NOT YET SCHEDULED FOR ORAL ARGUMENT

19-5125

United States Court of Appeals for the District of Columbia Circuit

STATE OF NEW YORK, et al.,

Plaintiffs-Appellees,

v.

U.S. DEPARTMENT OF LABOR, et al.,

Defendants-Appellants.

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

FINAL BRIEF FOR APPELLEES

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Dated: August 8, 2019

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), plaintiffs-appellees the States of New York, Massachusetts, California, Delaware, Kentucky, Maryland, New Jersey, Oregon, Pennsylvania, Virginia, and Washington, and the District of Columbia, certify as follows:

A. Parties and Amici

The plaintiffs-appellees are the States of New York, Massachusetts, California, Delaware, Kentucky, Maryland, New Jersey, Oregon, Pennsylvania, Virginia, and Washington, and the District of Columbia.

The defendants-appellants are the United States Department of Labor, United States Secretary of Labor R. Alexander Acosta (in his official capacity), and the United States of America.

The parties in this Court are the same as the parties in the district court, except that Acting Secretary of Labor Patrick Pizzella has been automatically substituted for former Secretary of Labor R. Alexander Acosta. There have been no other changes to the parties or the caption.

The *amici curiae* supporting the plaintiffs in the district court were the American Medical Association, the Medical Society of the State of New York, and the following Members of the United States House of

Representatives: Nancy Pelosi, Steny H. Hoyer, James E. Clyburn, Joseph Crowley, Linda T. Sánchez, Robert C. Scott, Frank Pallone, Jr., Jerrold Nadler, and Richard E. Neal.

The *amici curiae* supporting the defendants in the district court were the States of Texas, Nebraska, Georgia, and Louisiana; the Chamber of Commerce of the United States of America; the Society for Human Resource Management; the Restaurant Law Center; and the Coalition to Protect and Promote Association Health Plans.

The *amici curiae* supporting the plaintiffs-appellees in this Court are the American Medical Association; the Medical Society of the State of New York; the American Academy of Family Physicians; the American Academy of Pediatrics; the American College of Physicians; the American College of Emergency Physicians; the American College of Obstetricians & Gynecologists; the American Psychiatric Association; the Small Business Majority Foundation, Inc.; Families USA; the National Partnership for Women and Families; the National Women's Law Center; the National Employment Law Project; the National Health Law Program; the United Hospital Fund; Public Citizen; former Assistant Secretary of Labor Phyllis C. Borzi; former Solicitor of Labor M. Patricia

Smith; former Deputy Assistant Secretary of Labor Alan D. Lebowitz; former Associate Solicitor of Labor Marc I. Machiz; former Director of the Office of Health Plan Standards and Compliance Assistance Daniel J. Maguire; health care policy history scholars Henry J. Aaron, Linda J. Blumberg, Andrea Louise Campbell, Daniel Carpenter, Sabrina Corlette, David Cutler, Judith Feder, Steven Davidson, Doug Elmendorf, Robert Field, Sherry Glied, Colin Gordon, Colleen M. Grogan, Jacob S. Hacker, Mark A. Hall, John Holahan, David K. Jones, Timothy Stotlzfus Jost, Miriam Laugesen, Theodore Marmor, Rick Mayes, Jonathan Oberlander, Thomas R. Oliver, Dania Palanker, Mark Peterson, Harold Pollack, Sara Rosenbaum, William Sage, Mark Schlesinger, David Shactman, David Barton Smith, Michael Sparer, JoAnn Volk, Joseph White, Christen Linke Young, and Stephen Zuckerman; former National Association of Insurance Commissioners presidents Brian Atchinson, Jane Cline, Alessandro Iuppa, Monica Lindeen, Earl Pomeroy, Sandy Praeger, Kathleen Sebelius, and Susan Voss; former state insurance commissioners Joel Ario (Pennsylvania), Alice A. Molasky Arman (Nevada), Randy Blumer (Wisconsin), Sharon P. Clark (Kentucky), Dave Jones (California), Jack Ehnes (Colorado), Jorge A. Gomez (Wisconsin),

Thomas E. Hampton (District of Columbia), J. Robert Hunter (Texas), Christopher F. Koller (Rhode Island), Steven B. Larsen (Maryland), Sally McCarty (Indiana), Kent Michie (Utah), Lawrence Mirel (District of Columbia), John Morrison (Montana), John Oxendine (Georgia), Elizabeth Sammis (Maryland), and Karen Weldin Stewart (Delaware); former state insurance regulators Carrie Banahan (Kentucky), Elizabeth S. Berendt (Washington), Rick Diamond (Maine), Allen Feezor (North Carolina), Jean Holliday (North Carolina), Jeffrey L. Gabardi (Utah), Christina Lechner Goe (Montana), Suzette Green-Wright (Utah), Leslie Krier (Washington), Kip May (Ohio), Fred Nepple (Wisconsin), Guenther Ruch (Wisconsin), Georgia Alvarez Siehl (Idaho), and Barbara Yondorf (Colorado); association health care fraud experts Alissa Fox, Kevin Lucia, Karl Polzer, Robert Brace, and Matthew Smith; and the following Members of the United States House of Representatives: Nancy Pelosi (Speaker of the House), Steny H. Hoyer (Majority Leader), James E. Clyburn (Majority Whip), Ben Ray Luján (Assistant Speaker), Hakeem Jeffries (Democratic Caucus Chairman), Katherine Clark (Democratic Caucus Vice-Chair), Robert C. “Bobby” Scott (Chairman, Committee on Education and Labor), Frank Pallone, Jr. (Chairman, Committee on

Energy and Commerce), Jerrold Nadler (Chairman, Judiciary Committee), and Richard E. Neal (Chairman, Committee on Ways and Means).

