

Revised: 11/11/20

Virtual Meeting

REGULATORY FRAMEWORK (B) TASK FORCE

Thursday, November 19, 2020

1:00 p.m. – 2:00 p.m. ET / 12:00 – 1:00 p.m. CT / 11:00 a.m. – 12:00 p.m. MT / 10:00 – 11:00 a.m. PT

ROLL CALL

Michael Conway, Chair	Colorado	Grace Arnold	Minnesota
Bruce R. Range, Vice Chair	Nebraska	Chlora Lindley-Myers	Missouri
Jim L. Ridling	Alabama	Chris Nicolopoulos	New Hampshire
Lori K. Wing-Heier	Alaska	Mike Causey	North Carolina
Elizabeth Perri	American Samoa	Jon Godfread	North Dakota
Alan McClain	Arkansas	Glen Mulready	Oklahoma
Ricardo Lara	California	Andrew R. Stolfi	Oregon
Karima M. Woods	District of Columbia	Jessica K. Altman	Pennsylvania
David Altmaier	Florida	Raymond G. Farmer	South Carolina
Dean L. Cameron	Idaho	Larry Deiter	South Dakota
Robert H. Muriel	Illinois	Kent Sullivan	Texas
Doug Ommen	Iowa	Tanji J. Northrup	Utah
Vicki Schmidt	Kansas	Scott A. White	Virginia
Sharon P. Clark	Kentucky	Mike Kreidler	Washington
Eric A. Cioppa	Maine	James A. Dodrill	West Virginia
Gary Anderson	Massachusetts	Mark Afable	Wisconsin
Staff Support: Jolie Matthews/Jennifer Cook			

AGENDA

1. Consider Adoption of its Oct. 23, Sept. 24 and Summer National Meeting Minutes
—*Commissioner Michael Conway (CO)*
2. Consider Adoption of its Subgroup and Working Group Reports
 - a. Accident and Sickness Insurance Minimum Standards (B) Subgroup
—*Commissioner Glen Mulready (OK) and TBD*
 - b. ERISA (B) Working Group—*Robert Wake (ME)*
 - c. HMO Issues (B) Subgroup—*Scott A. White (VA) and Don Beatty (VA)*
 - d. MHPAEA (B) Working Group—*Commissioner Jessica K. Altman (PA) and Katie Dzurec (PA)*
3. Receive a Report from the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup—*TK Keen (OR)*
4. Hear a Presentation on “Protect Consumers from Individual Health Insurance Marketing & Sales Abuses”
—*Harold M. Ting (Healthcare Consumer Advocate)*
5. Hear a Discussion of the Decision in *Data Marketing Partnership, LP, et al vs. U.S. Department of Labor, et al*—*Marc I. Machiz (Justican Mediation, LLC)*
6. Discuss Task Force Possible Next Steps Regarding Health Care Sharing Ministries (HCSMs)
—*Commissioner Michael Conway (CO)*

7. Discuss Any Other Matters Brought Before the Task Force—*Commissioner Michael Conway (CO)*
8. Adjournment

Agenda Item #1

**Consider Adoption of its Oct. 23, Sept. 24 and Summer National Meeting Minutes
—*Commissioner Michael Conway (CO)***

Draft: 11/4/20

Regulatory Framework (B) Task Force
Virtual Meeting
October 23, 2020

The Regulatory Framework (B) Task Force met Oct. 23, 2020. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair (NE); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony Williams, William Rodgers and Yada Horace (AL); Alan McClain (AR); Elizabeth Perri (AS); Ricardo Lara represented by Bruce Hinze, Tyler McKinney and Sheirin Ghoddoucy (CA); David Altmaier (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler and Kathy McGill (ID); Robert H. Muriel represented by Eric Anderson (IL); Vicki Schmidt (KS); Sharon P. Clark represented by DJ Wasson (KY); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Grace Arnold represented by Peter Brickwedde and Candace Gergen (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Della Shepherd (NC); Jon Godfread represented by Chrystal Bartuska and Johnny Palsgraaf (ND); Chris Nicolopoulos represented by Maureen Belanger (NH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by TK Keen and Gayle L. Woods (OR); Jessica K. Altman (PA); Raymond G. Farmer represented by Kendall Buchanan (SC); Larry D. Deiter (SD); Kent Sullivan represented by Richard Lunsford, Rachel Bowden and Doug Danzeiser (TX); Tanji J. Northrup (UT); Scott A. White represented by Jackie Myers (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. Disbanded the HMO Issues (B) Subgroup

Commissioner Conway said the Health Maintenance Organization (HMO) Issues (B) Subgroup has completed its work with the Task Force's Sept. 24 adoption of the revisions to the *Health Maintenance Organization Model Act* (#430). These revisions addressed the redundancies and inconsistencies in its provisions with the 2017 revisions to the *Health and Life Insurance Guaranty Association Model Act* (#520). Given this, the Subgroup can be disbanded.

Commissioner Altman made a motion, seconded by Director Ramge, to disband the HMO Issues (B) Subgroup. The motion passed unanimously.

2. Adopted its 2021 Proposed Charges

Commissioner Conway said that prior to the meeting, NAIC staff distributed the Task Force's 2021 proposed charges. He explained that the proposed charges generally are unchanged from the Task Force's 2020 charges. He said the HMO Issues (B) Subgroup's 2020 charges were deleted because it has completed its work and has been disbanded. He explained that the Mental Health Parity and Addition Equity Act (MHPAEA) (B) Subgroup's charges are revised to reflect the Working Group's current and ongoing work with appropriate Market Regulation and Consumer Affairs (D) Committee groups.

Mr. Keen made a motion, seconded by Commissioner Altman, to adopt the Task Force's 2021 proposed charges (Attachment One-A). The motion passed unanimously.

3. Received an Update on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's Work

Mr. Keen discussed the Subgroup's drafting process to date. He said that after the Subgroup was appointed in late 2018, it decided during its first meetings in early 2019 that it wanted to obtain more information before drafting the new model that regulates pharmacy benefit managers (PBMs) and additional provisions related to PBM prescription drug pricing and cost transparency. He said the Subgroup met 12 times throughout the summer and early fall of 2019 to hear from various stakeholders on the issues the Subgroup wanted to hear more about, such as rebating, discounts, prescription drug pricing and how PBMs are currently regulated. He said the goal was to have the Subgroup members all equally educated on these issues before it started drafting a model.

Mr. Keen said that at the conclusion of these meetings, the Subgroup decided it had obtained sufficient information to move forward with its charge. The Subgroup then established an ad hoc drafting group to develop an initial draft based on the Subgroup's discussions. He said that after a series of meetings late last year and early this year, the ad hoc drafting group developed a draft for the Subgroup's review. He said the Subgroup met July 16 to discuss the ad hoc drafting group's draft and exposed the draft for a public comment period ending Sept. 1.

Mr. Keen said the Subgroup received 19 comment letters from various stakeholders. He said the Subgroup discussed the comments received during almost weekly meetings beginning in late September through October. He said that based on this discussion, the Subgroup revised the draft and anticipates adopting it during its next meeting Oct. 29. Once adopted, he anticipates forwarding it to the Task Force for its consideration during the Task Force's Nov. 19 meeting.

Mr. Keen explained that the draft reflects the differing viewpoints from the Subgroup members with respect to PBM regulation. He said some states currently have robust PBM regulatory schemes, while other states do not currently regulate them. He said this dichotomy of state PBM regulation was evident in the Subgroup's discussions with some Subgroup members at the beginning of the drafting process advocating for establishing an elaborate regulatory scheme in the draft with other Subgroup members advocating for a more incremental approach. He encouraged the Subgroup obtain a greater understanding of the impacts of PBM regulation on prescription drug pricing before committing significant state resources to such regulation. Given this lack of consensus, Mr. Keen said the Subgroup's draft is a straight-forward PBM licensing model that includes a gag clause provision and an information-sharing provision. He said the draft also includes a drafting note outlining 15 separate PBM-related issues, such as prohibiting clawbacks, prohibiting spread-pricing, and PBM network adequacy and transparency. Finally, the draft includes state statutory citations to provisions in current state laws that those states wanting to include such provisions as part of their adoption of the proposed PBM model can use.

Commissioner Conway said that before the Task Force considers adoption of the Subgroup's draft, the Task Force will expose it for a 30-day public comment period. He said that in discussing the Subgroup's draft with Mr. Keen, it is his understanding that the *Rutledge v. Pharmaceutical Care Management Association* case, which is currently before the U.S. Supreme Court, would not affect the proposed PBM model because the draft is focused on PBM licensing and not any of the provisions at issue in the Rutledge case. Mr. Keen agreed.

Commissioner Conway asked if anyone had any questions. There were no questions.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 9/28/20

Regulatory Framework (B) Task Force
Conference Call
September 24, 2020

The Regulatory Framework (B) Task Force met via conference call Sept. 24, 2020. The following Task Force members participated: Michael Conway, Chair, represented by Kate Harris (CO); Bruce R. Ramage, Vice Chair (NE); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony Williams, William Rodgers and Yada Horace (AL); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Tyler McKinney and Sheirin Ghoddoucy (CA); Karima M. Woods represented by Howard Liebers (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen (IA); Robert H. Muriel represented by Eric Anderson and Sara Stanberry (IL); Vicki Schmidt represented by Julie Holmes and Craig Van Aalst (KS); Sharon P. Clark represented by DJ Wasson (KY); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Grace Arnold represented by Sherri Mortensen-Brown and Candace Gergen (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by John Arnold, Chrystal Bartuska and Sara Gerving (ND); Chris Nicolopoulos represented by Maureen Belanger (NH); Glen Mulready represented by Ron Kreiter (OK); Jessica K. Altman represented by Katie Dzurec (PA); Raymond G. Farmer represented by Shari Miles (SC); Larry D. Deiter (SD); Kent Sullivan represented by Rachel Bowden (TX); Todd E. Kiser represented by Tanji Northrup (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill represented by Joylynn Fix and Tim Sigman (WV).

1. Adopted Revisions to Model #430

Ms. Harris said the main purpose of the Task Force's conference call is to consider adoption of the revisions to the *Health Maintenance Organization Model Act* (#430), as adopted by the Health Maintenance Organization (HMO) Issues (B) Subgroup on July 13. Mr. Beatty said that after the Subgroup was appointed and its charge adopted in 2019, the Subgroup met via conference call throughout 2019 to discuss its approach to completing its charge to revise provisions in Model #430 to address conflicts and redundancies with provisions in the revised *Life and Health Insurance Guaranty Association Model Act* (#520), which added HMOs as members of the guaranty association. He said that during these meetings, the Subgroup identified several provisions in Model #430 to delete to reconcile it with the 2017 revisions to Model #520. Those provisions include Section 14 – Continuation of Benefits, Section 20 – Uncovered Expenditures Deposit and Section 3HH, the definition of “uncovered expenditures.” Mr. Beatty said that for states that do not intend to adopt the revised Model #520, for reference, a new appendix to Model #430 includes these deleted provisions. He said the Subgroup also deleted Section 21 – Open Enrollment and Replacement Coverage in the Event of Insolvency because its provisions are obsolete due to the federal Affordable Care Act (ACA). Mr. Beatty said the Subgroup met July 13 via conference call and during this meeting, the Subgroup unanimously adopted the revisions and agreed to forward the revised model to the Task Force for its consideration.

Ms. Nollette made a motion, seconded by Ms. Northrup, to adopt the Subgroup report and the revisions to Model #430 (*see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment Four-B*). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 8/18/20

Regulatory Framework (B) Task Force Virtual Summer National Meeting August 4, 2020

The Regulatory Framework (B) Task Force met Aug. 4, 2020. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Rame, Vice Chair (NE); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Steve Ostlund and Yada Horace (AL); Alan McClain (AR); Ricardo Lara represented by Tyler McKinney (CA); Karima M. Woods (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Kate Morthland (IL); Vicki Schmidt represented by Justin McFarland and Craig Van Aalst (KS); Sharon P. Clark represented by DJ Wasson (KY); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa (ME); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread (ND); Chris Nicolopoulos represented by Maureen Belanger (NH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Tanji Northrup and Jaakob Sundberg (UT); Scott A. White represented by Julie Blauvelt and Don Beatty (VA); Mike Kreidler (WA); Mark Afable represented by Nathan Houdek (WI); and James A. Dodrill (WV).

1. Adopted its Feb. 20 and 2019 Fall National Meeting Minutes

The Task Force met Feb. 20 and Dec. 7, 2019. During its Feb. 20 meeting, the Task Force appointed the MHPAEA (B) Working Group and adopted its 2020 proposed charges.

Ms. Kruger made a motion, seconded by Commissioner Godfread, to adopt the Task Force's Feb. 20 (Attachment One) and Dec. 7, 2019, (*see NAIC Proceedings – Fall 2019, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Director Rame made a motion, seconded by Mr. Trexler, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Dec. 16, 2019, minutes (Attachment Two); the ERISA (B) Working Group (Attachment Three); the HMO Issues (B) Subgroup, including its July 13 minutes (Attachment Four); the MHPAEA (B) Working Group (Attachment Five); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 16 minutes (Attachment Six). The motion passed unanimously.

Commissioner Conway said in adopting the HMO Issues (B) Subgroup report, the Task Force is not adopting the proposed revisions to the *Health Maintenance Organization Model Act* (#430). He said the Task Force will meet via conference call in September to consider adoption of the proposed revisions.

3. Heard an Update on the CHIR's Work Related to the ACA

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR's work related to the federal Affordable Care Act (ACA) and other issues of interest to state insurance regulators. He highlighted the work the CHIR has been doing related to the COVID-19 pandemic. He said the CHIR has set up a tracking map and database concerning state decisions related to coverage requirements during the pandemic. He said the CHIR has written several issue briefs related to the COVID-19 pandemic. With the support of the Robert Wood Johnson Foundation (RWJF), the CHIR recently issued a research brief trying to gain insight into the insurer perspective regarding coverage decisions during the pandemic. The research brief is based on interviews conducted between late April and June with 25 executives from health insurance plans.

