No. 20-11179

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

DATA MARKETING PARTNERSHIP, L.P.;
L.P. MANAGEMENT SERVICES L.L.C.,

Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF LABOR; MARTIN WALSH, SECRETARY,
U.S. DEPARTMENT OF LABOR; UNITED STATES OF AMERICA,

Defendants-Appellants.

On Appeal from the U.S. District Court for the
Northern District of Texas, Fort Worth, No. 4:19-cv-800

MOTION FOR LEAVE TO FILE BRIEF FOR *AMICI CURIAE* THE LEUKEMIA & LYMPHOMA SOCIETY, THE AMERICAN CANCER SOCIETY, THE AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, THE CYSTIC FIBROSIS FOUNDATION, AND THE NATIONAL ORGANIZATION FOR RARE DISORDERS IN SUPPORT OF APPELLANTS AND REVERSAL

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April 7, 2021

Pursuant to Rules 27 and 29 of the Federal Rules of Appellate Procedure, The Leukemia & Lymphoma Society; The American Cancer Society; The American Cancer Society Cancer Action Network; The Cystic Fibrosis Foundation; and The National Organization for Rare Disorders (collectively, "the Patient Groups") respectfully move for leave to file the attached *amici curiae* brief in support of Appellants and reversal. Counsel for Appellants have consented to this motion. Counsel for Appellees have stated that they would not consent without reviewing the brief in advance, but that Appellees might not oppose the filing subject to a review of the brief submitted with this motion.

This Court should allow the Patient Groups to participate as *amici* in this appeal. Under the governing rules, motions for leave to file *amicus* briefs must state "the movant's interest" and "the reason why an *amicus* brief is desirable and why the matters asserted are relevant to the disposition of the case." Fed. R. App. P. 29(a)(3). The Court should grant this motion because the Patient Groups each have a keen interest in the joint state and federal framework for regulating health insurance and because the proposed *amicus* brief would assist the Court in its consideration of the important issues raised by this appeal.

I. The Patient Groups have an interest in this case.

Each of the Patient Groups has an interest in this case stemming from the potential implications of the district court's ruling.

The Leukemia & Lymphoma Society (LLS) is the world's largest voluntary health agency dedicated to fighting blood cancer and ensuring that the more than 1.3 million blood cancer patients and survivors in the United States have access to the care they need. The significant costs associated with essential blood cancer treatments — particularly hospitalization, stem cell transplantation, and anti-cancer drug therapies — put even routine cancer care out of reach for those patients without comprehensive and stable health insurance. LLS and its network of more than 100,000 advocacy volunteers promote policies that ensure access to high-quality, affordable insurance coverage and reduce barriers to vital cancer care.

The American Cancer Society (ACS)'s mission is to save lives, celebrate lives, and lead the fight for a world without cancer. ACS's extensive scientific findings have established that health insurance status is strongly linked to medical outcomes and that lack of adequate

insurance coverage is a major impediment to advancing the fight against cancer.

The American Cancer Society Cancer Action Network (ACS CAN) is the nonpartisan advocacy affiliate of ACS, supporting evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.

The Cystic Fibrosis Foundation's (CFF's) mission is to cure cystic fibrosis (CF) and to provide all people with CF the opportunity to lead long, fulfilling lives by funding research and drug development, partnering with the CF community, and advancing high-quality, specialized care. CFF advocates for policies that promote affordable, adequate, and available health coverage for all people with CF.

The National Organization for Rare Disorders (NORD) is the leading independent nonprofit organization representing the 25-30 million Americans living with one of the 7,000 known rare diseases. NORD, along with its more than 300 unique patient organization members, is committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services. Many people with rare diseases have complex and costly health

care needs and depend on regular access to specialized providers and therapies. Access to comprehensive, quality, affordable health care insurance is vital to rare disease patients in order to maintain their overall health and avoid costly emergency interventions.

One way the Patient Groups promote their interests and the interests of their members is by participating in cases with important implications for health care policy — like this one. This case interests *amici* because of the harm to patients, including Appellees' (collectively "Data Marketing's") own insureds, that may result from the district court's order. By forcing the Department of Labor to recognize Data Marketing's novel "partnership" scheme as an ERISA plan rather than a means of selling unregulated individual insurance products, the district court's order threatens to undermine a sophisticated state and federal regime for regulating health insurance. That regime has been carefully designed and refined to combat fraud, prevent insolvency, and secure the benefits of the insurance bargain to patients who need it most. It is thus critically important to the members of the Patient Groups that courts correctly apply ERISA and honor state and federal lawmakers' efforts to

ensure the quality and reliability of health insurance products available on the individual insurance marketplace.

II. The Patient Groups' brief is desirable and relevant.

"Even when a party is very well represented, an amicus may provide important assistance to the court." *Neonatology Assocs., P.A. v. Commissioner*, 293 F.3d 128, 132 (3d Cir. 2002) (Alito, J.). "Some friends of the court are entities with particular expertise not possessed by any party to the case. Others argue points deemed too far-reaching for emphasis by a party intent on winning a particular case." *Id.* (quotation marks omitted). In this case, the Patient Groups' proposed amicus brief fulfills both functions.

First, the Patient Groups have "particular expertise" relevant to this case concerning the workings of the health insurance industry and the importance of regulatory oversight. *Id.* Indeed, each of the Patient Groups has a special perspective on how the district court's decision could impact parties not directly before the Court. The Patient Groups have extensive knowledge of the history of health insurance regulation, various attempts to evade state and federal regulatory requirements, and the manifest harm done to consumers across the insurance marketplace

when substandard or fraudulent insurance products are allowed to proliferate. In their brief, the Patient Groups have offered perspective and color that will aid the Court's consideration of Data Marketing's request for an advisory opinion stating that their "partnership" scheme qualifies as a single-employer ERISA plan.

