[Not Yet Set for Oral Argument]

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.

UNITED STATES DEPARTMENT OF LABOR, ET AL.,
Defendants-Appellants.

On Appeal from the
United States District Court for the District of Columbia
No. 18-cv-1747 (JDB)

BRIEF OF FORMER STATE INSURANCE COMMISSIONERS AND FORMER STATE INSURANCE REGULATORS AND OTHER AHP FRAUD EXPERTS AS AMICI CURIAE IN SUPPORT OF APPELLEES AND AFFIRMANCE

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28 (a)(1), undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs are the State of New York; the Commonwealth of Massachusetts; the District of Columbia; the State of California; the State of Delaware; the Commonwealth of Kentucky; the State of Maryland; the State of New Jersey; the State of Oregon; the Commonwealth of Pennsylvania; the Commonwealth of Virginia; and the State of Washington.

Defendants are the U.S. Department of Labor; R. Alexander Acosta, in his official capacity as Secretary of the U.S. Department of Labor; and the United States of America.

Amici before the district court included: (1) the Chamber of Commerce of the United States of America and the Society for Human Resource Management; (2) the States of Texas, Nebraska, Georgia, and Louisiana; (3) Nancy Pelosi, Steny H. Hoyer, James E. Clyburn, Joseph Crowley, Linda T. Sanchez, Robert C. Scott, Frank Pallone, Jr., Jerrold Nadler, and Richard E. Neal; (4) the Restaurant Law Center; (5) the American Medical Association and the Medical Society of the State

of New York; and the (6) the Coalition to Protect and Promote Association Health Plans.

Amici before this Court as of July 19, 2019, include: the Oklahoma Insurance Department and the Montana State Auditor, Commissioner of Securities and Insurance, and (2) the Chamber of Commerce of the United States of America, State and Local Chambers of Commerce, the National Federation of Independent Business and the Texas Association of Business, on behalf of Defendant Appellant the U.S. Department of Labor; and the United States of America.

B. Rulings under Review

Appellants seek review of the district court's order and memorandum opinion entered on March 28, 2019 (Dkt. Nos. 78, 79). The rulings were issued by the Honorable D. Bates in Case No. 1:18-cv-1747.

C. Related Cases

None.

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 former insurance commissioners, former state insurance regulators and association health plan (AHP) fraud experts file this separate brief to address an issue that no other amicus discusses: The implementation of the U.S. Department of Labor's (DOL) Final Rule on AHPs will result in increased fraud and abuse perpetrated by unscrupulous promoters of AHPs. The increased fraud and abuse that will result from the elimination of long-standing safeguards and the subsequent proliferation of AHPs will place an additional cost and regulatory burden on state insurance regulators and will result in real economic harm to the states.

INTEREST AND IDENTITY OF *AMICI CURIAE*

Amici are twenty-six former state insurance commissioners, eight of whom are also former presidents of the National Association of Insurance Commissioners (NAIC), fourteen former insurance regulators, and five experts on AHP fraud and abuse. Their experience includes some or all of the following: finding and shutting down fraudulent association health plans and phony health insurance sold to real associations; trying to keep real association health plans financially solvent and taking over insolvent association health plans; working with federal and state law enforcement officials on civil and criminal investigations of association health plans; finding, seizing and administering assets for fraudulent or insolvent association health plans; holding hearings and issuing cease and desist orders to shut down phony or insolvent association health plans; defending Employee Retirement Income Security Act (ERISA) challenges to state legal authority brought by promoters of phony association health plans; and finding ways to protect insurance consumers against phony association health plans. The nationally recognized experts have published more than 10 reports on association health plans fraud and abuse.

These former state insurance Commissioners, state insurance regulators and fraud experts have a deep historical knowledge and vast amounts of experience in regulating health insurance and combating fraud. They maintain a strong and ongoing interest in protecting insurance consumers.

INTRODUCTION

These amici strongly support the U.S. District Court for the District of Columbia's decision in State of New York, et al. v. United States Department of Labor, et al., No. 1:18-cv-1747-JDB. This brief focuses on the additional cost and regulatory burden placed on state insurance regulators from increased fraud and abuse that will result from the elimination of long-standing safeguards and the proliferation of association health plans (AHPs). According to the District court, three plaintiff states alleged that "the Final Rule will cause 'a substantially increased regulatory burden on the States' as they 'substantially ramp up enforcement against a new type of plan […] or face a wave of fraud and abuse similar to what occurred under [multiple employer welfare arrangements ("MEWAs")] in past decades." Dist. Ct. Mem. Op. pg. 14. These amici explain that combatting fraud and abuse is a state constitutional and/or statutory obligation of state insurance regulators and that it is not "optional" as Department of Justice (DOJ) argues. The amici describe the types of AHP fraud and abuse that has been occurring for decades. The amici argue that the Final Rule will lead to more fraud

and abuse. And they argue that the federal government does not have a positive record of protecting consumers against phony health insurance promoted through associations.

