No. 19-5125

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

STATE OF NEW YORK, *et al.*,
Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF LABOR, *et al.*,
Defendants-Appellants.

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

BRIEF OF FORMER UNITED STATES DEPARTMENT OF LABOR OFFICIALS PHYLLIS C. BORZI, M. PATRICIA SMITH, ALAN D. LEBOWITZ, MARC I. MACHIZ AND DANIEL J. MAGUIRE AS *AMICI CURIAE* ON SUPPORT OF APPELLANTS AND AFFIRMANCE

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STATEMENT REGARDING CONSENT TO FILE AND SEPARATE BRIEFING

Pursuant to Circuit Rule 29(d), counsel for amici curiae hereby certifies that it is not practicable to file a joint brief with other potential *amici* supporting Appellees, and that it is necessary to file a separate brief.

IDENTITY AND INTEREST OF AMICI CURIAE

Amici curiae are former U.S. Department of Labor ("DOL" or "the Department") officials who have had substantial experience interpreting the terms and enforcing the provisions of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq*. ("ERISA") as they relate to employee welfare benefit plans. *Amici curiae* have an interest in assuring that ERISA is interpreted and enforced consistent with its terms and protective of the interests of plan participants and beneficiaries.

Phyllis C. Borzi served as the Assistant Secretary of Labor of the Employee Benefits Security Administration ("EBSA") from July 10, 2009 until January 20, 2017. As agency head, she oversaw the administration, regulation and enforcement of Title I of ERISA. Previously, Ms. Borzi was a research professor in the Department of Health Policy at George Washington University Medical Center's School of Public Health and Health Services. In that position, she was involved in research and policy analysis involving employee benefit plans, the uninsured, managed care, and legal barriers to the development of health information technology. In addition, she was Of Counsel with the Washington, D.C. law firm of O'Donoghue & O'Donoghue LLP, specializing in ERISA and other legal issues affecting employee benefit plans. From 1979 to 1995, Ms. Borzi served as pension

and employee benefit counsel for the U.S. House of Representatives, Subcommittee on Labor-Management Relations of the Committee on Education and Labor.

M. Patricia Smith was the Solicitor of Labor at the DOL from 2010 to 2017. She was responsible for all litigation and legal advice, including ERISA matters. From 1988 to 2007 she held various positions in the Labor Bureau of New York State Attorney General's Office, including eight years as Bureau Chief. During that time, she litigated numerous cases involving ERISA in state and federal trial and appellate courts, including cases involving MEWAs. She argued and won two ERISA cases in the United States Supreme Court; *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997).

Alan D. Lebowitz served as Deputy Assistant Secretary for Program Operations of EBSA from 1984 until his retirement in 2013. In this capacity, he was the chief operating officer of EBSA and oversaw EBSA's regulatory, enforcement and reporting activities relating to Title I of ERISA. Prior to joining the Department of Labor in 1979, Mr. Lebowitz held several positions in the Employee Plans area at the Internal Revenue Service, ending as Chief of the Prohibited Transactions staff. Mr. Lebowitz currently serves as a Senior Advisor to Newport Trust Company and previously served in a similar role with Evercore Trust Company, N.A., before its

acquisition by Newport Trust. The views expressed in this brief are those of Mr. Lebowitz in his individual capacity and do not reflect the views of Newport Trust.

Marc I. Machiz joined the DOL in 1978 as a trial attorney in the Plan Benefits Security Division of the Office of the Solicitor of Labor, the division responsible for providing legal advice and litigation services to EBSA with respect to Title I of ERISA. With a brief, two-year hiatus in 1984 and 1985, he served in the Division until 2000, leading it as Associate Solicitor of Labor from 1988 to 2000. From 2000 until 2012, he represented participants and independent fiduciaries in ERISA fiduciary litigation and related matters as a partner and head of the employee benefits practice group at Cohen Milstein Sellers and Toll PLLC. In 2012, he returned to the DOL to advise EBSA's Deputy Assistant Secretary for Program Operations on enforcement matters and became the Philadelphia Regional Director for EBSA from July 2012 until January 2016. Throughout 2016, he served as a Senior Advisor in EBSA's Office of Enforcement until he retired from federal service at the end of that year.