Second, the Patient Groups argue "points deemed too far-reaching for emphasis by a party intent on winning a particular case." *Id.* Although the parties rightly focus on the details of ERISA law and the particular representations made to the Department of Labor in the request for an advisory opinion, the Patient Groups' *amicus* brief makes more general points about the insurance product at issue, the principles undergirding the state and federal insurance-regulation regimes, and the impact this case could have on health insurance consumers and the broader health insurance marketplace.

All other preconditions are satisfied. Under Federal Rule of Appellate Procedure 29(a)(4)(E), the proposed *amici* certify that no party or party's counsel authored the attached brief in whole or in part; no party or party's counsel contributed money intended to fund the brief's preparation or submission; and no person other than the Patient Groups,

their counsel, and their members contributed money intended to fund the brief's preparation or submission. The brief is also timely because it is filed within seven days of the filing of Appellants' brief. *See* Fed. R. App. P. 29(a)(6). Finally, the brief complies with Federal Rule of Appellate Procedure 29(a)(5), because it is no more than half the maximum length of Appellants' brief.

CONCLUSION

This Court should grant the motion for leave to file the proposed *amicus* brief.

Respectfully submitted,

/s/ Joel McElvain

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April 7, 2021

CERTIFICATE OF SERVICE

I hereby certify that on the 7th day of April, 2021, an electronic copy of the foregoing motion was filed with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service will be accomplished by the appellate CM/ECF system upon the following registered CM/ECF users:

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/s/ Joel McElvain
Joel McElvain

Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE

The undersigned counsel for *amici* certifies that:

1. No privacy redactions were required in this motion.

2. Any required hard copies of this motion are exact copies of the ECF filing dated April 7, 2021.

3. The ECF submission was scanned for viruses with the most recent version of McAfee Endpoint Security, and, according to the program, is free of viruses.

4. This motion complies with the word limits of Fed. R. App. P. 27(d)(2) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), it contains 1,200 words.

5. This motion complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6), because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Century Schoolbook font.

Dated: April 7, 2021

/s/ Joel McElvain
Joel McElvain

Counsel for Amici Curiae

No. 20-11179

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Counsel for Amici Curiae

April 7, 2021

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record for *amici curiae* certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1, in addition to those listed in the Appellants' Certificate of Interested Persons, have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

The Leukemia & Lymphoma Society: The Leukemia & Lymphoma Society is a not-for-profit corporation exempt from income tax under section 501(c)(3) of the Internal Revenue Code, 26 U.S.C. § 501(c)(3). It does not have a parent corporation and no publicly held company has a 10% or greater ownership interest.

The American Cancer Society: The American Cancer Society is a not-for-profit corporation exempt from income tax under section 501(c)(3) of the Internal Revenue Code, 26 U.S.C. § 501(c)(3). It does not have a parent corporation and no publicly held company has a 10% or greater ownership interest.

The American Cancer Society Cancer Action Network: The American Cancer Society Cancer Action Network is a not-for-profit

corporation exempt from income tax under section 501(c)(4) of the Internal Revenue Code, 26 U.S.C. § 501(c)(4). It does not have a parent corporation and no publicly held company has a 10% or greater ownership interest.

The Cystic Fibrosis Foundation: The Cystic Fibrosis Foundation is a not-for-profit corporation exempt from income tax under section 501(c)(3) of the Internal Revenue Code, 26 U.S.C. § 501(c)(3). It does not have a parent corporation and no publicly held company has a 10% or greater ownership interest.

The National Organization for Rare Disorders: The National Organization for Rare Disorders Inc. is a not-for-profit corporation exempt from income tax under section 501(c)(3) of the Internal Revenue Code, 26 U.S.C. § 501(c)(3). It does not have a parent corporation and no publicly held company has a 10% or greater ownership interest.

Counsel for* Amici Curiae*: Joel McElvain and Gabriel Krimm, both of King & Spalding LLP.

Dated: April 7, 2021

/s/ Joel McElvain

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

INTEREST OF *AMICI CURIAE*

The Leukemia & Lymphoma Society (LLS) is the world's largest voluntary health agency dedicated to fighting blood cancer and ensuring that the more than 1.3 million blood cancer patients and survivors in the United States have access to the care they need. The significant costs associated with essential blood cancer treatments — particularly hospitalization, stem cell transplantation, and anti-cancer drug therapies — put even routine cancer care out of reach for those patients without comprehensive and stable health insurance. LLS and its network of more than 100,000 advocacy volunteers promote policies that ensure access to high-quality, affordable insurance coverage and reduce barriers to vital cancer care.

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insurance is vital to rare disease patients in order to maintain their overall health and avoid costly emergency interventions.

This case interests *amici* because of the harm to patients — including Data Marketing's own insureds — that may result from the district court's order. By forcing the Department of Labor to recognize Data Marketing's novel "partnership" scheme as an ERISA plan, rather than a means of selling individual insurance products, the district court's order threatens to undermine a sophisticated web of state and federal insurance regulations. That regulatory framework has been carefully designed to combat fraud, prevent insolvency, and secure the benefits of the insurance bargain to patients who need it most.