In the preamble to the Final Rule, the U.S. Department of Labor (DOL) states that it "anticipates that the increased flexibility afforded AHPs under this rule will introduce increased opportunities for mismanagement or abuse, in turn increasing oversight demands on the Department and State regulators." The DOL expressly states that the Final Rule will increase "oversight demands on …State regulators." 83 Fed. Reg. 28,912, at 28,953. DOL admits that its own past "enforcement efforts often were too late to prevent or fully recover major financial losses." *Id*. at 28,952. Despite these admissions in the final regulation, the Federal Government in its appellate brief argues that the state's additional regulatory burden to combat this fraud is "hypothetical" and "self-inflicted." Br. for Appellant at 24.

This brief discusses AHP fraud and abuse perpetrated by unscrupulous promoters and how state insurance regulators responded to prevent, find, and shut down such scams. It also discusses the instability of self-insured AHPs and the harms to consumers state insurance regulators have had to address.

ARGUMENT

I. The Regulatory Burden on States Constitutes Actual Economic Harm

The Appellants assert in their brief that “no law or principle requires States to prevent or restrain fraud. The States remain to free to decide whether the benefit of doing so are worth the costs…” Br. at 27. This assertion is not correct. All insurance commissioners are charged with protecting insurance consumers in their state. For instance, in Montana, the insurance commissioner is an elected office that is created in the state constitution, which specifically directs the commissioner to perform the duties set forth in Montana statute. Mont. Constitution, Art. VI, Part VI, Sections 1 and 4. Mont. Code Ann. § 33-1-311 (4) specifically states, “the commissioner shall administer the department to ensure that the interests of insurance consumers are protected.” The Montana insurance code requires that insurance consumers be protected from fraud: “The Insurer Insurance Fraud Protection Act.” Mont. Code Ann. § 33-1-1302 (1) states, “A person commits the act of insurance …fraud when: (a) in the course of offering or selling insurance, …the person misrepresents a material fact…” Insurance commissioners are legally charged with certain duties, and these duties are not “optional.” Montana is not unique.

In fact, forty-one states have some kind of insurance fraud division within their insurance departments. Most of these have law enforcement authority. For example, the North Dakota insurance fraud unit is established within the insurance department. The commissioner may appoint supervisory and investigative personnel to staff the insurance fraud unit. The insurance fraud unit is authorized to conduct independent investigations and receive reports from other law enforcement agencies. The fraud unit may make arrests and make criminal referrals. NDCC 26.1-02.1-08, ND ST 26.1-02.1-08. States without fraud divisions within the insurance department investigate and refer fraud matters to the state attorney general or other enforcement agency to investigate and prosecute as needed.

When specifically addressing AHP fraud, insurance commissioners have testified before Congress about AHP fraud that they have had to address. Former Kansas Insurance Commissioner and NAIC president, Sandy Praeger testified before congress in 2005 as follows:

> While the NAIC acknowledges State regulation may cost slightly more initially, those costs are offset by the protections provided to our consumers. Insurance is a complicated business, involving billions of dollars, with ample opportunity for unscrupulous or financially unsophisticated entities to harm millions of consumers. Unless oversight is diligent, consumers will be harmed. This is not just speculation, but fact borne of years of experience with Multiple Employer Welfare Arrangements (MEWAs), multi-state association plans, out-of-state trusts, and other schemes to avoid or limit State regulation. Within the last year, 16 States have shut down 48 AHP-like plans that had been operating illegally in those States, many through bona fide associations. Association plans in several States have gone bankrupt

> because they did not have the same regulatory oversight as state-regulated plans, leaving millions of dollars in provider bills unpaid and consumers liable for their payment. Each time oversight has been limited the result has been the same--increased fraud, increased plan failures, decreased coverage for consumers, and piles of unpaid claims.
>
> Sandy Praeger Testimony, United States Senate, Committee on Health, Education, Labor, and Pensions (April 21, 2005), available at https://www.govinfo.gov/content/pkg/CHRG-109shrg20954/html/CHRG-109shrg20954.htm.