Daniel J. Maguire served as Director of the Office of Health Plan Standards and Compliance Assistance in EBSA from 2000 until his retirement in 2015. As Director, he was responsible for overseeing the development of regulations, interpretive bulletins, opinions, forms, and rulings relating to health care portability, non-discrimination requirements and other related health provisions. In addition, he

ensured that the functions relating to training, technical assistance and guidance on health benefits were carried out for EBSA staff nationwide. Prior to that time, Mr. Maguire headed EBSA's Health Care Task Force which provided technical expertise relating to legislative, policy and regulatory issues involving health care. Before joining EBSA, Mr. Maguire served for 11 years in the Office of the Solicitor's Plan Benefits Security Division where he provided legal advice and technical skills in developing ERISA regulations implementing health care legislation. He received numerous awards, including the Secretary's Exceptional Achievement Award for the development of regulations, legislation and litigation involving multiple employer welfare arrangements ("MEWAs") and health care reform.

INTRODUCTION AND SUMMARY OF ARGUMENT

Rather than offering hope to America's small businesses and workers that they will be able to purchase affordable, comprehensive health care coverage, the Department of Labor Final Rule ("Final Rule") encourages the proliferation of entrepreneurial schemes designed to enrich the promoters rather than pay health care claims. In promulgating the Final Rule, the Department has abandoned legal interpretations which have guided it since ERISA was passed and reflect Congressional intent that ERISA regulate benefit programs offered by employers to their employees. While the Final Rule plays lip service to employment-based benefit plans, the association health plans ("AHPs") it creates are far removed from traditional employee benefit plans established by employers and employer groups that had a common business interest unrelated to the provision of benefits. Instead, the Final Rule allows disparate employers, loosely connected by something other than a common business interest, and individuals willing to check a box that they are self-employed, to band together solely to obtain health care coverage.

The Department does not justify abandonment of its previous positions, which have been adopted by numerous appellate courts, as necessary to protect plan participants – which is the purpose of the statute. Instead, the Final Rule's stated purpose is to offer "small businesses more attractive and affordable health coverage options than are currently available to them in the ACA-compliant individual and

small group markets." Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 28912, 28941 (June 21, 2018) (to be codified at 20 C.F.R. pt. 2510). But Congress did not pass ERISA to create new health care options, nor did it give the Department the authority to expand ERISA coverage beyond employment-based benefit arrangements.

Even if it were appropriate to accomplish the Final Rule's goals through ERISA regulations rather than health care legislation (which it is not), the Final Rule puts plan participants' health care benefits at greater risk by exposing them to fraudulent health care schemes. The Department is well-aware of this risk; its archives are full of examples of fraudulent association health plans that have collapsed, leaving millions of dollars of unpaid claims. Indeed, the Department provides statistics in the Final Rule's preamble showing the difficulties it has faced controlling these fraudulent schemes, but naively claims that the Final Rule's requirement that the group or association sponsoring the AHP have a formal organizational structure with a governing body and by-laws solves the problem. *Id.* at 28952. As discussed below, any clever entrepreneur could easily work around the requirement. In fact, it is not difficult to find examples of failed association health plans that had formal governing bodies and formal plan documents. *See, infra*, pp. 18-21.

This Court should affirm the district court's decision vacating the Final Rule. As discussed below, the Final Rule is an unreasonable interpretation of ERISA, contrary to Congress's clear intent that ERISA protect benefits arising out of employment relationships and puts the health care benefits of America's workers at substantial risk.

ARGUMENT

I. ERISA DOES NOT AUTHORIZE THE SECRETARY OF LABOR TO PROMULGATE REGULATIONS FOR THE PURPOSE OF EXPANDING THE HEALTH CARE MARKET.