No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amici*, their members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

Under the Employee Retirement Income Security Act of 1974 (ERISA), the Department of Labor has regulatory authority over health insurance plans offered by "employers," but the states retain their regulatory power over other forms of health coverage. The district court's ruling undermines this distinction and, in so doing, poses a substantial threat to patients across the American health care system. By usurping the Department of Labor's power to issue advisory opinions, the district court proclaimed a new judge-made regulatory regime that seriously undermines state and federal efforts to maintain the quality of individual health insurance products. If allowed to stand, the district court's policy would exacerbate well-documented defects in the insurance marketplace, leading to higher premiums, lower-quality plans, and increased incidents of fraud and insolvency. This Court should not join that project. Instead, it should respect the principles of federalism that motivated Congress to preserve a role for state insurance regulation, and it should reverse the judgment of the court below.

As a starting point for its review, this Court must begin with the facts. Despite what their letter to the Department might suggest,

Plaintiffs Data Marketing Partnership, L.P. and L.P. Management Services L.L.C. (collectively "Data Marketing") are in the health insurance business, not the data brokerage business. Through an affiliated nonprofit called the "EASE Alliance," Data Marketing attracts new "partners" by advertising a no-strings-attached opportunity to purchase low-cost health insurance products. EASE's marketing materials fail to mention that an enrollee would incur any employment responsibilities or partnership obligations, such as the management votes described in Data Marketing's letter. Instead, prospective enrollees are simply offered the opportunity to purchase health insurance, and the data-mining aspect of this scheme is candidly treated as an empty formality.

Treating this arrangement as a single-employer health plan under ERISA would turn the joint state and federal insurance regulation regime on its head. Private, individual health insurance plans have long been subject to state-led regulation and oversight. And when Congress enacted ERISA in 1974, it had no intention of disrupting that arrangement. Instead, ERISA's terms and preemption provisions merely recognized that health insurance tied to employment — genuine

employment — is a distinct animal that merits preferential treatment under a uniform set of national rules. When insureds are grouped by their relationship to a common employer, they naturally form a relatively stable and diverse risk pool, well-suited to collective insurance. And because the common employer has an interest in employee health, it has proper incentives to provide high-quality, reliable coverage. But Data Marketing and its "partners" do not fit that mold. Unlike real employees, there is nothing to bind or diversify Data Marketing's partners beyond their purchase of health insurance. And unlike a real employer, Data Marketing has no interest in its "partners" beyond their purchase of the company's insurance products. If Data Marketing is nonetheless allowed to qualify as a single-employer ERISA plan, it will effectively become a special, unregulated marketer of individual insurance products.

Legitimizing such a regulatory loophole will do harm to patients across the health insurance marketplace. By skirting state and federal regulations applicable to its competitors, Data Marketing will likely be able to offer lower premiums and draw lower-risk patients out of the broader individual insurance market. Those left behind by Data Marketing and its forthcoming imitators will see further premium

increases that the otherwise-applicable state and federal laws were put in place to avoid. Some will be priced out of health insurance entirely. At the same time, there is no guarantee that Data Marketing's own policy holders will be better off. In fact, they may well end up with plans that do not meet their coverage expectations, do not offer them better value than what is available through normally regulated plans, and do not shield them from the financial harms of medical debt. Indeed, insurance products comparable to Data Marketing's scheme have an established history of underdelivering to beneficiaries — even to the point of fraud and insolvency.

In sum, the district court's order threatens to disrupt a highly reticulated, democratically sanctioned system for maintaining the quality, transparency, and reliability of health insurance products offered on the individual marketplace. It should not be permitted to stand.

ARGUMENT

I. Data Marketing is an insurance company selling health insurance products on the individual market.

In deciding the Department's appeal, the Court should recognize the realities of this case. Data Marketing is not a data broker providing

health insurance as a fringe benefit to employees. Data Marketing is an insurance company that sells insurance plans to individual enrollees.

In a transparent effort to obtain a favorable advisory opinion, Data Marketing's letter to the Department put forth a bare-bones set of representations, which were never vetted by the Department or the court below. According to that letter, Data Marketing is a web of limited partnerships, the "primary purpose" of which "is the aggregation and profitable sale of electronic user data from its partners." R.9-1 at 1. The partners "exercise[]" their partnership rights "on a regular basis" by taking "votes" of unspecified frequency on unspecified issues regarding "how aggregated data will be sold or used" as well as other unspecified "partnership matters." R.9-1 at 3. The partners will supposedly receive "[i]ncome distributions" from the business at some uncertain time in the future, apparently based on revenue that the partnership has yet to begin generating. R.9-1 at 2. In the meantime, Data Marketing will allow partners to enroll in a health insurance plan that Data Marketing has established "[i]n an effort to attract, retain, and motivate" its ever-expanding roster of partners. R.9-1 at 3.

But the promotional efforts of Data Marketing and its sister organizations tell a different story. Data Marketing's own website — OurDataMarket.com — describes its business as a "100% free" way to passively market personal browsing data while participating in a "Health Benefits Plan[]." *About*, OurDataMarket.com (2020).[1] The site mentions the organization's partnership structure, but it says nothing of the "partnership votes" vaguely described in Data Marketing's letter to the Department. *See id.* Nor does it discuss the "hours of service" partners supposedly owe to the partnership as part of this novel arrangement. R.9-1 at 11. Instead, the focus is on providing "partners" an easy way to make free money. *See About*, OurDataMarket.

Heavy promotion of Data Marketing's health insurance product comes from elsewhere. In addition to representing Data Marketing as an attorney before the Department, counsel Alex Renfro also operates a nominally distinct organization dubbed the "ERISA Access Serving Everyone (EASE) Alliance." *See About the Ease Alliance*, EASEAlliance.org.[2] The stated purpose of the EASE Alliance is

[1] https://ourdatamarket.com/about.