The NAIC – an organization whose membership includes all state insurance commissioners -- has recognized for many years the importance of fighting fraud and has a standing committee, the Anti-fraud Task Force, which has developed model laws and bulletins for the states to use. *See e.g.* Insurance Fraud, NAIC, The Center for Insurance Policy and Research (May 14, 2019) available at https://www.naic.org/cipr_topics/topic_insurance_fraud.htm. The task force looks at fraud perpetrated by persons purporting to be health plans, as well as consumer fraud against insurers—and prevention as well as prosecution. In 2006, the NAIC published a specific bulletin warning the public about pending legislation that would loosen regulations for formation of AHPs. *See* Association Health Plan Legislation Would Harm Consumers, National Association of Insurance Commissioners (January 2006), available at https://www.naic.org/documents/topics_enzi_nelson_ahp_brief.pdf. In addition, the NAIC's ERISA Working Group focuses on protecting consumers against AHP fraud and abuse, as well as other ERISA-related issues where state oversight

authority is implicated. Through this committee, state insurance regulators share information and, as appropriate, coordinate with the DOL on phony and insolvent AHP enforcement cases. Many states fund consumer education campaigns warning residents about phony health insurance. The NAIC also has devoted significant resources to fund a national campaign educating consumers about phony health insurance promoted through AHPs.

The DOL acknowledges that it “anticipates that the increased flexibility afforded AHPs under this rule will introduce increased opportunities for mismanagement or abuse, in turn increasingly oversight demands on the Department and State regulators.” 83 Fed. Reg. at 28,953. In the initial action filed, several state insurance regulators attested that they have already hired additional staff and designated additional staff time to regulation and enforcement of state and federal laws regarding AHPs. DOJ’s assertion that States do not need to prevent or restrain fraud is unsupported by facts.

II. Contrary to DOJ’ Assertions, AHP Fraud and Abuse Exists and Has Existed Since ERISA’s Enactment

After ERISA was passed, individuals seeking to evade state oversight used associations to argue that these were entities covered by ERISA and that state insurance law did not apply. In 1982, after many multiple employer scams, Congress recognized that DOL was not willing to or not able to find and shut down

these scams. Congress amended ERISA to clarify that state insurance regulators had authority over associations and MEWAs, in addition to DOL having authority over such entities. The clarification helped states with oversight efforts but did not prevent phony association health plans. Even after ERISA was clarified, there have been several documented cycles of large-scale scams promoted through associations. According to the U.S. Government Accountability Office (GAO), between 1988 and 1991, operators of multiple employer entities left 400,000 people with medical bills exceeding $123 million. Another cycle of scams occurred between 2000 and 2002. One hundred forty-four entities left 200,000 policyholders with $252 million in unpaid medical bills. "Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entitles Selling Coverage," GAO-04-312, United State General Accounting Office, February 2004; "Employee Benefits: States Need Labor's Health Regulating Multiple Employer Welfare Arrangements," GAO/HRD-92-40, United States General Accounting Office, March 1992. Cycles of scams typically correspond to significant increases in premiums. M. Kofman, K. Lucia, and E. Bangit, Proliferation of Phony Health Insurance: States and the Federal Government Respond, The Bureau of National Affairs, (2003.) Promoters (often unlicensed) market to small businesses and individuals, offering premiums at prices below what is generally available. Before the ACA, promoters also targeted self-

employed people who could not pass medical underwriting or were charged higher rates based on their health. One self-employed person was left with $110,000 in medical bills. Her professional association, the National Writers Union, was duped into buying phony coverage from a nation-wide scam called Employers Mutual, LLC that had 30,000 victims and according to some estimates had owed as much as $54 million in medical claims. *Id.*

When Nevada insurance regulators became aware of Employers Mutual, LLC, Alice Molasky Arman, former Nevada Insurance Commissioner (1995-2008) issued a cease and desist order against Employers Mutual, LLC in June 2001. The commissioner also had to fight to freeze assets in Nevada banks in order to try to pay some of the unpaid medical claims. Other states, including Alabama, Colorado, Oklahoma, Texas, and Washington, issued cease and desist orders against Employers Mutual, LLC by December 2001. In 10 months, Employers Mutual, LLC collected more than $16 million in premiums from more than 30,000 people in all 50 states and the District of Columbia.

Florida regulators shut down many AHP scams and filed criminal charges against some promoters. For example, Florida brought criminal charges against Carmelo Zanfei and William Paul Crouse, operators of an Indiana-based entity called TRG Marketing, LLC. This unlicensed entity refused to pay claims totaling millions of dollars for more than 7,200 Floridians. Zanfei and Crouse plead guilty to charges of racketeering and unlawful transaction of insurance in 2005. Attorney General of the State of Florida, Office of Statewide Prosecution 2005 Annual Report (March 1, 2006) at 6-7, available at http://myfloridalegal.com/webfiles.nsf/WF/MRAY-6MHMJP/$file/AnnualReport2005.pdf.

Between 2001 and 2003, the Department of Financial Services shut-down 10 unlicensed entities in Florida, initiated administrative actions against approximately 80 agents, and brought criminal charges against six promoters of unlicensed insurance entities. (Gallagher, Posey Announce Felony Charges against Operators of Unlicensed Insurance Entity, Florida Department of Financial Services Press Release, April 14, 2003, available at https://www.myfloridacfo.com/sitePages/newsroom/pressRelease.aspx?id=1503.)