Mr. Giovannelli said the CHIR is continuing its work to track and analyze state regulatory approaches to short-term, limited-duration (STLD) plans in the wake of recent federal rule changes with respect to these products. He said the CHIR is also continuing to track state reforms affecting the individual market, including state actions involving the ACA's section 1332 waiver program and improving the affordability of comprehensive coverage. He said the CHIR anticipates publishing an issue brief examining state reinsurance programs developed under the section 1332 waiver program. He said initial findings have shown that state reinsurance programs have had a positive effect in terms of creating individual market stability because such programs make coverage more affordable for individuals not eligible for premium subsidies. He suggested that state insurance

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regulators may want to consider looking beyond reinsurance programs and/or looking at options to provide additional individual market stability that might work in tandem with state reinsurance programs to provide stability and benefits to all market participants, including those who are receiving premium subsidies.

Mr. Giovannelli discussed the CHIR's ongoing state technical assistance regarding insurance regulatory matters with the support of the RWJF through its State Health and Value Strategies Program. He also highlighted the CHIR's assistance, provided with the support by the Laura and John Arnold Foundation (LJAF), to state and federal policymakers regarding regulatory approaches to balance billing.

Commissioner Conway said Colorado enacted legislation last year providing additional funding to allow the Colorado Department of Insurance (DOI) to look at ways to use its reinsurance program in tandem with other initiatives to provide additional individual market stability. He expressed interest in having additional discussions with the CHIR and other experts on this topic.

4. Heard a Panel Presentation on HCSMs

Mr. Giovannelli provided an overview of health care sharing ministries (HCSMs). He discussed consumer confusion involving HCSMs. He said although HCSMs are careful to say they are not insurance, to consumers, they look like traditional health insurance coverage for a number of reasons, including: 1) the use of defined benefit packages; 2) monthly payment requirements similar to premiums; 3) the use of provider networks; and 4) cost-sharing requirements, such as deductibles, copayment and co-insurance limits. In addition, he said some HCSMs use insurance brokers to sell their plans, and they have marketing campaigns that describe HCSM plans as a replacement for insurance or suggest that consumers can rely on HCSMs for financial protection. He highlighted some examples from HCSM advertising and marketing materials illustrating these concerns and why consumers may be led to believe HCSM plans are traditional health insurance plans.

Mr. Giovannelli discussed potential harms to consumers and the individual health insurance market related to HCSMs, such as: 1) misaligned expectations that their claims will be paid; and 2) risk segmentation and undermining the traditional health insurance market. He also discussed the current regulatory framework for HCSMs, noting that neither the federal mandate exemption under the ACA nor any other federal provision preempts state regulatory authority over HCSMs, and that states can, and some do, set standards for HCSMs, which they enforce.

Mr. Giovannelli offered several regulatory options regarding the regulation of HCSMs, including: 1) active, ongoing oversight to ensure compliance with state standards, such as including demonstration of compliance at the front-end through a registration requirement; 2) prohibiting HCSMs from offering financial incentives for enrollment; and 3) prohibiting marketing materials that suggest that an HCSM is operating in a financially sound manner or that it has had a successful history of meeting subscribers' financial or medical needs.

Joel Noble (Samaritan Ministries) described Samaritan Ministries' approach to meeting its members' health care needs. He said Samaritan Ministries coordinates and connects members to care for the whole need with prayer, encouragement and financial support. Samaritan Ministries believes health care needs are multi-dimensional—emotional and spiritual—as much as physical and financial. Samaritan Ministries has been operating for just over 25 years. Currently, over \$30 million is shared each month among over 270,000 members nationwide.

Mr. Noble discussed Samaritan Ministries' best practices, found at <https://www.samaritanministries.org/bestpractices>, that it believes all HCSMs should follow. The best practices suggest that an HCSM should: 1) act primarily as a facilitator for the bearing of medical burdens through the voluntary medical burden-sharing process, which does not include the pooling of funds; 2) not assume any transfer of medical risk from its members or make any guarantee of payment for any member medical expenses; 3) conform with the statutory definition of a qualifying HCSM, as required under the ACA; 4) not require its members to apply for government assistance or state aid as part of the ministry's sharing; 5) ideally not use health insurance agents or brokers to enroll members into the ministry; and 6) clearly communicate in its marketing and advertising materials that the HCSM is not an insurance company. The sharing of medical costs is completely voluntary, and members maintain their legal responsibility to pay their medical bills irrespective of whether they receive payment from the voluntary actions of other members of the ministry through the sharing process.

Mr. Noble said Samaritan Ministries values transparency, and it would not find it burdensome to report information annually if a state mandates such a requirement for HCSMs. He explained that Samaritan Ministries routinely shares financial and other information with state agencies, upon request, and its members. However, he expressed concern with non-insurance entities, such as HCSMs, registering with a state DOI because HCSMs are section 501(c)(3) charities, and they should not be subject

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to any portion of the insurance code. As a charity, HCSMs should be regulated by the state attorney general's office, and they should be subject to the same state laws that apply to other charities. However, Mr. Noble acknowledged that state DOIs do receive calls from consumers about HCSMs. To address this, he suggested that any information a HCSM shares with the state attorney general's office should be shared with the state DOI.

Commissioner Conway discussed problems that Colorado has had with the marketing by some HCSMs that lead consumers to believe that they are offering a traditional insurance product. He asked Mr. Noble why Samaritan Ministries' best practices do not specifically address this issue by specifically suggesting that an HCSM should not use insurance terms in their marketing materials. Mr. Noble said an HCSM's marketing material should make it clear that the HCSM product is not an insurance product and not use insurance terms. He said Massachusetts has included in its HCSM regulations a prohibition on the use of confusion language and the use insurance terms like "coverage" or "deductible." He agreed with Commissioner Conway's concerns related to this issue.

Mr. Sundberg asked Mr. Noble if Samaritan Ministries used actuaries to set the level of monthly members sharing. Mr. Noble said Samaritan Ministries does not use actuaries. He said Samaritan Ministries looks at health care trends and monitors health care costs. Commissioner Conway asked what Samaritan Ministries uses to price the product if it does not employ actuaries. Mr. Noble said because the sharing is member-to-member, Samaritan Ministries is dealing with medical bills after they have been incurred. He said actuaries make assumptions about future events and set premium rates based on those assumptions. HCSMs are dealing with actual medical events after they have happened. Mr. Noble said Samaritan Ministries deals with this situation by including a pro rata provision in its member agreements, such that if the sharing needs exceed the monthly shares, then the sharing is at a pro rata rate. He explained that if such a short fall occurs three times in a row, then under Samaritan Ministries' guidelines, its members can vote to increase their monthly share amounts to address the current shortfall and avoid future shortfalls.

Commissioner Conway asked Mr. Noble about Samaritan Ministries' position on the payment of commissions to individuals who enroll people into its HCSM products. Mr. Noble said Samaritan Ministries does not support the payment of commissions because it could lead to possible fraudulent and deceptive practices surrounding enrollment that could be harmful to consumers.

5. Heard a Discussion on Premium Holidays, Early MLR Rebate Payments, and Adjustments to Cost-Sharing Benefits as a Result of Fewer Claims Filings in 2020 Due to COVID-19

Jason Levitis (Levitis Strategies LLC) said as many know, the COVID-19 pandemic has led to a substantial reduction in commercial health insurance claims, partly because consumers are avoiding non-urgent health care. He said some health insurers, particularly in the Medicare market, have responded with premium holidays or rebates. He said with respect to premium holidays and rebates, many state insurance regulators have been supportive of providing rebates and premium holidays to consumers, but it is unclear whether federal rules permit it, particularly with respect to individuals receiving coverage through the health insurance exchanges. He noted that the federal Centers for Medicare & Medicaid Services (CMS) have said subject to the states allowing it, pre-payment of medical loss ratio (MLR) rebates are allowed as an avenue for providing premium discounts; but again, the issue is how to apply it and its implications for those receiving coverage through the health insurance exchanges in light of advanced premium tax credits (APTCs). He said if the CMS does not address the premium holiday and rebating issue, then insurers could be receiving too much money when the rebate lowers the premium amount due; and consumers may be on the hook for paying back the excess amount when they file their taxes. He posed several questions that the CMS needs to consider in issuing any guidance to address this issue, including: 1) the financial impact on consumers; 2) the potential administrative burden on consumers; and 3) the impact on carriers.

Randy Pate (Center for Consumer Information and Insurance Oversight—CCIIO) discussed the CMS's current work related to the COVID-19 health emergency. He said while focusing on the health emergency, the CMS and the CCIIO are also focusing on the upcoming open enrollment period for 2021, and they are continuing their focus on increasing competition in the individual market and lowering premiums to make health care coverage more affordable. Mr. Pate said while he was speaking, the CMS just released guidance on a new temporary policy that will allow issuers to offer temporary premium reductions for individuals with 2020 coverage in the individual and small group markets. The guidance can be found at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Premium-Credit-Guidance.pdf>. Mr. Pate provided a general overview of the guidance provisions, noting that it touches on the questions Mr. Levitis posed, such as how the premium reductions will be reported to the Internal Revenue Service (IRS). Mr. Pate said the guidance requires that the premium reduction be a fixed percentage and be prospective only. He also said that he anticipates future rulemaking to address some of the questions that Mr. Levitis raised.

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Commissioner Conway asked about carriers who have already provided rebates or premium holidays. Mr. Pate said these carriers should submit the template to the CMS outlining what they have done, which the CMS will review. He said he anticipates the CMS providing flexibility to these insurers. Commissioner Conway asked Mr. Pate what he anticipates will be included in future rulemaking that he anticipates the CMS issuing. Mr. Pate said future rulemaking will most likely address risk adjustment issues.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Agenda Item #2

Consider Adoption of its Subgroup and Working Group Reports
—*Commissioner Michael Conway (CO)*

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS (B) SUBGROUP

Summary Report

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force has not met since Dec. 16, 2019 due to the COVID-19 health emergency and the loss of one of its co-chairs, the Subgroup has not met since December 2019. It is anticipated the Subgroup will begin meeting sometime in late January 2021, to complete its discussion of the comments received on Sections 1-5 of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) and begin discussion of the comments received on Sections 6 and 7 of Model #171.

Virtual Meeting

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) (B) WORKING GROUP
November 12, 2020

Meeting Summary Report

The Employee Retirement Income Security Act (ERISA) (B) Working Group met Nov. 12, 2020, in a regulator-to-regulator session pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

HEALTH MAINTENANCE ORGANIZATION (HMO) ISSUES (B) SUBGROUP

Summary Report

The Health Maintenance Organization (HMO) Issues (B) Subgroup of the Regulatory Framework (B) Task Force has not met since July 13, 2020. During that meeting the Subgroup completed its work in adopting revisions to the *Health Maintenance Organization Model Act* (#430) that address inconsistencies and redundancies in the model with the provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520), which added (HMOs) as members of the guaranty association. The Regulatory Framework (B) Task Force disbanded the Subgroup on Oct. 23.

Virtual Meeting

**MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP
October 6, 2020**

Meeting Summary Report

The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group met Oct. 6, 2020, in a regulator-to-regulator session pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

Agenda Item #3

**Receive a Report from the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
—TK Keen (OR)**

Conference Calls

PHARMACY BENEFIT MANAGER REGULATORY ISSUES (B) SUBGROUP

October 29, 2020 / October 22, 2020 / October 8, 2020 / October 1, 2020 / September 24, 2020 / September 14, 2020

Summary Report

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 29, Oct. 22, Oct. 8, Oct. 1, Sept. 24 and Sept. 14, 2020. During these meetings, the Subgroup:

1. Discussed the Sept. 1 comments received on the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model).
2. Adopted the PBM model and forwarded it to the Regulatory Framework (B) Task Force for its consideration.

Draft: 11/10/20

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
October 29, 2020

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 29, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson, Vice Chair (NE); Lori K. Wing-Heier, Sarah Bailey and Chris Murray (AK); Yada Horace (AL); Marjorie Farmer (AR); Bruce Hinze (CA); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain and DJ Wasson (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Amy Hoyt and Cynthia Amann (MO); David Dachs (MT); Robert Croom (NC); Gale Simon (NJ); Renee Blechner (NM); Michael Humphreys (PA); Rachel Jade-Rice (TN); Don Beatty (VA); Jennifer Kreidler and Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); Ellen Potter (WV); and Denise Burke (WY).

1. Adopted a PBM Model

Mr. Keen said following the Subgroup's Oct. 22 meeting, NAIC staff circulated a revised draft of the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) reflecting the Subgroup's discussion during that meeting. He also noted that the addition of additional state statutory citations in the drafting note for Section 8—Regulations. He asked for additional comments.

Commissioner Schmidt asked if the Subgroup plans to incorporate the additional state statutory citations provided by the National Community Pharmacists Association (NCPA) in its comment letter to the Subgroup. Mr. Keen suggested that the Subgroup add those additional citations, but not include the commentary related to those citations that the NCPA included in its comment letter. After discussion, Mr. Hinze made a motion, seconded by Commissioner Schmidt, to add the NCPA state statutory citations to the draft without the suggested commentary. The motion passed unanimously. Mr. Keen said additional state statutory citations may be added as the draft moves through the adoption process.

Mr. Hinze made a motion, seconded by Mr. Humphreys, to adopt the draft PBM model (Attachment ?-A) and forward it to the Regulatory Framework (B) Task Force for its consideration. The motion passed unanimously.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 10/29/20
A new model

Comments are being requested on this draft. Comments should be sent by email only to Jolie Matthews at jmatthews@naic.org.

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.

Section 2. Purpose

- A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.
- B. The purpose of this Act is to:
 - (1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;
 - (2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;
 - (3) Provide for powers and duties of the commissioner; and
 - (4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

- A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:
 - (1) Receiving payments for pharmacist services;
 - (2) Making payments to pharmacists or pharmacies for pharmacist services; or
 - (3) Both paragraphs (1) and (2).

- B. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

- C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.
- D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.
- E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:
- (1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
 - (2) Disbursing or distributing rebates;
 - (3) Managing or participating in incentive programs or arrangements for pharmacist services;
 - (4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
 - (5) Developing and maintaining formularies;
 - (6) Designing prescription benefit programs; or
 - (7) Advertising or promoting services.
- G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.
- H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.
- I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.
- J. (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.
- (2) “Pharmacy benefit manager” does not include:
- (a) A health care facility licensed in this state;

- (b) A health care professional licensed in this state;
- (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or
- (d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

Section 4. Applicability

- A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

Drafting Note: States may want to consider adding language to Subsection A above or Section 10—Effective Date providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

- B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.
- C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

- A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.
- B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

Drafting Note: States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

- C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

Drafting Note: States may want to consider reviewing their third party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

- D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of \$[X].
- E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.
- F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations, including the payment of an annual license renewal fee of \$[X] and completion of a renewal application on a form prescribed by the commissioner.

