NOT YET SCHEDULED 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.,
PLAINTIFF-APPELLEES,
V.
UNITED STATES DEPARTMENT OF LABOR, et al.,
DEFENDANT-APPELLANT.

ON APPEAL FROM AN ORDER OF THE
UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

AMICUS CURIAE BRIEF OF THE COALITION TO PROTECT AND PROMOTE ASSOCIATION HEALTH PLANS JOINED WITH ASSOCIATIONHEALTHPLANS.COM, IN SUPPORT OF APPELLANT UNITED STATES DEPARTMENT OF LABOR WITH THE CONSENT OF ALL PARTIES

Attorneys for The Coalition to Protect and Promote Association Health Plans and AssociationHealthPlans.com:

ISRAEL GOLDOWITZ
SUSAN ELIZABETH REES
Wagner Law Group
800 Connecticut Avenue, NW
Suite 810
Washington, DC 20006
(202) 969-2800
igoldowitz@wagnerlawgroup.com

Of Counsel:

CHRISTOPHER E. CONDELUCI
CC Law & Policy PLLC
1001 4th Street, SE
Washington, DC 20003
(703) 209-0690
chris@cclawandpolicy.com

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the 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 include: (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. Sánchez, 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 (6) the Coalition to Protect and Promote Association Health Plans.

Amici before this Court currently are: The Oklahoma Insurance Department and the Montana State Auditor, Commissioner of Securities and Insurance, on behalf of Defendant Appellants 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.

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 John D. Bates in Case No. 1:18-cv-1747.

C. *Related Cases.* None

D. *Corporate Disclosure Statement*

The Coalition to Protect and Promote Association Health Plans (the "Coalition") is an *ad hoc* coalition of national and state member-based organizations. The Coalition does not have corporate form, and thus has no parent corporation, nor does any publicly held company hold an ownership interest in it.

Kev Coleman is healthcare researcher and also the President of AssociationHealthPlans.com. The website AssociationHealthPlans.com is a

wholly-owned asset of the privately-held company Association Health Plans, Inc. Association Health Plans, Inc. is a for-profit Delaware corporation. No publicly held company has ownership in Association Health Plans, Inc.

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Coalition to Protect and Promote Association Health Plans (the "Coalition") is an *ad hoc* coalition of national and state member-based organizations. Several of our member-organizations currently sponsor an "association health plan" ("AHP") formed in accordance with the Department of Labor's ("DOL's") regulations (1) allowing geographic-based employer groups establish an AHP and (2) permitting self-employed individuals with no employees to participate in an AHP (the "Final Rule"). Other Coalition members are in the process of establishing an AHP in accordance with the Final Rule, and a number of our Coalition members have been sponsoring an AHP formed in accordance with the DOL's guidance issued prior to the release of the Final Rule for multiple years.

Through our members, the Coalition is especially well-situated to explain the legal and practical challenges to forming an AHP in the various States. For example, the appellees already prohibit certain AHPs from forming in their State, which has led members of our Coalition to refrain from engaging these States. A greater number of States, however, have conformed to the Final Rule in some way, and it is in these States that our Coalition members have formed an AHP in accordance with the Final Rule.

Our Coalition members, along with AssociationHealthPlans.com, understand how State laws apply to insurance policies, especially tax laws. And, our Coalition

and AssociationHealthPlans.com understand the types of AHPs that, to date, have formed in accordance with the Final Rule (i.e., virtually all of the AHPs formed to date are fully-insured, with a few exceptions). We also know that, to date, no enforcement actions have been taken against any AHP formed in accordance with the Final Rule in any State.

Our Coalition members and AssociationHelathPlans.com are uniquely positioned to explain to the Court the comprehensive health benefits that are currently being offered through the AHPs formed in accordance with the Final Rule, along with the broad provider networks that are available to AHP participants.

The Coalition's member-organizations represent over 1 million small employers and millions more who are employees of these employer-members or who are self-employed individuals with no employees, the majority of whom would be eligible to obtain health coverage through an AHP formed in accordance with the Final Rule. The Coalition, therefore, has a strong interest in the continued vitality of the Final Rule, which will enable them to offer comprehensive health coverage to the millions of employees and self-employed individuals they represent. Without the Final Rule, many Coalition members would be unable to provide quality and affordable health coverage to small employers and self-employed individuals who are currently struggling to afford health insurance offered in the existing "small group" and "individual" health insurance markets.