Following almost a decade of study of employee benefit plans, Congress enacted ERISA "to protect … the interests of participants in employee benefit plans and their beneficiaries[.]" 29 U.S.C. § 1001(b); *Nachman Corp. v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 362 (1980). "The floor debate … reveals that the crucible of congressional concern was misuse and mismanagement of plan assets by plan administrators and that ERISA was designed to prevent these abuses in the future." *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 n.8 (1985) (*citing* 120 Cong. Rec. 29932 (1974)).

Title I of ERISA, 29 U.S.C. § 1002 *et seq.*, contains provisions, administered and enforced primarily by the Department of Labor, that govern reporting and disclosure, fiduciary responsibility, and plan administration and enforcement, as well as substantive requirements for pension and group health plans. These

provisions are all designed to protect plan assets and to ensure that plan participants receive the benefits to which they are entitled. *LaRue v. DeWolff, Boberg & Assocs., Inc.,*552 U.S. 248, 254 (2008). To further these purposes, ERISA authorizes the Secretary of Labor to "prescribe such regulations as he finds necessary or appropriate to carry out the provisions" of Title I. 29 U.S.C. § 1135.

Although the Final Rule involves interpretation of Title I's definition of "employer," the Final Rule's preamble is devoid of any explanation as to why it was necessary to change the Department's long-standing interpretation of that term to serve any Title I purpose. Instead, the stated purpose of the Final Rule is to "expand access to affordable health coverage, especially for employees of small employers and certain self-employed individuals." Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. at 28912. But as the district court correctly stated, "[n]otably absent from ERISA's statement of policy is an expression of an intent to expand citizen access to healthcare benefits outside of an employment relationship or to directly regulate commercial healthcare insurance providers." *New York v. U.S. Dep't of Labor*, 363 F. Supp. 3d 109, 129 (D.D.C. 2019).[1]

[1] To the extent that Congress sought to encourage the formation of employee benefit plans, it did so by preempting state laws that relate to employee benefit plans, subject to certain exceptions, thus easing administrative burdens by making plans subject to only one set of nationwide rules. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) ("A patchwork scheme of regulation would introduce

As discussed below, instead of being necessary or appropriate for carrying out the provisions of Title I, the Final Rule departs from Congressional intent and re-defines employee benefit plans to include health plans composed of employers with no economic bonds other than the provision of the health plan's benefits. It also allows self-employed owners without any employees to participate in such health plans, even though ERISA has excluded such individuals from coverage since the statute was first passed. The Final Rule is not only contrary to the statute, but it encourages the proliferation of fraudulent health coverage schemes which prey upon small employers and leave their employees with unpaid medical claims – a result ERISA was designed to remedy.

II. THE FINAL RULE IS CONTRARY TO THE STATUTE AND LONG STANDING DOL INTERPRETATIONS.

As the district court correctly noted, it is evident from the Congressional findings and declaration of policy that ERISA "concerns benefit plans arising from employment relationships and accordingly regulates only those plans." *New York,* 363 F. Supp. 3d at 129. Title I was adopted by Congress to "remedy the abuses that

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considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). Congressional wariness of MEWAs, a category of association health plans, is evidenced by the fact that ERISA gives states broader authority to regulate plans that are MEWAs than it does for other types of plans. 29 U.S.C. 1144(b)(6).

existed in the handling and management of welfare and pension plan assets that constitute part of the fringe and retirement benefits held in trust for workers in traditional employer-employee relationships." *Schwartz v. Gordon*, 761 F. 2d 864, 868 (2d Cir. 1985) (*citing* S. Rep. No. 127, 93d Cong., 1st Sess. 3-5, *reprinted in* 1974 U.S. Code Cong. & Ad. News 4639, 4838, 4839-42). [2]

That ERISA regulates benefit plans arising from employment relationships is supported by ERISA's definition section. Section 3(a) defines an employee welfare benefit plan as a plan, fund, or program established or maintained by "an employer or by an employee organization, or by both" for the purpose of providing certain benefits for "participants or their beneficiaries." 29 U.S.C. § 1002(1). A "participant" is defined in section 3(7) of ERISA as an "employee of an employer" or "any member or former member of an employee organization" who is eligible to receive benefits from a plan which covers "employees of such employer" or "members of such organization" or whose beneficiaries may be eligible to receive such benefits. 29 U.S.C. § 1002(7). An "employer" is defined in section 3(5) of ERISA as "any person acting directly as an employer, or indirectly in the interest of

