No. 20-11179

IN THE
United States Court of Appeals for the Fifth Circuit

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

Plaintiffs-Appellees,

v.

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

Defendants-Appellants.

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

Case No. 4:19-cv-00800-O

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF IN SUPPORT OF DEFENDANTS-APPELLANTS BY NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

JENNIFER M. MCADAM
NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS
1100 Walnut Street, Suite 1500
Kansas City, MO 64106
Telephone (816) 783-8878
Facsimile (816) 783-8175

MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main Street, Suite 1000
Kansas City, MO 64112
Telephone (816) 983-8000
Facsimile (816) 983-8080
michael.raupp@huschblackwell.com

Attorneys for Amicus Curiae

April 7, 2021

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that—in addition to the persons and entities listed in the Appellants' Certificate of Interested Persons—the following persons and entities described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Plaintiffs-Appellees
Data Marketing Partnership, L.P.
L.P. Management Services, L.L.C.

Defendants-Appellants
U.S. Department of Labor
Martin Walsh, Secretary, U.S. Department of Labor
United States of America

Attorneys for Plaintiffs-Appellees
Jonathan D. Crumly, Sr.
Bryan Francis Jacoutot
Reginald L. Snyder

Attorneys for Defendants-Appellants
Mark B. Stern
Michael Shih

Amicus Curiae
National Association of Insurance Commissioners

Attorneys for Amicus Curiae
Michael T. Raupp, Husch Blackwell, LLP
Jennifer M. McAdam

April 7, 2021

Respectfully submitted,

/S/ MICHAEL T. RAUPP

MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main Street, Suite 1000
Kansas City, MO 64112
Telephone (816) 983-8000
Facsimile (816) 983-8080
michael.raupp@huschblackwell.com

JENNIFER M. MCADAM
NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS
1100 Walnut Street, Suite 1500
Kansas City, MO 64106
Telephone (816) 783-8878
Facsimile (816) 783-8175

Counsel for Amicus Curiae
National Association of
Insurance Commissioners

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

Pursuant to Fed. R. App. P. 29(a)(3), the National Association of Insurance Commissioners (NAIC) respectfully moves for leave to file an *amicus curiae* brief in support of Appellants in this matter. In further support of this motion, the NAIC states as follows:

1. Pursuant to Fed. R. App. P. 29(a)(2), the undersigned contacted counsel for all parties to request consent to file this *amicus* brief.

2. Counsel for Appellants responded, consenting to the filing of all timely-filed *amicus* briefs.

3. Counsel for Appellees responded, indicating that Appellees did not consent to the filing of this brief absent the opportunity to review the substance of the brief in advance.

4. The NAIC has substantial interest in the outcome of this case. *See* Fed. R. App. P. 29(a)(3)(A). The NAIC is the United States' standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five United States territories. The NAIC's members, together with the centralized resources of the NAIC, form the

national system of state-based insurance regulation in the United States.

5. The insurance commissioners of the various states are charged with the responsibility of regulating the business of insurance within their respective jurisdictions pursuant to the McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011-1015 (2012) ("McCarran-Ferguson Act"). The authority to regulate insurance issued in connection with employee welfare benefit plans is reserved to the states through the saving clause of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988) ("ERISA"); 29 U.S.C. § 1144(b)(2)(A) (saving clause).

6. The interplay of ERISA with the states' power to regulate the business of insurance is of great interest to the NAIC and its members. Because Congress has seen fit to defer to the expertise of the state insurance departments, the NAIC will zealously protect its members' right to regulate the business of insurance, including the types of schemes like the one at issue in this case.

7. The district court's opinion here acts as a powerful marketing tool for similar insurance schemes seeking to assert they

have no obligation to comply with laws requiring maintenance of funds necessary to pay claims, assessment of fair premiums, payment of adequate benefits, and honest marketing to consumers. The ability to cite this decision as a defense to state enforcement actions will impede the ability of NAIC members to prosecute such cases effectively, even though the dicta purporting to preempt state regulation went beyond the district court's jurisdiction.

8. Further, the NAIC's perspective in this case is desirable for the Court and is relevant to the disposition of this case. Fed. R. App. P. 29(a)(3)(B). The Department of Labor (DOL) and state regulators have worked together over the years to terminate operations similar to the one at issue in this case, which seek to evade state insurance laws.

9. This case falls within a greater context of various schemes perpetrated by similarly "entrepreneurial" insurance marketers ever since ERISA was enacted, and that context is important to the outcome of this case. The NAIC is able to provide the Court with that history and context through its *amicus* brief.

10. Further, The NAIC seeks to aid this Court by offering the legal and regulatory position and public policy perspectives of the NAIC

and its member states. Again, as those state insurance regulators are the entities charged with regulating schemes like the one at issue here, their collective voice is critical to this appeal.

11. Pursuant to Fed. R. App. P. 29(a)(3), the NAIC's proposed *amicus* brief is attached hereto.

WHEREFORE, the NAIC respectfully requests that this Court grant it leave to file an *amicus curiae* brief in support of Appellants, and for all other relief this Court deems just and proper.