III. AHPs Have Been Used as a Way to Misrepresent Products and to Induce Consumers into Believing that They Were Purchasing Comprehensive Health Insurance

The state insurance departments took action against many AHPs for misrepresenting the products they were selling. Some AHPs made claims that their "much cheaper" products were "just as good a major medical health insurance," when in fact the AHP product was a bundled package of excepted benefit or other non-major medical products. 29 C.F.R. § 2590.732(c). These "bundled" AHPs products typically include a variety of excepted benefit policies, such as "mini-med," accident only, hospital indemnity, and cancer/specified disease, and/or short-term, limited-duration plans or medical discount cards. Many people and small businesses were duped. Some associations told consumers that by joining the association, they were becoming employees of the association and could get less

expensive coverage. For example, between 2006 and 2015, former Montana Insurance Commissioner John M. Morrison (2000-2007) and former Montana Insurance Commissioner Monica J. Lindeen (2008-2016) initiated many investigations, filed multiple oversight actions and issued cease and desist orders against AHPs that were engaged in unlicensed activity regarding the sale of health plans and/or misrepresented the coverage sold to people, including sole proprietors and small employers.[1]

IV. Even Legitimate AHPs Have a History of Financial Instability and the Risk of Insolvencies Requires Extensive Monitoring by States

AHPs have a long history of insolvencies. Self-insured AHPs are inherently less stable than state regulated insurance companies. Approximately 20 states have licensing standards specifically for self-insured AHPs. M. Kofman and J. Libster, "Turbulent Past, Uncertain Future: Is it time to Re-evaluate Regulation of Self-insured Multiple Employer Arrangements?" Journal of Insurance Regulation, Vol. 23, No. 3, Spring 2005. All other states reported that they require self-insured AHPs to be licensed as insurance companies. Compared to traditional insurers,

[1] In the Matter of United National Workforce Association, et al, Case No. INS 2006-71; In the Matter of Consolidated Workers Association, Inc., Case No. INS-2008-55; In the Matter of Independent Electrical Contractors, Case No. INS.-2008-3; In the Matter of the National Better Living Association, Case No. INS-2009-70; In the Matter of the National Alliance of Associations, National Trade Business Association, et al., Case No. INS 2007-79; and In the Matter of Health Insurance Innovations, Case no. INS-2015-348. [see: https://csimt.gov/legal-actions/]

self-insured AHPs are at greater risk of becoming insolvent when claims exceed their reserves. States with special licensing schemes for AHPs apply lower solvency standards, such as reserve requirements, to AHPs than to traditional insurers. Low reserves make it harder for AHPs to avoid insolvency resulting from mismanagement or even just large unexpected claims. M. Kofman, E. Bangit, and K. Lucia, Group Purchasing Arrangements: Implications of MEWAs, California Health Care Foundation, July 2003, at 5. For example, an AHP in Michigan became insolvent due to unexpected claims from two premature babies. M. Kofman, Commonwealth Fund, 2004, at 9. The DOL Final Rule allows for the proliferation of AHPs, including AHPs that choose to assume insurance risk, and would expose members of AHPs to the risk of AHP insolvency and potentially millions of dollars in unpaid medical bills.

Even when regulated by states, the risk of AHP insolvency is considerable. There are numerous examples of legitimate, state-licensed professional and trade AHPs becoming insolvent. An insolvency of the New Jersey Coalition of Automotive Dealers left 20,000 people with $15 million in unpaid medical bills. M. Kofman, E. Bangit, and K. Lucia, "MEWAs: The Threat of Plan Insolvency and Other Challenges," The Commonwealth Fund, March 2004. According to former California Insurance Commissioner Dave Jones (2011-2019), in 2001, Sunkist Growers and Packers Benefit Plan Trust collapsed, "… forcing tens of

thousands of workers to switch insurance and leaving nearly 5,000 medical providers with unpaid bills…The plan covered 23,000 subscribers. When they collapsed, the plan owed 4,800 medical providers an estimated $10 million in unpaid claims." D. Jones, Comments regarding proposed rule, Definition of "Employer" Under Section 3(5) of ERISA_ Association Health Plans, 83 Fed. Reg. 614 (Jan. 5, 2018), California Insurance Department (March 6, 2018).