The *amici curiae* supporting the defendants-appellants in this Court are the States of Texas, Alabama, Georgia, Indiana, Kansas, Louisiana, Montana, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, and West Virginia; Governors Phil Bryant of Mississippi and Matt Bevin of Kentucky; the Oklahoma Insurance Department and Montana State Auditor; the Chamber of Commerce of the United States of America, and state and local chambers of commerce, the National Federation of Independent Business, the Texas Association of Business and the United Service Association for Health Care; the Coalition to Protect and Promote Association Health Plans and AssociationHealthPlans.com; the National Association of Realtors and state and local associations of Realtors; and the Restaurant Law Center.

B. Ruling Under Review

The rulings under review are the Memorandum Opinion of the Honorable John D. Bates (Dkt. No. 79 in Case No. 1:18-cv-1747), which is reported at 363 F. Supp. 3d 109 (D.D.C. Mar. 28, 2019); and the

accompanying Order (Dkt. No. 78), which is not reported.

C. Related Cases

The district court's order and the defendants' regulation have not previously been before this Court or any other courts. There are no other cases raising issues substantially similar to those raised in this case.

TABLE OF CONTENTS

Page

Page

Page

TABLE OF AUTHORITIES

Cases **Page(s)**

Cases **Page(s)**

Cases **Page(s)**

Cases **Page(s)**

Statutes

Statutes **Page(s)**

Administrative Materials

Regulations

Dep't of Labor Advisory Opinions

Administrative Materials **Page(s)**

Miscellaneous Authorities

Miscellaneous Authorities **Page(s)**

GLOSSARY OF TERMS AND ABBREVIATIONS

ACA	Patient Protection and Affordable Care Act
AHP	association health plan
APA	Administrative Procedure Act
ERISA	Employee Retirement Income Security Act of 1974
MEWA	multiple employer welfare arrangement

PRELIMINARY STATEMENT

At issue in this appeal is a Final Rule promulgated by the Department of Labor that upends decades of settled interpretation of the Employee Retirement Income Security Act (ERISA) to conduct an end-run around the Patient Protection and Affordable Care Act (ACA). The rule purports to accomplish this impermissible end-run in two steps. First, the Final Rule fundamentally alters the long-standing definition of "employer" under ERISA to expand the availability of association health plans (AHPs), which have historically been perpetrators of fraud and abuse. Second, the Final Rule seeks to exempt such AHPs from the critical consumer protections that the ACA imposes on the individual and small group markets, in open disdain for Congress's policy judgment. Each of these steps is unlawful—the first under ERISA, and the second under the ACA. The U.S. District Court for the District of Columbia (Bates, J.) vacated the Final Rule for exceeding the Department's statutory authority. This Court should affirm.

As a threshold matter, the district court correctly concluded that the States have standing based on injuries to their proprietary and sovereign interests. The Final Rule acknowledges that state regulators

will be required to ramp up enforcement efforts, as many States have already done—a regulatory burden that this Court has found confers standing on States. Several of the plaintiff States will also suffer lost tax revenue from health care premiums—a fiscal harm that the Final Rule not only recognizes, but openly touts.

On the merits, the district court rightly concluded that the Final Rule unreasonably expands ERISA's definition of "employer" to include associations of employers bound by nothing more than an interest in providing health benefits. Specifically, in conflict with decades of settled judicial and agency precedent, the Final Rule allows an association to have the principal purpose of sponsoring health plans, without any other substantial business purpose; and recognizes associations whose employer-members have nothing in common beyond being located in the same State or metropolitan area. These radical changes overturn the long-standing requirement that ERISA's definition of "employer" includes only "bona fide associations" tied together by some common interest unrelated to the provision of benefits, and obliterates Congress's careful distinction between employment plans under ERISA and entrepreneurial health insurance ventures.

The Final Rule is also contrary to law because it purports to exempt newly recognized AHPs from the ACA's requirements. One of the ACA's key reforms is to require small employers to offer their employees health plans that comply with critical consumer protections, including the provision of essential health benefits. But the Final Rule permits small employers to offer their employees non-compliant plans by the simple expedient of joining a sufficiently large association. The ACA unambiguously forbids this evasion of its requirements.

The district court also correctly set aside a provision of the Final Rule that would allow "working owners"—i.e., sole proprietors *without* employees—to join associations and thereby become "employers" collectively when none of them would be an "employer" individually. This "absurd" result is unambiguously barred under both ERISA and the ACA, which limits its own definition of "employer" to an entity with "two or more employees."

Finally, there is no merit to the Department's objections to the district court's vacatur of the Final Rule. Both the Administrative Procedure Act (APA) and this Court's precedents authorize vacatur when, as here, a rule exceeds the agency's statutory authority.

ISSUES PRESENTED

1. Whether the plaintiff States have standing because the Final Rule (a) imposes a direct regulatory burden on them; and (b) will deprive several States of revenue from taxes on health insurance premiums.

2. Whether the Final Rule unreasonably interprets ERISA's definition of "employer" to include associations of employers bound by no common interest beyond the provision of health benefits.

3. Whether the Final Rule conflicts with the ACA's unambiguous requirements by allowing small employers to sponsor health plans exempt from the consumer protections applicable to small group plans.

4. Whether the Final Rule's "working owner" provision conflicts with the unambiguous terms of both ERISA and the ACA.

5. Whether the district court correctly determined that the appropriate remedy is to vacate the Final Rule.

STATEMENT OF THE CASE

A. Statutory and Regulatory Background

1. The Employee Retirement Income Security Act of 1974 (ERISA)

Congress enacted ERISA in 1974 to protect the pension and welfare benefits of employees and pensioners. Congress was particularly concerned that employees lack the means to represent their own interests with respect to benefits because, unlike those who purchase or otherwise arrange for their own benefits, individuals who obtain benefits through "traditional employer-employee relationships" "usually lack the control and understanding required to manage . . . funds created for their benefit." *Schwartz v. Gordon*, 761 F.2d 864, 868 (2d Cir. 1985).

Congress thus targeted ERISA at benefit plans that are offered in the context of an employer-employee relationship. And ERISA's definitions reflect this congressional intent. An "employee" is "any individual employed by an employer." 29 U.S.C. § 1002(6).[1] An "employer" is "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and

[1] Pertinent statutes are reproduced in the Addendum.

includes a group or association of employers acting for an employer in such capacity." *Id.* § 1002(5). And an "employee welfare benefit plan" is a plan "established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits," or other benefits. *Id.* § 1002(1).

