamacare," https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/

only one or two insurers participating in their ACA exchanges.[19] In addition to facing increasing cost and decreasing choice, small groups have very little bargaining power when negotiating with insurance carriers.

In contrast, in the large group market, where large employers purchase coverage for their employees, insurance carriers can rate each employer based on its own claims experience. Further, plans maintained by large employers have a larger pool of participants over which to spread the risk of high-cost claims, which makes the overall risk of the pool more predictable. The stability of larger risk pools also means that self-insuring the plan's benefits is often more financially feasible and cost-effective than purchasing an insurance policy. Large groups also have greater clout when negotiating with insurance carriers over rates and plan options, and can spread administrative costs out over a larger population, resulting in lower per-capita administrative expenses incurred in providing health coverage to their employees.

Contrary to the assertions of its detractors, the Final Rule does not seek to undermine the ACA's protections in the individual and small group markets. Rather, it seeks to allow small businesses, including working owners without employees, to band together to form a single, large-group ERISA plan and thereby enjoy the same advantages as large employers when it comes to buying health insurance coverage.

[19] *Id.*

As noted above, prior to the Final Rule, only under very narrow circumstances could employers band together in a group or association and be deemed to be a single employer within the meaning of ERISA, sponsoring a single ERISA group health plan. In the vast majority of cases, such groups and the health plans they sponsored, would be treated and regulated as a collection of smaller single-employer ERISA group health plans. And, the Department's past interpretations of section 3(5) of ERISA[20] did not allow working owners without common law employees to participate in AHPs under any circumstances. As a result of these restrictions, the advantages of participation in an AHP remained out of reach of most businesses and all self-employed persons. In response to these significant obstacles facing small businesses and working owners in obtaining affordable health coverage, the President issued Executive Order 13813[21] directing the Department to issue rules to make AHPs more broadly available.

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

[20] 29 U.S.C. § 1002(5).
[21] 82 Fed. Reg. 48385 (October 17, 2017).

B. The Final Rule is consistent with the overarching policy of the ACA.

The RLC strongly disagrees with the District Court's conclusion that the Final Rule is an "end-run around the ACA".[22]

Quite to the contrary, the Final Rule is consistent with, and advances the overarching policy of the ACA—that is, to achieve "near-universal" health coverage, to "add millions of new consumers to the health insurance market," and to "increase the number and share of Americans who are insured."[23] Some of the mandates brought about by the ACA, however, had the unintended effect of making health coverage less accessible due to the associated higher costs, and risk-averse insurance carriers pulling out of ACA Health Insurance Marketplaces.[24] Seeking to reverse that trend, the Final Rule was born out of Executive Order 13813 and its directive that the DOL issue rules expanding the availability of, and access to health coverage.

As a result of the Final Rule, it is estimated that 400,000 previously uninsured people will be able to obtain coverage under an AHP, and approximately 3.6 million people will migrate away from their current coverage in favor of AHP coverage that

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[22] D. Ct. Op.
[23] 42 U.S.C. § 18091(2)(C) and (D).
[24] Exec. Order No. 13813 (Oct. 12, 2017); Olga Khazan, *Why So Many Insurers Are Leaving Obamacare*, The Atlantic, May 11, 2017, https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/.

better suits their needs.[25] In 2016, national health expenditures were $10,348 per person, and projected to grow at an average rate of 5.5% per year thereafter.[26] Health care providers expect to be paid for the services they render, and healthcare costs are rising consistently, year over year.[27] Furthermore, the ACA requires individual and small group plans to cover all ten categories of "essential health benefits" which includes: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care. Some individuals purchasing coverage on the Marketplace are eligible for federal premium tax credits, which shift some of the cost onto taxpayers, but for many others who do not qualify for premium tax credits, or who get their coverage from their employer, the coverage, while generous in scope, is simply out of their financial reach.[28] The Final Rule does not skirt or undermine ACA protections. It

[25] 83 Fed. Reg. 28912, *citing* U.S. Congressional Budget Office survey.
[26] NHE Fact Sheet.
[27] Joseph Walker, The Wall Street Journal, "Why Americans Spend So Much on Health Care—in 12 Charts, July 31, 2018, https://www.wsj.com/articles/why-americans-spend-so-much-on-health-carein-12-charts-1533047243
[28] The Editorial Board, *Trump's ObamaCare Lifeboat*, The Wall Street Journal, Jan. 7, 2018, https://www.wsj.com/articles/trumps-obamacare-lifeboat-1515361577?shareToken=stee195a8d7b4b4e5c9d1433fa2b9d4c3f&ref=article_email_share.

advances the ACA's goals, while aiding small employers by allowing them access to purchase coverage in the large group market—coverage that fits that particular business's employees and that can be scaled to the needs of that particular workforce.