[2] Congress recognized that "[i]ncreases in fringe and retirement benefits during [World War II and the Korean Conflict] became a means of compensating workers in lieu of increased wages, thus making pension benefits a form of deferred wages." S. Rep. No. 93-127, 93d Cong., 1st Sess. 3 (1973) *reprinted in* Legislative History of the Employee Retirement Income Security Act of 1974 at 587.

an employer," including "a group or association of employers acting for an employer" in relation to an employee benefit plan. 29 U.S.C. § 1002(5). As the district court correctly noted, "[i]f Congress had intended ERISA to regulate ordinary commercial insurance relationships existing outside of the employment context," it would not have framed ERISA's scope using these employment related terms. *New York,* 363 F. Supp. 3d at 130.

Despite the Department's acknowledgement that "the touchstone of ERISA is the provision of benefits through the employment relationship," the Final Rule expands the definition of an employee welfare benefit plan far beyond what Congress intended. *See* Proposed Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 614-01, 621 (Jan. 5, 2018).

A. The Final Rule's inclusion of working owners is inconsistent with the ERISA, the Department's prior position and the case law.

Almost immediately after the statute's enactment, the Secretary of Labor issued regulations clarifying the statutory definition of an "employee benefit plan" for Title I purposes. That regulation provides:

> (b) plans without employees. For purposes of [T]itle I of the Act and this chapter, the term "employee benefit plan" shall not include any plan, fund or program … under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called "Keogh" or "H.R. 10" plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered by [T]itle I.

29 C.F.R. § 2510.3-3(b). The regulation further excludes from the definition of "employee" under Title I, "[a]n individual and his or her spouse" employed by a business when one or both wholly owns the company. 29 C.F.R. § 2510.3-3(c)(1).

In promulgating this regulation, the Department concluded that the protective purposes of Title I were not necessary in such arrangements because the likelihood that abuse would occur was minimal. AO 77-75A, *citing* 40 Fed. Reg. 34526 (Aug. 15, 1975). As one court stated, because a self-employed person who provides for his own retirement or health benefits "has complete control over the amount, investment and form of the fund," the notice, disclosure and fiduciary standards of Title I serve no purpose. *Schwartz*, 761 F.2d at 868.

Since the regulation was issued, it has been the consistent position of the Department that Title I does not cover benefit arrangements that only cover sole proprietors. DOL Op. No. 75-19(A) (Oct. 10, 1975) (term "employee benefit plan" does not include plan in which the only participant is a sole proprietor or partner); DOL Op. No. 77-75(A) (Sept. 21, 1977) (plans covering only sole proprietors not covered by Title I because of the absence of a likelihood of abuse); DOL Op. No. 94-07(A) (Mar. 14, 1994) (noting that self-employed persons are not employers of common law employees); DOL Op. No. 95-01(A) (Feb. 13, 1995) (noting that the Department's regulations describe arrangements that do not constitute employee benefit plans); DOL Op. No. 03-13(A) (Sept. 20, 2003) (noting that associations

made up of employers and non-employers cannot sponsor a Title I plan). This includes *amicus* briefs filed by the Department in *Schwartz* (listing U.S. Secretary of Labor as *amicus*) and by the United States in *Raymond B. Yates, M.D. P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004).