From shortly after ERISA's enactment, it was understood that ERISA's focus on employer-employee plans necessarily excluded from its scope commercial ventures that market insurance products. In the congressional session following the enactment of ERISA, state insurance commissioners reported "that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans." Activity Report of the Committee on Education and Labor of the U. S. House of Representatives, H.R. Rep. No. 94-1785, at 48. The House Committee explained that these entrepreneurial ventures were not ERISA plans at all. *Id.*

The Department shared lawmakers' understanding that these health care ventures were not ERISA plans. The agency explained in advisory opinions during the early years of ERISA that "several unrelated

employers" that joined together to create "a vehicle for marketing insurance products" to their employees—a form of AHP—are not eligible to offer ERISA plans because they are not "acting in the interest of an employer" in doing so. *See, e.g.,* Dep't of Labor Op. No. 80-42A, 1980 WL 8941 (July 11, 1980). Similarly, the Department appeared in court proceedings as amicus curiae to explain that another form of AHP—a multiple employer enterprise selling health insurance coverage to small employers by subscription—would not qualify as "a single, umbrella-like ERISA plan." Br. for Appellant, at *7, *Donovan v. Dillingham*, No. 80-7879, 1980 WL 340211 (11th Cir. 1982). Courts agreed with the Department's statutory interpretation, observing that, when confronted with the question of whether such multiple-employer enterprises are themselves ERISA plans, "[t]he courts, congressional committees, and the Secretary uniformly held that they are not." *Donovan v. Dillingham*, 668 F.2d 1196 (11th Cir. 1982) (en banc).

The multiple employer arrangements that falsely claimed to be ERISA plans often engaged in widespread fraud and abuse, frequently resulting in plan insolvency. *See* Lucia Dec. ¶¶ 8-11(JA152-153). The failure of some plans left millions of injured people with hundreds of

millions of dollars of unpaid medical bills. *See* U.S. Gen. Accounting Office, *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage* 3–5, GAO-04-312 (2004). Insolvency often occurred because these entrepreneurial enterprises either took exorbitant profit from the plans or charged bargain-basement premiums that left the plans undercapitalized and unable to pay all eventual claims. *Oversight Investigation of Certain Multiple Employer Health Insurance Trusts Evading State and Federal Regulation*: *Hearing Before the Subcomm. on Labor-Management Relations of the H. Comm. on Education and Labor*, 97th Cong. 42 (1982).

It was against this backdrop that the Department identified the characteristics of "a bona fide employer group or association" that is "acting in the interest of an employer" and would thus be eligible to sponsor ERISA plans. Dep't of Labor Op. No. 80-42A, 1980 WL 8941 at *2. A key characteristic showing that an association acts in the interest of an employer, rather than being a commercial venture, is "a pre-existing relationship among the employer[s] . . . before the establishment" of the association. *Id.* at *3. Another characteristic of a

bona fide association is that it "does not solicit employers to participate in it." *Id.* at *3.

The Department has restated the factors relevant to identifying a bona fide association many times in the years since. As relevant here, those factors include: (1) the purpose for which the group was formed and "what, if any, were the preexisting relationships of its members"; (2) whether "the person or group that maintains the plan is tied to the employers and employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits"; and (3) whether the participating employers "exercise control over the program, both in form and substance." Dep't of Labor Op. No. 2005-20A, 2005 WL 2524365, at *3-4 (Aug. 31, 2005); *accord* Dep't of Labor Op. No. 94-07A, 1994 WL 84835, at *3-4 (Mar. 14, 1994).

To address the same problem of profit-seeking enterprises wrongly claiming ERISA status, Congress in 1983 amended ERISA to give States authority to regulate any "multiple employer welfare arrangement" (MEWA)—a term that encompasses AHPs—regardless of whether a given MEWA plan is an ERISA plan. *See* 29 U.S.C. § 1144(b)(6)(A); *see*

also Dep't of Labor, *MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* 3-5 (rev. 2013) ("MEWA Handbook")(JA284-286). But the 1983 amendments did not change the definition of an ERISA plan, and the Department has made clear that the overwhelming majority of MEWAs prior to 1983 had no colorable claim to being ERISA plans at all. *See id.* at 5(JA286).

2. The Patient Protection and Affordable Care Act (ACA)

Prior to the enactment of the ACA in 2010, the health insurance markets for individuals and employees of small employers (the individual and small group markets, respectively) were particularly prone to disadvantages in coverage, including in pricing and benefits. *See, e.g.,* Cong. Research Serv., *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act* 5 (Jan. 29, 2010). Many individuals were priced out of the market entirely, and insurance companies could discriminate in premiums or benefits against both individuals and employees of small employers based on pre-existing conditions, claims history, health status, and more. *Id.* These

discriminatory choices led to skimpy coverage and unsustainable fluctuations in costs in these markets. *Id.* By comparison, the market for employees of large employers was relatively stable. *See* Cong. Budget Office, *An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act* 5 (Nov. 30, 2009) (noting that seventy percent of the nonelderly population in the health insurance market was in the large group market, defined as employers having more than fifty employees).

To rectify this disparity, Congress focused the ACA's most comprehensive reforms on the individual and small group markets, with less stringent requirements for large employers. And Congress explicitly defined the scope of those markets: a "small employer" is an "employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year," and a "large employer" is an "employer who employed" more than fifty "employees" during the year. 42 U.S.C. §§ 300gg-91(e), 18024(b)(1)-(2).

