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District Court Invalidates Labor Department's 2018 Final Association Health Plan Rule

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INTRODUCTION

In June 2018, The Department of Labor (DOL) issued a final regulation (the "Final Rule")[1] amending the definition of "employer" in §3(5) of the Employee Retirement Income Security Act (ERISA) for the purpose of expanding access by small employers and self-employed individuals to association health plans (AHPs). On July 26, 2018, 11 states (New York, Massachusetts, California, Delaware, Kentucky, Maryland, New Jersey, Oregon, Pennsylvania, Virginia, and Washington) and the District of Columbia filed a complaint in the U.S. District Court for the District of Columbia seeking to invalidate the Final Rule. In *New York v. DOL*,[2] District Judge John D. Bates sided with the States, concluding that the Final Rule is an unreasonable interpretation of ERISA.

Historically, the ability of small employers to band together for these purposes was limited, and self-employed individuals were entirely barred from doing so. The Final Rule sought to make it easier for small groups to combine to form, and for the first time allow self-employed individuals to join, large-group AHPs. The Eleven states and the District of Columbia challenged the Final Rule fearing that it would wreak havoc on their small group and individual insurance markets. They succeeded at trial.

BACKGROUND

The debate over AHPs can be framed with a single, simple question: under what circumstances may a collection of small employers (generally, under 50 employees)[3] and self-employed individuals band together to form a large group for underwriting and other regulatory purposes? The references to the "small group," "large group," and "individual" markets refer generally to historic insurance market segmentation rules that predate and were modified by the Affordable Care Act (ACA).[4]

The ACA adopted a series of insurance market reforms that apply to all market segments—large group, small group, and individual. These mandates include, among other things, a ban on pre-existing conditions, lifetime and annual limits on essential health benefits, and rescissions of coverage absent fraud or misrepresentation. Plans must also include internal and external appeals processes, allow participants a choice of a primary care physician, pediatrician, and OB/GYN, provide direct access to emergency services, limit waiting periods, cover the cost of clinical trial participation, limit out-of-pocket expenses, and provide a Summary of Benefits and Coverage.

There is a smaller, separate set of ACA insurance market reforms that only apply in the small group and individual markets. These include:

- A requirement that plans and policies cover a series of 10 services referred to as "essential health benefits;"

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[1] Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912-28,964 (June 21, 2018) (to be codified at 29 C.F.R. pt. 2510).

[2] No. 18-cv-1747 (JDB), 2019 BL 109455 (D.D.C. Mar. 28, 2019).

[3] Public Health Service Act, 42 U.S.C. §300gg-91 (2014), §2791(e)(4).

[4] Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, (enacted March 30, 2010, Pub. L. No. 111-152); Care and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, 124 Stat. 3285 (2010); Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Pub. L. No. 112-9, 125 Stat. 36 (2011); Department of Defense and Full-Year Continuing Appropriations Act of 2011, Pub. L. No. 112-10, 125 Stat. 38 (2011); and Three Percent Withholding Repeal and Job Creation Act, Pub. L. No. 112-56, 125 Stat. 711 (2011).

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- A mandated risk adjustment program (that transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees);
- Guaranteed issue/renewability requirements that treat these groups as a single, consolidated risk pool (under which the claims experience of all individuals enrolled in plans offered by the issuer in the individual market is considered to be in a single risk pool); and
- Modified community rating (premiums may vary only by location, age (within certain limits), family size, and tobacco use (within certain limits)).

Large groups are not subject to these requirements, which gives them greater design flexibility.

In October 2017, President Trump issued an Executive Order titled ''Promoting Healthcare Choice and Competition Across the United States'' (the ''Executive Order''),[5] which, among other things, encouraged the DOL to ''expand [] the conditions that satisfy the commonality-of-interest requirements'' in the DOL's existing guidance and to ''consider ways to promote AHP formation on the basis of common geography or industry.''[6] In the view of the Trump Administration, these changes would allow small employers and self-employed individuals to be able to combine to more effectively compete for affordable health coverage on par with large employers.