Moreover, courts have consistently agreed with the Department that Title I's protections do not apply to benefit arrangements that cover only sole proprietors, partners or their spouses. As the Supreme Court stated in *Yates,* "[p]lans that cover only sole owners or partners and their spouses … fall outside Title I's domain." *Yates,* 541 U.S. at 4. *See also Schwartz*, 761 F.2d at 867 (holding that arrangement through which sole-proprietor received benefits was not a Title I employee benefit plan); *Marcella v. Capital Dist. Physicians' Health Plan, Inc*., 293 F.3d 42, 48 (2d Cir. 2002) (holding that sole proprietor with no employees cannot be considered an employer for purposes of Title I); *Dahl v. Charles F. Dahl, M.D. Defined Benefit Pension Tr*., 744 F.3d 623, 629 (10th Cir. 2014) (noting that plans that cover only sole owners or partners and their spouses are not covered by Title I); *House v. Am. United Life Ins. Co*., 499 F.3d 443, 450 (5th Cir. 2007) (noting that that plan that covers only company's owners is not covered by Title I); *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 639 (5th Cir. 2004) (same); *Slamen v. Paul Revere Life Ins. Co*., 166 F.3d 1102, 1105 (11th Cir. 1999) (same); *In re Watson*, 161 F.3d 593, 597 (9th Cir. 1998) (same).

The Department essentially concedes that the change in its position is not motivated by a need to expand Title I's protections to plans only covering a sole proprietor, partners and/or their spouses without any common law employees. The Department cannot point to any abuses that must now be addressed by placing such plans under Title I's protections. Instead, the sole reason why the Department is changing its long-held position is to allow individuals to obtain health care coverage through the newly created association health plans while avoiding the ACA's mandates and state insurance regulation.

This is evident from the Final Rule's self-certification provisions for working owners. The Final Rule does not merely expand the definition of eligible participant to the self-employed, but it allows AHPs to include anyone prepared to check a self-employment box, making these arrangements indistinguishable from commercial insurance. It is not difficult to imagine an AHP that includes no employers and not even an authentic self-employed individual but is instead composed entirely of individuals working for employers who do not provide coverage. Such an arrangement will not be controlled by employers, because there will be no employers in the AHP, even under DOL's expanded definition of employer.

Additionally, if the Final Rule's working owner definition was merely intended to allow self-employed owners to participate in AHPs, it would have required the "working owner" to do more than check a box stating that the 20 hour

a week/80 hour a month requirement had been met. The Final Rule also would have required the "working owner" to establish that the hourly requirements were met on an ongoing basis and not simply at enrollment. That the Final Rule does not require the AHP to verify or monitor working owners' self-certification is further evidence that the Rule is simply a fig leaf for the Department to expand employee benefit plans to include anyone willing to check a box. And while the Department notes that those administering AHPs will have a fiduciary duty to ensure that those participating meet the eligibility requirements, the Department's own experience with AHPs (see infra, pp. 17-18) is compelling evidence that the fraudsters that often run these arrangements are unlikely to be concerned with their fiduciary duties.

The Final Rule not only masquerades as being employment based, but it invites unscrupulous promoters to commit insurance fraud. There is nothing in the Final Rule that prohibits the association from auditing an individual who submits a large claim for benefits and denying the claim precisely because the same individual, when pressed, cannot document self-employed status. The individual may have obtained health care coverage at a lower cost than that available under the ACA, but the coverage is, at best, ephemeral.

While ERISA was designed to encourage the establishment of employee benefit plans by providing uniform nationwide standards, its mandate was not to create plans outside the employer/employee relationship that are best regulated by

state insurance laws. Nor did Congress give the Department a mandate to create health care plans designed to avoid other legitimate federal laws. To the contrary, ERISA's preemption provisions, designed to encourage the development and expansion of legitimate employment-based benefit programs, saves both state insurance regulation and other federal laws from ERISA's broad preemptive reach. 29 U.S.C. § 1134. The Final Rule not only does violence to ERISA's employment-based underpinnings, but also does violence to ERISA's preemption provisions which recognize the important role state and other federal laws play in regulating the provision of health care coverage to Americans.

B. Congress did not intend for an association of employers to qualify as an employer unless the association had pre-existing business ties unrelated to the provision of benefits.

