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How Government Overreach is Threatening Americans' Healthcare

Healthcare entrepreneurs battle Department of Labor to keep accessible, affordable coverage available

A group of entrepreneurs has pioneered an innovative health plan for Americans struggling to find affordable care. But instead of welcoming increased access to lower-cost healthcare, federal government bureaucrats have spent the past five years trying to end it.

And now, after losing in federal court and on appeal, the Department of Labor is wielding the full power of the government in an attempt to intimidate and bully the entrepreneurs into a surrender that will undo the department's legal losses.

"DOL's actions are nothing more than extortion based on lies," said Bill Bryan, one of the entrepreneurs. "They're the kind of tactics you'd expect from The Sopranos, not the U.S. government."

Companies reliant on the solutions developed by the health coverage innovators are fighting back, suing DOL in federal court and accusing the department of using improper and illegal coercive tactics to strongarm them into submission.

The lawsuit cites the recent unanimous Supreme Court decision in *National Rifle Association v. Vullo*, in which the justices held that a government agency cannot exert coercive regulatory pressure on companies doing business with parties it doesn't like.

"Our case and *NRA v. Vullo* are remarkably similar," said Jonathan Crumly, an attorney representing the plaintiffs. "The fact that the Supreme Court voted unanimously in favor of a decision written by Justice Sotomayor and against a powerful government agency should make DOL think twice before engaging in any further improper coercive behavior."

Ari Zieger, another member of the entrepreneurial group being targeted by DOL, said he and his partners have spent years "bending over backwards to reach reasonable compromise with DOL."

"By refusing to negotiate in good faith, DOL threatens health coverage for tens of thousands of people," he said.

This is a story of how government regulatory overreach is threatening to quash innovation and strip tens of thousands of Americans of their health coverage.

Here are the facts, background, and timeline.

The Healthcare Landscape

- The Affordable Care Act (ACA) will celebrate its 15-year anniversary in March and the issue of healthcare, both cost and coverage, continues to be part of the national conversation. It is a major issue in the 2024 election.

- While the number of uninsured Americans has decreased, owing in part to pandemic relief measures (now being unwound) and the expansion of Medicaid programs nationwide, the cost of health insurance has continued to climb.

- In 2023, the average annual health insurance premium was $23,968 for family coverage and $8,435 for single coverage, according to the Kaiser Family Foundation. The study showed that the average family premium has increased 22 percent since 2018 and 47 percent since 2013. Both family and single coverage premiums increased by 7 percent in 2023 alone.

- For people without access to group health insurance, typically through traditional W-2 employment, or government subsidized plans, the cost of

insurance is an undeniable burden.

- The increasing number of workers shifting to 1099 independent contractor status as part of the "gig economy" has greatly exacerbated the problem, because these jobs traditionally do not include health insurance benefits.

- With expanded subsidies for ACA plans set to expire in 2025, almost 7.5 million people are expected to lose their health coverage in the next five years, according to the Congressional Budget Office, and millions more will struggle to afford continued coverage. "If the enhanced subsidies expire, almost all ACA Marketplace enrollees will experience steep increases in premium payments in 2026," Kaiser reported.

- In theory, competition has always been a central tenet of controlling costs under the Affordable Care Act, but this has broken down in practice. In 2017, the White House issued an executive order directing the Department of Labor to expand access to large group health plans under ERISA, the Employee Retirement Income Security Act of 1974 that regulates health coverage for the vast majority of working-age Americans.

  This was supposed to give more people the ability to access large group plans (51 or more participants), which offer greater flexibility and lower costs than ACA Marketplace plans. The department issued a new Association Health Plan rule in 2018, but, the next year, a federal court struck down the rule.

Birth of 'Partnership Health Plans'

- Several entrepreneurs predicted the fate of the 2018 rule and saw both a need and an opportunity to provide affordable coverage.

    - *Suffolk Administrative Services* (SAS) provides consulting, plan design and compliance services to sponsors of health benefit plans governed

by ERISA. Alex Renfro is a benefits attorney. Bill Bryan and Ari Zieger, private equity investors, are SAS principals.

- *LP Management Services* (LPMS) operates limited partnerships that aggregate and monetize the electronic data usage of their limited partners. They also offer them group health benefits. Steven Lazarou is its CEO.

- Together, SAS and LPMS launched "Partnership Health Plans," a new health coverage structure aimed at lower-and middle-income Americans, small businesses, and independent contractors with few affordable options. These plans are the first to offer group health plan access to people willing to contribute their online user data as a form of employment.
  - This is part of the growing "Own Your Data" movement, seeking to give consumers their fair share of the trillions in value they've created for big tech companies like Google, Apple, Amazon, Meta (Facebook, Instagram, WhatsApp), and others.