The Executive Order's reference to the ''commonality-of-interest requirement'' is to prior law governing AHPs. Historically, only so-called ''bona fide associations'' could sponsor a consolidated, large group AHP. Bona fide associations had to display certain employer-like characteristics that distinguished them from commercial insurance-type arrangements. Prior law determined whether an association qualified as a bona fide association under three criteria:

- **Purpose**. Whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits;
- **Commonality of Interest**. Whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and
- **Control**. Whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program, both in form and substance.

Both before and after the ACA's enactment, an insurance carrier underwriting an AHP was generally required to look-through the group sponsoring the AHP to the underlying size of the AHP member. Under this ''look-through'' rule, small groups and individuals generally retained their status as such even where coverage was purchased through an association. The look-through rule was articulated in a CMS Insurance Standards Bulletin issued on September 1, 2011, which described the general rule and acknowledged a rarely occurring exception under which an AHP sponsored by a ''bona fide group or association of employers'' is treated as a single plan.[7] The Final Rule made it easier for small groups to qualify for, and for the first time provided self-employed individuals access to, the bona fide group or association exception.

Colloquially, the DOL sometimes refers to the prior AHP rules as ''Pathway 1,'' and to the rules established by the Final Rule as ''Pathway 2.'' While these terms have no independent legal significance, they provide a useful shorthand. Importantly, the district court found fault only with Pathway 2 when rejecting the changes wrought by the Final Rule. The court's decision left prior law, Pathway 1, intact.

THE DECISION

Before addressing the substance of the States' challenge to the Final Rule, the court took up the question of whether the States had standing, i.e., do the States have any legally cognizable injury for which the court could offer a remedy? The standing analysis takes up a surprisingly large part of the opinion, and the court rejected many of the States' standing claims—e.g., a steep rise in uncompensated care costs, loss of tax revenues, and an increase in regulatory burden. The court ultimately found that standing existed based on a ''fairly direct link'' between the Final Rule's intended expansion of self-insured AHPs and the decrease in tax revenues. Specifically, the court determined that state tax revenues will decrease due to the failure to collect premium taxes ''when individuals select coverage through a self-insured AHP.''[8]

With the matter of standing settled, the court next moved to the substance of the States' challenge. The States claimed that the Final Rule's bona fide association and working owner provisions conflict with the text and purpose of both the ACA and ERISA and exceed DOL's statutory authority. The court agreed.

The Final Rule as an 'End-Run' Around the ACA

Judge Bates opined that the Final Rule was ''designed to expand access to AHPs in order to avoid the most stringent requirements of the ACA.'' He appeared alternately annoyed and surprised that the La-

[5] Exec. Order No. 13813, 82 Fed. Reg. 48,385 (Oct. 17, 2017).

[6] *Id.* §2.

[7] CMS, Insurance Standards Bulletin, Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations (Sept 1, 2011).

[8] *New York*, 2019 BL 109455 at *9-11.

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bor Secretary publicly said as much.[9] In reaching this conclusion, Judge Bates focused only on the ACA's essential health benefits requirement, in the course of which he commits a glaring error, saying:

> Large-group market participants face a choice: They may decline to provide these essential health benefits and instead pay a tax—the so-called ''employer shared responsibility payment.''[10]

This is simply wrong. Large-group market participants do have choices: they can fail to offer coverage to substantially all their full-time employees and their dependents and risk exposure to penalties under IRC §4980H(a); they can offer, to substantially all their full-time employees and their dependents, minimum essential coverage that either fails to provide minimum value or is unaffordable and risk exposure to penalties under IRC §4980H(b); or they can insulate themselves from exposure to assessable payments under IRC §4980H(a) and §4980H(b) by offering affordable, minimum value coverage to all their full time employees. (In each case, penalties are imposed **only** if at least one full-time employee qualifies for premium tax credits and/or cost sharing subsidies from an ACA exchange/marketplace.) These results are unaffected by whether the offer of coverage includes essential health benefits. Nevertheless, because the Judge's view of the motivation underlying the Final Rule adoption is dicta, this error is in all likelihood harmless.