The Plaintiff States' concerns over the competitive pressure that the Final Rule might place on their small group and individual markets are no justification for dismantling the Final Rule and shutting small businesses out of the opportunity to obtain quality and comprehensive coverage that does not require federal subsidies.

III. AHPS ARE SUBJECT TO SUBSTANTIAL SAFEGUARDS.

Opponents of the Final Rule would have the court believe it will result in a "flood of inadequate or fraudulent plans newly offered by associations"[29] and that a rise in "insolvent and sham AHPs" and an "explosion of inadequate health insurance policies" lie just over the horizon.[30] These concerns are grossly overstated.

As an initial matter, the vast majority of associations, as a matter of sound business practice and plain self-preservation, would not risk their goodwill with their membership by selling "junk" insurance plans. Businesses that defraud or disappoint customers simply do not stay in business. In crafting the Final Rule, the DOL placed great weight on the need to distinguish between "bona fide" associations and commercial insurance-type arrangements to ensure that the interests of the AHP

[29] Complaint, ¶15, p. 8.
[30] AMA District Court Amicus Brief, pp. 22-23.

sponsor were closely aligned with its membership for this very reason.[31] Under the Final Rule, in order to constitute a "bona fide association" and therefore deemed to be a single "employer" under ERISA, the group or association of employers must have some substantial business purpose other than providing health care coverage to its members. As in any business relationship, client satisfaction—or in an association's case, member satisfaction—with the value of association membership is critical to the success of the association. And to be successful, associations must offer health plans at price points and benefit levels that are of value to their members and meet members' expectations. To do otherwise, and "make a quick buck" off of the membership by offering thinly funded plans with poor benefits, or misleading the membership as to the benefits being purchased, would be fruitless and self-destructive.

Second, implied in the distinction between small and large group health insurance markets, is the belief that those businesses purchasing coverage in the large group market can be trusted to offer sufficiently comprehensive coverage to their employees, and not to defraud them, or leave them underinsured. The large group market was not made subject to the same increased regulation by the ACA as the individual and small group markets because the large group market was seen to be functioning sufficiently well with respect to benefits offered and rating

[31] 83 Fed. Reg. 28912, 28928.

methodologies.[32] The goal of the Final Rule is to allow small businesses and the self-employed to participate in that well-functioning large group market and there is no reason to believe that small businesses and the self-employed cannot be trusted to purchase appropriate coverage for their employees or themselves, just as large businesses are assumed to do.

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

The Plaintiff States' concerns over fraud and abuse are also overstated because nothing in the Final Rule changes the fact that AHPs are group health plans that are subject to ERISA[33] and all of the federal laws that apply to large group health plans. ERISA protects the interests of employee benefit plan participants and their beneficiaries. It does so through a broad range of protections: by requiring fiduciaries of ERISA plans (including the association sponsor of an AHP) to act for the exclusive benefit of the plan's participants and beneficiaries, subject to civil and criminal penalties for failing to do so. It also imposes bonding requirements on those who handle ERISA plan assets; it requires annual reports containing detailed plan, financial, and service provider information be filed with the DOL; and it provides enforcement mechanisms through the DOL, the Internal Revenue Service, and through civil lawsuits. ERISA group health plans are subject to comprehensive

[32] *See* Congressional Amicus Brief, page 7.
[33] 29 U.S.C. § 1001, *et seq*.