- (2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

- A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:
 - (1) The nature of treatment, risks or alternative thereto;
 - (2) The availability of alternate therapies, consultations, or tests;
 - (3) The decision of utilization reviewers or similar persons to authorize or deny services;
 - (4) The process that is used to authorize or deny healthcare services or benefits; or
 - (5) Information on financial incentives and structures used by the insurer.
- B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.
- C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:
 - (1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
 - (2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:
 - (a) Marks as confidential any document in which the information appears; or
 - (b) Requests confidential treatment for any oral communication of the information.
- D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:
 - (1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
 - (2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.
- E.
 - (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.
 - (2) Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person's health benefit plan.

Section 7. Enforcement

- A. The commissioner shall enforce compliance with the requirements of this Act.
- B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

Drafting Note: States may want to consider including a reference to the cost of examinations in the *Model Law on Examinations* (#390).

Drafting Note: States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

- (2) The information or data acquired during an examination under paragraph (1) is:
 - (a) Considered proprietary and confidential;
 - (b) Not subject to the [Freedom of Information Act] of this state;
 - (c) Not subject to subpoena; and
 - (d) Not subject to discovery or admissible in evidence in any private civil action.
- C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner's duties to determine compliance with this Act.
- D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

Drafting Note: If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

Section 8. Regulations

The commissioner may adopt regulations regulating pharmacy benefit managers that not inconsistent with this Act.

Drafting Note: This Act is primarily intended to establish licensing standards for pharmacy benefit managers (PBMs). A number of states have enacted statutes or made suggestions that extend into the regulation of pharmacy benefit manager business practices. The provisions below, which are followed by citations to state law where applicable, provide topic areas that states pursuing this Act may wish to consider in their proposed legislation:

- (1) PBM network adequacy (Ark. Code 23-92-505 and Okla. Stat. 36-6961) (Also, see provisions in the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) and the *Health Benefit Plan Network Access and Adequacy Model Act* (#74));
- (2) Prohibited market conduct practices (Ark. Code 23-92-506; MD. ANN. CODE § 15-1642; N.M. Stat. 59A-61-5 and 59A-61-7; Oregon Rev. Stat. §§ 735.534 through 735.552; and South Carolina Code §38-71-2230(A)(1));
- (3) Data reporting requirements under state price-gouging laws;
- (4) Rebates (MD. ANN. CODE § 15-1624 and Texas Insurance Code §1369.502);
- (5) Prohibitions and limitations on the corporate practice of medicine (CPOM);
- (6) Compensation (Ark. Code 23-92-506(b)(5)(A) and N.J.S.A. 17B:27F-8 (New Jersey));

- (7) Procedures for pharmacy audits conducted by or on behalf of a PBM (Del. Ins. Code Chapter 33A §§ 3301A – 3310A; MD. ANN. CODE § 15-1629; Oregon Rev. Stat. §§ 735.540 through 735.552; and 40 PA. CONS. STAT. §§ 4511-4514);
- (8) Medical loss ratio (MLR) compliance;
- (9) Affiliate information-sharing (Ga. Code § 26-4-119 and § 33-64-11(a)(8));
- (10) Lists of health benefit plans administered by a PBM in this state (New Hampshire Rev Stat § 402-N:6)
- (11) Reimbursement lists or payment methodology used by PBMs (Ark. Code § 17-92-507; Del. Ins. Code Chapter 33A §§ 3321A – 3324A; Kansas Rev Stat §§ 40-3829 - 40-3830; 24-A Maine Rev. Stat. Ann. Chapter 56-C; Colo. Rev Stat. § 25-37-103.5; MD. ANN. CODE § 15-1628.1 and §15-1628.2; N.J.S.A. §17B:27F-2 (New Jersey); and Oregon Rev. Stat. § 735.534 and § 735.536);
- (12) Prohibiting clawbacks (Ala. Code § 27-45A-5; MD. ANN. CODE § 15-1628.3; Minn. Stat. 62W.13; N.J.S.A. 17B:27-7 (New Jersey); and Oregon Rev. Stat. § 735.534);
- (13) Affiliate compensation (Colo. Rev. Stat. § 10-16-122.3 and Ga. Code § 26-4-119 and § 33-64-11(a)(7));
- (14) Prohibiting spread pricing (LA. REV. STAT. ANN § 22:1867 and Va. Code § 38.2-3467(D)); and
- (15) Transparency provisions (24-A Maine Rev. Stat. Ann. Chapter 56-C and Texas Insurance Code § 1369.502).

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 10. Effective Date

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

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Draft: 11/5/20

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
October 22, 2020

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 22, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Laura Arp and Martin Swanson, Vice Chairs (NE); Sarah Bailey and Chris Murray (AK); Yada Horace (AL); Marjorie Farmer (AR); Bruce Hinze (CA); Andria Seip (IA); Vicki Schmidt (KS); DJ Wasson (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Cynthia Amann (MO); David Dachs (MT); Robert Croom (NC); Gale Simon (NJ); Paige Duhamel (NM); Michael Humphreys (PA); Rachel Irade-Rice (TN); Don Beatty (VA); Jennifer Kreidler and Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); Ellen Potter (WV); and Jeff Rude and Denise Burke (WY).

1. Discussed the Revised PBM Model

Mr. Keen said that following the Subgroup's Oct. 8 meeting, he and Ms. Arp reviewed the revised proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) reflecting the Subgroup's discussion of the Sept. 1 comments. He said based on that review, he and Ms. Arp found a few issues for the Subgroup's discussion during today's meeting. He said he would like to resolve these issues during the meeting and send out a clean copy of the draft model for the Subgroup's adoption during its next meeting in order to forward it to the Regulatory Framework (B) Task Force for its consideration during its Nov. 19 meeting.

Mr. Keen said the first issue concerns the definition of "covered entity" in Section 3C—Definitions. He said the definition of "covered entity" is similar to the definition of "health carrier" used in the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). He asked if the Subgroup wanted to retain this term and definition or replace it with the term "health carrier," as defined in Model #22. The Subgroup discussed the issue. After discussion, the Subgroup agreed that it should be consistent with the terms used in Model #22 and other NAIC models. Mr. Hinze made a motion, seconded by Mr. Humphreys, to delete the definition of "covered entity" in Section 3C and replace it with the defined term "health carrier," as used in Model #22. The motion passed unanimously.

Mr. Keen said the next issue concerns Section 6B—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices. He said this provision appears to be redundant because of Section 6C and should be deleted. The Subgroup agreed. Mr. Hinze made a motion, seconded by Ms. Seip, to delete Section 6B and renumber Section 6 accordingly. The motion passed unanimously.

Mr. Keen said the last issue concerns the legal citations for the drafting note in Section 8—Regulations. He requested that the Subgroup members submit any additional citations from their state laws to NAIC staff for inclusion in the draft to be voted on during the Subgroup's next meeting.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 11/3/20

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
October 8, 2020

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 8, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Laura Arp and Martin Swanson, Vice Chairs (NE); Sarah Bailey and Chris Murray (AK); Anthony L. Williams and Yada Horace (AL); Marjorie Farmer (AR); Bruce Hinze (CA); Andria Seip (IA); Vicki Schmidt (KS); DJ Wasson (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Gale Simon (NJ); Paige Duhamel (NM); Michael Humphreys (PA); Rachel Irade-Rice (TN); Don Beatty (VA); Jennifer Kreidler and Ron Pastuch (WA); Nathan Houdek and Jennifer Stegall (WI); Jamie Taylor (WV); and Denise Burke (WY).

1. Continued Discussion of the Sept. 1 Comments Received on the Draft PBM Model

Mr. Keen said that during the Subgroup's Oct. 1 meeting, the Subgroup agreed to revisit suggested revisions to Section 6—Gag Clauses Prohibited of the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) (*see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment Six-A*). He said that as the Subgroup requested, California, Kansas, New Mexico and Pennsylvania met and developed language for revising Section 6D and adding a new Section 6E to address confidentiality concerns, but not giving a pharmacy benefit manager (PBM) blanket authority to decide what information a pharmacy or pharmacist may disclose to the commissioner, law enforcement, and state and federal officials under certain specified circumstances. Mr. Humphries said the suggested language is a blend of language from Tennessee and New Mexico existing law. The Subgroup discussed the suggested language.

Mr. Hinze made a motion, seconded by Ms. Kwei, to adopt the suggested language with a few revisions suggested by the Subgroup. The motion passed unanimously.

The Subgroup next discussed adding language to Section 7—Enforcement suggested by Mr. Croom that would give the commissioner the authority to use any document or information provided under Section 6 in the performance of the commissioner's duties to determine compliance with this Act.

Mr. Hinze made a motion, seconded by Commissioner Schmidt, to add the suggested language to Section 7. The motion passed unanimously.

The Subgroup continued its discussion of the Sept. 1 comments. No comments were received on Section 9—Severability or Section 10—Effective Date. Mr. Keen said several stakeholders submitted comments suggesting the Subgroup add new sections. He said that many of these new sections involved PBM transparency and business practices. He asked for comments.

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said PBM cost transparency is an important issue for the Subgroup to consider and should be incorporated into the new model. She said the NAIC consumer representatives included in its comments to the Subgroup suggested language for a new section in the draft on PBM cost transparency. She said the suggested language for this new section is based on Connecticut and Washington provisions on the subject. Carl Schmid (HIV + Hepatitis Policy Institute) reminded the Subgroup that its charge includes considering the inclusion of provisions on PBM prescription drug pricing and cost transparency in the new model. Daniel Blaney-Koen (American Medical Association—AMA) expressed support for including a cost transparency provision into the new model. He also said the AMA suggested in its comments the Subgroup include a new section prohibiting PBMs from interfering with the patient-physician relationship with respect to prescribing or dispensing prescription drugs.

The Subgroup discussed the NAIC consumer representatives' suggestion to add a new section on PBM cost transparency. Ms. Farmer said Arkansas has a rebate data collection requirement in its law. She said the Arkansas Department of Insurance (DOI) has had issues with the volume and breadth of data that it is required to collect and receive. Mr. Keen said he has heard from states on both sides—wanting to include in the new model and not wanting to include in the new model. He suggested adding transparency provisions to the list of provisions in the Section 8—Regulations drafting note the states can consider for inclusion in their laws. Mr. Hinze expressed support for adding transparency to the list in the Section 8 drafting note. After additional discussion, the Subgroup agreed to accept Mr. Keen's suggestion to add transparency to the list in the Section 8 drafting note.

Mr. Keen said the Subgroup needs to revisit Section 3—Definitions to determine if any changes need to be made based on the revisions the Subgroup made to the draft's substantive sections. He said that he and Ms. Arp will conduct this review. Mr. Keen said he hopes the Subgroup can review the revised draft and vote to send it to the Regulatory Framework (B) Task Force for its consideration during its next meeting Oct. 15.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 10/14/20

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
October 1, 2020

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Oct. 1, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Lori K. Wing-Heier, Sarah Bailey and Chris Murray (AK); Anthony L. Williams and Yada Horace (AL); William Lacy and Marjorie Farmer (AR); Bruce Hinze (CA); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain and DJ Wasson (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Andrew Kleinendorst (MN); Chlora Lindley-Myers and Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Gale Simon (NJ); Paige Duhamel (NM); Michael Humphreys (PA); Rachel Jrade-Rice (TN); Don Beatty (VA); Jennifer Kreidler and Ron Pastuch (WA); Jennifer Stegall (WI); Tonya Gillespie (WV); and Jeff Rude and Denise Burke (WY). Also participating was: Phil Keller (VT).

1. Continued Discussion of the Sept. 1 Comments Received on the Draft PBM Model

Mr. Keen said the Subgroup ended its discussion during its Sept. 24 conference call with the Sept. 1 comments received on Section 6—Gag Clauses Prohibited of the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) (*see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment Six-A*). He said the Subgroup agreed to revisit suggested language for revising Section 6 during this call.

Mr. Humphreys discussed his suggested revisions to Section 6D and a new Section 6E to address concerns raised during the Subgroup's Sept. 24 conference call about a pharmacy benefit manager's (PBM's) ability to prohibit a pharmacy or pharmacist from disclosing information to the commissioner, law enforcement, and state and federal officials under certain circumstances because a PBM decides the information is proprietary or confidential. The Subgroup discussed Mr. Humphreys' suggested revisions. Some Subgroup members expressed concern with the language. Ms. Duhamel suggested that the Subgroup defer deciding on the suggested revisions and review New Mexico's law on the issue. After additional discussion, the Subgroup deferred deciding on Mr. Humphreys' suggested revisions to allow Mr. Humphreys and a few other Subgroup members to work on revising the language for the Subgroup to consider during its next meeting on Oct. 8.

Mr. Humphreys discussed his suggested revisions to Section 6 to incorporate the NAIC consumer representatives' suggested revisions to this section, which would add language to Section 6 prohibiting a PBM from requiring a consumer to pay a cost-sharing amount more than what the consumer would have paid without insurance coverage. Mr. Hinze made a motion, seconded by Mr. Humphreys, to add Mr. Humphreys' suggested language to Section 6. The motion passed unanimously. Mr. Hinze suggested that the Subgroup consider revising Section 6's short title to reflect the just added provisions. After discussion, Mr. Hinze made a motion, seconded by Commissioner Schmidt, to revise Section 6's short title to read "Gag Clauses and Other Prohibited Pharmacy Benefit Manager Prohibited Practices." The motion passed unanimously.

The Subgroup next discussed Section 7—Enforcement. Mr. Humphreys said, as discussed during the Subgroup's Sept. 24 conference call, he suggests adding language to Section 7 specifically permitting the commissioner to impose a penalty on a PBM, a health carrier, or both for a violation of any provision of the proposed PBM model act. Mr. Dachs suggested that the Subgroup consider adding language to Mr. Humphreys' suggested language to specifically add "any other person performing an activity for the PBM." The Subgroup discussed Mr. Humphreys' suggestion and decided that adding such language is unnecessary because it is implied. Kris Hathaway (America's Health Insurance Plans—AHIP) expressed concern with the language giving the commissioner the ability to impose a penalty on both the PBM and the health carrier. She also suggested that the Subgroup add an appeals process. The Subgroup discussed whether to add language providing for an appeals process to Mr. Humphreys' suggested language. After additional discussion, the Subgroup agreed to add a drafting note to Mr. Humphreys' language regarding an appeals process. After additional discussion, Mr. Hinze made a motion, seconded by Mr. Humphreys, to adopt Mr. Humphreys' suggested language, including the suggested drafting note. The motion passed unanimously.