Judicial Deference and the Chevron Framework

The matter of the DOL's authority and the deference owed by the court to that authority has received a good deal of attention lately. In *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-844 (1984), the Supreme Court held that, if a statutory term is ambiguous, the agency has authority to construe that term and interpret its meaning within the statutory scheme by promulgating regulations following Administrative Procedure Act notice and comment procedures. If the procedures are followed, a court must defer to the agency's interpretation. This legal doctrine is referred to as the ''Chevron deference,'' and it has been criticized by various judges, including Supreme Court Justice Neil Gorsuch (then sitting on the Tenth Circuit).[11]

If the efficacy of *Chevron* deference was on the court's mind, there is no indication of it in the opinion. Rather, the court agreed that the deferential standard applied to the DOL's interpretation of ''employer'' in ERISA.[12] Following the two-step *Chevron* framework, the court had no problem determining that the statute (here, ERISA) was ambiguous. The court next moved on to the second *Chevron* prong, explaining that it would uphold the Final Rule unless the rule was ''procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute.''[13] The court held that the DOL's interpretation failed this latter prong because the Final Rule constituted an impermissible construction of the statute. The court thereupon undertook a thorough analysis of why the DOL's regulatory interpretation of ERISA was not reasonable.

ERISA and the Employment Relationship

The court was troubled by the DOL's failure to establish meaningful limits on the types of associations that may qualify to sponsor an ERISA plan. This, said the court, violated ''Congress's intent that only an employer association acting 'in the interest of' its members falls within ERISA's scope.''[14] The court was of the same view where self-employed individuals are concerned. In sum, the court was persuaded that the Final Rule fails to honor the employment nexus that is at the core of the ERISA regulatory scheme.

Employers Acting in the Interest of Employers

The court next focused on the ERISA requirement that, for employer associations to qualify as ''employers'' for the purpose of sponsoring an employee benefit plan, the group or association of employers acts ''in the interest of an employer.'' Explaining that associations qualifying as employers must act ''in the interest of'' an employer, the court noted that the statutory text is not infinitely elastic. Rather, the phrase ''in the interest of an employer'' distinguishes employer associations that stand in the shoes of an ''employer'' for the purpose of sponsoring an ERISA plan from every other employer association. Thus, entrepreneurial ventures selling insurance for a profit to unrelated groups are unequivocally outside of ERISA's scope.[15] The court flagged this issue, returning to it later throughout the balance of the opinion.

The Final Rule Is Not Reasonable

According to the court, the Final Rule's bona fide association provision is not reasonable because it unlawfully expands ERISA's scope. While the Final Rule adopted the same prior law standards for determining which associations are ''bona fide'' (purpose, commonality of interest, and control), the court determined that the Final Rule departs too far from the DOL's prior sub-regulatory guidance.

Purpose Test

The Final Rule allows an association to sponsor an AHP as long as the association has ''at least one sub-

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[9] *See* Alexander Acosta, *A Health Fix for Mom and Pop Shops*, Wall St. J. (June 18, 2018) (expressing the view that ''ObamaCare imposes starkly different rules on large companies and small businesses,'' and making clear that the Final Rule was designed to eviscerate that distinction).

[10] *New York*, 2019 BL 109455 at *4 (quoting I.R.C. §4980H).

[11] *See Gutierrez-Brizuela v. Lynch*, 834 F.3d 1142, 1149 (10th Cir. 2016) (Gorsuch, J., concurring).

[12] *New York*, 2019 BL 109455 at 13.