ERISA defines "employer" as a "group or association of employers acting for an employer" in relation to an employee benefit plan. 29 U.S.C. § 1002(5). Courts have consistently interpreted this provision as requiring that the organization sponsoring the plan and those who benefit from the plan must be "tied by a common economic or representation interest, unrelated to the provision of benefits." *Wis. Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1063 (8th Cir. 1986) ("*WEAIT*"). *See also MDPhysicians & Assocs. v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir. 1992); *Int'l Ass'n of Entrpreneurs of Am. Benefit Tr. v. Foster*, 883 F. Supp. 1050, 1057 (E.D. Va. 1995); *Plog v. Colo. Ass'n of Soil*

Conservation Dists, 841 F. Supp. 350, 353 (D. Colo. 1993); *Atl. Health Care Benefits Tr. v. Foster*, 809 F. Supp. 365, 373 (M.D. Pa. 1992), *aff'd*, 6 F.3d 778 (3d Cir. 1993). "This special relationship protects the employee, who can rely on the … person 'acting indirectly in the interests of' [his] employer to represent the employee's interests relating to the provision of benefits." *MDPhysicians*, 957 F.2d at 186.

This "relationship between the plan sponsor and the participants … distinguishes an employee welfare benefit arrangement from other health insurance arrangements." *Id*. In contrast, a relationship stemming only from the benefit plan "is similar to the relationship between a private insurance company, which is subject to myriad state insurance regulations, and the beneficiaries of a group insurance plan." *WEAIT*, 804 F.2d at 1063.

The requirement that those sponsoring the plan and those receiving benefits under the plan must be tied by an employment relationship is supported by legislative history. Shortly after ERISA was passed, Congress noted that entrepreneurs had begun to market insurance products to unrelated employers as ERISA-covered plans, arguing that they were protected from state insurance regulation under ERISA's preemption provisions. The Activity Report of the Committee of Education and Labor asserted that "we are of the opinion that these programs are not 'employee benefit plans' … [T]hey are not established or

maintained by the appropriate parties to confer ERISA jurisdiction … They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan." H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977).[3]

Over the past decades, the Department has consistently taken the position that an employment relationship must exist between the organization providing benefits and the recipient of those benefits for an ERISA-covered plan to exist. This is a well-considered position that has been expressed in numerous advisory opinions issued over a period of almost 40 years. *See, e.g.*, DOL Op. No. 79-41A (June 29, 1979); DOL Op. No. 80-42A (July 11, 1980); DOL Op. No. 89-19A (Aug. 18, 1989); DOL Op. No. 91-42A (Nov. 12, 1991); DOL Op. No. 2007-06A (Aug. 16, 2007).

These advisory opinions have analyzed whether the organization sponsoring the plan is a "bona fide" employer group or association by examining (1) whether a pre-existing relationship among employer members existed before establishment of the plan, (2) the process by which the association was formed and the purpose for which it was formed, (3) whether employer members were solicited, (4) who participates in the plan, and (5) whether employer members actually control and direct the activities of the plan. These factors reflect the reality that where there is a

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[3] "'While not contemporaneous legislative history,'" courts have found the Report "'virtually conclusive' as to legislative intent." *See MDPhysicians*, 957 F.2d at 184 (quoting *Hamberlin v. VIP Ins. Tr.*, 434 F. Supp. 1196, 1199 (D. Ariz. 1977)).

strong reason other than offering health coverage to exist, the employer group or association has established the plan to provide benefits to the members' employees as part of their compensation package rather than for commercial reasons. Because of the direct link between the employer group or association and the employers' employees, the failure to provide the promised benefits will be directly attributable to the employers, thus incentivizing them to ensure that the arrangement is financially solvent. "[T]he control requirement is a reasonable means of ensuring that the administrators of multi-employer welfare benefit plans in fact act 'in the interest of' their employer members." *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 787 (3d Cir. 1998).

The Department of Labor has also participated as *amicus* in numerous cases arguing that plans established and operated by associations of unrelated businesses which solicit employers are not employee benefit plans. *See Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208, 1210 (5th Cir. 1980) (agreeing with the Secretary of Labor that an insurance arrangement in which unrelated employers subscribed was not an employee benefit plan); *WEAIT*, 804 F.2d at 1065 (agreeing with the Department that the trust was not an employee benefit plan because it provided benefits to individuals who were neither represented nor employed by the labor organizations that sponsored WEAIT); *MDPhysicians*, 957 F.2d at 186 (agreeing with the Department that without a protective nexus between the entity

providing benefits and the individual receiving benefits, an entity is not a "group or association of employers" acting indirectly for the subscribing employers).