To reduce risk segmentation within the individual and small group markets—and thus bring down costs—the ACA required insurers to treat all enrollees in each of those markets as "members of a single risk

pool." 42 U.S.C. § 18032(c). The ACA also required that all individual and small group plans provide a "comprehensive" benefits package known as the "essential health benefits package." 42 U.S.C. § 300gg-6(a); *see also* Compl. ¶¶ 3, 52, 57(JA20, 38, 40). The essential health benefits package must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services, substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. 42 U.S.C. § 18022(b). And the ACA mandated "community rating" in the individual and small group markets, forbidding premium variation except based on certain narrow factors. 42 U.S.C. § 300gg. The ACA also established exchanges in each State to enable marketplace shopping for individual and small group plans. *See* 42 U.S.C. § 18031; *see generally King v. Burwell*, 135 S. Ct. 2480 (2015).

Because the large group market required less correction, Congress imposed fewer specific requirements on large employers. Broader variation in premiums is allowed, and coverage need not meet the standards of comprehensiveness set for the individual and small group markets.

Large employers are, however, subject to a tax penalty (known as the "employer mandate") if they decline to provide health coverage meeting federal standards. *See* 26 U.S.C. § 4980H. A large employer pays this tax penalty if the coverage the employer provides is either unaffordable or does not provide "minimum value," in the sense that it covers sixty percent of essential health benefit costs on an actuarial basis. *Id.* § 4980H(b)(1)(B).

B. The Final Rule

In October 2017, President Trump signed Executive Order 13,813, stating that the ACA "has largely failed to provide meaningful choice or competition between insurers" and directing his administration to explore three avenues of regulatory action, including promotion of AHPs. 82 Fed. Reg. 48,385, 48,385 (Oct. 12, 2017). The President explained that his goal was to "allow more small businesses to avoid many of the [ACA]'s costly requirements." *Id.* To carry out the President's objectives, the Department released the Final Rule at issue in this case in June 2018. *See* Dep't of Labor, *Definition of 'Employer' under Section 3(5) of ERISA – Association Health Plans*, 83 Fed. Reg. 28,912 (June 21, 2018) ("Final Rule")(JA222) (codified at 29 C.F.R. §§ 2510.3-3(c), 2510.3-5).

The Final Rule makes two primary changes to expand the availability of AHPs. *First*, the Final Rule reinterprets ERISA's definition of "employer" to include associations of numerous unrelated employers that join together primarily to offer health insurance. Reversing the Department's long-standing definition of "bona fide association," the Final Rule would recognize such an association under ERISA even if the employers are bound by nothing more than geographical proximity—i.e., so long as they "have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area (even if the metropolitan area includes more than one State)." Final Rule 28,922(JA232). The Final Rule also purports to allow small employers to offer plans that disregard the ACA's protections for the small group market by allowing an association of such employers to aggregate "the total number of employees of all the member employers participating in the AHP" and thus be deemed a single large employer subject to the ACA's more lenient large group regulations. Final Rule 28,915(JA225).

Second, for the first time in ERISA's history, the Final Rule deems "working owners" with no other employees—i.e., sole proprietors—to be

"employers" under ERISA, thus enabling them to form and/or join "employer" associations. Final Rule 28,964(JA274). While such sole proprietors would previously have obtained health coverage on the individual market, subject to the ACA's consumer protections for that market, the Final Rule would allow sufficiently large "associations" of such sole proprietors to offer them less protective large group plans instead.

The Final Rule concedes that "some AHPs and other MEWAs suffered from mismanagement and abuse, leading to unpaid claims and loss of coverage," and that "this rule will introduce increased opportunities for mismanagement or abuse, in turn increasing oversight demands on the Department and State regulators." Final Rule 28,939, 28,953(JA249, 263). It recognizes in particular that self-insured AHPs—those in which the plan itself assumes the risk of coverage instead of purchasing insurance from a third-party insurer—"have historically been at greater risk of fraud, and are also less common than fully-insured AHPs at this time."[2] Final Rule 28,961(JA271).

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[2] An AHP that contracts with a third-party insurance company is known as a "fully insured" AHP.

Admitting that the Department's past "enforcement efforts often were too late to prevent or fully recover major financial losses," Final Rule 28,952(JA262), the Final Rule expressly relies on "the vast expertise of the States in combating MEWA fraud and mismanagement" to prevent abuses, Final Rule 28,961(JA271). Indeed, the Final Rule explicitly adopted staggered effective dates to give "State regulators . . . extra time to strengthen their enforcement programs." Final Rule 28,960-61(JA270-271). The Final Rule allowed fully insured AHPs to form under the new criteria for "bona fide associations" starting on September 1, 2018; existing self-insured AHPs starting January 1, 2019; and new self-insured AHPs starting April 1, 2019. Final Rule 28,960(JA270).

C. Procedural History

In July 2018, eleven States and the District of Columbia filed this lawsuit challenging the rule under APA § 706(2). The complaint alleged that the Final Rule is (a) not in accordance with law because it is contrary to both ERISA and the ACA, *see* Compl. ¶¶ 108-129(JA61-66); (b) in excess of the Department's statutory authority to implement and interpret ERISA, *see id.* ¶¶ 130-136(JA67-68); and (c) arbitrary and

capricious, *see id.* ¶¶ 137-145(JA68-69). Both sides moved for summary judgment, and the Department also moved to dismiss on standing grounds.

In March 2019, the district court (Bates, J.) denied the Department's motions and granted summary judgment to the States. Memorandum Opinion (Dkt. No. 79) ("Mem. Op.")(JA177-219). The court held that all of the plaintiff States have standing because of the "Final Rule's direct imposition of an increased regulatory burden on them," noting that "State regulators are a central, essential piece of the Final Rule's enforcement scheme." Mem. Op. 14, 19(JA190, 195). Separately, the district court found that three of the plaintiff States—Washington, New Jersey, and Delaware—were independently injured because the Final Rule will directly deprive them of tax revenue: specifically, the rule has the purpose and likely effect of diverting customers from certain health plans (which would generate state tax revenue) to AHPs (which would not). Mem. Op. 15-16(JA191-192).

On the merits, the district court struck down both the "bona fide association" and "working owners" provisions of the Final Rule as unreasonable interpretations of ERISA's definition of "employer." Mem.