Mr. Keller asked if Section 7A should specifically spell out the commissioner's enforcement authority. The Subgroup discussed his suggestion. After discussion, the Subgroup decided not to include such language because it could unintentionally limit the scope of the commissioner's potential enforcement actions. Mr. Keller suggested adding a drafting note to Section 7B alerting the states that they might want to consider incorporating their existing market conduct examination statutes into this model act.

rather than relying on the examination authority provided in Section 7B. The Subgroup did not make a decision on this suggested language.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 10/1/20

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
Sept. 24, 2020

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Sept. 24, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Sarah Bailey and Chris Murray (AK); William Rodgers and Yada Horace (AL); William Lacy and Marjorie Farmer (AR); Bruce Hinze (CA); Cynthia Banks Radke (IA); Vicki Schmidt (KS); Sharon P. Clark and Daniel McIlwain (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Sherri Mortensen-Brown (MN); Chlora Lindley-Myers and Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Ralph Boeckman (NJ); Michael Humphreys (PA); Rachel Jade-Rice (TN); Don Beatty (VA); Jennifer Kreidler and Ron Pastuch (WA); Nathan Houdek (WI); Ellen Potter (WV); and Jeff Rude and Denise Burke (WY). Also participating was: Emily Brown (VT).

1. Continued Discussion of the Sept. 1 Comments Received on the Draft PBM Model

Mr. Keen said that during its Sept. 14 conference call, the Subgroup discussed the Sept. 1 comments received on Section 1 through Section 3 of the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) (*see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment Six-A*). He said the Subgroup agreed to revisit those comments after it completes its review and discussion of the comments received on the substantive sections of the PBM model.

The Subgroup next discussed Section 4—Applicability. Carl Schmid (HIV + Hepatitis Policy Institute) pointed out the HIV + Hepatitis Policy Institute’s suggested changes to this section. There was no Subgroup support for making changes to Section 4.

The Subgroup next discussed Section 5—Licensing Requirement. Mr. Hinze expressed support for the NAIC consumer representatives’ suggestion to add the word “first” to Section 5A. Ms. Brown pointed out the Vermont Department of Insurance’s (DOI) suggested revisions to add language to Section 5E clarifying that a commissioner can refuse to renew a pharmacy benefit manager’s (PBM) license in addition to not issuing a license. She said the Vermont DOI also suggests adding language to allow a commissioner to refuse to issue or renew a PBM license if the applicant or any individual responsible for the conduct of the affairs of the applicant “has been found to have violated the insurance laws of this state or any other jurisdiction.” Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said the NAIC consumer representatives suggest adding language to Section 5 providing for penalties for any PBM not obtaining a license as required under Section 5. Mr. Schmid said the HIV + Hepatitis Policy Institute submitted comments suggesting revisions to Section 5. He pointed out one suggested revision to Section 5F that would limit the duration of a PBM license to one year. Aaron Turner (URAC) said URAC suggests adding a new provision to Section 5 concerning accreditation if the Subgroup decides to include the option of accreditation to satisfy the PBM model’s requirements. Kris Hathaway (America’s Health Insurance Plans—AHIP) said AHIP suggests a few wordsmithing revisions to Section 5. Clay McClure (Blue Cross Blue Shield Association—BCBSA) said the BCBSA suggests the Subgroup add language to Section 5 establishing an appeal process for PBMs to use if denied licensure. Matthew Magner (National Community Pharmacists Association—NCPA) said the NCPA suggests revising Section 5D to add language specifying that the commissioner set the PBM licensing application fee based on the DOI’s reasonable costs for administering the PBM model.

Mr. Hinze reiterated his support for the NAIC consumer representatives’ suggested revision to Section 5A to add the word “first.” He also expressed support for the Vermont DOI’s suggested revisions to Section 5E, the HIV + Hepatitis Policy Institute’s suggested revisions to Section 5F and the NAIC consumer representatives’ suggested comment to add a penalty provision to the section. Mr. Humphreys said he believes that if the Subgroup adds a penalty provision, such a provision should be added to Section 7—Enforcement. Mr. Hinze agreed with Mr. Humphreys suggestion.

The Subgroup discussed whether to make the suggested revision to Section 5F limiting the duration of a PBM license to one year. Ms. Arp discussed the potential implications of such a requirement and suggestions for the Subgroup to resolve these issues using a different approach than the HIV + Hepatitis Policy Institute’s suggested revision. After additional discussion, the Subgroup decided to defer making a decision on whether to revise Section 5F and revisit it later.

Mr. Hinze made a motion, seconded by Ms. Potter, to revise Section 5A and Section 5E as the Subgroup discussed. The motion passed unanimously.

The Subgroup next discussed Section 6—Gag Clauses Prohibited. The Subgroup noted that some commenters suggested aligning Section 6's language with the federal law on gag clauses. Some Subgroup members expressed support for adding the NAIC consumer representatives' language to Section 6 prohibiting a PBM from requiring consumers to pay a cost-sharing amount more than what a consumer would have paid without insurance coverage. Mr. Humphreys suggested revisions to the language if the Subgroup decided to add it.

Mr. Magner highlighted the NCPA's suggestion to add language to Section 6 that would address prescription drug prices and transparency. He also noted the NCPA's suggested revision to Section 6D to add an additional provision to prohibit a PBM from prohibiting, restricting or limiting a pharmacy or pharmacist from disclosing information when the information is being gathered for public policy purposes. He explained the NCPA's reasoning for the suggested language. The Subgroup discussed the NCPA's suggested revision to Section 6D. Leanne Gassaway (CVS Health) expressed concern with the NCPA's suggested revision because of its potential to permit the disclosure of confidential information in a public setting. After additional discussion, the Subgroup decided to defer making a decision on any revisions to Section 6 to permit Subgroup members and interested parties to submit additional suggestions for the Subgroup's consideration during its next meeting Oct. 1 via conference call.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 9/29/20

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Conference Call
Sept. 14, 2020

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Sept. 14, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Sarah Bailey (AK); Yada Horace (AL); William Lacy and Marjorie Farmer (AR); Bruce Hinze (CA); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Sharon P. Clark and Daniel McIlwain (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Sherri Mortensen-Brown (MN); Chlora Lindley-Myers and Amy Hoyt (MO); David Dachs (MT); Gale Simon (NJ); Paige Duhamel (NM); Michael Humphreys (PA); Rachel Jrade-Rice (TN); Don Beatty (VA); Jennifer Kreidler and Ron Pastuch (WA); Nathan Houdek (WI); Ellen Potter (WV); and Denise Burke (WY). Also participating was: Emily Brown (VT).

1. Discussed Sept. 1 Comments Received on the PBM Model

Mr. Keen said the purpose of the Subgroup's call is to begin discussion of the Sept. 1 comments received on the proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model) (*see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment Six-A*). He outlined a plan for the Subgroup to review the comments, including meeting weekly via conference call. Commissioner Schmidt asked about a timeline for the Subgroup to complete its work on the proposed new PBM model. Mr. Keen said he hopes the Subgroup can complete its work before the Fall National Meeting.

Mr. Keen suggested that the Subgroup begin its discussion of the Sept. 1 comments with a discussion of the comments received on Section 8—Regulations, specifically Section 8B, which includes a list of potential provisions the states could include in any regulations adopted to implement the proposed PBM model's provisions. Mr. Humphreys said that, as currently drafted, Section 8B would not be something the Pennsylvania legislature would support. He suggested deleting Section 8B and moving its provisions to a drafting note or deleting Section 8B from the draft model entirely and developing a white paper on the provisions listed in it. The Subgroup discussed Mr. Humphreys' suggestion, with some Subgroup members expressing concern and others expressing support.

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) agreed with some Subgroup members' comments that Section 8B, as currently written, is not workable, but expressed disagreement with Mr. Humphreys' suggestion for addressing those concerns. She said there is a growing consensus across the states regarding some of the provisions listed in Section 8B. She urged the Subgroup to take a different approach than Mr. Humphreys' suggestion and consider retaining some of the provisions in Section 8B, particularly those related to transparency. Carl Schmid (HIV + Hepatitis Policy Institute) expressed support for Ms. Killelea's comments. He urged the Subgroup to specifically consider retaining the provisions related to rebates. Matthew Magner (National Community Pharmacists Association—NCPA) suggested that the Subgroup work to fill in the language in Section 8B to provide specific language for state legislatures to consider if they decide to include any of the provisions listed in Section 8B in legislation enacting the PBM model. Lauren Rowley (Pharmaceutical Care Management Association—PCMA) expressed support for Mr. Humphreys' suggestion. Kris Hathaway (America's Health Insurance Plans—AHIP) also expressed support for Mr. Humphreys' suggestion. She also cautioned the Subgroup on including language in the PBM model that would affect prescription drug rebates because of plans' use of rebates to save money. Clay McClure (Blue Cross Blue Shield Association—BCBSA) also expressed support for Mr. Humphreys' suggestion.

Mr. Humphreys made a motion, seconded by Ms. Jrade-Rice, to delete Section 8B and move its provisions to the drafting note and amending the drafting note to state: "This Act is primarily intended to establish licensing standards for pharmacy benefit managers (PBMs). A number of states have enacted statutes that extend into the regulation of PBM business practices. The provisions below, which are followed by citations to state law, provide topic areas that states pursuing this Act may wish to consider in their proposed legislation." Commissioner Schmidt expressed concern with removing Section 8B because of the transparency provisions it includes, which could be lost if moved to a drafting note. A few other Subgroup members expressed similar concerns. The motion passed with 16 states in favor of the motion, three states opposed and six states abstaining. Director Lindley-Myers said Missouri voted in favor of the motion based on the NAIC process, which provides that a state is not required to adopt an NAIC model word-for-word. Each state can make changes to an NAIC model that are appropriate for that state and what the state's legislature will or will not pass based on what is best for the state.

The Subgroup next discussed the Sept. 1 comments received on Section 1 through Section 3. Ms. Brown said the Vermont Department of Insurance (DOI) submitted comments on the definition of “health benefit plan” in Section 3E suggesting that the definition of a “health benefit plan” include a stand-alone prescription drug plan. Ms. Killelea asked if the Subgroup could revisit the discussion of the comments received on Section 1 through Section 3 after the Subgroup completes its discussion of the comments received on the draft PBM model’s substantive provisions. She said the changes the Subgroup will make to the substantive provisions will affect the provisions in Section 1 through Section 3. Mr. Keen agreed. The Subgroup discussed additional suggested revisions to Section 1 through Section 3, but after additional discussion, the Subgroup decided to defer making any changes to these sections until after it completes its review and discussion of the comments received on the substantive provisions of the draft PBM model.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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DRAFT

Agenda Item #4

Hear a Presentation on “Protect Consumers from Individual Health Insurance Marketing & Sales Abuses”—Harold M. Ting (Healthcare Consumer Advocate)



**More That
Should Be
Done**

Protect Consumers from Individual Health Insurance Marketing & Sales Abuses

*Harold M. Ting, PhD FACHE
NAIC Unfunded Consumer Representative*

*Presentation to
NAIC Regulatory Framework (B) Committee
November 19, 2020*

Problem of Deceptive Sales of Non-ACA Plans Is Well-Established¹

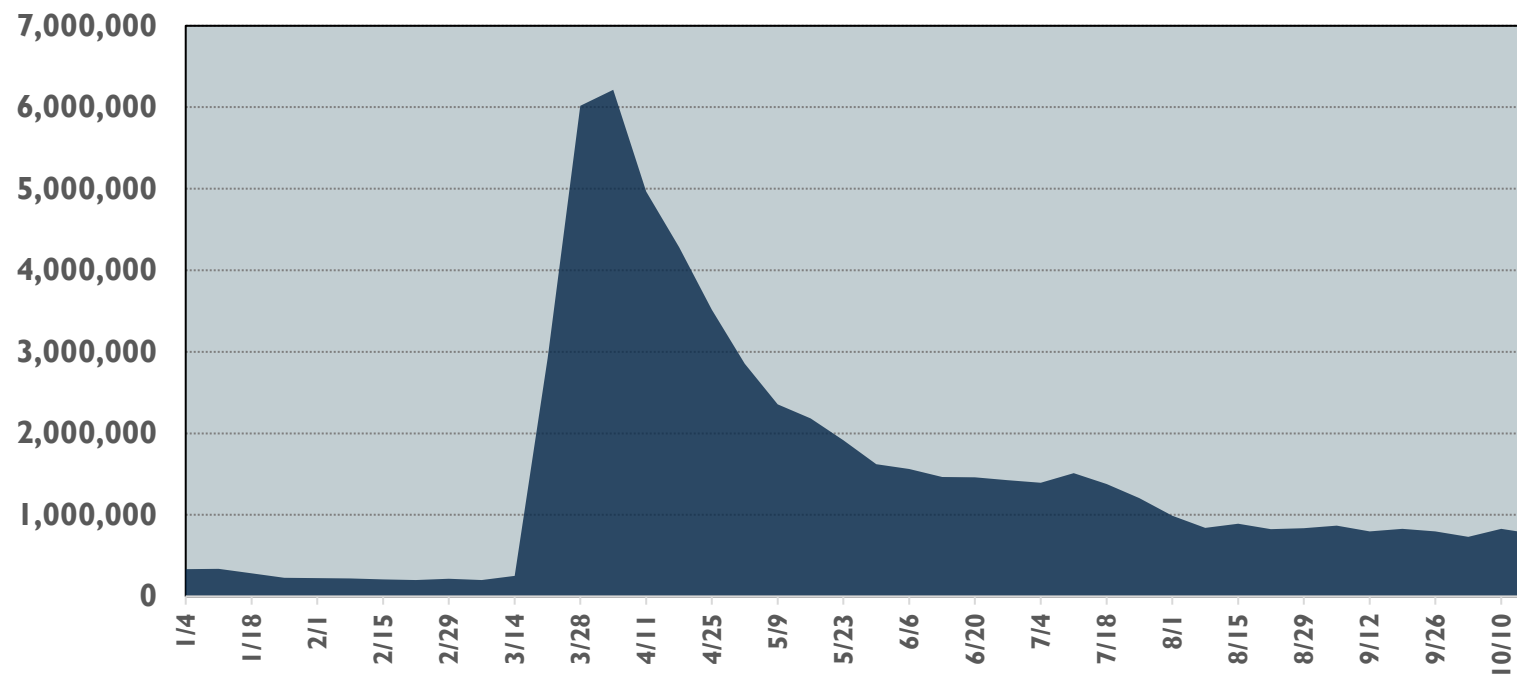
- GAO, House Energy & Commerce Committee
- Commonwealth Fund, Brookings, Urban Institute, Georgetown CHIR
- Coalition Against Insurance Fraud, Houston Chronicle, Philadelphia Enquirer, NY Times, Anchorage Daily News
- State actions – WA, TX, PA, CO, NH, NV

Serious Harm to Consumers

- Thousands of dollars in uncovered medical bills
- Inability to afford medical care needed
- Unwarranted rescission of policies for pre-existing conditions
- Financial ruin.