[13] *Id.* (quoting *United States v. Mead Corp.*, 533 U.S. 218, 227, 229 (2001)).

[14] *Id*. at *13.

[15] *Id*. at *15.

stantial business purpose'' unrelated to the provision of health care, even if its primary purpose is ''to offer and provide health coverage to its employer members and their employees.''[16] The DOL's rule does not define ''substantial business purpose.'' Rather, it simply requires that a group or association would be a viable entity in the absence of sponsoring an employee benefit plan. For the court, this approach went too far. In particularly frank language, the court opined that:

> The Final Rule's ''safe harbor'' provision reveals how flimsy the purpose test really is. The safe harbor provision specifies that an association that ''would be a viable entity in the absence of sponsoring an employee benefit plan'' will satisfy the purpose test. [ ] The ''substantial business purpose'' test, then, is only an ex post facto, perfunctory requirement—merely a box to check—that virtually any association may fulfill on the side and thereby qualify to sponsor an AHP under the Final Rule. This business purpose does not, in fact, need to be ''substantial'' in the ordinary sense of that term, because it need not make the association viable in the absence of the association's AHP. This requirement therefore is more aptly called the ''other business task'' test. It sets such a low bar that virtually no association could fail to meet it.[17]

Thus, the court concluded that the Final Rule's purpose test provides **no** meaningful limit on the associations that would qualify as bona fide ERISA employers.

Commonality of Interest

The court characterized the commonality of interest test as ''arguably the most important of the three criteria because it most directly relates to the core concern of the statute: employers' interests.''[18] Under the Final Rule, to demonstrate commonality of interest, employers must either share a common trade, industry, line of business, or profession, or else each employer must have ''a principal place of business in the same region that does not exceed the boundaries of a single State or a metropolitan area (even if the metropolitan area includes more than one State).''[19] It was the latter requirement, geography, that troubled the court. Before an association can act ''in the interest of'' an employer member, said the Court, ''that interest must be defined,'' which common geography cannot do.[20]

Control

The Final Rule did not materially change the control requirement. According to the Court, the control test largely duplicates the conditions in the DOL pre-2018 guidance. Both under prior law and under the new rule, control requires that the functions and activities of the group or association are controlled by its employer members, and the group's or association's employer members that participate in the group health plan control the plan. Employer members are deemed to have control where they can nominate, elect, and remove directors and approve or veto material amendments.[21] A careful reading of the previous sentence discloses that there are two levels of control, the level of the association and the level of the plan. This means, for example, that a Chamber of Commerce with a self-nominating board (which is common in our experience) cannot satisfy the control test, because members are not generally free to nominate, elect, and remove directors and approve or veto material amendments.

CONCLUSION

It's too soon to tell whether the decision in *New York v. DOL* is a battle in a larger war or the war itself. That depends on the parties. The government is likely to appeal the decision. The decision's outcome appears to us to be at least sound. Whether that outcome rises to the level of unassailable, only time will tell.

Lest it go unnoticed, we hasten to add that one need not stray at all from the decision's text to discern a powerful and ringing endorsement of the prior law ERISA rules governing bona fide associations, i.e., Pathway 1. The opinion enunciates clearly what those standards are (purpose, commonality of interest, and control), holds them up as exemplars, and finds the new rules wanting by comparison. The court found no fault with the September 2011 CMS notice, which posits a general rule that looks through an association and a narrow exception for bona fide, Pathway 1 arrangements. This has important ramifications for those state regulators who, in the wake of the issuance of the Final Rule, issued guidance categorically rejecting **any** large group AHPs.

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[16] *Id.* at *16 (quoting 29 C.F.R. §2510.3-5(b)(1)).

[17] *Id.* at *17.

[18] *Id.* at *18.

[19] 29 C.F.R. §2510.3-5(c)(1).

[20] *New York*, 2019 BL 109455 at *18.

[21] *Id.* (citing 83 Fed. Reg. at 28,920).

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