As a public advocate of AHPs, and having invested considerable time in AssociationHealthPlans.com, Mr. Coleman similarly has a keen interest in the appeal of the District Court's ruling. If the Final Rule in invalidated, AssociationHealthPlans.com's value proposition and business model for assisting AHPs forming in accordance with the Final Rule will be eroded.

ARGUMENT

I. The District Court Is Allowing the Appellees to Dictate How Other States Can Regulate Their Insurance Markets, Resulting In the Loss of Health Insurance for Individuals Residing Outside the Appellees' States

A. The Appellees Can Prohibit AHP Formation In Their State Without Invalidating the Final AHP Regulations

The district court failed to recognize that the appellees are effectively taking away affordable and quality health insurance from individuals living outside their own respective States. This inequity is amplified by the fact that the appellees have the exclusive authority to prohibit AHPs from forming in their State if they so choose. More specifically, if the appellees do not want AHPs forming in their State, they can outright prohibit AHP formation by enacting their own State laws. The appellees have chosen to, instead, file a lawsuit to invalidate the final AHP regulations to the disadvantage of those States that believe the Department of Labor's ("DOL") interpretation of ERISA is reasonable, and to the detriment of individuals currently covered under an AHP formed in accordance with the final AHP regulations in those States.

Virtually all the States that are party to this case *already* prohibit certain types of AHPs from forming in their State, as permitted by federal law. *See* 29 U.S.C. §§ 1144(b)(2)(A) and 1144(b)(6). For example, California has prohibited the formation of self-insured AHPs for 24 years now. *See* CA Ins. Code § 742.23, which requires self-insured multiple-employer welfare arrangements ("MEWAs") to obtain a certificate of compliance from the Department of Insurance to operate within the State; since 1995, the Department of Insurance ceased providing such certificates, effectively precluding the formation of any new self-funded AHPs. Washington State similarly prohibits self-insured AHPs. *See* R.C.W. 48.125.020, which requires self-insured MEWAs to obtain a certificate of authority; since 2005, the Office of the Insurance Commissioner ceased providing such certificates, thus, prohibiting self-insured AHP formation.

New York, the lead appellee, has a law that *already* prohibits a fully-insured AHP from being treated as one, single group health plan, regardless of what the final AHP regulations may allow. Specifically, New York law provides that a small employer member of a fully-insured AHP can only enroll in coverage that is subject to the "small group" market rules and that individual members of a fully-insured AHP can only enroll in coverage that is subject to the "individual" market rules. *See* NY Ins. Law §§ 3231(g) and 4317(d). New York also requires a self-insured AHP to be licensed as an insurance company in the State, which is a significant deterrent to

self-insured AHP formation. *See* NY Ins. Law § 1102(a).

Like New York, Massachusetts and New Jersey have laws that *already* prohibit fully-insured AHPs from being treated as one, single group health plan, as permitted under the final AHP regulations (i.e., a small employer member of a fully-insured AHP can only enroll in a small group market plan and an individual member of a fully-insured AHP can only enroll in an individual market plan). *See* M.G.L. c. 176J and N.J.S.A 17B:27A-19(j)(1), N.J.S.A 17B:27A-2. Massachusetts also requires a self-insured AHP to be licensed as an insurance company, which as stated above, is a significant deterrent to self-insured AHP formation. *See* M.G.L. c. 175.[1]

In addition, DC law only allows a small employer to enroll in a small group market plan and an individual to enroll in an individual market plan, effectively prohibiting fully-insured "large group" AHPs from forming. *See* D.C. Code § 31-3302.06a and § 31-3303.01(b). DC also requires a self-insured AHP to be licensed as an insurance company. *See* D.C. Code § 31–3303.13c(a).[2]

Delaware requires a self-insured AHP to be licensed as an insurance company *See* 18 Del. Admin. Code 505(d), and both Delaware and Maryland limit small

[1] Massachusetts and New Jersey also require each of their respective citizens to obtain some form of health insurance (i.e., "credible coverage") or face a penalty tax. Unlike Massachusetts, however, New Jersey law provides that if coverage through an AHP does not comply with the small group market insurance requirements, the AHP coverage will not qualify as "creditable coverage" for purposes of avoiding a penalty tax. *See* N.J.S.A. 54A:11-4.