An Urgent Issue

Weekly New U.S. Unemployment Claims, 2020¹



Today's Presentation

- Deceptive practices – my secret shopper experience
- Steps states & NAIC should take
 - Regulation
 - Consumer outreach

My Secret Shopper

- 30 year old, out-of-work, \$30-35k annual income, healthy or had diabetes
- Searched online for “health insurance”- 6 states, Feb-Nov
- Went to top sites & reviewed plan recommendations
- Spoke with salespeople who called
- Shown at least 60 plans

Secret Shopping Experience

- Multiple rounds of requests for detailed personal info by lead generating websites¹
- Repeatedly prompted to call an agent
- Simultaneously called by sales reps
- Most recommended plans – fixed indemnity & healthcare shared ministry more than STLDI

The “Sellers”

- Most would not give their full name
- Of 11 who gave their names
 - one had her license revoked in 1981
 - another was voluntarily terminated in 2009

Misrepresentation

- Deceptive use of BC, Aetna logo or name
- No explanation of pre-existing condition exclusions
- Misleading examples to give illusion of comprehensive benefits
- Shared ministry plans portrayed as excellent *insurance*.
“The White House endorses this type of plan.”
- Some gave impression of drug coverage when a discount card
- Association membership requirement not mentioned – dues were \$90 of \$205 monthly premium in one case.

*“Many are switching to X plan. It’s just common sense.
The prices are cheaper & the coverage is great!”*

- *“ObamaCare plans are very expensive, have high deductibles & limit the doctors & hospitals you can see.”*
- Most did not mention possibility of premium tax credits.
- Not worth it, because *“you don’t need pregnancy, mental health or substance abuse benefits, right?”*.
- Yet several tried to bundle in accident or dental insurance to increase premiums & commissions.

“You’ll Get Written Info After You Apply”

- Resisted providing plan documentation
 - ” Just tell me what questions you have & I’ll answer them.”
- Brochures
 - Name of insurer unclear. NAIC Code never given
 - “description of benefits, exclusions or limitations may vary depending on state laws.”

Fast Talking, High Pressure Sales

- Pressured to enroll next day -- “Premiums change day to day”.
- Shared ministry plans - “*Premiums will never change.*”
- One agent insulted me when I said I needed more time.
- Shared ministry plan seller reduced premium by \$300, when told I was talking with another agent too.

Actions States & NAIC Should Take

Enhance Transparency

- Require the official **name** of the insurer & its **NAIC Code** on all sales & policy literature
- Mandate **Statements of Benefits & Coverage**
- Mandate a standardized chart summarizing **other key policy provisions**
- **Provide at least 2 days before application**

KEY POLICY PROVISIONS

Period covered by policy

Renewal guarantees, limitations

Annual benefit payment limits

Lifetime benefit payment limits

Provider network

Drug formulary

Look back period

Other

Possibility of Financial Assistance

- Require all marketing & plan materials to
 - advise consumers they may be eligible for financial assistance if they buy ACA plans or qualify for Medicaid
 - provide information on how to contact Navigators in their state to explore those options.

Strengthen Pre-Existing Condition Protections

- Prohibit policy rescissions unless enrollee made a false statement with **intent to deceive**, which materially affected the issuer's acceptance of risk. [PA HB 2730]
- Only hold consumers accountable for pre-existing condition exclusions, where a licensed medical professional **provided the consumer a document** that states those conditions were present.

Hold Insurers & Producers Accountable

[PA HB 2730]

- Hold **insurers** independently responsible for violation of state regulations by sellers of their plans
- Hold **general agents** or **independent agencies** independently responsible for their producers' violations of state regulations.

Survey People Enrolled in Plans of Interest

- **Enrollee surveys** are the only way to assess whether sellers communicated honestly
- They are standard practice at CMS, NCQA
- Require insurers provide info on enrollees & the names of sellers commissioned for those sales
- Certified vendors survey a sample of enrollees a few months after enrollment.

Types of Survey Questions

- Did you receive a written policy before you enrolled?
- Was your plan presented to you accurately? If not, why?
- STLDI's – Were you aware that pre-existing conditions are not covered? Did the insurer or seller explain to you whether you had any excluded conditions?
- HCSM's – Were you aware that your policy is not insurance?

Use of Survey Findings

- Identify plans & sellers that should be investigated for misrepresentation
- Incent sellers to follow ethical sales practices & insurers to drop unethical sellers
- Provide consumer ratings in a national NAIC website on plans & their sellers

Undertake Aggressive Outreach NOW

- Post state advice regarding non-ACA plans¹
- With sister agencies give this info to
 - People filing for unemployment insurance
 - Applicants turned down for Medicaid
 - Users of federal/state exchanges.

Misrepresentation is the Covid of the Individual HI Market



- It's deadly financially & possibly physically
- When it strikes, harm can be irreversible
- State Insurance Depts are the consumers' public health system
 - **FIND** where it is coming from
 - **PREVENT** it from spreading
 - **FIGHT** it with a coordinated national effort.



**YOU CAN
DO MORE
NOW**

*We know consumers are
being harmed & what
you're doing isn't enough*

REPORTS & ARTICLES ON DECEPTIVE MARKETING & SALES PRACTICES
OF INDIVIDUAL HEALTH PLANS

1. "Private Health Coverage: Results of Covert Testing for Selected Offerings" GAO-20-634R)
2. "Shortchanged: How the Trump Administration's Expansion of June Short-Term Health Insurance Plans Is Putting Americans at Risk", U.S. House Energy & Commerce Committee, June 2020.
3. D. Palanker, J. Volk and M. Kona, "Seeing Fraud and Misleading Marketing, States Warn Consumers About Alternative Health Insurance Products," To the Point (blog), The Commonwealth Fund, October 30, 2019. <https://dol.org/10.26099/c32n-5998>
4. C.L. Young and K. Hannick, "Misleading Marketing of Short-Term Health Plans Amid COVID-10," Brookings Institute, March 24, 2020.
5. S. Corlette, K. Lucia, D. Palanker, O. Hoppe, "The Marketing of Short-Term Plans: An Assessment of Industry Practices and State Regulatory Responses," Urban Institute, January 2019.
6. E. Curran, D. Palanker and S. Corlette, "Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections," To the Point (blog), Commonwealth Fund, January 31, 2019. <https://dol.org/10.26099/n2qe-rk02>
7. Georgetown University Center on Health Insurance Reforms, "State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Short-Term Health Plans," Georgetown University Health Policy Institute, December 2017. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441920
8. "Philly woman shops on website selling fake health insurance," Insurance Fraud News, Coalition Against Insurance Fraud, May 22, 2019.
9. Reed Abelson, "It Looks Like Health Insurance, but It's Not. 'Just Trust God', Buyers Are Told," New York Times, January 2, 2020. <https://nyti.ms/35gb2GX>
10. J. Deam, "A doctor's scribbled note leads to patient losing health insurance," Houston Chronicle, November 27, 2019 updated December 3, 2019. <https://www.houstonchronicle.com/business/article/A-doctor-scribbled-note-leads-to-patient-14865448.php>
11. J. Deam, "Risky Business: Buying health insurance in the new age of deregulation," Houston Chronicle, November 27, 2019 updated December 3, 2019. <https://www.houstonchronicle.com/business/article/Risky-Business-Buying-health-insurance-in-the14865415.php>
12. S. Gantz, "Short-term health plan regulations vary significantly by state, study finds," Philadelphia Inquirer, May 7, 2019.

Agenda Item #5

***Hear a Discussion of the Decision in Data Marketing Partnership, LP, et al vs.
U.S. Department of Labor, et al—Marc I. Machiz (Justican Mediation, LLC)***

I. BACKGROUND

Data Marketing Partnership (“DMP”) is a Texas limited partnership that specializes in the production and sale of its limited partners’ (“Limited Partners”) electronic data to third party purchasers. LP Management Services, LLC (“LPMS”) is the general partner of DMP. This case arises out of an adverse advisory opinion (the “Department’s Opinion”) issued by the Department of Labor (the “Department”) in response to a request (the “Request”) by LPMS. LPMS requested confirmation from the Department that the proposed plan (the “Plan”) is governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1) (West 2019) (“ERISA”) as a single-employer welfare benefit plan and that DMP’s Limited Partners are “participants” as defined by ERISA. In response, the Department’s Opinion concluded that the Plan is not governed by any title of ERISA, the limited partners are not “participants,” and that one common-law employee is not a sufficient basis for the Plan to cover any number of Limited Partners.

Plaintiffs, DMP and LPMS (sometimes collectively, “Plaintiffs”), filed this lawsuit to challenge the Department’s Opinion. The facts are largely undisputed.¹ The key issues are (1) whether the Plan is a single-employer welfare benefit plan, (2) whether the Limited Partners are “working owners” and bona-fide partners such that they are “participants” under ERISA, and (3) whether any number of Limited Partners may participate in an ERISA plan alongside at least one common-law employee. The Court finds the Limited Partners are working owners and bona-fide partners. As such, the Limited Partners may participate in the Plan if at least one common-law employee is covered by the Plan. The Department’s Opinion is arbitrary and capricious under the APA and contrary to law under ERISA. Accordingly, Defendants are enjoined from refusing to

¹ The parties state that this “case rests on issues of law, with no need for discovery to be conducted by either party.” *See* Joint Statement 1, ECF No. 18.

acknowledge the ERISA-status of the Plan and refusing to recognize the Limited Partners as working owners of DMP.

A. Facts

DMP is a limited partnership with thousands of limited partners and one general partner. Compl. 1, ECF No. 1. The primary business purpose of DMP is data marketing. *Id.* Specifically, the Request stated that:

[Limited Partners] install specific software which, among other things, tracks the capture of such data by other companies, such as Google or Facebook, and provides access of such data to [DMP]. [DMP] then decides how such data is used and sold to third-party marketing firms, generating revenue. [Limited Partners] control and manage the capture, segregation, aggregation, and sale of their own data, empowering [Limited Partners] in a manner not otherwise available to them when they utilize services over the Internet through their computers, phones, televisions, and other devices.

Request 4, ECF No. 1-3. The Request also provided that although “[t]he primary business purpose of [DMP] is the aggregation and profitable sale of electronic user data from its partners . . . [i]n addition to other inducements, including guaranteed payments, [DMP] wishes to offer access to its group health plan as an inducement to attract, retain, and motivate partners.” *Id.* LPMS is the general partner, plan administrator, and named fiduciary for the Plan maintained for DMP’s common-law employees and Limited Partners. *Id.*

1. The Request

On November 8, 2018, LPMS requested an advisory opinion from the Department. Request, ECF No. 1-3. The Request stated that “[t]he plan will be organized as a single-employer self-insured group health plan that will provide major medical health benefits to [DMP]’s eligible employees, along with [DMP]’s limited partners.” *Id.* at 1. To provide assurances to DMP’s Limited Partners that the Plan would be governed by ERISA, LPMS sought the following opinions:

- (1) The single-employer self-insured group health plan sponsored by LP is an “employee welfare benefit plan” within the meaning of ERISA section 3(1).
- (2) The limited partners participating in LP’s single-employer self-insured group health plan are “participants” within the meaning of ERISA section 3(7).
- (3) The single-employer self-insured group health plan sponsored by LP is governed by Title I of ERISA.

Id.

The Request continued with a detailed factual explanation concerning LPMS, the related limited partnership(s), and the proposed structure of the employee benefit plan. *Id.* at 2-6. DMP, at the time the Request was submitted², sought to establish a single-employer self-insured group health plan. The Request asserted that both “employees and partners are eligible to participate in the Plan.” *Id.* at 4. Additionally, the Request stated that the Limited Partners regularly vote on how their aggregated data will be sold or otherwise used by DMP, commit time and service to revenue-generating activity on behalf of the limited partnership, and receive guaranteed payments in the form of income distributions. *Id.* The Request stated that limited partners “may permissibly be considered ‘participants’ in an ERISA-covered plan where at least one common-law employee is a participant.” *Id.* To be eligible participants in the Plan, the Limited Partners must each contribute at least five-hundred hours of work per year through the generation, transmission, and sharing of their electronic data. *Id.* at 7-12. The Request went unanswered for almost a year, so Plaintiffs filed suit on October 4, 2019. Compl., ECF No. 1. As of January 30, 2020, nearly 50,000 Americans have elected to be automatically enrolled as eligible common-law employees or elected to join the Plan after signing a joinder agreement as a Limited Partner of DMP. Am. Compl. 3, ECF No. 9. A few months after suit was filed, the Department issued an advisory opinion.

² Since this request was written in 2018, the language speaks to the fact that DMP “will seek” or “seeks” to establish the Plan. The Plan has since been established by DMP. Am. Compl. at 1, ECF No. 9.

2. *The Department's Advisory Opinion*

On February 3, 2020, Defendants issued the Department's Opinion. Advisory Op. 1, ECF No. 9-2. The Department's Opinion concluded that "ERISA does not sweep so broadly as to regulate the commercial sale of insurance in the manner proposed by [LPMS]." *Id.* The Department's Opinion articulated three reasons why the Plan was not governed by ERISA—(1) the employment relationship, (2) the ownership interest, and (3) the employee-to-partner ratio. First, according to the Department's Opinion the purported and sole "service" that the Limited Partners appear to perform for or through the partnership ("the Service") is not sufficient to establish an employment relationship. *Id.* at 2. Second, the Limited Partners do not have a "meaningful ownership interest." *Id.* at 3. Third, even if the Limited Partners could be participants in an ERISA Plan, the presence of one common-law employee is "not sufficient to extend ERISA coverage to all the limited partners, without any stated limit." *Id.* at 4.

a. Employment Relationship

The Department's Opinion stated that the employment relationship between the Limited Partners and DMP was insufficient to satisfy ERISA because the traditional hallmarks of an employment relationship were not present. Advisory Op. 1, ECF No. 9-2. The Department concluded the following:

You assert that limited partners would participate in global management issues through periodic votes of all partners, but you provided no information on such votes. You assert that each limited partner agrees to contribute more than five-hundred (500) hours of "work" per year through the generation, transmission, and sharing of their data, but you provide no information on how that 'work' differs in any meaningful way from the personal activities individual limited partners would otherwise engage in while using their personal devices.