April 7, 2021

Respectfully submitted,

/S/ MICHAEL T. RAUPP
MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main Street, Suite 1000
Kansas City, MO 64112
Telephone (816) 983-8000
Facsimile (816) 983-8080
michael.raupp@huschblackwell.com

JENNIFER M. MCADAM
NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS
1100 Walnut Street, Suite 1500
Kansas City, MO 64106
Telephone (816) 783-8878
Facsimile (816) 783-8175

Counsel for Amicus Curiae
National Association of
Insurance Commissioners

CERTIFICATE OF COMPLIANCE

This motion complies with the type-volume limitation of Fed. R. App. P. 5(c)(1) because it contains 636 words, excluding the parts of the motion exempted by Fed. R. App. P. 32(f). This motion 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 it has been prepared in a proportionally spaced typeface using Microsoft Word in Century Schoolbook font size 14.

/S/ MICHAEL T. RAUPP
MICHAEL T. RAUPP
Counsel for Amicus Curiae
National Association of
Insurance Commissioners

CERTIFICATE OF SERVICE

The undersigned, an attorney, hereby certifies that on April 7, 2021, *Amicus Curiae* National Association of Insurance Commissioners, caused the foregoing MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF to be filed with the Clerk of Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service will be accomplished on all counsel of record by the appellate CM/ECF system.

/S/ MICHAEL T. RAUPP
MICHAEL T. RAUPP
Counsel for Amicus Curiae
National Association of
Insurance Commissioners

No. 20-11179

IN THE
United States Court of Appeals for the Fifth Circuit

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

Plaintiffs-Appellees,

v.

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

Defendants-Appellants.

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

Case No. 4:19-cv-00800-O

BRIEF FOR *AMICUS CURIAE* NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF DEFENDANTS-APPELLANTS

JENNIFER M. MCADAM
NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS
1100 Walnut Street, Suite 1500
Kansas City, MO 64106
Telephone (816) 783-8878
Facsimile (816) 783-8175

MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main Street, Suite 1000
Kansas City, MO 64112
Telephone (816) 983-8000
Facsimile (816) 983-8080
michael.raupp@huschblackwell.com

Attorneys for Amicus Curiae

April 7, 2021

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that—in addition to the persons and entities listed in the appellants' Certificate of Interested Persons—the following persons and entities described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Plaintiffs-Appellees
Data Marketing Partnership, L.P.
L.P. Management Services, L.L.C.

Defendants-Appellants
U.S. Department of Labor
Martin Walsh, Secretary, U.S. Department of Labor
United States of America

Attorneys for Plaintiffs-Appellees
Jonathan D. Crumly, Sr.
Bryan Francis Jacoutot
Reginald L. Snyder

Attorneys for Defendants-Appellants
Mark B. Stern
Michael Shih

Amicus Curiae
National Association of Insurance Commissioners

Attorneys for Amicus Curiae
Michael T. Raupp, Husch Blackwell, LLP
Jennifer M. McAdam

April 7, 2021

Respectfully submitted,

/S/ MICHAEL T. RAUPP

MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main Street, Suite 1000
Kansas City, MO 64112
Telephone (816) 983-8000
Facsimile (816) 983-8080
michael.raupp@huschblackwell.com

JENNIFER M. MCADAM
NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS
1100 Walnut Street, Suite 1500
Kansas City, MO 64106
Telephone (816) 783-8878
Facsimile (816) 783-8175

Counsel for Amicus Curiae
National Association of
Insurance Commissioners

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutory Authorities

Rules and Regulations

Additional Authorities

STATEMENT OF INTEREST[1]

Founded in 1871, the National Association of Insurance Commissioners (NAIC) is the United States' standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five United States territories. *See generally* https://www.naic.org/. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, coordinate regulatory oversight, and represent the collective views of all state regulators domestically and internationally. The NAIC's members, together with the centralized resources of the NAIC, form the national system of state-based insurance regulation in the United States.

Throughout its history, the NAIC's purpose has been to provide its members with a national forum which enables them to work cooperatively on regulatory matters that transcend the boundaries of

[1] Pursuant to Fed. R. App. P. 29(a)(2)-(3), this brief is being attached to a motion for leave to file it. Further, pursuant to Fed. R. App. P. 29(a)(4)(E): this amicus brief was not authored in whole or in part by either party's counsel; neither a party nor a party's counsel contributed money that was intended to fund preparing or submitting the brief; and no person—other than the *amicus curiae*, its members, or its counsel—contributed money that was intended to fund preparing or submitting the brief.

their own jurisdictions. This allows for consistency in regulating companies doing business in multiple states and provides a central point of communication and facilitation for joint initiatives with federal and international regulators. The NAIC also regularly assists federal regulators, federal agencies, members of Congress, and the Government Accountability Office by providing information and data related to state insurance regulation. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, handbooks, white papers, and actuarial guidelines that promote and establish uniform regulatory policy. The overriding objectives of the NAIC and its members are to protect consumers, promote competitive markets, and maintain the financial solvency of insurance companies and the financial stability of the insurance industry as a whole.

The insurance commissioners of the various states are charged with the responsibility of regulating the business of insurance within their respective jurisdictions pursuant to the McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011-1015 (2012) ("McCarran-Ferguson Act"). The authority to regulate insurance issued in connection with employee welfare benefit plans is reserved to the states through the saving clause

of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988) ("ERISA"); 29 U.S.C. § 1144(b)(2)(A) (saving clause).

The NAIC seeks to aid this Court by offering the legal and regulatory position and public policy perspectives of the NAIC and its member states. The interplay of ERISA with the states' power to regulate the business of insurance is of great interest to NAIC members. Because Congress has seen fit to defer to the expertise of the state insurance departments, the NAIC will zealously protect its members' right to regulate the business of insurance.