[2] District of Columbia ("DC") law also provides that if a DC resident enrolls in an AHP formed after December 15, 2017, this DC resident will be subject to a penalty tax (i.e., AHP coverage offered after December 15, 2017, is not considered "creditable coverage" for purposes of complying with the requirement that DC residents obtain some form or health insurance or pay penalty tax). *See* D.C. Code § 47-5101(11)(C).

employers to small group market plans, thereby prohibiting small employers from forming fully-insured large group AHPs. *See* 18 DE Admin. Code 1308-3.3 and Md. Code, Ins. Law § 15-1202(c). Oregon and Pennsylvania, while not having specific laws in place, have simply adopted a regulatory position that fully-insured "large group" AHPs formed in accordance with the final AHP regulations cannot operate in their State. *See* Oregon Division of Financial Regulation Bulletin No. DFR 2018-07 and Association Health Plans In Pennsylvania, Frequently Asked Questions, dated December 4, 2018. And, we believe that Virginia has adopted a similar position without issuing any guidance or enacting any laws.

B. The Appellees Are Dictating How Twenty-Eight Other States Should Regulate Their Insurance Markets

These laws and related actions differ from those in twenty-eight (28) other States that have taken some sort of action to conform to the final AHP regulations. This includes nineteen (19) States that have issued guidance or have taken actions implementing the final AHP regulations: Alabama, Insurance Bulletin 2018-05; Alaska, Insurance Bulletin B-19-02; Georgia, Comment Letter and Amicus Brief; Illinois, Company Bulletin 2018-07; Indiana, Insurance Bulletin 245; Louisiana, Insurance Advisory Letter 2018-03; Michigan, Insurance Bulletin 2018-21; Minnesota, Frequently Asked Questions; Mississippi, Insurance Bulletin 2018-8; Missouri, Insurance Bulletin 18-04; Nebraska, AHP Approval and Amicus Brief; Nevada, AHP Approval; North Dakota, Statement; Ohio, Frequently Asked

Questions; South Carolina, Comment letter; Tennessee, AHP Approval; Texas, AHP Approval and Amicus Brief; Utah, Insurance Bulletin 2018-5; and West Virginia, AHP Approval.

Another nine (9) States have specifically enacted a law conforming to the final AHP regulations in some form: Arizona, S.B. 1085; Arkansas, Act 919; Florida, S.B. 322; Hawaii, H.B. 2208; Iowa, S.F. 2349; Kansas, H.B. 2209; Kentucky, H.B. 396; Oklahoma, S.B. 943; and South Dakota, S.B. 37.

It is clear that these twenty-eight (28) States would not have taken these actions to conform to the Final Rule if they believed that the DOL's interpretation of ERISA was unreasonable.

C. The Appellees Are Effectively Taking Away Health Insurance From Individuals Residing Outside Their Own States

Statistics show that roughly 30,000 individuals living in the various States listed above are covered by an AHP formed in accordance with the Final Rule. [*See Association Insurance Pushes On Despite Court Ruling,* Kaiser Health News, April 25, 2019. For example, various members of our Coalition have established an AHP in accordance with the Final Rule in Alabama, Kansas, Michigan, Missouri, Nebraska, Nevada, and Tennessee. Other States including Florida, Texas, and West Virginia have also seen AHPs formed by organizations that are currently not members of our Coalition.

If the district court ruling is upheld, the appellees will effectively take away

health coverage for tens of thousands of individuals who do not live in their States. In essence, despite each State's authority to independently regulate their own insurance markets, the appellees will effectively dictate what types of health coverage twenty-eight (28) other States should and should not make available to their citizens.

In the end, employees of small employers and self-employed individuals with no employees currently enrolled in an AHP formed in accordance with the final AHP regulations will face a choice: (1) they will experience a 10-percent to 30-percent premium increase (depending on the savings under their existing AHP) or (2) they will go without coverage. The overreach is apparent, especially as (1) virtually all of the appellees already prohibit some form of AHPs from operating in their State and (2) all of the appellees have the broad authority to supplement their own laws to prohibit *any* AHP formation in their State. *See* 29 U.S.C. §§ 1144(b)(2)(A) and 1144(b)(6).