Moreover, during the past 40 years, the Department has instituted litigation against numerous MEWAs, a form of AHPs, alleging that they were not themselves employee benefit plans because the requisite employment nexus did not exist. The Department has articulated this position in a booklet designed to "provide a better understanding of the scope and effect of ERISA coverage" but also to "serve to facilitate State regulatory and enforcement efforts, as well as Federal-State coordination, in the MEWA area." U.S. Department of Labor, *MEWAS-Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*, (Revised Aug. 2013) https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

III. THE FINAL RULE IS DETRIMENTAL TO THE INTERESTS OF EMPLOYEE BENEFIT PLAN PARTICIPANTS.

Shortly after ERISA was enacted, entrepreneurs began offering association health plans to small businesses looking for affordable coverage for themselves and their employees. *See, supra*, pp. 13-14. The entrepreneurs claimed that the insurance arrangement was an employee benefit plan and could offer favorable rates because it was not subject to state insurance regulation. Because these arrangements were not actuarially sound, and the fees and expenses were often exorbitant, the arrangements

frequently collapsed leaving millions of dollars of unpaid claims. DOL investigators usually learned of the scheme when participants began complaining that their claims were not being paid. While the Department and state insurance regulators could shut the scheme down, there was seldom enough money left to pay what often amounted to millions of dollars of unpaid medical claims. *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf; https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/mewa-enforcement.pdf.

The Department explains the scope of the problem in the preamble to the Final Rule. The preamble reports that since 1985, the Department's records indicate that it has pursued 968 civil enforcement cases involving MEWAs, affecting more than 3 million participants, and has collected more than $235 million from ERISA violations. Additionally, it has pursued 317 criminal MEWA-related cases, resulting in 118 convictions and guilty pleas, and $173 million in court-ordered restitution. These statistics, however, do not reflect the full scope of the problem. As noted in the preamble, "[t]he Department's enforcement efforts often were too late to prevent or fully recover major financial losses." Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. at 28952. And as the preamble further notes, "[t]he Department generally does not consistently measure

or record those associated unpaid claims or their financial impacts on patients and healthcare providers." *Id*.

The problems with MEWAs have not magically disappeared. As recently as February 2019, the Department shut down a MEWA that had approximately $24 million in processed but unpaid claims with insufficient assets to pay them. The complaint alleged that the MEWA operators failed to set adequate premium rates to properly fund the MEWA, failed to hold the assets in trust, and charged excessive fees. As unpaid claims mounted, the MEWA operators delayed payment of approved claims and cherry-picked which claims to pay. *See* https://www.dol.gov/newsroom/releases/ebsa/ebsa20190211.[4]

While the preamble to the Final Rule acknowledges the problem with fraudulent MEWAs, the Final Rule allows them to continue (now with the blessing of the Department). The Final Rule allegedly includes provisions to protect AHPs against mismanagement and abuse, and while marginally better than the proposed rule, the Final Rule's supposed protections can easily be manipulated. The primary protection, for example, is the requirement that the group or association sponsoring

[4] *See also* https://www.dol.gov/newsroom/releases/ebsa/ebsa20190619 (announcing 2019 guilty plea by MEWA entrepreneurs who caused at least $40 million in losses to IRS and plan participants); https://www.dol.gov/newsroom/releases/ebsa/ebsa20181004-0 (announcing 2018 amendment of complaint seeking $50 million in unpaid claims from MEWA operators).

the AHP have a formal organizational structure with a governing body and by-laws or other similar indications of formality. Someone seeking to defraud could easily establish a formal organizational structure that meets these requirements and seduce unsuspecting small employers, many of whom will have little time or inclination to play a role in the AHP, to sign up in hopes of obtaining health care coverage for a low rate.