[2] https://easealliance.org/#about.

"promot[ing] affordable healthcare plans." *Id.* And promotion is exactly what the EASE Alliance does — specifically, promotion of Data Marketing's health insurance products.

Indeed, the EASE website is entirely devoted to publicizing Data Marketing's health insurance by less-than-transparent means. The site's cover page hosts a video in which "EASE Plan members talk about their experiences" with "EASE Plans." *Id., Voices*.[3] The testimonials generally explain how customers were able to purchase cheap health insurance and save on premiums. *See id.* The video then concludes by telling the viewer to visit www.ourdatamarket.com "[f]or more information." *Id.* Likewise, in its "Frequently Asked Questions" section, the EASE Alliance explains that "[t]he most popular EASE plan sponsor is the company that owns the Legend web browser." *Id.*, *FAQ*.[4] That company is Slide Technology, LLC, which does business as OurDataMarket. *See About*, OurDataMarket. And despite describing Mr. Renfro as a "widely recognized … expert[]" in federal health insurance law, the EASE

[3] The same video is also available at https://www.youtube.com/watch?v=X9T8Bv9s6ck.

[4] Available under the question "What do these partnerships do?".

Alliance site fails to mention Mr. Renfro's role as an advocate for Data Marketing. *Executive Director- Alexander Renfro*, EASEAlliance.

The EASE Alliance site is, however, explicit about the purported "benefits" of Data Marketing health insurance. According to EASE, Data Marketing's health plans deliver savings to policy holders by using ERISA to avoid otherwise-applicable minimum standards. *See FAQ*, EASEAlliance. The plans also skirt "other" unspecified "rules that [otherwise] make [individual insurance] very expensive." *Id.*[5] These rules likely include state-law standards to maintain minimum reserves (to guarantee an insurer can actually pay claims) and essential health benefit requirements (to guarantee a plan actually offers meaningful coverage to its enrollees). Only by evading these standards can Data Marketing claim to deliver "health insurance" at 20% to 75% of the costs of products offered by competitors in the regulated individual market. *See* Kimberly Leonard, *New Group Will Boost Non-Obamacare Plans Halted by Trump Administration*, WASH. EXAMINER (Feb. 14, 2020).

[5] Available under the question "Why would someone want to join an EASE plan instead of buying individual insurance on the ACA exchanges?"

Consistent with these promotional efforts, a recent investigation by the State of Washington's Insurance Commissioner indicates that Data Marketing and its affiliates are black-market insurance providers, not partnerships for selling electronic data. According to state investigators, individual policy holders who purchased these types of insurance products "did not know they were involved in a 'limited partnership' [that] required them to download software to their computers [or] phones … and none of [them] recalled doing so." Office of Ins. Comm'r, State of Wash., OIC Case No. 1609841, Final Investigative Report: Providence Ins. Partners, LLC/Providence Ins. Co. [hereinafter Wash. Rpt.], at 24 (Oct. 23, 2020). What policy holders did know was that they paid a monthly premium and, in exchange, could expect to receive some measure of coverage for medical expenses. *See id.* 31–32. Simply put, they believed they had purchased individual health insurance.

State and federal lawmakers have spent many decades constructing a sophisticated regulatory regime for health insurance products, with special attention paid to individual plans. Data Marketing is a health insurance company selling individual insurance plans; it should have to play by the same rules as other insurers.

II. ERISA governs employer-provided group health insurance, not individual health insurance plans.

Data Marketing's business model depends on evading state and federal insurance regulations by pretending to be an ERISA plan. The law is not as malleable as Data Marketing suggests.

Our federal system preserves the states' traditional power to regulate insurance products, including private health insurance plans. *See* Christopher C. French, *Dual Regulation of Insurance*, 64 VILL. L REV. 25, 37–42 (2019). In fact, Congress has actively preserved state regulatory authority in this area through the McCarran-Ferguson Act, Pub. L. No. 79-15, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015). And the states have wielded their power in the best interest of their citizens as determined through legitimate democratic processes. *See* HHS, The Regulation of the Individual Health Insurance Market, at 15 (2008) (noting that state regulation "reflect[s] different values, political climates, and expectations" in each state). Indeed, "every state has adopted certain basic standards" and enforcement regimes aimed at "protect[ing] consumers" in the often-opaque health insurance marketplace. *Id.* at 4; *see also* Joshua Phares Ackerman, *The Unintended Federalism Consequences of the Affordable Care Act's Insurance Market*

*Reform*s, 34 PACE L. REV. 273, 281–304 (2014) ("From the outset, state regulation of health plans has sought to balance the competing aims of making health coverage affordable and ensuring that it is widely available — even to those whose health status makes them expensive to insure.").

States typically employ a two-pronged approach. *First*, most states regulate the scope and means of providing coverage in order to bring transparency to a market notoriously "rife with inefficiencies." Rick Swedloff, *The New Regulatory Imperative for Insurance*, 61 B.C. L. REV. 2031, 2038 (2020); Baird Webel & Carolyn Cobb, Cong. Research Serv., RL 31982, Insurance Regulation: History, Background, and Recent Congressional Oversight, at 3 (2005); *see* Ackerman, 34 PACE L. REV. at 289–99. This often includes mandating certain claims procedures, limiting policy cancellation and renewal, and imposing coverage mandates to ensure that insurance products meet consumer expectations with respect to the "persons, services, or providers" insured under a policy. Timothy Stoltzfus Jost, Wash. & Lee Univ., The Regulation of Private Health Insurance [hereinafter Private Insurance], at 13 (2009); *see id.* at 3, 11.