participant disclosure requirements, as well, so that plan participants and beneficiaries are notified of the plan's terms regarding eligibility, benefits, claims and appeals procedures, and any exclusions from coverage under the plan. Summary plan descriptions ("SPDs") and Summaries of Benefits and Coverage ("SBCs") are required to be distributed to participants and must be updated as plans change, so that participants are aware of the terms, conditions, and limitations of their coverage. As ERISA group health plans, AHPs are also subject to nondiscrimination rules of the Health Insurance Portability and Affordability Act of 1996, as amended ("HIPAA")[34], which prohibit plans and insurers from discriminating against participants and beneficiaries on the basis of their health status. Specifically, AHPs, as ERISA plans, cannot exclude or limit coverage of preexisting conditions, or refuse to cover an individual because of a preexisting condition. AHPs are also subject to the federal Mental Health Parity Act of 1996[35] and Mental Health Parity and Addiction Equity Act of 2008,[36] which together require group health plans that provide benefits for mental health and substance use disorders to provide those benefits on equal footing with the plan's medical and surgical benefits. Federal law also requires ERISA group health plans to cover certain pediatric vaccines,[37]

[34] Pub. L. No. 104-191 (1996).
[35] Pub. L. No. 104-204 (1996); ERISA Section 712.
[36] Pub. L. No. 110-343 (2008), *as amended by* Pub. L. No. 110-460 (Dec. 23, 2008), *amending* ERISA Section 712.
[37] Pub. L. No. 103-66 (1993); ERISA Section 609(d).

mastectomy reconstruction and related services,[38] and minimum hospital stays for childbirth and newborns.[39] The Pregnancy Discrimination Act, an amendment to Title VII of the Civil Rights Act of 1964,[40] requires employer-provided coverage, which encompasses AHPs, to cover pregnancy and pregnancy-related conditions on the same basis as other medical conditions. Finally, many of the ACA's participant protections also apply to AHPs under the Final Rule, including required coverage of dependents to age 26, a ban on retroactive cancellations of coverage (called "rescissions") except in cases of fraud, the prohibition on lifetime dollar limits on coverage, the prohibition on annual dollar limits on the essential health benefits covered under the plan, the complete elimination of preexisting condition exclusions, elimination of eligibility waiting periods exceeding 60 days, annual limitation on out-of-pocket maximums, required first-dollar coverage of certain preventive services, patient protections regarding coverage of emergency services, enhanced claim and appeals procedures, and coverage of approved clinical trials.

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

In crafting the Final Rule, a chief concern of the DOL was ensuring that expanding access to AHPs would not result in the very kind of adverse risk selection

[38] Women's Health and Cancer Rights Act, Pub. L. 105-277 (1998), ERISA Section 713.
[39] Newborns and Mothers Health Protection Act, ERISA Section 711.
[40] 42 U.S.C. § 2000e, *et seq*.

that Amici in support of Plaintiff's content will occur. To address this concern, and to further "distinguish genuine employment-based plans from commercial enterprises that claim to be AHPs but that are more akin to traditional insurers selling insurance in the employer marketplace," the DOL included in the Final Rule a set of nondiscrimination rules designed to ensure that associations do not restrict membership in the association—and therefore in the AHP—based on participants' health factors.[41] These nondiscrimination rules build upon the existing HIPAA nondiscrimination rules, to which AHPs also remain subject.

HIPAA prohibits all group health plans from discriminating *within* groups of similarly situated individuals on the basis of a health factor with regard to premiums and eligibility for benefits. Health factors include health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability. As a result, plans may not, for example, charge higher premiums to, or restrict eligibility for coverage for individuals based on their past claims experience. Group health plans may, however, discriminate *across* groups of similarly situated individuals, as long as those groups are defined by reference to bona fide employment classifications consistent with the employer's usual business practice—such as full-time or part-time status, geographic location, date of hire, membership in a collective bargaining unit, length of service, current

[41] Preamble to Proposed Rule, 83 Fed. Reg. 614, 623 (January 5, 2018).

versus former employee status, and different occupations. For example, individuals at different geographic locations may be charged different premiums or be subject to differing eligibility criteria. These distinctions are not permitted, however, if the creation or modification of a coverage classification is directed at individual participants or beneficiaries, based on any health factor. With or without the Final Rule, AHPs are subject to these nondiscrimination rules, to the same extent as any other group health plan.