II. The District Court Was Mistaken in Concluding That the Final AHP Regulations Increase Regulatory Costs for the Appellees

The foregoing explains why the appellees cannot and will not be injured by the Final Rule. This conclusion is justified by the fact that insurance producers and legal practitioners are aware of the barriers to AHP formation in the appellee States. That has led our Coalition members who are interested in establishing an AHP in accordance with the final AHP regulations to refrain from engaging these States. As

a result, the need to respond to "multiple inquiries" and the need to "incur costs in hiring staff to enforce state and federal law" that the appellees "anticipated" or "expected" has *not* materialized. Thus, any purported injury due to the final AHP regulations is speculative or attenuated, and not direct and concrete.

Indeed, as the district court stated, "an injury must be direct and concrete and not speculative or attenuated." Mem. Op. at 17, *citing Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013). The district court then recites various attestations and representations made by the appellees. *Id*. at 17 - 18. In particular, the district court notes that the appellees "anticipate" and "expect" to incur new costs and "intend" to designate staff time to AHP enforcement. "[A]nticipating" and "expecting" to incur new costs, and "intending" to dedicate staff time, however, are not "direct and concrete" injury, but "speculative or attenuated." Indeed, there have been *no* regulatory enforcement actions taken against *any* AHP formed in accordance with the final AHP regulations in *any* State, let alone any of the appellee States, so the costs that were "anticipated" and "expected" have *not* materialized, and any "intention" to dedicate staff to AHP enforcement has *not* needed to be acted upon.

To be sure, as the district court notes, some of the appellee States have "already" incurred costs and dedicated staff time to understanding and preparing to respond to inquiries about the Final Rule. But that could be said of any new federal regulation. As an example, the ACA required States to conduct "rate review" that

was dictated by hundreds of pages of regulations and follow-up sub-regulatory guidance. *See e.g.*, 75 Fed. Reg. 81,004 (December 23, 2010); 76 Fed. Reg. 29,964 (May 23, 2011); 76 Fed. Reg. 54,969 (September 6, 2011); *see also*, CCIIO Sub-Regulatory Guidance: Timing of Submission and Posting of Rate Filing Justifications for the 2015 Filing Year for Single Risk Pool Compliant Coverage Effective on or after January 1, 2016. States had no choice but to reallocate resources, incur new costs, and designate staff time to understanding all of the details of these new Federal rate review requirements.

Moreover, "preparing" for what the appellees contend is "potential" fraud and abuse is not a "direct and concrete" injury. For example, a homeowner preparing for a hurricane that meteorologists predict will make landfall will incur costs associated with boarding up her windows and purchasing a generator. But, if the hurricane veers off into the sea, has the homeowner suffered a "direct and concrete" injury on account of her preparations?

The district court also notes that New Jersey "will expend additional resources and monies to enforce applicable state laws against . . . *AHPs that are fraudulent and/or underfunded*." Mem. Op. at 17 - 18. But, as stated above, there has been *no* enforcement activity against *any* AHPs formed in accordance with the Final Rule, *nor* have there been *any* insolvencies. We are not suggesting that fraud and insolvencies will never happen. But, the inability to predict them with any

confidence shows that the claims are "speculative."

Last, the district court cites in-Circuit precedent that "injuries related to purported regulatory burden [do] not confer standing where the alleged injury [is] largely speculative based on attenuated predictions of future illegal third-party conduct." Mem. Op. at 18, *citing Arpaio v. Obama*, 27 F. Supp. 3d 185, 202-03 (D.D.C. 2014), aff'd, 797 F.3d 11, 20 (D.C. Cir. 2015), cert. denied 136 S. Ct. 900 (2016). The court relied on attestations from Massachusetts, Pennsylvania, New York, Maryland, Oregon, and the District of Columbia that these States will incur "future costs" due to enforcement of the Final Rule. Mem. Op. at 18. Such attestations ignore the very decision the court cites, that this Court's teachings that anticipated "future costs" predicated by "predictions of future illegal third-party conduct" is merely an "alleged injury" that is "speculative" and is not "direct and concrete."