While the district court's opinion that state law is preempted is not legally binding on the states, none of which were parties to the case, it acts as a powerful marketing tool for similar insurance schemes seeking to assert they have no obligation to comply with laws requiring maintenance of funds necessary to pay claims, assessment of fair premiums, payment of adequate benefits, and honest marketing to consumers. The ability to cite this decision as a defense to state enforcement actions will impede the ability of NAIC members to prosecute such cases effectively, even though the dicta purporting to

preempt state regulation went beyond the district court's jurisdiction. *See Data Mktg. Partn., LP v. U.S. Dept. of Lab.*, No. 4:19-CV-00800-O, 2020 WL 5759966 (N.D. Tex. Sept. 28, 2020).

The NAIC respectfully submits this *amicus curiae* brief in support of Appellants.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

This case involves a scheme to exploit the provisions of ERISA that exempts *bona fide* self-insured employee benefit plans from insurance regulation by the states. There is a long history of attempts by unscrupulous actors to avoid insurance regulation by fraudulently claiming ERISA preemption of state laws. *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation*, *Typical Illegal Operations Claiming ERISA Status,* NAIC, p. 56 (2019), https://www.naic.org/documents/prod_serv_legal_ers_om.pdf.

The Department of Labor (DOL) and state regulators have worked together over the years to terminate similar operations seeking to evade state insurance laws. The latest attempt, by Data Marketing Partnership (DMP) and other affiliated enterprises, involves the sale of

health coverage to the general public by inviting customers to become "limited partners" who are eligible to pay for membership in the partnership's "benefit plan." Although DMP characterizes its customers as "working owners," their limited partnership gives them no meaningful ownership stake in the business and the only "work" they perform is to install a tracking app on their phones, which allows the partnership to sell their personal data usage to third parties (although, as of the filings in the underlying case, no data has actually been sold).

DMP's scheme falls within a greater context of various schemes perpetrated by similarly "entrepreneurial" insurance marketers ever since ERISA was enacted, and that context is important to the outcome of this case.

This Court must determine whether the plan sold by DMP is an insurance product or an "employee benefit plan". If the plan is an insurance product, it is subject to state regulation. If the plan is an "employee benefit plan" it is subject to federal ERISA law.[2]

---

[2] There is a third category, as discussed below: If a plan is both an "employee benefit plan" and a "multiple employer welfare arrangement" (MEWA), it is subject to concurrent state and federal regulation. *See infra* Section II.A. But the DMP plan is not a MEWA, because it is marketed to individuals and, except with regard to the one common-law

State insurance regulators play a vital and indispensable role in the regulation of health insurance generally, and ERISA plans in particular. Appropriately viewed in the history of federal and state regulators addressing similar schemes, DMP's plan is not governed by ERISA as an employee welfare benefit plan, but is instead subject to state insurance laws, as a commercial insurance enterprise.

ARGUMENT

I. DMP's Plan Is Subject to State Insurance Laws.

A. Congress has long recognized state regulation of insurance.

States have been regulating the business of insurance since 1851, when New Hampshire became the first state to establish a department of insurance. *See About Us*, New Hampshire Insurance Department (Mar. 24, 2021), www.nh.gov/insurance/aboutus. In enacting the McCarran-Ferguson Act in 1945, Congress affirmed the primacy of the states in the regulation of the business of insurance, declaring that "the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation

---

employee employed by DMP's general partner, LMPS, there is no employer involved in the DMP plan, let alone multiple employers.

or taxation of such business by the several States." 15 U.S.C. § 1011. McCarran-Ferguson specifies when a federal law would supersede state law, stating "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . *unless* such Act specifically relates to the business of insurance[.]" 15 U.S.C. § 1012(b) (emphasis added).

In light of the states' role in regulating insurance, state insurance commissioners' powers are extensive and include the power to grant, revoke, renew, or suspend licenses, to regulate insurance rates, and to prescribe the form, terms, and conditions of an insurance policy. Holmes' Appleman on Ins. 2d, ch. 170 (2005). The insurance commissioner also has broad investigation and enforcement powers in regulating the insurance industry. *Id.* This extensive authority serves the fundamental purpose of insurance regulation: protecting consumers by monitoring the solvency and market conduct of insurers.

"State regulation of health and other insurance starts with the licensing of entities that sell insurance within the state." *How Private Health Coverage Works: A Primer*, *2008 Update*, Kaiser Family Found.,

https://www.kff.org/wp-content/uploads/2013/01/7766.pdf. Selling insurance without a license is a criminal offense. *See, e.g.*, 18 Pa.C.S.A. 4117(a)(4) (1990); Wash. Rev. Code Ann. § 48.17.063 (2007); Ala. Code § 27-12A-5 (2012); Alaska Stat. Ann. § 21.36.360(j) (2016); Ark. Code Ann. § 23-65-101 (2019).

Once a company is licensed, it is subject to multiple requirements ensuring it is operating properly. For example, each insurance company must file a Corporate Governance Annual Disclosure, providing regulators with a summary of its corporate governance structure, policies, and practices. *Corporate Governance Annual Disclosure Model Act* (#305),[3] and *Corporate Governance Annual Disclosure Model Regulation* (#306).[4] States also prescribe requirements for insurance

[3] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-305.pdf.