Op. 19-20(JA195-196). Noting that "[t]he Final Rule would permit a group of employers with no common characteristic other than presence in the same state to qualify as a single employer," the court concluded that "the Final Rule does not functionally constrain bona fide associations to those acting 'in the interest of' employers." Mem. Op. 32-33(JA208-209).

With respect to the "working owners" provision, the district court held that the Department's "contention that two working owners without employees, neither of whom is within ERISA's scope alone, could associate with one another and thereby come within the statute's reach is absurd." Mem. Op. 35(JA211). The court also noted that the ACA independently limits the definition of "employer" to "employers of two or more employees," making the "working owners" provision illegal under the ACA even if it were to pass muster under ERISA. Mem. Op. 39-42(JA215-218).

The court set aside the bona fide association, commonality of interest, and working owners provisions of the rule—29 C.F.R. § 2510.3-5(b), (c), and (e)—and otherwise remanded the rule to the

agency for consideration of severability of the remaining provisions of the rule. Order (Dkt. No. 78)(JA175-176).

SUMMARY OF ARGUMENT

I. All of the plaintiff States have standing because the Final Rule directly imposes a regulatory burden upon them. The Final Rule expressly acknowledges and relies on the States' adoption of measures to prevent damage that the Final Rule would otherwise cause. Final Rule 28,960-61(JA270-271). These oversight demands have already cost the States money and will continue to do so, imposing the type of "pocketbook injury" that this Court recently recognized will confer standing on States. *Air Alliance Houston v. EPA*, 906 F.3d 1049, 1059-60 (D.C. Cir. 2018) (quotation marks omitted).

In addition, the States have standing because several of them will lose revenue from taxes that they impose on health-insurance premiums. The purpose and likely effect of the Final Rule is to divert customers from health plans that would generate taxable premiums to AHPs, which would not. The rule thus predictably and intentionally inflicts "a

direct injury in the form of a loss of specific tax revenues." *Wyoming v. Oklahoma*, 502 U.S. 437, 447-48 (1992).

II. The Final Rule "was intended and designed to end run the requirements of the ACA . . . by ignoring the language and purpose of both ERISA and the ACA." Mem. Op. 42(JA218). With respect to ERISA, the Final Rule's new criteria for forming a "bona fide association" are not a reasonable interpretation of ERISA § 3(5)'s definition of "employer" because they do not require that an association act "in the interest of an employer." Longstanding judicial and agency precedent has interpreted this language to require that an association have a substantial business purpose, and that its members share a genuine common interest, *unrelated* to the provision of benefits. The Final Rule eradicates both requirements, allowing associations to sponsor ERISA plans without the close nexus that Congress intended to impose.

III. Even if the Final Rule were a valid interpretation of ERISA, it would be invalid under the ACA because it improperly allows small employers in associations to offer plans to their employees that violate the ACA's consumer protections for the small group market, which the ACA regulates more stringently than the large group market. The Final

Rule accomplishes this impermissible effect by allowing associations to aggregate the employees of their multiple employer-members in determining the applicable market-size regulations for their plans—thus allowing multiple small employers to become a single large employer. But the plain language of the ACA does not permit such aggregation. The ACA explicitly defines the market applicable to an entity's plans by reference to the "employees" who are "employed" by that entity. 42 U.S.C. § 300gg-91(e). As both case law and the Department have confirmed, that language is limited to common-law employees—and there is no dispute that associations cannot count their employer-members' employees as the association's common-law employees. Moreover, the ACA provides explicit aggregation rules for multiple-employer arrangements but includes no provision for associations, thus implicitly prohibiting the type of aggregation that the Final Rule would permit. Put simply, when an AHP offers health insurance benefits, the ACA requires that the size of each individual employer-member—not the size of the overall association—determine whether small group or large group ACA protections apply. The Final Rule's disregard of this principle renders it unlawful.

IV. The "working owners" provision of the Final Rule is also an unreasonable interpretation of ERISA. Sole proprietors without employees are simply beyond the scope of ERISA's definition of "employer," as both the courts and the Department have consistently held. And the Final Rule's treatment of sole proprietors also plainly conflicts with the ACA, which expressly limits its definition of "employer" to "employers of two or more employees." 42 U.S.C. § 300gg-91(d)(6). A "working owner" cannot satisfy this definition because she would have only one employee—herself.

V. The district court properly vacated the Final Rule once it determined that the Department had exceeded its statutory authority. The Department's suggestion that the district court should have adopted narrower relief draws on an ongoing debate over nationwide equitable relief that simply has no application here, where the APA expressly contemplates vacatur and the district court awarded no injunctive relief.

ARGUMENT

POINT I

THE STATES HAVE STANDING BASED ON INJURIES TO THEIR PROPRIETARY AND SOVEREIGN INTERESTS

A. The States Have Standing Because the Final Rule Inflicts Increased Regulatory Burden on Them.

A State has standing to challenge a federal agency rule that harms the State's "proprietary interests or sovereign interests." *Air Alliance Houston,* 906 F.3d at 1059 (quotation marks omitted). When a federal regulation forces a State to expend resources to mitigate harm that would have been prevented but for the regulation, the State sustains "precisely the kind of pocketbook injury" that confers standing. *Id.* at 1059-60 (quotation marks omitted).

Here, the district court correctly held that the Final Rule injures the States' proprietary interests by its "direct imposition of an increased regulatory burden on them." Mem. Op. 17(JA193). The Final Rule expressly recognizes that loosening the standards for AHPs will increase the risk of fraud and mismanagement, and that the States will be required to increase their enforcement efforts to protect against that risk. Because the Department's own enforcement efforts are likely to be

inadequate, Final Rule 28,952(JA262) (admitting the Department's past "enforcement efforts often were too late to prevent or fully recover major financial losses"), the Final Rule admits that it "depends on state insurance regulators for oversight and enforcement to, among other things, prevent fraud, abuse, incompetence and mismanagement, and avoid unpaid health claims." Final Rule 28,960(JA270). Confirming this point, the Final Rule delayed its effective dates specifically to allow States "time to build and implement adequate supervision and possible infrastructure to prevent fraud and abuse" and "to implement a robust supervisory infrastructure and program." Final Rule 28,953-54(JA263-264).