Association health plans that self-insure successfully for years may still experience volatility and insolvency. For example, the Indiana Construction Industry Trust had provided health insurance for its members for over 30 years before becoming insolvent. M. Kofman, E. Bangit, K. Lucia, Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of M-1 Filings, Journal of Insurance Regulation, Fall (2004). Former Indiana Insurance Commissioner Sally Baker McCarty (1997–2004) reports about her experiences with the Indiana Construction Industry Trust:

> The Indiana Construction Industry Trust (ICIT) was a Multiple Employer Welfare Arrangement operating in Indiana in which relatively small construction trade businesses were able to pool resources to buy health insurance for their employees. The plan was able to assert ERISA exemption but the federal government did not assertively exert its authority over ICIT. When I began to receive complaints that the plan was not paying its claims, the Indiana Insurance Department became involved. After investigation, I learned that, due to weak federal oversight, the plan's principals had been extending membership to non-construction-related industries to grow the fund. They did so to cover up their embezzlement of more than $400,000 in premiums collections. The money was used to purchase a Florida condo, a

> boat, and luxury cars. The Department closed down the plan and aggressively pursued all responsible individuals and entities (principals, agents, attorneys, legal and board malpractice insurers). The DOI was able to recover $24 million in funds to pay claims. Eventually, the U.S. Department of Labor became involved, and two ICIT principals were sentenced to federal prison for sentences of 30 and 37 months.

Former Montana Insurance Commissioner Monica J. Lindeen (2008–2016) reports that between 2015 and 2017, at least three licensed MEWAs in Montana voluntarily shut down their health plans primarily because of their own concerns about remaining solvent and their strong motivation to protect employees from unpaid claims. According to Commissioner Lindeen, these were MEWAs that had properly obtained licensing, were following applicable laws and were long-standing associations of professionals who were in the same trade. These MEWAs were managed by experienced insurance professionals, and the plans utilized well-established, reputable and adequate networks of hospitals and healthcare providers.

AHPs cannot participate in guaranty funds and the application of receivership laws can be unclear. When a licensed insurer becomes insolvent, usually a state's guaranty fund will pay most of the claims. Different from an insurer, when an AHP becomes insolvent, covered people are stuck with unpaid medical bills. When there is joint and several liability, then the AHP can assess participating employers and they are responsible for any unpaid medical bills. This

exposes participating employers to significant financial risk. Many small employers do not understand this risk and do not have the financial resources to bear this risk. State receivership laws, which allow insurance departments to take over financially failing insurance companies, sometimes exclude AHPs or are unclear. Without a receivership, an AHP ends up in bankruptcy court, where consumers line up with other creditors. Different from receiverships, outstanding medical claims do not receive priority status in bankruptcy court. California Healthcare Foundation, Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs, July 2003, available at https://www.chcf.org/wp-content/uploads/2017/12/PDF-HIMUbriefMEWAs.pdf. When self-insured AHPs become insolvent, their members' medical bills go unpaid, leaving consumers with huge debts for medical care and harming medical providers when those debts are not paid.

Many states that license or certify self-insured AHPs invest significant resources to prevent problems and detect problems early. For example, to avoid problems like unqualified management, states require background checks on senior management prior to receiving authorization to operate a self-insured AHP. Self-insured AHPs often require greater state regulator resources for financial oversight than traditional insurers because solvency standards are lower for AHPs. One state devoted one full-time employee per AHP it licensed. This included monthly

examinations of AHP financial condition, which required state regulators on-site to review AHP books. States also sometimes require prior approval of rates. This helps to ensure that rates are adequate and not artificially low. Inadequate rates can mean an insolvency when claims are higher than what is collected in premiums to pay the claims. Kofman, Commonwealth Fund, 2004; Kofman, Journal of Insurance Regulation, 2005. Solvency regulation and careful monitoring is critically important. This requires significant state resources. When the number of self-insured AHPs increases, the economic burden on states also increases.

V. The Final Rule Will Lead to Increased Fraud, Insolvency and Regulatory Uncertainty Concerning State Jurisdiction

The DOL Final Rule's stated purpose is to encourage the growth of AHPs, and more AHPs means more fraud and abuse. The Regulatory Impact Analysis Operational Risks Section (RIA) for this regulation begins by admitting that, "Historically, a number of MEWAs have suffered from financial mismanagement or abuse, often leaving participants and providers with unpaid benefits and bills." 83 Fed. Reg. 28,912 at 28,951. The preamble continues by describing how both state insurance regulators and DOL have devoted substantial resources to detecting, correcting and prosecuting wrongdoers. DOL then cites *Id.* at 28,951, Footnote 134. a GAO study, GAO-92-40, for a history of the abuses these types of entities have inflicted on individuals and families. DOL also cites in the same footnote two articles articulating the regulatory difficulties and the financial and

medical harm that these entities cause when they fail. The DOL itself acknowledges that the Final Rule will exacerbate these problems. 83 Fed Reg. at 28,953. AHPs "will introduce increased opportunities for mismanagement or abuse, in turn increasing oversight demands on the Department and State regulators"; *Id*. at 28,928.