[4] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-306.pdf. The model laws cited here have been adopted in substantially similar fashion in each state. *See e.g.*, *NAIC Model Laws, Regulations, Guidelines, and Other Resources*, https://content.naic.org/prod_serv_model_laws.htm (state pages are located directly after each individual model law).

companies' financial reserves.[5] States monitor the financial condition of insurance companies by requiring them to file annual reports. *Annual Financial Reporting Model Regulation* (#205).[6] Every five years, or more often, state regulators conduct a thorough exam of insurance companies. *Model Law on Examinations* (#390).[7] These laws ensure that companies can pay claims without becoming insolvent.

When a state regulator identifies problems with a company, there are tools it can use to protect policyholders, creditors, and the general public. *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition* (#385).[8] As a backstop for solvency requirements, each state

---

[5] *See e.g., Standard Valuation Law* (#820), https://content.naic.org/sites/default/files/inline-files/MDL-820.pdf; *Risk-Based Capital (RBC) Model Act* (#312), https://content.naic.org/sites/default/files/inline-files/MDL-312.pdf; and *NAIC Health Insurance Reserves Model Regulation* (#10), https://content.naic.org/sites/default/files/inline-files/MDL-010.pdf.

[6] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-205.pdf.

[7] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-390.pdf.

[8] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-385.pdf.

has a guaranty fund mechanism to protect policyholders in the event a company does become insolvent or otherwise impaired such that it is unable to pay its claims. *See e.g., Life and Health Insurance Guaranty Association Model Act* (#520).[9] In addition to these laws, insurance regulators have authority to enforce a number of other statutes and regulations that promote competitive markets and protect consumers, including requirements related to policy forms, rates, and market conduct. *See NAIC Model Laws, Regulations, Guidelines and Other Resources*, https://content.naic.org/prod_serv_model_laws.htm.

B. Federal and State regulators share jurisdiction under ERISA.

When Congress passed ERISA in 1974, its focus was on pension benefits rather than welfare benefits, like health coverage. *See* 29 U.S.C. § 1001(a). ERISA was enacted at a time when the "growth in size, scope, and numbers of employee benefit plans . . . ha[d] been substantial" and a finding had been made "that the continued well-being and security of millions of employees and their dependents [were] directly affected by these plans." *Id.* For these reasons, Congress

[9] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-520_0.pdf.

adopted the law in order that "disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans[.]" *Id.* Unfortunately, "ERISA contains many substantive standards, including solvency standards, that apply to pension plans with no counterpart for employee welfare benefit plans." *ERISA: Barrier to Health Care Consumer's Rights*, NAIC, p. 2 (2000), https://www.naic.org/prod_serv/ERI-HC99.pdf.

Despite the minimal protection ERISA offers in the welfare benefit plan context, its preemption of state law is broad as it "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144. But, consistent with the McCarran-Ferguson Act, state law is preserved through the saving clause, which provides in relevant part that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." *Id.*[10]

[10] The saving clause is limited by ERISA's "deemer clause," which provides that an employee benefit plan shall not be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to

Furthermore, ERISA explicitly states: "nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." 29 U.S.C. § 1144(d). Known as an "equal dignity" clause, this provision protects the McCarran-Ferguson Act from being superseded or modified by ERISA. In other words, ERISA does not prohibit the states from applying state insurance laws to entities engaged in the business of insurance.

When there is an ERISA plan at issue, federal law regulates self-insured employee benefit plans, while state law regulates the insurance company and the contract providing coverage to an insured employee benefit plan.[11] Because of this dual regulatory framework, the Department of Labor and the state insurance departments collaborate to address a number of matters affecting both types of employee welfare benefit plans. When there is no ERISA plan at issue, as in this case, the

---

regulate insurance companies, [or] insurance contracts . . . ." 29 U.S.C. § 1144 (b)(2)(B).

[11] While ERISA governs both an insured and a self-funded plan, the term "ERISA plan" is often used colloquially to refer to a self-funded plan. In this brief, the term "ERISA plan" is used in the correct sense to include a reference to both a "self-funded" plan and an "insured" plan.

state has authority to regulate it as it would any other insurance enterprise.

C. The health coverage offered by DMP is not governed by ERISA.

ERISA's primary objective is safeguarding the well-being and security of workers and apprising them of their rights and obligations under an employee benefit plan. *Meredith v. Time Ins. Co.*, 980 F.2d 352, 358 (5th Cir. 1993) (citing *Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982)). Of critical importance in determining whether a plan meets this objective is whether an employer-employee relationship exists. This Court looks to "the two primary elements of an ERISA 'employee welfare benefit plan' as defined by the statute: (1) whether an employer established or maintained the plan; and (2) whether the employer intended to provide benefits to its employees." *Meredith*, 980 F.2d at 355 (citations omitted).

1. DMP's "Limited Partners" are not "Working Owners."

In this case, the district court first found that the plan beneficiaries were "working owners" and then that they were also "bona fide partners." This holding, however, contained minimal analysis. *Data Mktg. Partn.*, 2020 WL 5759966, at *14 ("The Court already concluded

that the Limited Partners are working owners who are actively engaged in the business. Given that the bona-fide partner standard is a lower threshold, the Limited Partners are bona-fide partners of DMP."). In reality, the so-called "partners" are neither workers nor owners.