III. The District Court Was Mistaken in Concluding That the Final Rule Will Result In Lost Tax Revenue for the Appellees

The district court also concluded that the appellees have standing because the appellee States will lose tax revenue. This conclusion is based on the belief that if there is a reduction in the number of individuals insured by a health plan under-written by an insurance company offering coverage in the "small group" or "individual" insurance markets (i.e., a fully-insured "small group" or "individual" market plan), the State will *not* be able to collect "premium taxes" that these States

impose on fully-insured plans.

The appellees argue that there will be a reduction in the number of individuals covered by a fully-insured small group or individual market plan because individuals will shift to a self-insured AHP. The appellees also argue that the final AHP regulations will increase the number of people who are currently enrolled in a fully-insured small group or individual market plan to go without insurance. The appellees fail to explain, however, that States *also* collect "premium taxes" on a health plan underwritten by an insurance company in the "large group" market (i.e., a fully-insured "large group" market plan).

A. The Appellees Will Not Lose Tax Revenue On Account of Individuals Shifting to a Self-Insured AHP

To date, virtually all of the AHPs formed in accordance with the final AHP regulations are under-written by an insurance company (i.e., these AHPs are fully-insured health plans).[3] This means that even if individuals who are currently covered by a fully-insured small group or individual market plan enroll in a fully-insured AHP, these individuals will *remain* enrolled in a fully-insured large group market plan. There will be *no* tax revenue loss, because States will continue to collect premium tax revenue on these individuals, who will remain covered under a fully-insured plan.

[3] The only self-insured AHP formed in accordance with the final AHP regulations that we are aware is The Land O'Lakes self-insured AHP that is currently operating in Minnesota and Nebraska. *See Early Association Health Plans Defy Fears, Offer Comprehensive Benefits*, Modern Healthcare, November 10, 2018.

More important, two of the appellees currently prohibit self-insured AHPs from forming in their State (California and Washington). These States by definition will *not* lose any tax revenue, because individuals in these States will continue to be covered by some form of fully-insured health plan, which will continue to generate premium taxes for these States. Notably, the district court singled out California and Washington as two States that will surely lose tax revenue on account of the Final Rule. It went so far as to rely on an attestation from the chief executive officer of the Washington Health Benefit Exchange ("WAHBE"), who claimed that WAHBE will lose tax revenue due to a "decrease in the number of enrollees" on account of what the district court called the "Final Rule's intended expansion of self-insured AHPs." Mem. Op. at 16. The district court failed to understand that Washington currently prohibits self-insured AHPs, and thus, failed to recognize that there is *no* basis for accepting the claim that Washington would lose tax revenue on account of newly formed self-insured AHPs.[4]

In addition, many of the appellees (including Delaware and Massachusetts, two other States that the district court singled out as losing tax revenue on account of the Final Rule) require a self-insured AHP to be licensed as an insurance company,

[4] States like Washington and Virginia claim that their "individual" ACA Exchange markets will be adversely affected by the Final Rule. Washington also claims that a decrease in enrollment in its "individual" ACA Exchange market will reduce the tax revenue that WAHBE otherwise collects on Exchange plans. The non-partisan Congressional Budget Office ("CBO"), however, estimates that over a 10-year period, only 150,000 Exchange plan holders will discontinue their coverage and enroll in an AHP. *See* *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans*, January 2019, page 7 - 8 and Table 1. CBO's estimate does *not* corroborate Washington's and Virginia's claim of a decrease in enrollment, and CBO's estimate does *not* support the claim that WAHBE will lose tax revenue other than possibly de minimis amounts.

which, as discussed above, is a significant deterrent to forming a self-insured AHP. As a result, it is highly unlikely that these States will lose any tax revenue because, again, individuals will continue to be covered by a fully-insured health plan that will continue to generate premium taxes. Even if there is a concern that self-insured AHPs will go through the onerous process of becoming licensed as an insurance company, there are easy solutions to the potential loss of tax revenue. First, a State can pass a law that outright prohibits self-insured AHP formation. Second, a State can impose premium taxes on self-insured AHPs.