*Id.*³ Additionally, the Department concluded that the Limited Partners “do not appear to report to any assigned ‘work’ location or otherwise notify the partnership that they are commencing their work; and they are not required to possess any work-related skills.” *Id.* ERISA plans require an employer-employee relationship, but the Department’s Opinion stated that “there is no employer-employee relationship between the partnership and the limited partners, and as a matter of economic reality, it does not appear that the limited partners depend on the limited partnership as a source of business revenue.”⁴ *Id.* Because the work the Limited Partners perform for the partnership is not distinguishable from the partner’s ordinary use of their electronic devices and “numerous firms already track . . . activities on the Internet, without claiming any employment relationship[,]” the Department concluded that the Limited Partners do not have a cognizable employment relationship with the limited partnership and could therefore not be participants in an ERISA plan. *Id.*

b. Ownership Interest

The Department’s Opinion stated that “if the limited partners work[] for or through the partnership, [have] a *material ownership interest* in the partnership, and earn[] income for work that generated material income for the partnership, it would be plausible to treat them as employed in the relevant sense.” *Id.* at 3 (emphasis added). Additionally, the Department stated that “in such circumstances, the partners could have dual status, like self-employed individuals who earn their income from their self-employment with respect to a group health plan.” *Id.* The Department

³ The Department contends that the *Darden* factors must be applied to determine who is an “employee” because the statute does not define the term in a helpful manner. *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 321 (1992) (employing a common-law analysis to determine whether somebody is an employee for purposes of an ERISA plan).

⁴ The Department opines that the “revenue that a limited partner could reasonably expect from the limited partnership will typically be approximately zero.” Advisory Op. 3, ECF No. 9-2. The Department does not state how it reaches this conclusion.

agreed that the Limited Partners *could* be an “employer” for purposes of the maintaining the partnership’s Plan and an “employee” for purposes of participating in the Plan, but only if the Limited Partners have a material ownership interest in the partnership and “meaningfully” worked and generated material income for the partnership. *Id.* The Department believed that the Limited Partners’ “nominal interests do not appear to have economic or operational substance” and the Limited Partners “do not appear to perform labor for the partnership in any meaningful sense.” *Id.* Additionally, the Department said there is no basis to conclude the limited partners will derive any income from the partnership for the performance of services[] and the limited partners neither take nor give directions in a work context from the partnership. *Id.* Therefore, the Department concluded that the Limited Partners cannot be participants in an ERISA plan. *Id.*

c. Ratio of Common-Law Employee(s) to Limited Partner(s)

The Department’s Opinion also concluded that “the presence of a single employee participant is [not] sufficient to extend ERISA coverage to all the limited partners, without any stated limit” because “that position cannot be squared with ERISA’s text.” *Id.* at 3. Although the text of the governing ERISA provision states a “plan under which *one or more common law employees*, in addition to the self-employed individuals, are participants under the plan, will be covered under title I” of ERISA, the Department claimed that “the text of the regulation” will not support LPMS’s position. Advisory Op. 3, ECF No. 9-2 (citing 29 C.F.R. § 2510.3-3(b)).

B. Procedural History

Plaintiffs filed suit on October 4, 2019. Compl., ECF No. 1. After the Department’s Opinion was issued, Plaintiffs filed their Amended Complaint and a Motion for Temporary Restraining Order and Preliminary Injunction. Am. Compl., ECF No. 9; TRO Motion, ECF Nos. 10–11. In the Amended Complaint, Plaintiffs asserted the following claims for relief: 1)

declaratory judgment under 29 U.S.C. §§ 1132(a)(3), (k); 2) injunctive relief under 29 U.S.C. §§ 1132(a)(3), (k), and Federal Rule of Civil Procedure 65; and 3) violations of the Administrative Procedure Act (“APA”), codified at 5 U.S.C. § 702. The Court ordered the parties to meet, confer, and file a proposed schedule. Order, ECF No. 15. A week later, the parties submitted another Joint Status Report with alternative scheduling proposals for this case. Joint Report, ECF No. 18. After consideration, the Court directed Defendants to file a Cross Motion for Summary Judgment, consolidated with its responses to Plaintiffs’ motions. Order, ECF No. 19. The pending motions are ripe for review.

II. LEGAL STANDARDS

A. Summary Judgment

The Court may grant summary judgment where the pleadings and evidence show “there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a). Summary judgment is not “a disfavored procedural shortcut,” but rather an “integral part of the Federal Rules as a whole, which are designed to secure the just, speedy and inexpensive determination of every action.” *Celotex Corp. v. Catrett*, 477 U.S. 317, 327 (1986).

“[T]he substantive law will identify which facts are material.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A genuine dispute as to any material fact exists “if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” *Id.* The movant must inform the court of the basis of its motion and demonstrate from the record that no genuine dispute as to any material fact exists. *See Celotex*, 477 U.S. at 323. “The party opposing summary judgment is required to identify specific evidence in the record and to articulate the precise manner in which that evidence supports his or her claim.” *Ragas v. Tenn. Gas Pipeline Co.*, 136 F.3d 455, 458 (5th Cir. 1998).

When reviewing the evidence on a motion for summary judgment, courts must resolve all reasonable doubts and draw all reasonable inferences in the light most favorable to the non-movant. *See Walker v. Sears, Roebuck & Co.*, 853 F.2d 355, 358 (5th Cir. 1988). If there appears to be some support for disputed allegations, such that “reasonable minds could differ as to the import of the evidence,” the court must deny the motion. *Anderson*, 477 U.S. at 250.

B. Administrative Procedure Act

Where the APA provides the cause of action, judicial review is limited to “final agency action.” 5 U.S.C. § 704 (West 2019). “Two conditions . . . generally must be satisfied for agency action to be ‘final’ under the APA.” *U.S. Army Corps of Eng’rs v. Hawkes Co.*, 136 S. Ct. 1807, 1813 (2016) (citing *Bennett v. Spear*, 520 U.S. 154 (1997)). “First, the action must mark the consummation of the agency’s decision-making process—it must not be of a merely tentative or interlocutory nature. And second, the action must be one by which rights or obligations have been determined, or from which legal consequences will flow.” *Id.* (quoting *Bennett*, 520 U.S. at 177–78) (internal quotations omitted)).

Under the APA, courts must hold unlawful and set aside agency action that is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 5 U.S.C. § 706(2)(A) (West 2019). Courts must also set aside agency action that is “in excess of statutory . . . authority.” *Id.* § 706(2)(C). Agency action is arbitrary and capricious:

if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Tex. Oil & Gas Ass’n v. EPA, 161 F.3d 923, 933 (5th Cir.1998) (quoting *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)).

Courts must disregard any *post hoc* rationalizations of the agency action and evaluate it solely on the basis of the agency's stated rationale at the time of its decision. *See Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168–69 (1962) (citing *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947)) (“The courts may not accept appellate counsel’s *post hoc* rationalizations for agency action; *Chenery* requires that an agency’s discretionary order be upheld, if at all, on the same basis articulated in the order by the agency itself.”) “Review of agency action under § 706(2)’s ‘arbitrary or capricious’ standard is limited to the record before the agency at the time of its decision.” *Geyen v. Marsh*, 775 F.2d 1303, 1309 (5th Cir.1985); *see also Camp v. Pitts*, 411 U.S. 138, 142 (1973) (“[T]he focal point for judicial review should be the administrative record already in existence, not some new record made initially in the reviewing court.”).

C. ERISA Procedure

ERISA provides for judicial review in “[s]uits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan” to (1) review a final order of the Secretary [of Labor], (2) to restrain the Secretary [of Labor] from taking any action contrary to the provisions of this Act, or to (3) compel him to take action. 29 U.S.C. § 1132(k). Such suits “may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.” *Id.*

III. ANALYSIS

A. This Court has Jurisdiction to Review the Final Agency Action Taken by the Department

The Court has jurisdiction to review this action if the Department’s Opinion marks the consummation of its decision-making process and if legal consequences or obligations will flow from the decision. *Hawkes*, 136 S. Ct. at 1834. In evaluating whether a challenged agency action

meets these two conditions under *Hawkes*, courts apply a “flexible” and “pragmatic” interpretation of the APA’s finality requirement. *Qureshi v. Holder*, 663 F.3d 778, 781 (5th Cir. 2011).

1. *The Department’s Opinion Marks the Consummation of the Department’s Decision-making Process*

Under ERISA Procedure 76-1, the Department may issue an “advisory opinion that interprets or applies the Act to a specific factual situation.” ERISA Procedure 76-1 § 3. The Department has discretionary authority to render advisory opinions. *Id.* § 5. Generally, “an advisory opinion will not be issued on alternative courses of proposed transactions, or on hypothetical situations, or where all parties involved are not sufficiently identified and described, or where material facts or details of the transaction are omitted.” *Id.* “An advisory opinion is an opinion of the [D]epartment as to the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions.” *Id.* § 10. “The opinion assumes that all material facts and representations set forth in the request are accurate and applies only to the situation described therein.” *Id.* “Only the parties described in the request for opinion may rely on the opinion, and they may rely on the opinion only to the extent that the request fully and accurately contains all the material facts and representations necessary to issuance of the opinion and the situation conforms to the situation described in the request for opinion.” *Id.* Information letters are “informational only and [] not binding on the [D]epartment with respect to any particular factual situation,” as compared to advisory opinions upon which the “parties described in the request are *entitled to rely*.” *Id.* §§ 10, 11 (emphasis added). The Department’s own procedure, therefore, entitles Plaintiff LPMS to rely on the Department’s Opinion, which Plaintiffs seek to do.

Based on the facts Plaintiff LPMS provided in the Request, the Department concluded that “the limited partners are not participants in a single-employer group health plan or in an ERISA

plan at all.” Advisory Op. 2, ECF No. 9-2. Under Section 9 of ERISA Procedure, requestors of advisory opinions may withdraw requests only “prior to receipt of notice that the Department intends to issue an adverse opinion.” *Id.* at 2 n.2 (citing ERISA Procedure 76-1 § 9, 41 Fed. Reg. 36281, 36283 (Aug. 27, 1976)). Since the Department’s Opinion was adverse, LPMS is now unable to withdraw its Request.

The Department relies on *American Airlines, Inc. v. Herman* to support its position that the Department’s Opinion constituted “tentative” or “interim” action, and thus is non-final and non-reviewable. 176 F.3d 283 (5th Cir. 1999); Combined Br. 10–11, ECF No. 28. In that case, the Fifth Circuit held the Assistant Secretary’s denial of summary judgment was not final agency action because it did not impact the rights of Herman beyond prolonging the administrative process. *Id.* at 288. Courts have analogized the requirement of “final agency action” to the final judgment requirement of 28 U.S.C. § 1291, which generally prohibits appeal of an interlocutory order. *See DRG Funding Corp. v. Sec’y of Hous. & Urban Dev.*, 76 F.3d 1212, 1220 (D.C. Cir. 1996) (Ginsburg, J., concurring). The Department’s Opinion in this case is distinguishable from a denial of summary judgment because the Department has no further action to take.

Lastly, the Department’s Opinion states that Title I of ERISA does not govern the Plan because the Plan is not an ERISA-covered plan of any type. Advisory Op. 6 n.6, ECF No. 9-2. (“In light of our conclusion that the programs are not ERISA-covered plans . . .”). Based on its determination that the Plan is not governed by ERISA, the Department then argues that LPMS does not have standing to bring suit.⁵ The Department’s Opinion cannot be used as both a sword and shield. The Department cannot state that its advisory opinions are non-final in one instance and then next argue that its determination of who is “an administrator, fiduciary, participant, or

⁵ Because ERISA only permits such suits by “an administrator, fiduciary, participant, or beneficiary of an employee benefit plan,” the Department argues that Plaintiffs do not have standing. 29 U.S.C § 1132(k).

beneficiary of an employee benefit plan” should be binding for the purpose of standing. *See* Combined Br. 15 n.7, ECF No. 28. Given the lack of any further action needed (or available)⁶ from the Department, the Department’s Opinion marked the consummation of its decision by opining that the Plan is not governed by ERISA.

2. *Legal Consequences Will Flow from the Department’s Opinion*

The Department argues that even if this marked the consummation of the decision-making process, Plaintiffs are not subject to any new obligations or legal consequences. Advisory Op. 6 n.6, ECF No. 9-2. Plaintiffs argue to the contrary that the lack of federal preemption under ERISA subjects the Plan to costly state regulatory enforcement. Pl.’s Mot. Summ. J. 1, ECF No 24. “The fact that the advisory opinion procedure is complete and deprives the plaintiff of a legal right . . . which it would enjoy if it had obtained a favorable resolution in the advisory opinion process denies a right with consequences sufficient to warrant review.” *Env’tl. Def. Fund, Inc. v. Ruckelshaus*, 439 F.2d 584, 589 n.8 (D.C.Cir. 1971) (internal quotations omitted); *see also Texas v. United States*, 201 F. Supp. 3d 810, 825 (N.D. Tex. 2016) (holding that final agency action existed in light of agency guidelines that have immediate effect on rights and regulations of the regulated parties). Agency action has legal consequences when it “has the effect of committing the agency itself to a view of the law that, in turn, forces the plaintiff either to alter its conduct or to expose itself to potential liability.” *Texas v. EEOC*, 933 F.3d 433, 446 (5th Cir. 2019).

The Supreme Court’s decision in *Hawkes* is instructive here because it addressed the impact of an agency’s jurisdictional determination on a federal court’s subject matter jurisdiction. 136 S. Ct. at 1812. In *Hawkes*, the Supreme Court addressed the legal effect of the Army Corps of Engineers issuing a jurisdictional determination of whether particular property contained

⁶ ERISA Procedure 76-1 has no further administrative appeal process available to LPMS.