The district court relied heavily on *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004) (hereinafter "*Yates*"). In that case, however, there was no question Dr. Yates was a "working owner" of the corporation, in fact, he was acting as ***the*** "working owner"; he is the one who established the plan. *Yates*, 541 U.S. at 3 ("Under ERISA, a working owner may wear two hats, i.e., he can be an employee entitled to participate in a plan and, at the same time, the employer who established the plan"). Here, there is no indication the DMP "limited partners" had any input in establishing the plan.[12] In fact, the definition of a "limited partner" is one that does not take an active role in managing the business. *Black's Law Dictionary* 514 (2nd ed. 1995).

[12] DMP's complaint asserts that "DMP established a self-insured health plan for its common law employees and partners[.]" First Amended Complaint for Declaratory and Injunctive Relief, *Data Mktg. Partn., LP v. U.S. Dept. of Lab.,* No. 4:19-CV-00800-O at 2 (N.D. Tex. Feb. 3, 2019). DMP does not have any common law employees, although its general partner, LP Management Services, LLC (LPMS) employs one common law employee.

Management of the business is left to the general partner(s). *Id.*

ERISA does not contain a definition for the term "working owner" that applies throughout. When this is the case, courts "look to other provisions of the Act for instruction." *Yates*, 541 U.S. at 12. While the term is not defined in the Act, it is defined identically in two different regulations—one applying to multiple employer defined contribution pension plans and one applying to association health plans. 29 C.F.R. § 2510.3–55(d)(2) (2021); 29 C.F.R. § 2510.3–5(e)(2) (2021).

At the very least, these regulations provide persuasive guidance and demonstrate that DMP cannot meet even this very low standard. These provisions define the term "working owner" to mean a person:

> (i) Who has an ownership right of any nature in a trade or business, whether incorporated or unincorporated, including a partner or other self-employed individual;
>
> (ii) Who is earning wages or self-employment income from the trade or business for providing personal services to the trade or business; and
>
> (iii) Who either:
>
> > (A) Works on average at least 20 hours per week or at least 80 hours per month providing personal services to the working owner's trade or business, or
> >
> > (B) . . . has wages or self-employment income from such trade or business that at least equals the working

> owner's cost of coverage for participation by the working owner and any covered beneficiaries in any group health plan sponsored by the group or association in which the individual is participating[.]

29 C.F.R. § 2510.3–55(d)(2) (2021); 29 C.F.R. § 2510.3–5(e)(2) (2021) (emphasis added).

According to these provisions, a "working owner" must make a showing of at least twenty hours per week providing services to the business and wages or income at least equal to the cost of the health plan. Here, DMP asserts that each "limited partner contributes five hundred (500) hours of work per year through the generation, transmission, and sharing of their marketable electronic data." Even if the passive transmission of data derived by using one's smart phone could be described as "work," DMP admits its "limited partners" are providing less than 42 hours of "work", far less than the 80 hours per month required by the regulations. Regarding income, in its district court filings, DMP acknowledged that "neither DMP nor the other entities managed by [the parent company] have enrolled sufficient numbers of partners to reach the quantity of electronic data necessary to generate profitable offers to purchase the data." Decl. of Randall W. Johnson, *Data Mktg. Partn., LP v. U.S. Dept. of Lab.,* No. 4:19-CV-

00800-O (N.D. Tex. Feb. 3, 2020).

In other words, DMP concedes it does not operate with any revenue (other than the sale of health coverage to "limited partners" and their families) and the "partners" do not receive compensation. Although the trial court gave credence to DMP's claim that the "limited partners" are equity owners, they have made no investment in the enterprise. *See infra* § I.C.2.

"[L]imited partners" are those who "contribute capital and share profits but who cannot manage the business and are liable only for the amount of their contribution." *Black's Law Dictionary* 515 (2d ed. 1995). Here, the limited partners' only contribution is the passive usage of their smart phone—something they would be doing even if they had not signed an agreement.

2. DMP's "Limited Partners" are not "Bona Fide Partners."

In this case, the district court acknowledged DOL regulations expressly addressing the ability of partners to participate in a group health plan sponsored by a partnership, and that: "Under ERISA regulations, a partner must be a 'bona-fide partner' to establish an employment relationship between the partner(s) and the

partnership. . . . Whether an individual is a bona-fide partner is determined based on 'all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.'" *Data Mktg. Partn.*, 2020 WL 5759966, at *14 (quoting 29 C.F.R. § 2590.732(d)(2)-(3)). The court further provided that this analysis "requires a more-than-pretextual relationship between the employer and employee." *Id.* However, the court concluded that this test was satisfied because: "The Court already concluded that the Limited Partners are working owners who are actively engaged in the business." *Id.*

That conclusion is unsupported by the facts. The court's determination that the "partners" are "working," merely by installing a tracking app on their personal phones, rests on the novel doctrine that in the "gig economy," anything counts as "work." *Id.* at *23. And the facts thoroughly refute the court's conclusion that the "Limited Partners are not passive owners in the way that a passive owner in a publicly traded corporation will receive distributions without having any say in business operations." *Id.* at *27. While the comparison is helpful, it points in precisely the opposite direction: the "partners" have

not actually received any distributions, and as the passive holders of limited partnership certificates, they do not even have the voting rights of common shareholders, because control of a limited partnership is vested in the general partner. *Black's Law Dictionary* 515 (2d ed. 1995).