A. Final Rule Opens Door to Fraud and Abuse

The DOL Final Rule's stated purpose is to encourage the growth of AHPs, and more AHPs means more fraud and insolvencies. The Final Rule includes specific changes that will make it easier for unscrupulous promoters to set up scams. Overturning decades worth of guidance, the Final Rule under 29 C.F.R §§ 2510-3.5(a) and (b) would allow entities to form for the primary purpose of offering health coverage. Furthermore, there is no requirement that an entity be in existence for any period of time. This is equivalent to setting up an insurance company without the type of standards that apply to insurance companies to ensure that promises are kept, bills are paid, and consumers are protected. These entities can spring up with ease and target unsuspecting small businesses and self-employed people. For example, operators of Employers Mutual, LLC, established 16 associations in one day in Nevada. In less than a year, they collected more than $16 million in premiums and had more than $24 million in unpaid clams. Kofman, BNA, Fall 2003. Unlike states that license and certify entities to keep individuals

with suspicious backgrounds out of the insurance business, DOL does not certify or license ERISA plans and has no way to prevent or mitigate AHPs set up by inexperienced or unscrupulous operators.

The Final Rule contradicts Congressional intent expressed when ERISA was amended and articulated as follows:

> It has come to our attention, through the good offices of the National Association of Insurance Commissioners, 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 the profiting from the provision of administrative services are establishing insurance companies and related enterprises. . .

House Committee on Education and Labor, Activity Report of Pension Task Force (94th Congress 2d Session, 1977) quoted in Cong. Rec. (daily ed. May 21, 1982) (statement of Rep. Erlenborn).

DOL proposes some minimal standards for AHPs under 29 C.F.R. § 2510-3.5(b), but none of those can prevent fraud and there are no standards similar to those found in state insurance regulatory frameworks, such as background checks for people who set up and operate AHPs.

Also, the limited standards in the Final Rule will not ensure that AHPs are financially stable. There are no solvency standards under ERISA for AHPs. The standards in the Final Rule do not address the financial soundness of these entities. Moreover, by allowing AHPs to "operate across state lines," the Final Rule creates

confusion regarding states' ability to establish the regulatory jurisdiction. *See* 83 Fed. Reg. at 28,925.

The weak AHP standards in the Final Rule will no doubt lead to the establishment of many new AHPs. The lack of protections to ensure solvency, and DOL's checkered record of oversight of AHPs, will allow individuals with limited or no expertise in health plan operations to operate AHPs. This puts small businesses and self-employed individuals at risk of having millions of dollars in unpaid medical bills when an AHP becomes insolvent. The State departments of insurance have many decades of experience effectively regulating health plan solvency. The DOL in the rule admits its own shortcomings in this area and asserts that it will rely on the states. Solvency regulation and oversight is expensive and time consuming. Additional economic burden on the states is inevitable when AHPs proliferate. Furthermore, jurisdictional uncertainty regarding ERISA-covered AHPs that operate across state lines undermines the ability of states to regulate effectively.

B. Final Rule Creates New Jurisdictional Ambiguity and Will Make It Harder for State Insurance Regulators to Protect People from Phony AHPs

The DOL Final Rule adds new ambiguity to ERISA that will be used by promoters to evade state oversight. For example, the Final Rule would permit an AHP to operate in a metropolitan area that crosses into multiple states. 29 C.F.R. § 2510.3-5(c). In addition, an AHP comprised of employers from the same trade or

profession can sell across state lines—even nationwide. 29 C.F.R. § 2510.3-5(c)(1)(ii). Of course, many licensed health insurers operate in many states, but there are safeguards in place to ensure that insurers comply with licensing and other state insurance laws in each state where they operate. However, State regulators will have difficulty even identifying all of the AHPs that may be operating in their state because AHPs can be formed in one state, but then sell nationwide or across a region of several states, using internet marketing tools. Unless regulators receive a complaint from a consumer or information from a local broker alerting the state regulators, they may not know that a particular AHP is operating in their state. Such AHPs may avoid state regulations until the harm has already been done. Even if a state enacts laws that are more protective than the federal law, proactive enforcement will be difficult. Historically, operators of AHPs claim that states are preempted by ERISA.

A Former Texas Insurance Commissioner, in his testimony before Congress summarized this problem:

> I want to stress from the outset that the current problem is not that the states cannot stop illegal ERISA plans from operating in their jurisdictions. It is that the **shield of a potential exemption from state regulation under ERISA currently creates the opportunity for scams to operate for significant periods of time before they are recognized as illegal and before formal action can be taken against them**. In Texas, we have the authority to shut down these scams, and we do stop them, but we normally cannot do so until after they have already done a great deal of damage to the public. In Texas, we have issued cease and desist orders against these plans, ordered

> millions of dollars in penalties against the operators, and we have taken action against those who have sold the plans. In 2003, for instance, I issued over 100 orders against licensed insurance agents who sold unauthorized insurance, ordering them to pay the unpaid claims – but the salesmen often do not have the money to pay all of the claims.