In light of these admissions in the Final Rule itself, the district court correctly rejected the Department's contention that the harm to the States was speculative or self-inflicted, holding that "these regulatory expenditures are not merely incidental to the federal action" but "a central, essential piece of the Final Rule's enforcement scheme." Mem. Op. 18-19(JA194-195). The Department "ha[s] done much of the legwork" of showing the States' standing. *Massachusetts v. United States Dep't of Health & Human Servs.*, 923 F.3d 209, 224-25 (1st Cir. 2019).

And the Department's admissions have been borne out by the States' practical experience: as the plaintiff States laid out in their declarations below and as the district court summarized in detail, the States have already begun to expend significant resources on enforcement.[3]

On appeal, the Department's response is that "[n]o law or principle requires States to prevent or restrain fraud." Br. for Appellants ("Br.") 27. This Court has already rejected this extraordinary argument. No law or principle "requires" States to respond to or investigate petroleum refinery explosions that release chemicals into the environment, but this Court recently held that States have standing to challenge a federal regulation that would increase the likelihood of such explosions based on "the expenditures states have previously made and may incur again" to address such harms. *See Air Alliance Houston*, 906 F.3d at 1059.

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[3] *See* Navarro Decl. ¶¶ 7, 11-12(JA116-117); Vullo Decl. ¶¶ 17-18, 20(JA145-147); Caride Decl. ¶¶ 10, 12(JA85-86); Gasteier Decl. ¶ 8(JA91); Monahan Decl. ¶ 36(JA110); O'Connor Decl. ¶ 13(JA122); Stolfi Decl. ¶¶ 9-10(JA127-128); Taylor Decl. ¶ 16(JA135-136); *see also* Mem. Op. 17-18 & n.11, n.12, n.13, n.14(JA193-194) (summarizing declarations).

The States' standing is even clearer here than in *Air Alliance Houston* because the Final Rule expressly identifies and relies on the States' regulatory responses to prevent predictable risks. Final Rule 28,961(JA271). The Department cannot rely on increased state enforcement as justification for the Final Rule's reasonableness while at the same time dismissing the States' efforts as "alarmist" or "self-inflicted." Br. 25.

The Department also has no basis to claim that the States' injuries are "speculative" because they will stem from the misconduct of abusive AHPs. Br. 26-27. As the Supreme Court recently concluded, when "third parties will likely react in predictable ways" to a federal agency action, any resulting injury is fairly traceable to the agency, even if the predictable behavior is also unlawful. *Department of Commerce v. New York*, 139 S. Ct. 2551, 2566 (2019); *accord Renal Physicians Ass'n v. U.S. Dep't of Health & Human Servs.*, 489 F.3d 1267, 1275 (D.C. Cir. 2007). In *Department of Commerce*, the Court held that States had standing to challenge the inclusion of a citizenship question on the decennial census questionnaire based on a showing that noncitizens would respond at lower rates to such a question, thereby costing the States seats in

Congress and federal funding. 139 S. Ct. at 2566. Moreover, the Court found those injuries to be traceable to the federal action even though they depended on "third parties choosing to violate their legal duty to respond to the census." *Id.* at 2565. Contrary to the Department's contention (Br. 29), the States' standing does not depend on a finding that the Final Rule officially endorses fraudulent AHPs; it is enough that a significant increase in the risk of AHP fraud is a predictable consequence of the Final Rule. *See Department of Commerce*, 139 S. Ct. at 2566*; see also Block v. Meese*, 793 F.2d 1303, 1309 (D.C. Cir. 1986) (Scalia, J.) (standing "requires no more than *de facto* causality").

The Department largely fails to discuss the precedents relied on by the district court—its brief never mentions *Air Alliance Houston*—and instead relies (Br. 26–29) on cases in which non-governmental organizations based their standing on their voluntary choices to divert resources from other activities. *See National Treasury Emps. Union v. United States*, 101 F.3d 1423, 1430 (D.C. Cir. 1996); *Fair Emp't Council of Greater Wash., Inc. v. BMC Mktg. Corp.*, 28 F.3d 1268, 1276-77 (D.C. Cir. 1994). But none of those cases involved an official finding by the agency of increased risks, let alone an express reliance by the agency on

state enforcement in response to those risks. The "required nexus" between agency action and harm to plaintiffs here thus "is established by the agency's own pronouncements." *Natural Res. Def. Council v. National Highway Traffic Safety Admin.*, 894 F.3d 95, 104 (2d Cir. 2018).

Finally, the Department is wrong to argue (Br. 27) that the States' injury will occur only after illegal AHPs begin to form and the Department's own enforcement efforts fail. As the Final Rule itself acknowledges—most concretely in its staggering of effective dates—States must expend those resources *before* any AHPs form, in order to "strengthen their enforcement programs" in time to respond to the predicted risks of such AHPs. Final Rule 28,960(JA270). And, indeed, the States have already sustained injuries by expending resources in anticipation of the need for enforcement. That burden is enough to confer standing.

B. The States Also Have Standing Based on Loss of Specific Tax Revenue.

Independently, the district court correctly concluded that three States—Washington, Delaware, and New Jersey—will suffer "a direct injury in the form of a loss of specific tax revenues." *See Wyoming*, 502

U.S. at 448. The standing of any one of those States would be "sufficient to satisfy Article III's case-or-controversy requirement" for this case. *Rumsfeld v. Forum for Acad. & Inst. Rights, Inc.*, 547 U.S. 47, 52 n.2 (2006).

Here again, the Department itself has conceded the relevant injury. The Final Rule touts savings on state taxes as an advantage for AHPs by listing several ways in which AHPs can "avoid the potentially significant cost" of state regulation, including the taxes that some States levy on health insurance premiums. Final Rule 28,943(JA253). Specifically, the Final Rule points out that small employers that band together to form a large AHP can self-insure, bypassing the payment of premiums to issuers entirely. Final Rule 28,943(JA253).