Here, a review of the facts reveals that DMP has created a false, pretextual relationship for the sole purpose of selling commercial insurance to the public. In its First Amended Complaint, DMP states: "If a limited partner desires to enroll in the Plan, the partner agrees to contribute at least 500 hours of work per year through the generation, transmitting, and sharing of their electronic data." First Amended Complaint, ¶ 35. "This is a clear condition of eligibility for the Plan." *Id.* The wording of this statement suggests that "partners" may not even be "working" prior to becoming eligible to enroll in health care coverage. More likely, there is no relationship at all until enrollment in the plan.

DMP further states that "[t]he generation and aggregation of these bytes of electronic data transmitted by each partner represents the most significant commodity which DMP seeks to sell to third parties." *Id.* And "[w]ithout the generation, tracking and transmission of significant quantities of data by limited partners, DMP would have

no ability to attract buyers and become profitable." *Id.* DMP's own statements make clear that its business model is entirely dependent upon enrollment in its health plan. If a business would not exist but for the health plan, the business is selling insurance.

These facts substantiate the DOL's advisory opinion, which reached the conclusion that the "partners" were "merely consumers purchasing health coverage in exchange for premiums and an agreement that the partnership can track their personal activities on their personal devices." 2020-01A ERISA SEC. 3(1), *Data Mktg. Partn., LP*, Docket No. 4:19-CV-00800-O (Dep't of Labor Jan. 24, 2020). ("You have provided no facts that would support a conclusion that the limited partners are meaningfully employed by the partnership or perform any services on its behalf."). For the same reasons, this Court should see the scheme for the pretext that it is. DMP's scheme is not a legitimate limited partnership, and this Court should reject its contrary claim.

D. There are strong policy reasons ERISA pertains only to the employer-employee relationship.

The DMP plan does not meet the definition of an ERISA plan. Arrangements not meeting this definition and whose activities fall under the state's definition of the business of insurance must acquire a

state certificate of authority as a licensed insurer, or otherwise cease operations. Such arrangements that do not comply with state law are subject to the unauthorized insurer statutes of the various states. *See, e.g.*, *Bell v. Employee Security Benefit Association*, 437 F.Supp. 382 (D. Kan. 1977).

The DMP plan is not an ERISA plan but a voluntary health insurance purchasing pool subject to state regulation. There are "two key differences between a large employer and a pool composed of small employers or individuals: the stability of the group, and its expected risk profile." *Insurance Markets, What Health Insurance Pools Can and Can't Do*, California HealthCare Found., p. 1 (November 2005), https://www.cga.ct.gov/ph/tfs/20070101_HealthFirst%20Connecticut%20Authority/20080501/What%20Health%20Insurance%20Pools%20Can%20And%20Can%27t%20Do.pdf. First, a voluntary health insurance pool does not have group stability, or cohesion, like a large employer plan does. Cohesion is what keeps the group together, providing members with strong incentives to remain part of the group. *Id.* at 2. In an employer-sponsored health plan, group stability and cohesion exist because the members are part a "natural group" that have joined for

reasons other than purchasing health insurance. *Id.* at 3. Single-employer natural groups are more attractive to insure "because employees are by definition healthy enough to work and because the employer's contribution is generally large enough to motivate almost all employees to participate in the plan, even if they are in perfect health." *Id.* This is important because it means "there is a much lower chance that the group is composed disproportionately of people in poor health." *How Private Health Coverage Works: A Primer*, *2008 Update*, p. 7 (April 2008), https://www.kff.org/wp-content/uploads/2013/01/7766.pdf. When a pool is voluntary and not tied to employment, there will be a disproportionate number of unhealthy members since their sole motivation to join likely was to access health insurance coverage. *Id.* at 7.[13] This leads to the second problem with voluntary pools: adverse selection.

The risk profile for a voluntary pool is much higher than that of a single-employer group, as higher-risk individuals join solely for the

[13] *See also Insurance Markets, What Health Insurance Pools Can and Can't Do*, California HealthCare Found., at 1 (November 2005), https://www.cga.ct.gov/ph/tfs/20070101_HealthFirst%20Connecticut%20Authority/20080501/What%20Health%20Insurance%20Pools%20Can%20And%20Can%27t%20Do.pdf.

purpose of purchasing health insurance. *Insurance Markets*, California HealthCare Found. at 3-4. Healthy people who can obtain a lower price for coverage elsewhere will do so and the voluntary pool will eventually be left with unhealthy people who are unable to obtain alternative coverage and will drain the plan's assets. This is known as "adverse selection" and will lead to a "premium spiral," meaning those left in the voluntary pool will face increased premiums, which will eventually price them out of the market, ultimately resulting in the pool's insolvency. *See American Academy of Actuaries, Risk Pooling: How Health Insurance in the Individual Market Works,* American Academy of Actuaries, https://www.actuary.org/content/risk-pooling-how-health-insurance-individual-market-works-0; *Insurance Markets*, California HealthCare Found. at 3-4. Alternatively, the pool gatekeepers could remove the unhealthy individuals, leaving them without the coverage they were promised. Either scenario would be harmful to consumers.

The DMP plan bears all the hallmarks of a voluntary purchasing pool. A random collection of individuals with smart phones lack a "natural cohesion" or reason to stay together other than the purchase of insurance, which results in a strong risk of adverse selection and

insolvency. This is precisely the reason Congress preserved the regulation of insurance with the states and allowed preemption of state authority only in the limited circumstances where there is a true single-employer plan.