Jose Montemayor, Commissioner of the Texas Department of Insurance, Testimony, United State Senate, Committee on Finance, , March 3, 2004, available at https://www.finance.senate.gov/imo/media/doc/030304jmtest.pdf.

Actions taken after consumer harm has occurred are always more expensive, often involving criminal and civil action in an effort to recoup funds to cover claims costs, and litigation costs associated with ERISA preemption claims.

Also, jurisdictional uncertainty is a significant problem for the states, as discussed in an NAIC report, State Extraterritorial and Jurisdictional White Paper. National Association of Insurance Commissioners, State Jurisdictional and Extraterritorial Issues White Paper: States' Treatment of Regulatory Jurisdiction Over Single-Employer Group Health insurance, (2009), at 9, available at http://www.naic.org/documents/committees_b_jurisdictional_issues_states_treatment_reg_jurisdiction.doc. The Final Rule authorizes certain AHPs to organize in one state and then sell nationwide. This creates jurisdictional ambiguity because the laws concerning the applicability of a state's insurance laws over a health plan issued in another state are not uniform. The Final Rule creates new jurisdictional ambiguity for the states and has no real standards and no regulatory framework under which the DOL can license or certify entities to keep bad actors out.

Legitimate AHPs could be crowded out by a proliferation of scams that lure in small employers and individual sole proprietors with rates and terms that are too good to be true.

VI. Oversight and Enforcement

Strong oversight of AHPs by both DOL and State Insurance Departments is essential because of a long and well-documented history of AHP fraud and insolvencies. Since ERISA was enacted, Congress has expanded DOL's oversight authority and has given DOL new enforcement tools. In 1982 Congress amended ERISA to clarify that both DOL and states have authority to regulate AHPs. In 1996 Congress granted DOL authority to require AHPs to register (MEWA registration, also called Form M-1 requirement). In 2010, Congress granted DOL new oversight authority including cease-and-desist authority to shut down insolvent or fraudulent AHPs administratively without first having to go to court. Congress also added new Section 520 authority giving additional tools to DOL for fraud and abuse. While all of these federal enforcement tools are important, none compare to the enforcement authority that states have--and use. Further, while DOL has some enforcement tools, it lacks adequate staffing or funding to conduct meaningful oversight. And even if DOL gained resources, DOL could never replace or replicate state regulation and oversight: Federal oversight is reactive, while state oversight is proactive.

A. Comparing State Oversight Tools and Record with DOL's Oversight Tools and Record

States have a strong record of effective oversight – in cases of both scams and insolvencies. Registration or licensing requirements, including background checks to keep convicted felons from operating self-insured AHPs, help mitigate risk of mismanagement. Depending on the financial strength of AHP in their states, state regulators use varied approaches.

In contrast with states' strong oversight record, there is no evidence that DOL is performing oversight. Although AHPs must register with DOL, there is no evidence that DOL conducts regular reviews or takes actions based on filings. For example, the Indiana Construction Industry Trust reported doubling in size in one year--explosive growth that usually points to a solvency issue. DOL did nothing. Just one year later, the association became insolvent leaving 22,000 members with $20 million in medical claims. Kofman, Journal of Insurance Regulation, Fall 2004. In 2016 an entity reported in its M-1 filing with DOL that the entity had been under investigation for five years, since 2011. It is concerning that the organization was investigated for five years with no apparent corrective action by DOL. This entity reports covering approximately 10,000 participants (total covered lives unknown) nationwide (M-1 filings DOL database). DOL has itself admitted that there is a high M-1 noncompliance rate and estimated that in 2003 fewer than half of existing MEWAs registered with DOL. "Reporting by Multiple

Employer Welfare Arrangements," Fed. Reg. 68, No. 68 (April 9, 2003): 17495, 17498.

States have oversight and enforcement resources that DOL simply does not have. DOL generally investigates plans only after they establish a pattern of failing to pay claims. Thus, by the time DOL acts, consumers have already been harmed. States have numerous tools that allow them to conduct regular oversight and intervene before consumers are harmed. These tools include background checks for operators and management of AHPs, financial and market conduct examinations, form reviews, rate reviews, etc. Thanks to the broker community, states also have "eyes and ears" on the ground to quickly identify bad actors who promote fake insurance. States also have and use enforcement tools, including cease-and-desist authority and state receivership laws. States have vigorously pursued bad actors in the AHP market and have been able to act earlier and quicker than DOL, better protecting consumers from harm. *See* Kofman, BNA, Fall 2003.