B. The Final Rule Will Actually Produce an Increase in Health Coverage, and Thus an Increase In Tax Revenue

The non-partisan Congressional Budget Office ("CBO") released a report on January 31, 2019, concluding that – after factoring in the availability of the ACA's premium tax credits and behavioral changes among individuals and employers – AHPs will not "spur a noticeable decline in insurance coverage." *See* *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans*, January 2019, page 1. CBO also estimated that "400,000 people will have new AHP coverage who otherwise would be uninsured over the 2019 - 2028 period." *Id.* at 9.

Consistent with the trend that AHPs formed in accordance with the final AHP regulations will primarily be fully-insured, this means that States will have newly insured individuals on which they may collect premium taxes. In other words, if

more individuals are covered by a fully-insured health plan (here a fully-insured large group plan), States will actually collect *more* tax revenue than they would have without the final AHP regulations.

C. States May Lose Tax Revenue Based on an Individual's Voluntary Act of Opting Against Enrolling In Health Insurance, Not on Account of the Final Rule

The district court's suggests that the final AHP regulations will result in a loss of tax revenue fails to recognize that enrolling in any type of health insurance in the first place is a voluntary act. The CBO informs us that between 2016 and 2018, the number of non-subsidized individuals enrolled in a fully-insured individual market health plan dropped by roughly 31 percent. *See* *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018*, April 2019, Table 1. This reduction resulted in lost tax revenue for States like the appellees, which occurred *before* any AHP formed in accordance with the final AHP regulations was even effective.[5] This trend will likely continue with or without the final AHP regulations. So, to suggest that States will lose tax revenue because of the final AHP regulations cannot be justified, much less reliably quantified.

IV. The District Court Misunderstands How the ACA Applies to Large Employer Health Plans and Fails to Recognize the Federal and State Law Requirements Applicable to AHPs

[5] Although the final AHP regulations allowed fully-insured AHPs to begin operating as of September 1, 2018, all of the fully-insured AHPs currently operating today did not make coverage effective until at least January 1, 2019.

The district court explains that large employers sponsoring a health plan face a choice: (1) they must cover the ACA's "essential health benefits" or (2) pay a penalty tax. Mem. Op. 3 - 4. This is *incorrect*. Large employers sponsoring a health plan (i.e., a "large group" plan) are *not* required to cover the EHBs under *any* provision of the ACA. It is true that the ACA's employer mandate/penalty tax provision requires large employers to provide "minimum value," which means large employers must cover at least 60 percent of the cost of the benefits covered under the plan, or pay a penalty tax. *See* 26 U.S.C. § 4980H(b)(1)(B) and § 36B(c)(2)(C)(i). But, the employer mandate does *not* require large employers to cover the EHBs.

The district court also fails to recognize that *all* AHPs are subject to the ACA's "group health plan" requirements, which among other things, prohibits an AHP from denying coverage based on a pre-existing condition, prohibits annual and lifetime limits on EHBs covered under the plan, requires the AHP to provide free coverage for certain preventive services, and requires the AHP to cover adult children up to age 26.[6] Furthermore, the district court overlooks that AHPs are

[6] According to the ACA, a fully-insured and self-insured AHP – as a "group health plan" – *must*: Eliminate all pre-existing condition exclusions for all plan participants, s*ee* PHSA section 2704; Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan, s*ee* PHSA section 2711; Provide coverage for certain preventive health services with no cost-sharing, s*ee* PHSA section 2713; Cover "adult children" up to age 26, *see* PHSA section 2714; Stop rescinding coverage absent fraud or misrepresentation s*ee* PHSA section 2712; Include new internal and external appeals processes (and provide notice), *see* PHSA section 2719; Allow participants a choice of primary care physician/pediatrician/OB/GYN, *see* PHSA section 2719; Provide direct access to emergency services, *see* PHSA section 2719A; Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information, *see* PHSA section 2705; Limit the plan's cost-sharing to certain maximum out-of-pocket limits, *see* PHSA section 2707(b);

subject to other Federal laws, including ERISA, HIPAA, COBRA, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Genetic Information Nondiscrimination Act.

In addition, fully-insured AHPs are required to cover a State's "mandated" health benefits. And, as discussed above, States have broad authority to impose any insurance coverage requirement on self-insured AHPs.