For example, a promoter could easily set up an AHP with a formal structure and by-laws, but then hand-pick the initial members who could be insurance agents that sell the arrangement to other employers. These hand-picked members sit on the board, appoint the officers of the association and are all too willing to go along with whatever the promoter wants – especially since there is financial gain from doing so. A vote from outsiders does not occur until after a year, and even assuming a self-employed individual or small business person is elected to the board, he or she would be unlikely to have the time, interest or ability to take control of an association that is already on a path toward collapse. While on paper there is control by association members, in real life, the promoter controls the AHP's operation and has already bled it dry through excessive fees or outright theft, leaving behind the unpaid medical claims of the members' employees.

The Department has seen similar scenarios time and time again. While not a Department case, *Gruber* tells the typical story. In that case, J. Patrick Karle, the

principal of the brokerage firm, Hubbard Bert Karle Weber, Inc. ("HBKW"), created the Lake Erie Employers' Association ("LEEA"), a non-profit corporation made up of diverse businesses in the Northwestern Pennsylvania area. *Gruber,* 159 F.3d at 783. Karle served as the President and Chairman of the Board of Directors of LEEA. *Id*. Four other HBKW principals also served on the Board and were officers of LEEA. 159 F.3d at 784. Although LEEA was formed ostensibly to serve as a forum where small business owners could obtain information about changes in the law and regulations governing employee benefit plans, its primary purpose was to provide health and other benefits to the employees of its employer members. *Id*.

Shortly after LEAA was created, the Board established the LEAA Benefit Trust and the Accident and Health Plan. *Id*. After the Trust was established, four of the HBKW principals resigned (Karle remained) and four new employer-member directors joined the Board. *Id*. The bylaws, however, were amended three months later to provide that the four former directors, who remained officers of LEEA, would be "ex-officio members of the Board of Directors by virtue of the independent management functions which they performed for the Corporation … [with] equal standing and authority with other members of the Board." *Id*. Not surprisingly, HBKW became the administrative agent of the plan and received fees from LEEA in exchange for maintaining records and processing claims for the LEEA plans. *Id*.

LEEA's formal organizational structure with a governing body and by-laws did not save it. Within three years of creation, the LEEA plan was insolvent. *Id*. The Third Circuit concluded that the LEEA plan was, in fact, controlled by LEEA members, but that it did not meet the other requirements established by the Department for determining whether an organization is a "bona fide employer organization." *Id.* at 788. As the court noted, (1) LEEA members were solicited by salespeople working for HBKW who attempted to sell membership in the LEEA Plan and other HBKW insurance products; (2) the restrictions placed on membership were few, continued to change and the by-laws allowed for the admission of "associate members" who did not satisfy membership requirements; and (3) there were no preexisting relationship between the LEEA employer members and solicitation of new members was not based on appeals to the shared interest of the organization, but on the sale by HBKW employees of participation in the plan. *Id*. at 788 n.5. Like the AHPs promoted by the Department, formal organizational structure did not save a plan that was, in fact, a for-profit venture marketed to small business owners hoping to purchase low cost health coverage for their employees.

Under these circumstances, the Final Rule is neither necessary nor appropriate to carry out the provisions of Title I. To the contrary, it puts millions of American

workers at risk that their benefits will not be paid – the very risk Title I was designed to avoid.

CONCLUSION

For the foregoing reasons, the District Court's decision should be affirmed.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitations of Fed. R. App. P. 29(a)(5), Fed. R. App. P. 32(a)(2), and D.C. Cir. Rule 32(e)(3) because it contains 6,116 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief complies with the type-face requirements and the type-style requirements of Fed. R. App. P. 32(a)(4)-(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.

CERTIFICATE OF SERVICE

I hereby certify that, on July 22, 2019, I electronically filed the foregoing brief of Former United States Department of Labor Officials Phyllis C. Borzi, M. Patricia Smith, Alan D. Lebowitz, Marc I. Machiz and Daniel J. Maguire as Amicus Curiae in Support of Appellants and Affirmance with the Clerk of the United States Court of Appeals for the District of Columbia Circuit by using the electronic CM/ECF system, and served copies of the foregoing via the Court's CM/ECF system on all ECF-registered counsel.

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