“waters of the United States.” *Id.* The Supreme Court held that *both* a Corps determination that property does not contain jurisdictional waters (a negative determination) and an Army Corps determination that property does contain jurisdictional waters (an affirmative determination) give rise to a legal consequence. *Id.* at 1814; *see also EEOC*, 933 F.3d at 442 (discussing *Hawkes* in that “the issuance of JDs produced ‘legal consequences,’ giving plaintiffs a safe harbor or not.”). Similarly, in *Frozen Food Express v. United States*, 351 U.S. 40, 44–45 (1956), the Supreme Court considered the effect of an agency order specifying which commodities the Interstate Commerce Commission believed were and were not exempt from regulation. The order was immediately reviewable because it warned every carrier of the risk of transporting those commodities without authority from the Commission. *Id.* Similarly, in this case, the Department made a jurisdictional determination that the Plan lies outside ERISA. *See Hawkes*, 136 S. Ct. at 1812. Additionally, the Department warned that LPMS would be subject to the state regulatory scheme, which the parties agree subjects LPMS to enforcement. *See Frozen Food Express*, 351 U.S. at 44–45.

In *Texas v. EEOC*, the Fifth Circuit addressed whether EEOC guidance steering employers away from considering arrest records for hiring purposes was final agency action and thus subject to review in the district court. 933 F.3d at 445. It held that the Guidance was final agency action because the Guidance created a safe harbor for employers to, in the agency’s view, comply with anti-discrimination hiring policies under federal law. *Id.* Thus, employers were entitled to rely on the agency’s interpretation when creating internal hiring practices regardless of whether the EEOC could, at some time in the future, change its position. Here, the Department’s Opinion *removes* the safe harbor. If the Department opined that the Plan was covered by ERISA, the Plan would have the safe harbor of federal preemption, removing the Plan determinatively from the state regulatory scheme. LPMS sought the “safe harbor” determination that ERISA applies which would have

subjected the Plan to *only* the federal regulatory scheme. Advisory Op. 6 n.6, ECF No. 9-2 (“In light of our conclusion that the programs are not ERISA-covered plans, the programs would be subject to broad state insurance regulation.”) The Department removed the safe harbor of federal preemption, which has legal consequences for LPMS by creating new obligations for LPMS to conform to complex state regulatory schemes.

The Department argues that if the facts change, its opinion *could* change.⁷ It cites dicta from *Texas v. EEOC* to support its proposition that, under [*Luminant Generation Co. v. U.S. E.P.A.*, 757 F.3d 439, 442 (5th Cir. 2014)] if an agency can change its policy position, then the advisory opinion is not a final determination. *See EEOC*, 933 F.3d at 445 (5th Cir. 2019). Combined Brief 12, ECF No. 28. *Luminant*’s conclusion and the EPA’s agency review in that case are distinguishable for two reasons. 757 F.3d at 442. First, the governing agency procedure is different. Under EPA-specific procedure, the EPA issues notices of violation and then must wait thirty days before exercising its discretion to “issue an order or administrative penalty” after a formal hearing or to “bring a civil action.” 42 U.S.C. § 7413(a)(1). Second, the EPA had further decisions to make because the notice only marks the beginning of a process designed to test the agency’s conclusion. *Luminant*, 757 F.3d at 442. In contrast, the Department here has informed LPMS that it has nothing to do with the regulation of the Plan, effectively determining its status as a non-ERISA plan. The Department now claims this decision was interlocutory. Combined Br.

⁷ Plaintiffs have not indicated any intention to change the business structure and request a new opinion on new facts. It is not required to do so. Here, the parties filed cross-motions for summary judgment and do not dispute the relevant facts. Additionally, the Court of Appeals for the D.C. Circuit has rejected the reasoning that an agency’s refusal to issue a favorable advisory opinion to plaintiffs was unripe where “[t]he issue presented is a relatively pure legal one that subsequent enforcement proceedings will not elucidate”) *Chamber of Commerce of U.S. v. FEC*, 69 F.3d 600, 604 (D.C. Cir. 1995). The Court finds the D.C. Circuit’s reasoning persuasive.

10–11, ECF No. 28. However, agencies cannot continuously evade review under the guise of “interlocutory” decisions.⁸

The Department argues that there is no “need for immediate judicial review of the Department’s statement of its view of the law” because “any party that disagrees with the Department’s informal opinion is under no obligation to follow it” and that if “any authority sought to implement that view of the law, it could be litigated at that point.” *Id.* at 21. However, “contrary to the [Department]’s notion, parties are commonly not required to violate an agency’s legal position and risk an enforcement proceeding before they may seek judicial review.” *See Alaska Dep’t of Env’tl Conservation v. EPA*, 540 U.S. 461, 483 (2004) (holding that the finality requirement in a statute governing the EPA was satisfied in a pre-enforcement challenge where EPA had spoken its “last word” on the legal issue in dispute and the regulated party “would risk civil and criminal penalties if it defied” the EPA’s directive). On the cross-motions for summary judgment, the facts are static. ECF Nos. 23–28. The Department has spoken its last words on the legal issue in dispute, now asking LPMS to risk violating state laws if it ignores the Department’s Opinion. The Court recognizes that not every advisory opinion issued by an agency will constitute final agency action. *Unity08 v. FEC*, 596 F.3d 861, 866 (D.C. Cir. 2010) (discussing the overlapping doctrines of finality, ripeness and exhaustion of administrative remedies). But it is paramount to consider the agency that issued the advisory opinion, the internal procedures, and the substance of the opinion given. *Id.* Here, the Department’s Opinion satisfies the first and second

⁸ The Supreme Court rejected this same argument in *Hawkes*. Although the Corps could revise its jurisdictional determination within five years based on new information, “that possibility [to submit new facts to the agency] . . . is a common characteristic of agency action and does not make an otherwise definitive decision nonfinal.” *Hawkes*, 136 S. Ct. at 1814.

prongs of *Hawkes*. Therefore, subject matter jurisdiction exists to review the Department's Opinion.

B. The Department's Opinion is Not Entitled to Deference

Defendants contend that the Court should defer to its reasonable conclusion made in the Department's Opinion. Combined Brief at 21, ECF No. 28 Plaintiffs counter that the Court should set aside the Department's Opinion as arbitrary and capricious under the APA and contrary to law under ERISA. Pls.' Mot. Summ. J. 1, ECF No 24. Generally, an advisory opinion is entitled to deference as the persuasive view of the agency tasked with interpreting and enforcing ERISA's complex regulatory scheme. *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). The Supreme Court has characterized advisory opinions issued under ERISA Procedure 76-1 as "agency view[s] . . . reflect[ing] a 'body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 18 (2004) (quoting *Skidmore*, 323 U.S. at 140). Whether an advisory opinion is entitled to deference will depend on "the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Id.* Courts should:

defer to an agency interpretation of the statute that it administers if the agency has conducted a careful analysis of the statutory issue, if the agency's position has been consistent and reflects agency-wide policy, and if the agency's position constitutes a reasonable conclusion as to the proper construction of the statute, even if we might not have adopted that construction without the benefit of the agency's analysis."

Cathedral Candle Co. v. U.S. Int'l Trade Comm'n, 400 F.3d 1352, 1366 (Fed. Cir. 2005). Further, "[d]eference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213 (1988).

1. *The Department's Opinion Lacks Legal and Factual Support*

Defendants argue that the Department's Opinion is legally and factually supported. Advisory Op. 1, ECF No. 9-2. However, the Department fails to point to a single statute, regulation, or any governing case law that supports its imposition of newfound "materiality" standards and its "ratio" requirement on the employment and ownership qualifications for ERISA-plan participants. The Court is not persuaded that such requirements are supported by current law, as discussed below in Section III(C). Since the Department has never used these materiality or ratio standard before in its regulations or interpretations, there is no statutory interpretation to which a court must defer. *See United States v. Mead Corp.*, 533 U.S. 218, 226–27 (2001) (setting forth the framework for when and to what degree courts must defer to agency interpretation "of a particular statutory provision"). "Expanding the scope" of a regulation "in vast and novel ways is valid only if it is authorized" by the statute. *Chamber of Commerce v. Dep't of Labor*, 885 F.3d 360, 369 (5th Cir. 2018). When an agency waits decades to discover a new interpretation of a rule it "highlights the Rule's unreasonableness," and "gives us reason to withhold approval or at least deference for the Rule." *Id.* at 380.

The Department's Opinion lacks factual support. Plaintiffs argue that the Department manipulated facts in a "conclusion-driven" analysis in the Department's Opinion. Pl.'s Mot. Summ. J. 38, ECF No 24. For example, the Request stated that "[i]ncome distributions by [DMP] to the [Limited Partners] resulting from such revenue-generating activities will be reported as guaranteed payments and will be subject to employment taxes." Request 8, ECF No. 1-3. However, the Department's Opinion stated that "the revenue the limited partner could reasonably expect from the limited partnership will typically be zero." Advisory Op. 3, ECF No. 9-2. The Department has provided no factual basis for such a conclusion. The Department's Opinion also paints in

broad, conclusory strokes in asserting that the partnership does not qualify as an employer, the Limited Partners do not qualify as employees, and the work the Limited Partners do to generate income for the partnership is not “work” at all, contrary to the Request’s factual representations, because in the Department’s view, the work is not “meaningful” and the Limited Partners’ ownership interest is “nominal.” *Id.*

2. *The Department’s Opinion is Contrary to the Department’s Prior Pronouncements*

Further, the Department’s Opinion contradicts its own advocacy and its prior advisory opinions by resorting to common-law principles to determine whether the Limited Partners are “participants” under ERISA. The Department’s Opinion strayed from its previous pronouncements in two key ways: (1) by imposing a common-law analysis to determine whether a working owner is an “employee” and therefore a “participant” under ERISA and (2) by analyzing the degree of control the limited partnership has over the Limited Partners. The Department previously advocated that ERISA’s text resolves this question that it now seeks to answer differently. Specifically, the Department previously urged that:

resort[ing] to common-law principles (even for guidance) is not appropriate in resolving whether working owners may be participants in ERISA plans because the *text of ERISA itself resolves that question*. Even if the Court were to consult the common law, however, it should also consider the purposes of ERISA ... [b]ecause the purposes of ERISA differ from those underlying the ADA and other anti-discrimination statutes, *a test that focuses on the extent of the business’s control over the working owner is not appropriate* to resolve the ERISA coverage question.

Reply 35, ECF No. 30 (citing DOL Amicus, p. 4, n. 6 (emphasis added)).⁹ Plaintiffs now take the position for which the Department advocated in its *amicus* brief a year ago at the same time

⁹ The Department filed this amicus brief in *New York v. U.S. Dep’t of Labor*, 363 F. Supp.3d 109 (D.C. Cir. 2019). The Department’s position in the amicus brief that the “text of ERISA itself” resolves the question of whether working owners may be participants in an ERISA plan is directly from the Supreme Court’s opinion in *Yates*. 541 U.S. at 12.

Plaintiff LPMS submitted the Request, while the Department abandoned this position in favor of the common-law factors.¹⁰

The Department coined the term “working owner” as a term of art in a prior opinion (the “Prior Opinion”), DOL Op. No. 99-04A, the only other advisory opinion that addresses this concept. In the Prior Opinion, the Department defined “working owner” to “include ‘*any owner* that earns wages or self-employment income from a company,’ including sole proprietors of unincorporated businesses.” DOL Op. No. 99-04A (emphasis added). The Department further stated that “working owner” means:

any individual who has *an equity ownership right of any nature* in a business enterprise and who is *actively engaged* in providing services to that business, as distinguished from a passive owner, who may own shares in a corporation, for example, but is not otherwise involved in the activities in which the business engages for profit.

DOL Op. No. 99-04A (emphasis added). The Prior Opinion found *clear intent* from Congress, within the text of the statute, to treat working owners as participants under ERISA—forgoing the common law analysis it now claims must be used for Plaintiffs.

The Department’s failure to adhere to its own articulated definition of working owner in the Prior Opinion is suspect and unsupported by present law. Nothing in the record indicates why the Department decided to impose new standards on the Plaintiffs and stray from governing law in its analysis of the Plan. The Department’s Opinion serves as the sole authority contrary to Plaintiffs’ legal position. As a result, the Department’s Opinion is not entitled to *Skidmore*

¹⁰ The Department contends that the Limited Partners must meet the test articulated in *Darden* to be an “employee” under ERISA. Combined Br. 38, ECF No. 28. The factors include skill required, the source of the instrumentalities and the tools, the location of the work, whether the hiring party has the right to assign additional projects to the third party, the extent of the hired party’s discretion over when and how long to work, the method of payment, and the provision of employee benefits. *Darden*, 503 U.S. at 324.

deference. Accordingly, the Court will address the merits without deferring to the Department's Opinion.

C. The Plan is a Single Employer Employee Welfare Benefit Plan Under Title I of ERISA

As previously explained, the Department found that ERISA did not govern the Plan. The main issues to resolve, therefore, are whether (1) the Plan is a single-employer welfare benefit plan, (2) the Limited Partners are “working owners” and bona-fide partners such that they are “participants” under ERISA, and (3) if any number of Limited Partners may participate in an ERISA plan alongside at least one common-law employee. The APA permits courts to “set aside an agency action that is ‘arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.’” *Sierra Club v. EPA*, 939 F.3d 649, 663 (quoting 5 U.S.C. § 706(2)(A)). An action is arbitrary and capricious if:

the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id. at 663–64 (quoting *State Farm*, 463 U.S. at 43). Additionally, the Court may set aside agency action under ERISA that is contrary to law.¹¹ See 29 U.S.C. § 1132(k). Because the Court finds the Department's Opinion arbitrary and capricious under the APA and contrary to law under ERISA, the Court sets aside the Department's Opinion and finds the Plan is governed by Title I of ERISA. Because the Limited Partners are working owners and bona-fide partners, they may participate in the single-employer welfare benefit plan set up by DMP, so long as DMP covers at least one common-law employee under the Plan.

¹¹ The Court notes that these distinct standards have substantial overlap. Therefore, since the Department's analysis fails under both standards the Court will address the standards simultaneously.