V. To Date, AHPs Provide Better Coverage Than ACA-Compliant Small Group and Individual Market Plans

Amici in the district court went to great lengths to argue that because AHPs are not required to cover the EHBs, AHPs are inherently bad and that individuals covered under an AHP will suffer. This led the district court to conclude that AHPs are an "end-run around the ACA." Mem. Op. at 42. The Amici's claims had no basis, and they led the district court to error.

To date, all of the AHPs formed in accordance with the Final Rule by members of our Coalition *voluntarily* cover all or virtually all of the EHBs.[7] This includes fully-insured AHPs established by The Nebraska Farm Bureau, Transcend AHP, the Baldwin County Association of REALTORS®, the Greater Las Vegas

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Eliminate waiting periods that exceed 90 days, *see* PHSA section 2708; Cover the cost of clinical trial participation, *see* PHSA section 2709; Provide participants with a summary of benefits and coverage, s*ee* PHSA section 2715; Provide annual reports describing the plan's quality-of-care provisions, *see* PHSA section 2717.

[7] The American Veterinary Medical Association ("AVMA"), the largest veterinary medical association with over 93,000 members nationwide, was in the process of establishing an AHP in accordance with the Final Rule which would have covered all ten EHBs and provided access to broad network of providers. The district court ruling forced the AVMA to pause the launch of their AHP.

Association of REALTORS®, the Kansas City Regional Association of REALTORS®, the Nevada REALTORS®, and the Tennessee REALTORS® that were effective on or after January 1, 2019. All of these AHPs cover all ten EHBs, including pediatric services, although many of them do not cover pediatric dental or vision, which is a component of the tenth EHB. The reason the insurance policies for these AHPs do not cover pediatric dental or visions is that the board governing the AHP determined that pediatric dental and vision benefits can best be provided through a stand-alone product that is readily made available, instead of through the insurance policy itself.

The Court should bear in mind that the "control" test imposes a fiduciary duty on the Board governing the AHP, requiring the Board to "act solely in the interest" of the AHP participants and "for the exclusive purposes of providing benefits to participants and their beneficiaries . . . and . . . defraying reasonable expenses of administering the plan. . . ." 29 U.S.C.§ 1104(a)(1)A). If AHP participants believe that the Board violated these standard by choosing only to offer pediatric dental and vision coverage through a stand-alone product (instead of the through the AHP's insurance policy), they could file suit against the Board. *See* 29 U.S.C. § 1132(a)(3).[8] (Such a suit would likely fail, as insurance experts would likely opine that a stand-alone product provides better coverage at less cost for these services).

[8] Note, this same private right of action is not available to individuals covered under an ACA-compliant plan. Only participants in an ERISA-covered – like an AHP – are afforded this right.

The AHPs established by our Coalition members also provide better major medical health coverage than ACA-compliant small group and individual market plans in a number of ways. In addition to voluntary covering all or virtually all of the EHBs, AHPs offer access to broader network of medical providers.[9] This is a welcome change to current AHP participants, who are no longer required to drive hours to and from a physician's office or a hospital that are in-network to receive medical treatment or to even get a routine medical check-up.[10] In addition, current AHP participants enjoy lower deductibles for the same level of coverage as they would receive under an ACA-compliant small group or individual market plan.[11] And savings for AHP participants ranges from 5 to 35 percent.[12] Contrary to the Amici's claims – and the district court's conclusion – AHPs formed in accordance with the Final Rule are actually providing better coverage than ACA-compliant small group and individual market plans.

VI. The DOL's Final Rule Is Reasonable and Provides Flexibility In the Narrow Circumstance of Providing Access to Affordable and Quality

[9] Industry studies confirm that ACA-compliant small group and individual market plans primarily have "narrow networks." *See* *Plans with More Restrictive Networks Comprise 73% of Exchange Market*, Avalere Health, Nov. 30, 2017.

[10] As explained in the *Amicus Curiae* submitted by the National Association of REALTORS®, a participant in the Nevada REALTORS® AHP informed this Court that the participant and his wife "are able to go to the best hospital in Northern Nevada as well as have a network of local providers that were not covered under our previous plan. As we live in a remote area at Lake Tahoe, we would normally have to drive an hour or more to go to preferred providers under the previous Obamacare plan and now we can use local providers."