That bypass will deprive Washington, New Jersey, and Delaware of state tax revenue that would otherwise be generated from the premiums that AHPs can avoid altogether. *See* MacEwan Decl. ¶ 16(JA98) (Washington); Caride Decl. ¶ 15(JA87) (New Jersey); Navarro Decl. ¶ 10(JA117) (Delaware). Those States have thus shown standing because they stand to suffer "a direct injury in the form of a loss of specific tax revenues." *Wyoming*, 502 U.S. at 448. By allowing

individuals and small employers to join self-insured AHPs, rather than obtaining coverage from insurance companies, the Final Rule will allow small employers to avoid taxes that would otherwise apply to premiums paid to such companies. Final Rule 28,943(JA253). The injury to the States is direct because it is an intended consequence of the Final Rule.

The cases the Department cites are inapposite. This Court's decision in *Commonwealth of Pa. ex rel. Shapp v. Kleppe*, 533 F.2d 668 (D.C. Cir. 1976), predated the Supreme Court's decision in *Wyoming*, which clarified that a State has standing when an agency action directly affects "specific tax revenues" and distinguished *Kleppe* as a case in which no specific tax had been identified. *Wyoming*, 502 U.S. at 448. The Eighth Circuit's decision in *State of Iowa ex rel. Miller v. Block* likewise predated *Wyoming* and mentioned no specific state taxes. *See* 771 F.2d 347, 353 (8th Cir. 1985). Similarly, the plaintiffs in *Arias v. DynCorp* alleged only that aerial pesticide spraying would drive people away from affected areas, reducing taxes generally. 752 F.3d 1011, 1015 (D.C. Cir. 2014).

Cases such as *Kleppe* and *Block* are also inapposite because they were suits to *compel* government action—specifically, to force the Small Business Administration to release disaster funds. *See Block*, 771 F.2d

at 348; *Kleppe*, 533 F.2d at 670. In those cases, the harm to the States' general tax base came from natural disasters, not government action. Here, by contrast, an affirmative federal policy seeks to enable or facilitate avoidance of specific state taxes.

There is no merit to the Department's contention that these States' tax injuries are outside the zone of interests of ERISA or the ACA. *See* Br. 22-25. As an initial matter, the Department has forfeited this argument by failing to raise a zone-of-interests challenge before the district court. *See American Inst. of Certified Pub. Accountants v. IRS*, 804 F.3d 1193, 1199 (D.C. Cir. 2015) (zone-of-interests inquiry is not jurisdictional and is subject to waiver).

In any event, under the APA's "generous review provisions," the zone-of-interests test "is not meant to be especially demanding"; so long as injury-in-fact is satisfied, the suit will be permitted unless "the plaintiff's interests are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit." *Clarke v. Securities Indus. Ass'n*, 479 U.S. 388, 399-400 & n.16 (1987) (quotation marks omitted). Here, the States easily fall within the zone of interests of both ERISA

and the ACA. ERISA expressly preserves the States' historic role in regulating traditional insurance—i.e., health coverage other than that provided in an ERISA plan. *See* 29 U.S.C. § 1144(b)(6)(A). And the ACA confers on States the principal regulatory role over their own health care markets. *See* 42 U.S.C. §§ 18031, 18041.

POINT II

THE FINAL RULE IS CONTRARY TO LAW AND THEREFORE INVALID BECAUSE IT CONFLICTS WITH ERISA

The district court correctly held that "[t]he Final Rule was intended and designed to end run the requirements of the ACA . . . by ignoring the language and purpose of both ERISA and the ACA." Mem. Op. 42(JA218). Point II of this brief—immediately below—discusses the Final Rule's conflict with ERISA; Point III explains its conflict with the ACA. This Court may affirm on either or both grounds.

A. An Association May Qualify as an "Employer" Within the Meaning of ERISA Only If Its Employer-Members Share a Common Interest Unrelated to the Provision of Benefits.

The Final Rule purports to be an exercise of the Department's authority to reinterpret the definition of "employer" in ERISA § 3(5). That section reads in full: "The term 'employer' means any person acting

directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." 29 U.S.C. § 1002(5). The district court correctly held that "the Final Rule stretches the definitions of 'employer' beyond what the statute can bear." Mem. Op. 21(JA197). *See Utility Air Regulatory Grp. v. EPA*, 573 U.S. 302, 321 (2014) (agency interpretation must be "within the bounds of reasonable interpretation") (quotation marks omitted).

This Court has long recognized that the phrase "in the interest of an employer" does not allow *any* entity that "discharges some responsibility in regard to a corporation's employee benefit plan" to "be swept within the definition and thereby become an 'employer.'" *International Bhd. of Painters & Allied Trades Union v. George A. Kracher, Inc.*, 856 F.2d 1546, 1548 (D.C. Cir. 1988). Among other things, it has been understood since ERISA's enactment—by the Department, Congress, and courts—that an association does not act "in the interest of an employer" if the association formed principally for the purpose of marketing health insurance. Dep't of Labor Op. No. 80-42A, 1980 WL 8941, at *2-3 & n.1;

see also *supra* at 6-10 (discussing early history of ERISA during the 1970s and 1980s).

Rather, to fall under ERISA's definition of "employer," "the entity that maintains the plan and the individuals that benefit from the plan [must be] tied by a common economic or representation interest, *unrelated to the provision of benefits*." *Wisconsin Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059, 1063-65 (8th Cir. 1986) (emphasis added) ("*WEAIT*"); *accord Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 786-87 (3d Cir. 1998); *MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir. 1992). By contrast, when the principal relationship between an association and its employer-members "stems from the benefit plan itself," the "relationship is similar to the relationship between a private insurance company . . . and the beneficiaries of a group insurance plan," and thus falls outside of ERISA's scope. *WEAIT*, 804 F.2d at 1063.