II. There Is A Long History of Unauthorized Insurers Claiming ERISA Preemption of State Laws.

Opportunistic entrepreneurs have been exploiting ambiguities in ERISA since its enactment in 1974. The DMP plan is just one of the most recent in a long line of predecessor schemes claiming ERISA preemption to evade state insurance laws governing reserves, funding, and benefits. *See supra* § I.A.

The NAIC advised Congress of such schemes as early as 1977. A Congressional Report describes one attempt to evade state law, with striking similarity to the DMP plan:

> It has come to our attention, through the good offices of the National Association of State [sic] 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. . . . The entrepreneur will then argue that his enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation. . . . As described to us, these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. . . . They are no more ERISA

> plans than is any other insurance policy sold to an employee benefit plan.

ERISA Oversight Report of the Pension Task Force of the Subcomm. on Labor Standards, House Comm. On Education and Labor, H.R. Doc. No. 342-9, 94th Cong., 2d Sess., p. 10 (Jan. 3, 1977), https://ufdc.ufl.edu/AA00022220/00001/1j.

A. Congress reemphasized the States' role in preventing unauthorized insurers from preying on the public.

In the decade after ERISA was enacted, third-party promoters exploited ERISA as a profit-making opportunity. There was a proliferation of multiple employer trusts (METs or MEWAs)[14], which claimed to provide small employers with a way to band together to access health coverage on terms similar to large employers, without being subject to state insurance regulation. *See generally Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation*, *Typical Illegal Operations Claiming ERISA Status,* pp. 47-67 (explaining the history of MEWAs). They claimed ERISA preemption of state laws, even though the MEWA

[14] When ERISA was amended in 1983, it established a new category, called "multiple employer welfare arrangements" (MEWAs), which includes but is not limited to multiple employer trusts. ERISA 3(40) (29 U.S.C. § 1002(40).

rarely, if ever, qualified as an ERISA plan. *See id.* at 50. MEWA promoters took advantage of the regulatory confusion and made money at the expense of their participants. These MEWAs were plagued by insolvencies, whether through malice or incompetence, which resulted in significant sums of unpaid claims and the loss of health insurance for participants. *Id.* at 48.

In the past, some MEWAs became insolvent simply because the they did not want to raise rates for their member employers and employees. Solvency is also a challenge for MEWAs under the best of circumstances because they are, by their very nature, an unstable risk pool. They do not have the consistency of membership like a true large employer. *See supra* § I.D.

In 1982, the NAIC adopted a resolution supporting federal legislation to amend ERISA, stating in a whereas clause, "unscrupulous [MEWA] operators have successfully thwarted timely investigations and enforcement actions of state insurance departments by asserting that such entities are exempt from state regulation pursuant to . . .

ERISA[.]" NAIC Proceedings, Vol II, p. 43. (1982).[15] In 1983, Congress adopted amendments to ERISA to counter what the drafters termed abuse by the "operators of bogus insurance trusts," *see* 128 Cong. Rec. E2407 (1982) (statement of Congressmember Erlenborn). The 1983 amendments provided that fully-insured MEWAs are subject to states' standards for reserves and contributions. Treatment of Multiple Employer Welfare Arrangements Under Employee Retirement Income Security Act of 1974, Pub. L. No. 97-473, § 302, 96 Stat. 2612 (Jan. 14, 1983).[16]

The amendments further provided that MEWAs that are not fully insured—even if they qualify as ERISA plans—are subject to all state laws not inconsistent with ERISA, including insurance laws that would otherwise be preempted under the deemer clause, unless the U.S. Department of Labor has specifically exempted the MEWA. *Id.*

B. Federal and State regulators collaborate to stop "sham union" plans.

While the federal Multiple Employer Welfare Arrangement Act of

---

[15] *Available at* https://naic.soutronglobal.net/Portal/DownloadImageFile.ashx?objectId=5245.

[16] *Available at* https://www.govinfo.gov/content/pkg/STATUTE-96/pdf/STATUTE-96-Pg2605.pdf.

1983 significantly enhanced the states' ability to regulate MEWAs, problems in this area persisted. Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A), 65 Fed. Reg., 209, 64483 (Oct. 27, 2000). The next round of sham ERISA plans involved exploiting the MEWA exception for union plans. Certain entities claimed that they were collectively bargained or single-employer plans, rather than MEWAs, and thus were exempt from state regulation. *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage* (Feb. 2004) p. 11, https://www.gao.gov/assets/gao-04-312.pdf; *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, U.S. General Accounting Office (Mar. 1992) p. 8, https://www.gao.gov/assets/220/215647.pdf.

As the DOL proposed a regulatory fix for this new kind of fraudulent ERISA plan, it described the problem this way: "the exception for collectively bargained plans contained in [ERISA] is being exploited by some MEWA operators who, through the use of sham unions and collective bargaining agreements, market fraudulent insurance schemes under the guise of collectively bargained welfare

plans exempt from state insurance regulation." 65 Fed. Reg. at 64483. State departments of insurance believed many of the entities were contrived solely to avoid state regulation. *Id.* For example, insurance regulators in Florida "questioned the validity of entities' claiming exemption as collectively bargained plans, noting that by selling 'associate memberships,' these entities marketed health benefit coverage to individuals with no participation or representation in the union." *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements* at 8.