Second, state regulators further protect the public by ensuring plan solvency and preventing and prosecuting fraud. *See id.* at 4. To that end, state-licensed and regulated insurers must typically "meet specific capitalization requirements" and "are subject to periodic examinations and audits by state insurance departments." *Id.* at 10. This helps "to ensure [that] an entity" selling insurance "can provide coverage promised to policyholders." HHS, *supra*, at 4. Of course, preventative measures can only do so much, which is why most states also take an active interest in investigating and prosecuting insurance fraud. For example, between 2001 and 2003 alone, "the Texas Insurance Department shut down 129 unauthorized insurance companies, affiliates, operators, and their agents whose illegal actions affected more than 20,000 Texans." Mila Kofman et al., Health Insurance Scams: How Government is Responding and What Further Steps are Needed [hereinafter Scams], at 4 (2003).

ERISA (the *Employee* Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq*.) provides a superseding federal regime for health insurance tied to *employment*. In the middle of the 20th Century, employer-provided insurance emerged as a highly popular fringe benefit aimed at attracting and retaining employees. *See* Comm. on Employer-

Based Health Benefits, Inst. of Medicine, Employment and Health Benefits: A Connection at Risk [hereinafter Fields & Shapiro], at 70–71 (Marilyn J. Fields & Harold T. Shapiro, eds., 1993); S. Rep. No. 93-127, at 2–3 (1973), *as reprinted in* 1974 U.S.C.C.A.N. 4838, 4839–40. By the mid-1970s, Congress determined that subjecting employer-provided insurance plans to multiple, sometimes-inconsistent state regulatory regimes was "inefficien[t]" and "could work to the detriment of plan beneficiaries." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). So, Congress brought such plans within ERISA's unified federal regulatory structure and largely preempted State regulation of them. *See Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320–21 (2016). As a result, "[t]rue single-employer [ERISA] plans are not required to comply with state benefit mandates or solvency standards, nor may they be required to pay premium taxes and assessments, or adopt complaint resolution procedures which might otherwise be required by the state." Nat'l Ass'n of Ins. Comm'rs, Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation [hereinafter NAIC], at 45 (2019).[6] And Congress has

[6] https://www.naic.org/documents/prod_serv_legal_ers_om.pdf.

likewise exempted certain ERISA plans from various federal health insurance regulations as well. *See* Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 27, 29, 58 (2011). As a result, particular federal health insurance regulations, such as provisions guaranteeing coverage to all comers, 42 U.S.C. § 300gg-1(a), ensuring that each policy offers a set of essential health benefits, *id.* § 300gg-6(a), and requiring standardized "community rated" premiums for all participants, *id.* § 300gg, apply to the individual health insurance market but not to ERISA plans.

This special treatment for employer-provided plans makes sense for several reasons. To begin, employers have both the capacity and incentive to ensure that any health plan they provide to attract and retain employees is, in fact, decent and reliable insurance. Employees thus "benefit from the expertise of employers in purchasing, as well as from economies of scale." Private Insurance at 4; *see also MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 186 (5th Cir. 1992) ("This special relationship protects the employee, who can rely on the … employer to represent the employee's interests relating to the provision

of benefits."). In addition, it is often the case that business staffing decisions make employee groups relatively diverse risk pools, because employers generally do not hire employees based on their health insurance needs. *See* Fields & Shapiro at 67. And similarly, employees usually have ties to the employer, and each other, that are grounded in the interests of the business and have nothing to do with their medical needs. This makes them a relatively stable risk pool, not readily subject to slicing and dicing based on medical need.

Of course, all the rationales justifying ERISA's regulatory structure break down in the absence of a genuine employment relationship between the plan sponsor and the beneficiaries. If the plan sponsor is not an employer, it will lack an interest in employee well-being and have much less incentive to offer a transparent, high quality product. And if the plan is what unifies the beneficiaries, as opposed to being a mere fringe benefit of some other enterprise, then the beneficiaries are much less likely to make up a heterogenous and stable risk pool. In short, without a genuine tie to a common employer, the participants in an ERISA plan would look (and be treated by insurance providers as) individuals shopping for plans all on their own.

This is precisely why ERISA's explicit language ties its regulatory regime to the employer-employee relationship. Indeed, the stated purpose of the act is to regulate insurance plans "established or maintained by an employer." 29 U.S.C. § 1002(1). And a person can only legally qualify as a "participant" in an employer-provided ERISA plan if that person is an "employee," a "bona fide partner" of the sponsoring employer, or a "working owner[]" of a business "wear[ing] two hats": that of employer *and* employee. *See* Dep't Br. 6–8.

The district court's analysis distorts Congress's work in this area. By ignoring the very basic foundations of ERISA, the order below allows thousands of unrelated individual insureds to be transformed into a "partnership" of ERISA plan participants, creating a largely unpoliced alternative to the legitimate individual insurance plan marketplace. As is so often the case when judges try to set policy, the unintended consequences of this decision will far outweigh the perceived improvements to the work of state and federal legislators.

III. Allowing Data Marketing to masquerade as an employer to escape state and federal insurance regulations will harm patients across the health care system.

The district court's ruling threatens to open an enormous loophole in the joint state and federal system for regulating health insurance. If it is allowed to stand, the sale of individual health insurance plans would migrate to an unregulated, opaque, and inefficient market, highly susceptible to fraud and abuse. And consumers in that market will have little or no recourse against plan providers, who will not have to answer to state oversight. This will harm patients and the broader public in a way that duly-elected policymakers have carefully studied and sought to avoid.