- Here's how the partnership health plans work:
  - People sign up to become limited partners in a company that collects and sells online data.
  - They are paid for producing data, which the company markets (and are therefore "working owners," as defined and affirmed in several court decisions), controlling how and when their data is collected.
    - For example, the app that partners use to access their health plan information also allows them to decide how, when and where they want to share their online data.
  - Working owners, like partners in other business entities such as law firms, are eligible for group health benefits, which are traditionally more affordable than those found on the individual market.

- SAS devised and LPMS implemented a benefit plan structure based on ERISA, the law governing employer-provided health care, which allows

members of a partnership to be treated as employees for purposes of ERISA health plan eligibility.

- These plans provide more than 30,000 Americans with affordable health coverage. A typical partnership plan participant will pay 35% to 40% less than the cost of an ACA "Bronze" plan for their annual health care.[1]

- There are no deductibles or co-pays for most services covered by partnership plans, which encourages participants to use their coverage when they need it, rather than put off seeking care while their condition may worsen.

- In 2020, to help explain to the public how these new data partnership plans work, the nonprofit EASE Alliance was formed to educate policymakers, lawmakers, journalists, and anyone else interested in lowering the cost of quality healthcare. It counts SAS and LPMS among its supporters and donors.

Litigation Background

- In October 2018, LPMS met with DOL and was told that the best way to ensure approval of its innovative plan structure was to use DOL's formal process for requesting an Advisory Opinion, which LPMS did shortly after the meeting.

- In March 2019, LPMS met with the Labor Secretary's chief of staff, who called the plan structure "ingenious" but said DOL could not respond to the Advisory Opinion request because of unspecified conflicts with other DOL personnel and agendas.

[1] Estimated savings include the cost of coverage, as well as projected out-of-pocket costs based on actuarial studies of health care utilization nationally. Projected savings vary by age – at 27, projected savings are 41.2%; at 37, 38.4%; at 47, 36.7%; at 57, 34.8%.

- LPMS did not withdraw its request, and in response DOL launched what it called the "Anjo Investigation" into the business of Alex Renfro, the architect of the partnership plan, the next month, April 2019.
    - Anjo LLC is Renfro's company through which he owned a now divested interest in SAS, and also provided legal and consulting services to LPMS and other clients. DOL claimed that the Anjo Investigation was unrelated to Renfro's work on behalf of LPMS, and instead sought evidence of possible ERISA violations by SAS and other companies servicing the LPMS partnership health plans while providing services to traditional employers.
    - SAS and these other companies are the only companies providing essential services to the LPMS partnership health plans to ensure they operate as intended. If these companies were to stop doing business with LPMS, the limited partnership plan model would collapse.

- In October 2019, after a year of asking DOL for an opinion on the legality of its innovative plan structure and receiving no response, Data Marketing Partnership LP (DMP), one of the plan sponsors managed by LPMS, was forced to file suit against the department in the U.S. District Court in Texas, where DMP is based.

- In September 2020, the Court issued a sweeping ruling in favor of DMP and LPMS. The Department of Labor challenged that outcome before the 5th Circuit Court of Appeals, which largely upheld the original decision in August 2022.

- The courts ruled that DOL could not block data partnerships from offering health plans under ERISA.

- All the corporate and individual targets of the Anjo Investigation cooperated fully with DOL, providing hundreds of thousands of pages of

documents, submitting to questioning, and volunteering to make modifications to business practices that DOL deemed necessary.

- DOL has threatened to sue the Anjo targets, alleging that they acted as fiduciaries, overcharged and hid fees. The Anjo targets deny the allegations, arguing that they disclosed their fees, which were, in fact, below industry standards. They are not fiduciaries, they argue, as evidenced by the fact that in each case they were hired by ERISA plan sponsors, who are the actual fiduciaries. In addition, none of the Anjo targets has ever collected money from plans or their participants. Licensed third-party administrators receive premiums, and make payments to health care providers, insurers, and other vendors.

State of Play

- Early in 2024, the Department of Labor began insisting on "global settlement negotiations," directly tying the Anjo investigation and DMP litigation together, despite the fact that none of the Anjo targets hold any interest in or control over LPMS, DMP, or any other health plan sponsor.

- The department directly tied the settlement amount in Anjo to dismissal of the DMP case.

- Unless DMP agreed to abandon the case, its business model and the more than 30,000 health plan participants, DOL demanded fines that it knew the Anjo Targets could not pay.
    - **In other words, DOL is using its investigative powers as leverage to bully the health plan sponsors into withdrawing their lawsuit. If they agree to drop the suit, DOL said it will settle its investigation on reasonable terms.**

- Left with no choice, on November 1, DMP and LPMS filed a supplemental complaint in the original suit, alleging improper and illegal coercive tactics

by DOL. DOL has threatened to bring its own suit against SAS and Providence Insurance Company (PIC), a related entity that provides “stop loss” or “reinsurance” to the LPMS-managed plans and hundreds of traditional employer sponsored plans, as well as against the individual owners of SAS and PIC. Since 2018, PIC has paid tens of millions of dollars to LPMS-managed plans to cover claims made by participants in Partnership Health Plans.