The DOL described them as "vehicles for marketing health care coverage to individuals and employers with no relationship to the bargaining process or the underlying bargaining agreement." 65 Fed. Reg. at 64483. The DOL believed it was "necessary to distinguish organizations that provide benefits through collectively bargained employee representation from organizations that are primarily in the business of marketing commercial insurance products." 63 Fed. Reg. 183, 50543 (Sept. 22, 1998).

As these sham plans were marketed to the general public, they caused adverse consequences for consumers. "Between January 1988

and June 1991, MEWAs left at least 398,000 participants and their beneficiaries with over $123 million in unpaid claims and many other participants without insurance." *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements* at 2.

Because of these persisting problems, the NAIC issued advisory bulletins about these scams—one directed to unsuspecting insurance agents asked to sell the plans and one directed to consumers. *Agents Beware – Illegal "ERISA" and "Union Plan" Scams; Consumers Beware – Illegal "ERISA" and "Union Plan" Scams,* NAIC Proceedings, Vol. I, 2d Qtr., p. 267, 363-66 (2004), *available at* https://naic.soutronglobal.net/Portal/DownloadImageFile.ashx?objectId=5293.

Shortly thereafter, the DOL issued a new regulation to prevent MEWAs from fraudulently claiming protection under the collective bargaining exception. "An employee welfare benefit plan shall not be deemed to be 'established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements' for any plan year in which: . . . The agreement under which the plan is established or maintained is a scheme, plan, stratagem or artifice of evasion, a principal intent of which is to evade compliance

with state law and regulations applicable to insurance: . . . ." 29 C.F.R. § 2510.3-40(c) (emphasis added).

To address this issue at the state level, in 2006, the NAIC adopted the *Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation* (#220).[17] The model regulation establishes specific standards—including requirements for reporting—as to persons and licensees who become aware of, or are asked to assist, such an operation. The penalty provision of the model regulation works in tandem with the NAIC's *Nonadmitted Insurance Model Act* (#870),[18] to ensure there are consequences for evading state regulation. The NAIC's model regulation on MEWAs represents a collaborative effort among the states to prevent the illegal operation of these entities. The NAIC's efforts in this area demonstrate widespread support for aggressive regulation of unauthorized health insurers.

During the upsurge in MEWA shams, state insurance regulators

[17] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-220_0.pdf.

[18] *Available at* https://content.naic.org/sites/default/files/inline-files/MDL-870.pdf.

and the DOL's Employee Benefits Security Administration (EBSA) increased their "coordination efforts regarding investigative and oversight responsibilities of MEWAs and other entities offering health care coverage." *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage* at 46-48. The NAIC and the DOL continue to collaborate on these issues today.

C. State regulators, working through the NAIC, remain ever vigilant in preventing the unauthorized sale of insurance.

Problems with MEWAs and other sham ERISA plans, like this one, persist. The NAIC remains vigilant in monitoring these schemes as they are uncovered. The NAIC provides education and training to its members so that regulators are better able to identify ERISA shams before they become insolvent, leaving consumers with unpaid medical claims.

Through its ERISA Working Group, under the Regulatory Framework Task Force within the Health Insurance and Managed Care (B) Committee, the NAIC acts as a liaison between the DOL and state departments of insurance. *See Employee Retirement Income Security Act*

(ERISA) (B) Working Group, https://content.naic.org/cmte_b_erisa.htm. One of the ongoing charges of the group is to "Monitor, facilitate and coordinate with the states and the U.S. Department of Labor (DOL) related to sham health plans." *Id.* When the DOL uncovers a fraudulent plan, that information is shared with the states through the NAIC and, likewise, when the states uncover one, the NAIC shares this with the DOL. This provides insurance regulators with an avenue to coordinate multistate fraud investigations and take action, including issuing cease and desist orders.

In addition to the public-facing ERISA Working Group, the NAIC has developed other avenues for sharing information directly between state and federal regulators, including various bulletin boards and regular conference calls to discuss health care reform implementation and improper marketing of insurance.

Unfortunately, there is no shortage of opportunists looking for "creative" ways to exploit loopholes and ambiguity in federal law to profit from unsuspecting consumers. DMP has found a way to market insurance products to the general public by creating a scheme that generates no revenue or profit and has no means of paying its

"partners". Because there is no employment relationship, ERISA is irrelevant and inapplicable to DMP's health benefit plan. This is exactly the scenario where state insurance regulators, with assistance from the NAIC—and in coordination with the DOL—can enforce solvency and consumer protection laws. It is critical that the Court recognize and understand the states' role in ensuring consumers are not at risk of losing the health coverage they are promised.

CONCLUSION

This Court should reverse the judgment of the district court.

April 7, 2021

Respectfully submitted,

/S/ MICHAEL T. RAUPP

MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main Street, Suite 1000
Kansas City, MO 64112
Telephone (816) 983-8000
Facsimile (816) 983-8080
michael.raupp@huschblackwell.com

JENNIFER M. MCADAM
NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS
1100 Walnut Street, Suite 1500
Kansas City, MO 64106
Telephone (816) 783-8878
Facsimile (816) 783-8175

Counsel for Amicus Curiae
National Association of
Insurance Commissioners

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) because this brief contains 6,285 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f). 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 Word in Century Schoolbook font size 14.

/S/ MICHAEL T. RAUPP
Counsel for Amicus Curiae
National Association of
Insurance Commissioners