Current health insurance regulation recognizes the fact that people who have access to adequate health insurance enjoy better health outcomes. For example, those with insurance are nearly twice as likely to have access to early cancer-detection procedures, like mammography or colorectal screenings, whereas the uninsured are twice as likely to be diagnosed with advanced-stage breast cancer and 1.3 times more likely to be diagnosed with colorectal cancer. *See* Elizabeth Ward et al., *Association of Insurance with Cancer Care Utilization and Outcomes*, 58

CANCER J. FOR CLINICIANS 9, 21 (2008); Elizabeth M. Ward et al., *The Association of Insurance and Stage at Diagnosis Among Patients Aged 55 to 74 Years in the National Cancer Database*, 16 CANCER J. 614, 619 (2010). This is a critical disparity, given the strong correlation between early detection and survival. *See* Am. Cancer Soc'y, Cancer Facts & Figures 2020, at 21 (2020).[7] Likewise, uninsured cardiovascular-disease patients experience higher mortality rates and poorer blood-pressure control than their insured counterparts. Tefera Gezmu et al., *Disparities in Acute Stroke Severity, Outcomes, and Care Relative to Health Insurance Status*, 23 J. STROKE & CEREBROVASCULAR DISEASES 93, 95–97 (2014).

Access to health insurance is also crucial for pregnant women and their children. Nearly 700 women in the U.S. die each year due to pregnancy or pregnancy-related complications. MMRIA, Report from Nine Maternal Mortality Review Committees, at 6 (2018).[8] Another

[7] https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2020/cancer-facts-and-figures-2020.pdf.

[8] https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf.

50,000 women annually experience severe maternal morbidity. CDC, *Severe Maternal Morbidity in the United States*, CDC.gov (2021).[9] Adequate insurance is critical to reduce these preventable deaths and complications. March of Dimes, Maternal Mortality and Severe Maternal Morbidity, at 2 (2018).[10]

Yet the presence of companies like Data Marketing in the insurance marketplace will undermine legislative efforts to maintain the quality and affordability of insurance products. To begin, even assuming it remains solvent and non-fraudulent, Data Marketing's ability to pass as an "employer" rather than an insurance provider may allow it to "screen[] out" any potential "partner[]" "who might have health problems." Lydia Wheeler & David Glovin, *Health Plans Undercutting Obamacare Get Boost from Texas Ruling*, BLOOMBERG (Sept. 30, 2020). In so doing, Data Marketing could cordon off a pool of healthy, low risk insureds for its policies, limiting its own expenses by screening out prospective beneficiaries with greater medical needs. When "insurers are allowed to

[9] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

[10] https://www.marchofdimes.org/materials/March-of-Dimes-Maternal-Mortality-and-SMM-Position-Statement-FINAL-June-2018.pdf.

exclude coverage for high cost but uncommon conditions (or even some common but avoidable conditions such as pregnancy), persons who need coverage for those conditions [are] forced to deal with a limited pool of insurers, who … then need to charge more for coverage (and, indeed, potentially significantly more as healthy insureds defect as the cost of coverage rises)." Private Insurance at 14.

But even without such deliberate discrimination, individuals might sort themselves into less diverse risk pools, leading to the same adverse outcomes. Those looking for cheaper coverage might be attracted to Data Marketing's "partnership" if it offered lower premiums compared to the rest of the marketplace, even if it also provided less comprehensive coverage or higher deductibles. At the same time, those in need of more comprehensive care (such as individuals with pre-existing conditions or greater anticipated health needs) may be discouraged from enrolling in Data Marketing's product and, as a result, be relegated to more costly alternatives. As the two groups become more and more segregated, costs for the latter group could rise to the point where they are entirely out of reach — a classic insurance "death spiral." This is not a theoretical phenomenon. When Kentucky allowed similarly under-regulated

"association health plans" to compete with more comprehensive individual insurance products roughly thirty years ago, it thoroughly disrupted the marketplace and forced nearly all fully regulated individual plans off the market. *See* Dustin Pugel, Ky. Ctr. for Econ. Pol'y, *Kentucky's History with Association Health Plans Shows They Undermine Health Coverage Protections* (Aug. 5, 2019); *see also* Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. HEALTH POL., POL'Y & L. 133, 151–55 (2000) ("[T]he most distinctive characteristic of Kentucky's reform experience is an unintended, adverse consequence: A dearth of insurers selling in the individual market ….").

These effects on the broader market would also likely come coupled with risks to Data Marketing's own policy holders. Roughly 50,000 people have already signed up for Data Marketing's insurance, with thousands more to follow suit if the district court's order is affirmed. And it stands to reason that Data Marketing will not be the last "partnership" to spring up with promises of unregulated, bargain-basement health insurance. Yet, without robust oversight from state insurance authorities, there is little to ensure that the tens of thousands of people

buying into these arrangements are not throwing their premiums away into a fraudulent enterprise or an insolvency-in-waiting.