Historically, DOL has been slow to take action against insolvent or fraudulent AHPs, in part because it did not have cease-and-desist authority, and it relied on states to shut down bad actors. GAO 2004. According to the GAO, during the 2000 scam cycle, states issued cease and desist orders against 41 entities, while DOL shut down three entities. *Id.*

Evidence shows that DOL is unable to perform appropriate oversight. In 1996, Congress empowered DOL to require AHPs to register with it and file information annually. A 2004 study found that 100 of 700 filings had missing information, conflicting information, and inaccurate information such as fake NAIC numbers. Some falsely claimed that they did not have to file. There was no evidence that DOL ever reviewed the filings. *See* Kofman, Journal of Insurance Regulation (2004). There is a fine of $1,558 per day if AHPs do not file or filed information is not complete. *See* U.S. Department of Labor, Employee Benefits Security Administration, Form M-1 Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claims Exception (ECEs): Form M-1 Instructions, Self-Compliance Tool, available at https://www.dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/forms/m1-2018.pdf. There is no evidence that DOL has ever used this authority to fine delinquent AHPs.

DOL's Final Rule encourages AHPs to proliferate and does not provide any indication that it would be able or willing to protect consumers from fraud and insolvencies. And, the standards DOL established are not meaningful as the District Court points out. For example, DOL asserts that requirements in 29 CFR § 2510.3-5(b) for a formal AHP organizational structure and control by employer members, are intended to ensure that AHP sponsors are bona fide employment-

based associations not prone to abuse. These looser standards (compared to the ones that existed for decades) will not protect consumers. Given the history of fraud and abuse under more stringent standards (pre DOL rule), it is certain that looser standards will lead to more fraud and abuse. Furthermore, DOL admits that its own past "enforcement efforts often were too late to prevent or fully recover major financial losses." *Id.* at 28,952, DOL acknowledges that additional funding would be necessary to increase DOL's own enforcement resources, but in its Appellate brief, alleges that the state's additional regulatory burden to combat this fraud is "hypothetical" and "self-inflicted." Br. at 24 That statement is in direct conflict with DOL's own admissions throughout the preamble to the Final Rule.

B. Resource Issues

Contrary to DOJ's assertion that the states have not "…supplied any reason to believe that the Department will be incapable of combating fraud . . .", it is well documented that DOL has neither the resources nor the expertise to combat fraud and abuse by AHPs if states did not act and DOL served as the sole regulator. Br. at 28. The Employee Benefits Security Administration (EBSA), DOL's office charged with oversight of AHP plans, has recently experienced attrition, making it even more challenging to meet the increased oversight and enforcement need created by the Final Rule. EBSA has an estimated 750 people responsible for health and pension plans. Only a small fraction are investigators. By comparison,

state insurance departments have an estimated 11,209 employees and for FY 2018, a total of $1,417,145,120 budget. National Association of Insurance Commissioners, "2016 Insurance Department Resources Report," Vol, One, June 2017, Table 7, 29. Congress approved a $181,000,000 budget for FY2019 (same as FY2018) for DOL, with no mention of AHP enforcement. H.R. 6157 Department of Defense for the Fiscal Year Ending September 30, 2019 and for Other Purposes (September 13, 2018), available at https://www.congress.gov/congressional-report/115th-congress/house-report/952/1. This amount was even less than DOL requested.

In 2007, the GAO found that DOL had a ratio of one employee conducting oversight or enforcement activities for every 8000 plans. Enforcement Improvements Made but Additional Actions Could Further Enhance Pension Plan Oversight, GAO, January 2007[2]. A decade earlier when Congress considered legislating standards for AHPs, DOL testified that it can review plans under its jurisdiction once every 300 years. Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997. In 2005 when Congress considered a similar AHP law change, the Congressional Budget Office (CBO) estimated that

[2] This report noted that because of limited data their estimate of the number of plans actually underestimated the number of plans under EBSA jurisdiction.

the legislation would have required DOL to hire 150 additional employees and spend an additional $136 million over 10 years to properly oversee an expansion of AHPs. "H.R. 525: Small Business Health Fairness Act of 2005," Congressional Budget Office, April 8, 2005, at 6. Importantly, since DOL's Final Rule goes further to expand the proliferation of AHPs than the 2005 AHP bill, DOL would need even more staff to regulate effectively.

VII. Conclusion

The Court should affirm the district court's judgment.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing Brief for Amici Curiae in Support of Appellees and Affirmance complies with the type-volume limitations of F.R.A.P. 32(a)(7)(B) and 29(d). The brief is composed in a 14-point proportional typeface, Times New Roman. As calculated by my word processing software (Microsoft Word 2016), the brief (excluding those parts permitted to be excluded under the Federal Rules of Appellate Procedure and this Court's rules) contains 6216 words.

CERTIFICATE OF SERVICE

I hereby certify that, on July 22, 2019, this Brief for Amici Curiae in Support of Appellees and Affirmance was served through the Court's ECF system on counsel for all parties.

/s/ David Branch
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