The Final Rule, however, goes one step farther, and also restricts AHPs from treating member employers as distinct groups of similarly-situated individuals if they wish to be treated as a single employer under ERISA section 3(5), sponsoring a single ERISA plan. This means that the AHP cannot charge each member employer different premiums based on the claims experience or other health factors of its employees and their beneficiaries. The Department specifically designed this rule to distinguish bona fide AHPs from commercial insurance arrangements, which are permitted to "experience-rate" employer groups (i.e., to set premiums based on the group's past claims experience) in the large group market.[42] As noted by the DOL, "a group or association that seeks treatment as an 'employer' under ERISA section 3(5) for purposes of sponsoring a single group health plan under ERISA section 3(1) cannot simultaneously undermine that status by treating different

[42] 83 Fed. Reg. 28912, 28928.

employers as different groups based on health factor of an individual or individuals within an employer member."[43] In other words, the DOL was unwilling to let associations have it both ways—if the association is "bona fide" under the Final Rule, established to act in the interests of its members, it cannot simultaneously act like a commercial insurance arrangement when it comes to setting rates. The DOL recognized that it is inconsistent for a group of employers to be treated as a single "employer" for some purposes, but to then treat each employer member separately for purposes of applying the nondiscrimination rules, and it structured the Final Rule's nondiscrimination provisions to further emphasize the commonality that must exist across the association, which in turn ensures that the association safeguards the interests of its members.

C. AHPs are subject to robust state regulation.

In 1983, Congress enacted Section 514(b)(6)[44] of ERISA, which created an exception to ERISA's broad preemption provisions to allow states regulatory authority over MEWAs. Accordingly, a fully-insured AHP is subject to State laws and enforcement mechanisms relating to maintenance of specified contribution and reserve levels, and of course, the insurance contract that funds benefits under the AHP is subject to State laws regulating insurance. States' power to regulate

[43] *Id.*
[44] 29 U.S.C. § 1144(b)(6).

insurance contracts means that States can require AHPs to cover state-mandated benefits. If the AHP is not fully insured, States have authority to apply any State law that regulates insurance, to the extent the law is not inconsistent with ERISA. Such laws include, for example, those regulating solvency, benefit levels, or rating methods. States routinely also require AHPs to be registered or licensed as insurers with the state insurance department, require AHPs to meet the state's individual and small group market rules, engage in market conduct and financial examinations, require AHPs to contribute to state guaranty funds, and how the power to place AHPs into receivership, if needed.[45] As of 2016, the majority of states had enacted laws specifically regulating MEWAs.[46] Moreover, *all* states have the authority to do so, should they determine that existing state and federal laws do not adequately regulate AHPs.

In the preamble to the Final Rule, the DOL sided with those commenters who urged the Department to "make it clear that the final rule in no way limits the ability of States under State insurance laws to regulate AHPs, health insurance issuers

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

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

offering coverage through AHPs, and insurance producers marketing that coverage to employees."[47] The Department expressly agreed that the Final Rule "does not modify or otherwise limit existing State authority as established under section 514 of ERISA."[48] Indeed, the Department expressly declined to entertain suggestions by commenters arguing for increased federal regulation of MEWAs, and that the Department should use the Final Rule to exempt AHPs from State insurance laws.[49] In response to the Final Rule, at least eighteen states have already made legislative changes, engaged in rulemaking, or issued subregulatory guidance addressing AHP regulation under state law.[50] In fact, some States have already effectively nullified certain portions of the Final Rule as applied within their jurisdictions—for example, by requiring that sole proprietors without common law employees cannot be covered under group policies, but instead must be issued policies from the individual market,[51] or restricting AHPs to those whose association has been in existence for some minimum number of years.[52] Existing State regulation, and the capacity for further State regulation, should States deem it advisable, provide yet another layer

[47] 83 Fed. Reg. 28912, 28936.
[48] *Id*.
[49] 83 Fed. Reg. 28912, 28937.
[50] AL, CA, CT, DE, IL, IN, IA, LA, MA, MD, MI, MO, NH, NJ, NY, OR, UT, WA.
[51] CA, CT, PA.
[52] IA, MD, MA, NY, OR, PA, VT.

of protection to participants of AHPs. The Final Rule does nothing to change that, and in fact, it expressly preserves States' authority to do so.

CONCLUSION

For the foregoing reasons, the District Court's decision regarding the Final Rule should be reversed.

Respectfully submitted,

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1. This brief complies with the type-volume limitations of Fed. R. App. P. 29(a)(5) because it contains 6,128 words, excluding those parts of the brief exempted by F.R.A.P. 32(a)(7)(B)(iii).

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I hereby certify that on this the 7th day of June, 2019, the foregoing document was filed with the Clerk of the Court via the Court's CM/ECF system which will notify all counsel of record.

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