[11] A working owner with no employees who is a participant in the Transcend AHP, sponsored by the Small Business Association of Michigan and Michigan Business and Professional Association, explained that she now has access to a national network and access to richer coverage than her previous Exchange health plan.

[12] Another working owner with no employees who participates in the Transcend AHP reports that due to the savings on health care cost, this working owner was able to hire an employee, and this employee reports that coverage under the Transend AHP is superior to their ACA Exchange plan.

Health Coverage Through an AHP

We believe that the other Amici in support of the appellants make cogent arguments why the DOL acted reasonably in its interpretation of the law and its development of the Final Rule. We do not want to advance duplicative arguments. We do want to emphasize, however, that geography does indeed create a "genuine representational bond" among employers that may not share the same industry. This common bond is grounded in competitive labor market forces that drive employers – *both* large and small – to (1) attract and retain talented workers and (2) ensure that an employer's employees remain healthy and productive. To achieve both of these goals, employers – both large and small – *must* offer comprehensive health coverage. The labor market demands it.

Unlike small employers, large employers typically have the resources and bargaining power to offer comprehensive health coverage. Through an AHP – which is treated like a large employer health plan – small employers will finally be able to compete with large employers and offer comprehensive coverage at an affordable price. This will help small employers attract and retain talented workers, which will, in turn, improve the local economy and improve the health and welfare and lifestyle of the men and women and their families that live in the local community. This is yet another common representational bond among employers, regardless of industry. The DOL's interpretation that geographic-based "ERISA bona fide associations" that

may sponsor an AHP that is treated like a large employer plan therefore *is* reasonable.

We also believe that due to the changing workforce, the DOL – which is charged with improving the lives of workers – has the responsibility to develop flexible standards that will continue to help employees, but also self-employed individuals with no employees, access comprehensive health coverage. The bottom line is this: The Supreme Court allows a federal agency to supersede its prior interpretation of a regulation or statute to address marketplace developments and new policy and regulatory issues. *Perez v. Mortgage Bankers Ass'n, 542 U.S. ____, 135 S. Ct. 1199, 1203* (2015). With the continued growth of the "gig economy," and more and more millennials working as self-employed individuals – by choice or by circumstance – our federal and state governments can no longer ignore the needs of these types of workers. *See* *Independent work: Choice, Necessity, and the Gig Economy*, McKinsey Global Institute, October 2016, page 4. In our view, it is therefore incumbent upon the DOL to develop new policies that not only reflect current market dynamics, but that provide access to meaningful workplace benefits that self-employed individuals with no employees so glaringly lack solely because they choose – or are forced – to work without a traditional employer.

Based on the foregoing, we believe the district court's failed to recognize that

working owners (i.e., self-employed individuals with no employees) who are generating income – and paying taxes on this "income" – have an employment relationship that reasonably allows them to be considered both an employer and an employee for the narrow circumstance of accessing quality and affordable health coverage through an AHP. Such a flexible interpretation of the law is not only reasonable, but it is an interpretation that is grounded in the DOL's mission to improve the lives of workers, even if those workers are self-employed individuals with no employees.

CONCLUSION

The Court should overturn the district court's conclusions that provisions of the Final Rule, codified at 29 C.F.R. §§ 2510.3-5(b), (c) and (e), were unreasonable.

Respectfully submitted,
/s/ Israel Goldowitz
Israel Goldowitz

ISRAEL GOLDOWITZ
SUSAN ELIZABETH REES
Wagner Law Group
800 Connecticut Avenue, NW
Suite 810
Washington, DC 20006
(202) 969-2800
igoldowitz@wagnerlawgroup.com

Attorneys for The Coalition to Protect and Promote Association Health Plans and AssociationHealthPlans.com

Of Counsel:

CHRISTOPHER E. CONDELUCI
CC Law & Policy PLLC
1001 4th Street, SE
Washington, DC 20003
(703) 209-0690
chris@cclawandpolicy.com

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(g). This brief contains 5,720 words.

/s/ Israel Goldowitz
ISRAEL GOLDOWITZ

CERTIFICATE OF SERVICE

I hereby certify that on June 7, 2019, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system. Those who are not will be served by other electronic means.

/s/ Israel Goldowitz
ISRAEL GOLDOWITZ