Indeed, Data Marketing's product bears a close resemblance to — and, in fact, takes a step beyond — the Multiple Employer Welfare Arrangements, or "MEWAs," that have been subject to abuse since the early days of ERISA. *See* Mila Kofman et al., MEWAs: The Threat of Plan Insolvency and Other Challenges [hereinafter MEWAs], at 1 (2004); Fields & Shapiro at 84. MEWAs were originally conceived as a way to pool the resources of multiple small employers into one large benefits network, which would (theoretically) operate similar to the way a large employer did. But Congress failed to "anticipate[] the involvement of third-party promoters using [MEWAs] as profit making vehicles." NAIC at 48. The "abuses started also as soon as ERISA became law in 1974." *Id*. Taking "advantage of [a] regulatory void" similar to the one Data Marketing seeks to create and exploit here, MEWA operators "made money at the expense of their participants" by setting up insolvent or downright fraudulent insurance schemes and absconding with management fees before the bottom fell out. Letter from Raymond G. Farmer et al., Nat'l Ass'n of Ins. Comm'rs, to the Honorable Eugene

Scalia, Sec'y of Labor, at 1 (Nov. 19, 2020).[11] "These insolvencies, whether through malice or incompetence, resulted in significant sums of unpaid claims and the loss of health insurance for participants." *Id.*; *cf.* MEWAs at 2 (offering several more-recent examples of multi-million-dollar insolvencies). Eventually, Congress stepped in to reestablish state regulatory oversight and combat such abuses. *See* Scams at 3; *see also* MEWAs at 3–10 (discussing state regulatory efforts to prevent further abuse of MEWAs).

There is little reason to think that Data Marketing's request for an even broader regulatory loophole will play out any differently. In fact, investigators in the State of Washington have already found a "theme of … misrepresentation" in the way these "partnership" plans deal with their enrollees. Wash. Rpt. at 21. One customer who was assured comprehensive coverage was instead sold "a plan that didn't cover really anything except preventative care." *Id.* at 20. Another described the product as "the worst insurance coverage [her] family has ever had." *Id.* at 21. Yet another explained that he paid for such a "plan for two months before [he] realized it was junk." *Id.* at 24.

[11] https://www.naic.org/documents/government_relations_201119.pdf.

The district court's order licenses this "junk" insurance by effectively assuming the Department of Labor's power to offer advisory opinions based on untested factual assertions. Such policy decisions should be left to the political branches of the state and federal governments. This Court should reverse the order on appeal.

CONCLUSION

The district court erred in granting summary judgment to Data Marketing. This Court should reverse.

Respectfully submitted,

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April 7, 2021

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I hereby certify that on the 7th day of April, 2021, an electronic copy of the foregoing brief was filed with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service will be accomplished by the appellate CM/ECF system upon the following registered CM/ECF users:

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The undersigned counsel for *amicus* certifies that:

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Dated: April 7, 2021

/s/ Joel McElvain
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ADDENDUM

EASEAlliance.org

ABOUT THE EASE ALLIANCE

ERISA Access Serving Everyone (EASE) Alliance is a nonprofit that promotes affordable healthcare plans for all, including self-employed Americans, like real-estate agents, Uber drivers, and small business owners.

VOICES

EASE ALLIANCE

EASE PLAN MEMBERS TALK ABOUT THEIR EXPERIENCES

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EXECUTIVE DIRECTOR - ALEXANDER RENFRO

Alex Renfro is widely recognized as one of the leading national experts in the interpretation and implementation of the Employee Retirement Income Security Act ("ERISA") and the Patient Protection and Affordable Care Act, ("ACA," also known as Obamacare). He began analyzing ACA even before its passage, and was the first ERISA and welfare benefits attorney in the US to design and file a patent application for a health plan based around Minimum Essential Coverage.

Alex is an honors graduate of the University of Notre Dame, received his Juris Doctor, cum laude, from SMU Dedman School of Law, and an LLM in Taxation with a Certificate in Employee Benefits from the Georgetown University Law Center. Alex lives with his family in Nashville, TN.

FAQ

What is an EASE plan?

EASE, which stands for ERISA Access Serving Everyone, supports benefit plans that offer everyone including self-employed Americans, like real-estate agents, Uber drivers, and small business owners, the opportunity to form a partnership and gain access to affordable, flexible group health coverage.

Self-employed individuals do not have the opportunity to purchase group health insurance plans through a traditional employer. More than twenty million self-employed people don't have access to employer-sponsored plans or to Obamacare subsidies. Many of these individuals have been priced out of health insurance, as premiums and deductibles have risen, and do not qualify for subsidies.

Under the law that governs employee benefit plans, a partnership is considered a single employer. Therefore, members of a partnership qualify to purchase group health

insurance plans under ERISA.

EASE Alliance supports plans that adhere to the following principles including: protection against discrimination, financial stability, compliance with federal law including ACA and ERISA, and access for self-employed individuals.

Hide Answer...

Who is EASE intended for?

Many different types of people, including the self-employed, independent contractors (including realtors, truckers, ride share drivers, seasonal and temp workers, and other members of the so-called "gig economy"), as well as employees of small, medium, and even large companies that do not offer comprehensive health plans. Many of these people do not qualify for Obamacare subsidies, due to income, immigration status, or other factors.

Hide Answer...

How does EASE work?

EASE provides a structure under which people who do not have access to traditional employer-sponsored health coverage can nevertheless participate in large group market plans under ERISA. Certain companies which are structured as partnerships may serve as ERISA plan sponsors, and by becoming limited partners, individuals may participate in these plans.

EASE plans do not discriminate against anyone, on any basis. Sponsors of EASE plans are required to permit all individuals, irrespective of health status, pre-existing conditions, medical history, race, ethnicity, gender, age, or orientation to join both the partnership and health plan.

Hide Answer...

What do these partnerships do?

Each partnership is different and has its own requirements. The most popular EASE plan sponsor is the company that owns the Legend web browser. Limited Partners download

Legend and use it in place of Chrome, Safari, etc., in return for a share of any profits made by the company and access to affordable, flexible group health plans.

Hide Answer...

What is the "Own Your Data" movement and what happens to the data collected from limited partners?