ERISA is designed to protect “participants” who are “employees” that participate in employee benefit plans which are subject to its regulatory scope. *Schwartz v. Gordon*, 761 F.2d 864, 868 (2d Cir. 1985). Accordingly, ERISA has specific rules and regulations that apply to defining (1) an “employee welfare benefit plan,” (2) “employees,” and (3) “participants” that may participate in an “employee welfare benefit plan”. 29 U.S.C.A. § 1002 (West 2019). Under ERISA, an “employee welfare benefit plan” means:

any plan, fund, or program which was heretofore or is hereafter established or *maintained by an employer* or by an employee organization, or by both, to the extent that such plan, fund, or program was established or *is maintained for the purpose of providing for its participants* or their beneficiaries, through the purchase of insurance or otherwise

29 U.S.C.A. § 1002 (emphasis added). The term “participant” means “any employee ... who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer” *Id.* The term “employee,” at the center of this dispute, is defined as “any individual employed by an employer.” *Id.* Because an employee-employer relationship is necessary to establish an ERISA plan, defining who is an “employee” is vital.

In some instances, the *Darden* factors must be applied to determine who is an “employee” because the statute does not define the term in a helpful manner. *Darden*, 503 U.S. at 321 (employing a common-law analysis to determine whether an independent contractor is an employee for purposes of an ERISA plan). Additionally, for ERISA purposes, an equity owner may be an “employer” in one sense and an “employee” in another. *See Yates*, 541 U.S. at 12 (holding that an individual can wear two hats at the same time for the purpose of maintaining a plan as an employer but participating in the plan as an employee).

Here, the Department incorrectly concluded that the Plaintiffs’ Plan did not meet the criteria for ERISA coverage. Combined Br. 38, ECF No. 28. For the following reasons, the Court

determines that Plaintiff DMP's Plan is a single employer¹² employee benefit plan under Title I of ERISA, and the Limited Partners may participate in the Plan if DMP covers at least one common-law employee under the Plan.

1. *The Limited Partners May Participate in the Plan as "Working Owners"*

The central issue in this case is whether the Limited Partners are "working owners." Plaintiffs argue that the Limited Partners are working owners because although they do not have many of the "hallmarks" of work in a traditional sense, in a "gig economy and the economic reality of today, the Limited Partners' work should be recognized, and the employment relationship satisfies the statutory and regulatory requirements. Pls.' Mot. Summ. J. 37, ECF No. 24. ("While that [Service] differs from being a plumber, teacher, security guard, or career bureaucrat, it is no less a form of work in the modern 'gig economy'."). The Department argues that because the Limited Partners do not fit squarely into the working owner analysis, the common-law analysis is necessary. Combined Br. 38, ECF No. 28. ("Plaintiffs' claims here do not present a clear-cut case of working owners like medical doctors who own their own practice or the law firm partners addressed by the Fifth Circuit in *House*"; see also *House v. Am. United Life Ins. Co.*, 499 F.3d 443, 450 (5th Cir. 2007) (holding that law partners may be participants in an ERISA plan). The Department urges the Court to apply the *Darden* factors. Combined Br. 41, ECF No. 28 (arguing that the statutory and regulatory provisions are ambiguous and require a common-law employment analysis under *Darden*).

¹² Plaintiffs additionally seek a declaration that the Plan is not a multiple-employer welfare arrangement ("MEWA") under ERISA. Since DMP is a singular entity that maintains the Plan, with LPMS as the fiduciary and DMP's Limited Partners as equity owners and participants for ERISA purposes, it is clear that there is only one employer, DMP. Pls.' Mot. Summ. J. at 7, ECF No. 24; see 29 U.S.C. § 1002(40) (defining a MEWA as "an employee welfare benefit plan, or any other arrangement" that provides benefits to "the employees of two or more employers" or their beneficiaries).

The reliance on *Darden* is misplaced here because whether an equity owner qualifies as a participant in an ERISA plan is analyzed solely under *Yates*. 541 U.S. at 1. There, the Supreme Court held that a working owner can wear two hats, as an employer and employee.¹³ *Id.* at 16. “ERISA’s text contains multiple indications that Congress intended working owners to qualify as plan participants. Because these indications combine to provide ‘specific guidance,’ there is no cause in this case to resort to common law.” *Id.* at 12. Moreover, the *Yates* majority explicitly held that the *Darden* common-law test concerning employee qualifications to participate in an ERISA-covered plan simply did not apply because Yates was clearly a working owner of his own medical practice. *Yates*, 541 U.S. at 12, n.3 (distinguishing *Darden*). Notably, Justice Thomas noted in his concurrence in *Yates* that “members of this class [working owners] are now considered categorically to fall under ERISA’s definition of ‘employee’.” *Yates*, 541 U.S. at 25, n.* (Thomas, J., concurring). The common-law employment analysis under *Darden* is not necessary here if the Limited Partners are working owners because working owners categorically may participate in an ERISA plan as an “employee”.

Finding the *Darden* factors unnecessary for equity owners, the Court will turn to the analysis articulated by the Department in the Prior Opinion. The Department defined “working owner” as:

any individual who has *an equity ownership right of any nature* in a business enterprise and who is *actively engaged* in providing services to that business, as distinguished from a passive owner, who may own shares in a corporation, for example, but is not otherwise involved in the activities in which the business engages for profit.

¹³ The Supreme Court cited 26 U.S.C. § 401(c)(4) to support this proposition. *Yates*, 541 U.S. at 16 (“An individual who owns the entire interest in an unincorporated trade or business shall be treated as his own employer. A partnership shall be treated as the employer of each partner who is an employee within the meaning of [§ 401(c)(1)].”).

DOL Op. No. 99-04A (Feb. 4, 1999) (emphasis added) (internal citations omitted). Therefore, for the Limited Partners to be “working owners,” they must (1) have an equity ownership right of any nature in a business enterprise and (2) be actively engaged in providing services to that business.

a. The Limited Partners are Owners

Defendants required for the first time in the Department’s Opinion that the Limited Partners have a “material” ownership interest to be a participant under ERISA. Advisory Op. 5, ECF No. 9-2. The Department’s Opinion stated that the Limited Partners’ “*nominal* ownership interests do not appear to have economic or operational substance.” *Id.* The Department’s definition of working owner requires “an equity ownership right of any nature.” DOL Op. No. 99-04A.

Here, the Limited Partners obtained an ownership interest through the execution of a joinder agreement, periodically vote on how to organize and market the aggregated “data bank,” and exercise management responsibilities over the sale of this data bank to third parties. Reply 47, ECF No. 30. Because the Limited Partners have an ownership interest “of any nature,” and the imposition of a “materiality” standard is arbitrary and capricious, the Limited Partners are owners. *See Luminant*, 675 F.3d at 930 (holding it was arbitrary and capricious for the agency to impose a new requirement that is neither necessary nor warranted by any applicable provision of the Act, and thus agency reliance on the requirement was unjustified).

b. The Limited Partners are Actively Engaged in Providing Services to the Partnership

Next, the Limited Partners must be “actively engaged” in providing services to that business. DOL Op. No. 99-04A. The Department’s Opinion states that Limited Partners are not sufficiently “active” because “allowing one’s electronic data to be tracked, collected, and marketed is not ‘work’ or ‘performing any services’” and it does “not appear to differ in any meaningful way from the personal activities . . . [the Limited Partners] would otherwise engage in while using

their personal devices.” Advisory Op. 3, ECF No. 9-2. The Department’s Opinion qualifies the nature of the service the Limited Partners provide to the partnership—aggregating the data generated from the ordinary use of their personal devices—as “too passive” to qualify as “work.” *Id.*

Plaintiffs argue that the business venture is a form of employment innovated to take control and market their own aggregated data, rather than leave the commercial benefit to third parties. Pls.’ Mot. Summ. J. 37, ECF No. 24 (“The partners are taking control of at least some portion of the data reflecting their internet usage and attempting to aggregate that data with others to create a product for which there is undeniably already a market.”). Plaintiffs also argue that the business of data mining is a twenty billion-dollar industry that is gaining significant ground in the United States. *Id.* at 37 n.45.¹⁴ Additionally, Plaintiffs argue that DMP’s business enterprise is innovative because the Limited Partners’ personal activities can double as a stream of income in the same way that drivers for Uber and Lift can generate income by aggregating hours driven using different ride assignment technologies even if the driver would have been driving the same routes in his personal time. Reply 44, ECF No. 30.

Defendants argue that the Department’s Opinion is not arbitrary because consumers regularly and unwittingly allow third parties to aggregate their data without claiming any employment relationship, so the Plaintiffs cannot claim an employment relationship exists here. Advisory Op. 2, ECF No. 9-2. (“Allowing the partnership to track consumers’ activities on the Internet is instead similar to what consumers already permit numerous firms, such as internet browsers and social media companies, to do without claiming that the tracked consumers work for

¹⁴ See Dylan Curran, “Are you ready? Here is all the data Facebook and Google have on you,” *The Guardian*, March 30, 2018, <https://www.theguardian.com/commentisfree/2018/mar/28/all-the-data-facebook-google-has-on-you-privacy>.

them.”). The Department views the business enterprise as a “sham” created as a means to provide health insurance coverage to the Limited Partners. *Id.* (stating that the only purpose of the limited partners joining the partnership is to acquire health insurance).

Plaintiffs are correct that the Limited Partners are “involved in the activities in which the business engages for profit.” Reply at 51, ECF No. 30 (The Limited Partners “provide personal services for the partnership by contributing electronic data that individually and collectively is a material, income-producing factor for the partnership.”). The Limited Partners download specific software on their device, the software collects data, and the data is then aggregated with the other partners’ data to form a data bank owned by the partnership. *Id.* at 4. The Limited Partners then collectively decide what to do with that data bank on behalf of the partnership. *Id.* The only distinction between the Limited Partners here and the law partners in *House* is the *type* of work performed. *Id.* ERISA does not demand such a distinction.

The Limited Partners are not passive owners in the way that a passive owner in a publicly traded corporation will receive distributions without having any say in business operations. Therefore, whether the Department considers the Plaintiffs’ business enterprise “legitimate” or “meaningful” is irrelevant because the Limited Partners are not merely passive owners under the Department’s own test. *See State Farm*, 463 U.S. at 43 (holding that agency action is “arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider”). The Department simply does not agree that the services are a legitimate business enterprise, which is not a consideration required by law. The Court will not impose an extra-textual view of what services or industry in which business enterprises must engage to qualify for ERISA coverage. The Limited Partners are actively engaged in the partnership’s business. Accordingly, the Court finds

that the Limited Partners are working owners because the Limited Partners have an equity ownership interest of any kind and are actively engaged in partnership's business.

2. The Limited Partners are Bona-Fide Partners

The Department's Opinion states that the requisite employment relationship between the Limited Partners and DMP does not exist. Advisory Op. 3, ECF No. 9-2. ("The regulations emphasize the need for an employment or self-employment services-based relationship with respect to the partners participating in a group health plan maintained by a partnership."). Under ERISA regulations, a partner must be a "bona-fide partner" to establish an employment relationship between the partner(s) and the partnership. 29 C.F.R. 2590.732(d)(2)-(3). Whether an individual is a bona-fide partner is determined based on "all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership." *Id.*

The Department's Opinion categorizes the Limited Partners as "merely consumers purchasing health coverage in exchange for premiums and an agreement that the partnership can track their personal activities on their personal devices." Advisory Op. 4, ECF No. 9-2 ("You have provided no facts that would support a conclusion that the limited partners are meaningfully employed by the partnership or perform any services on its behalf."). Plaintiffs argue that the Limited Partners "provide personal services for the partnership by contributing electronic data that individually and collectively is a material, income-producing factor for the partnership." Reply 51, ECF No. 30. The bona-fide partner analysis simply requires a more-than-pretextual relationship between the employer and employee. The Court already concluded that the Limited Partners are working owners who are actively engaged in the business. Given that the bona-fide partner standard is a lower threshold, the Limited Partners are bona-fide partners of DMP.

3. *ERISA States no Limit to the Number of Working Owners That May Participate in a Plan Alongside at Least One Common-Law Employee*

Lastly, the Department's Opinion concluded that "the presence of a single employee participant is [not] sufficient to extend ERISA coverage to all the limited partners, without any stated limit" because "that position cannot be squared with ERISA's text." Advisory Op. 3, ECF No. 9-2. Because in its view "the text of the regulation" does not allow the Plan to be arranged as proposed in the Request, the Department seeks to impose some imprecise employee-employer ratio requirement on Plaintiffs. *See id.* In response, Plaintiffs argue that one common-law employee is sufficient because ERISA regulations state that a "plan under which *one or more common law employees*, in addition to the self-employed individuals, are participants under the plan, will be covered under Title I" of ERISA. 29 C.F.R. § 2510.3-3(b) (emphasis added); Reply at 33, ECF No. 30.

ERISA's "one or more common-law employees" regulation unambiguously means that so long as one common-law employee is covered by the plan, it is an ERISA plan in which an unlimited number of working owners may participate. *Id.*; *see Robertson v. Alexander Grant & Co.*, 798 F.2d 868, 869 (5th Cir. 1986) (finding a benefit plan for only partners is not covered by ERISA without the presence of a *single* common-law employee). But once the Plan covers a single common-law employee, ERISA imposes no ratio requirement on the number of working owners that may participate. Therefore, the Department's Opinion is incorrect to specify the number of working owners eligible for the Plan beyond that set out by regulation. The Court concludes that the presence of a single common-law employee may extend ERISA coverage to any number of working owners.

IV. CONCLUSION

For the foregoing reasons, the Court **GRANTS** Plaintiffs' Motion for Summary Judgment (ECF No. 23), **DENIES** Defendants' Cross Motion for Summary Judgment (ECF No. 25), and **DENIES as moot** Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction (ECF No. 10). Because the Limited Partners are working owners and bona-fide partners, they may participate in the single employer welfare benefit plan set up by DMP, so long as DMP employs at least one common-law employee. Accordingly, the Department's Opinion is set aside as arbitrary and capricious under the APA and contrary to law under ERISA and Defendants are **ENJOINED** from refusing to acknowledge the ERISA-status of the Plan or refusing to recognize the Limited Partners as working owners of DMP.

SO ORDERED on this 28th day of September, 2020.


Reed O'Connor
UNITED STATES DISTRICT JUDGE

Agenda Item #6

***Discuss Task Force Possible Next Steps Regarding Health Care Sharing Ministries (HCSMs)
—Commissioner Michael Conway (CO)***

Agenda Item #7

Discuss Any Other Matters Brought Before the Task Force
—*Commissioner Michael Conway (CO)*