These partnerships are part of the "Own Your Data" movement, which has sprung up worldwide as a response to growing distrust of giant technology companies. The giant tech companies such as Google and Facebook collect user data without paying anything to the people who create it, then sell it for billions of dollars.

In these data partnerships, limited partners agree to use a web browser that is owned by the partnership, instead of (for example) Safari or Chrome. No personal information about limited partners or their internet use is ever captured, stored, or sold. Any profits generated through the sale or use of fully anonymized data is shared among the partners, who collectively own the partnerships.

Hide Answer...

Why would someone want to join an EASE plan instead of buying individual insurance on the ACA exchanges?

In order to get ACA passed, the Obama administration agreed to leave ERISA plans (and their 160 million members) pretty much alone. By contrast, the newly-created ACA exchange plans were required to provide ten categories – and many dozens of sub-categories – of so-called "Essential Health Benefits" or EHBs. Exchange plans also have other rules that, along with EHBs, make them very expensive for insurers to provide. (The giant carriers who dominate the exchanges actually like it this way, because their profit margins are set by regulators, and therefore the more they spend, the more they make.) ERISA plans, on the other hand, are not subject to most of these rules. That is why the employer-sponsored large group market is relatively stable, while premiums have more than tripled for individual market plans.

Hide Answer...

Are EASE plans paid for by taxpayers?

No. EASE plan participants pay all of the cost of their own coverage. By contrast, the federal government pays premiums for more than 90% of ACA plan participants through subsidies.

Hide Answer...

What benefits do EASE plans provide?

EASE plans provide a wide range of benefits, and are priced accordingly. One of the main advantages of ERISA plans is their flexibility – people can choose the type and amount of coverage they need, rather than being forced into "one size fits all" plans. Currently available EASE plans range from low-cost basic preventative coverage to full major medical.

Hide Answer...

Who stands to benefit?

Our policy and legal initiatives directly benefit the more than 50,000 individuals who already get coverage through EASE plans and the millions more who could join a partnership. ERISA is a federal law that applies to everyone, and we expect many partnerships and individuals to take advantage of the work we've done, in order to access better and more affordable health plans.

Hide Answer...

RESOURCES

US District Court Decision Upholding EASE

•

The Gig Economy is the Future

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About

As you're probably aware of by now, your personal and private data is quietly being collected every time you browse the internet, use an app on your phone, or even just TURN ON your phone. Your valuable data is then sold by phone makers, app and software developers, social media sites and other companies for billions of dollars each year. We believe this isn't right.

OurDataMarket offers a new way for people to be directly compensated for their own data. Find out how below.

Start Databanking

How It Works

First—Become a member of one of our five Limited Partnerships, which is 100% free, and you are an OWNER in the partnership, and receive a share of your partnership's profits. You are then eligible to participate in OurDataMarket. Write us at admin@ourdatamarket.com for more details on how to join.

Second—Download our proprietary data apps. For desktop, we have apps for Chrome and Firefox. For mobile, an Android version is currently available, and Apple version is in development and will be available soon. They allow you to collect and store your data securely in your personal OurDataMarket account. No one else can see or use your personal data in your account. Your data is secured and encrypted. And you can delete it all at any time. We are fully compliant with the new California Consumer Privacy Act data privacy rules (the strictest in the US.) SEE MORE DETAILS BELOW.

Third—We handle all the data marketing and bring you the data sales opportunities. There are two ways to earn money from your data. You can collect a simple one-time or monthly sale. Or you can participate in our innovative DataPlus Program and make a data sales fee by selecting and sending data from your personal contacts for referrals. These offers will include unique discounts, so it's a win-win all around! SEE MORE DETAILS BELOW.

Additional Benefits—Be healthy! All of our active partners are eligible to participate in the partnerships' Health Benefits Plans (plan enrollments will resume soon.)

Start Databanking

MORE DETAILS

FIRST: PRIVATIZE YOUR DATA

The first thing you need to do is recapture your rights to your data. Fortunately, California has adopted a new Consumer Privacy Act (CCPA), and we now have the right to DEMAND that companies stop selling our data (you don't need to be a resident of CA to express these rights.) We are working to build technology that will automate the process for all our partners. For now, here is a link to the website that has links to companies that have implemented the notification process: https://www.donotsell.org/

NEXT: HOW WE STORE YOUR DATA FOR YOU

As mentioned above. we currently have two desktop apps, for Chrome and Firefox, have a mobile app for Android, and are developing one for Apple which will be available soon. These apps safely and securely store select personal data.

HOW WE MONETIZE YOUR DATA AND PAY YOU

The apps “anonymize” and send your search engine data to your own data bank account at our secure cloud storage. As a limited partner, you can elect to participate in our negotiated data marketing

programs to monetize your personal data bank data, and earn extra money on a regular basis.

OUR CURRENT DATA SALES PROGRAMS:

We have signed DataPlus license agreements with four specific businesses to pay you for your your phone and computer contacts (phone numbers, emails, etc.) that you personally send them from your cellphone and computer data via the apps. You will be authorizing the businesses to make specified, limited contacts with your referrals. who will only be offered the specified products and services. The license businesses CANNOT sell or transfer or use this data in any other way. YOU CAN TERMINATE YOUR SALE OF DATA IN ANY PROGRAM AT ANY TIME. You will receive a commission from each business if they make sales to any of the DataPlus referrals you send to them.

For details on the CCPA, see https://www.oag.ca.gov/privacy/ccpa

Start Databanking

Notice: only OurDataMarket partners can participate in our DataBanking programs.

Questions? Contact us.

Learn more about us.