These principles follow from "ERISA's language and Congress' intent," with "no need to resort to [the Department's] interpretations." *WEAIT*, 804 F.2d at 1059. In particular, the distinction between ERISA plans and entrepreneurial plans is confirmed by ERISA's preemption

clause, which preempts state laws regulating an "employee benefit plan" but not state laws "regulat[ing] insurance. 29 U.S.C. § 1144(b)(2)(A)-(B). As the Supreme Court has recognized, Congress drew this distinction based on its recognition that the employee benefit plans subject to ERISA were distinguishable from more familiar insurance products, which remain under state control. *FMC Corp. v. Holliday*, 498 U.S. 52, 62-63 (1990).

Since the 1980s, the Department has adhered to this statutory distinction by recognizing associations as ERISA employers only if certain factors are satisfied that render them "bona fide associations." See *supra* at 8-9. Central to this analysis is whether "the person or group that maintains the plan is tied to the employers and employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits." Dep't of Labor Op. No. 2008-07A, 2008 WL 4559903, at *3 (Sept. 26, 2008). That "common economic or representation" test, the Department has explained, is what satisfies the statute's requirement of a "cohesive relationship between the provider of benefits and the

recipient of benefits under the plan" that derives from factors other than the employee benefit plan alone. *Id.*

When that nexus is absent, the Department has deemed the plan to be outside the scope of ERISA. *See id.* For example, in a 2008 opinion letter, the Department explained that the health insurance plan offered by the Chamber of Commerce of Bend, Oregon, was not an ERISA plan. *Id.* The only "economic nexus between the member employers," the Department observed, "is a commitment to private business development in a common geographic area." *Id.* Because "virtually any employer in the region" could join the Chamber plan, the requisite "connection between member employers" was lacking. *Id.*

B. The Final Rule Unreasonably Eliminates ERISA's Mandate That an Association Sponsoring an Association Health Plan Serve Some Common Interest Other Than the Provision of Benefits.

At the outset, the Department rightly concedes (*see* Br. 32) that an entity "fails to act in the interests of its members" if it "too closely resembles" a commercial insurance enterprise. And in the preamble to the Final Rule, the Department acknowledges the holdings of *WEAIT* and *MDPhysicians* that ERISA requires that "the entity that maintains

the plan and the individuals who benefit from the plan are tied by a common economic or representational interest." Final Rule 28,913(JA223) (quoting *WEAIT*). Indeed, the Final Rule affirmatively rejected comments that urged the Department to adopt an interpretation of ERISA § 3(5) that would allow any two employers to form an association "with no 'nexus' required." Final Rule 28,917(JA227). Although commenters argued that ERISA "does not expressly require commonality or control," the Final Rule states that "the Department does not agree." Final Rule 28,916-17(JA226-227).

But the Final Rule's alterations to the "bona fide association" test—particularly its effective elimination of (a) the requirement that an association be bound by a purpose unrelated to providing benefits and (b) the commonality-of-interest factor—do not reasonably apply these principles. As the Department has previously acknowledged, a meaningful, non-benefits-related "relationship between the plan sponsor and the participants is what distinguishes an employee welfare benefit plan from other health insurance arrangements." Br. of the U.S. Sec'y of Labor as Amicus Curiae, *MDPhysicians & Assocs., Inc. v. Wrotenbery*, 5th Cir. No. 91-1469 (5th Cir. July 30, 1991), 1991 WL 11248117 at *7. Yet the Final

Rule's changes to the "bona fide association" test permit—and indeed openly invite—AHPs to form for the primary purpose of offering health insurance, including for profit, and allow them to market that insurance to employers that have nothing more in common than being in the same State or metropolitan area. Final Rule 28,942-43(JA252-253).

The Department's assertion that the Final Rule is simply "an alternative method" of applying its "historical understanding" of ERISA is thus mistaken. Br. 32. As previously explained, the plans newly permitted by the Final Rule would not have been regarded as ERISA plans at the time the statute was enacted—not by Congress, not by the courts, and not by the Department. *See Kisor v. Wilkie*, 139 S. Ct. 2400, 2426 (2019) (Gorsuch, J., concurring) (citing "the government's early, longstanding, and consistent interpretation of a statute . . . as powerful evidence of its original public meaning."). The Department cannot sweep such plans into ERISA now by regulatory fiat.

1. The Final Rule improperly allows an association to form for the primary purpose of offering health coverage.

The problem begins with the first prong of the Final Rule's new definition of a bona fide association: the "purpose" provision. *See* 29

C.F.R. § 2510.3-5(b)(1). Under the Final Rule, for the first time since ERISA was enacted, an association would be able to qualify as a "bona fide association"—and thus as an "employer"—even if its "primary purpose . . . [is] to offer and provide health coverage to its employer members and their employees." *Id.* This provision invites associations to form for purely entrepreneurial purposes—contrary to ERISA's text, purpose, and history. See *supra* at 6-10. Indeed, the Final Rule permits an AHP's "substantial business purpose" to be turning a profit on the health coverage the association provides to its employer-members. Final Rule 28,918 & n.16(JA228).

Correctly recognizing that "associations that exist *solely* for the purpose of sponsoring an AHP" would not be acting in the interest of employers for purposes of ERISA § 3(5), the Department added to the Final Rule a requirement that a bona fide association have "at least one substantial business purpose" unrelated to the provision of benefits. Final Rule 28,918(JA228). But as the district court correctly recognized, the Final Rule's definition of a "substantial business purpose" is so broad—encompassing even "de minimis" activities such as publishing a newsletter—that it would essentially allow *any* employer association to

qualify. Mem. Op. 25-26(JA201-202). "This business purpose does not, in fact, need to be 'substantial' in the ordinary sense of that term," and "does no work towards narrowing" the Department's otherwise expansive interpretation. Mem. Op. 26(JA202).

Moreover, as the district court properly reasoned, the Final Rule's "safe harbor" actually illustrates "how flimsy the purpose test really is." Mem. Op. 26(JA202). The existence of a "safe harbor" for associations that "would be a viable entity *in the absence* of sponsoring an employee benefit plan," Final Rule 28,962(JA272) (emphasis added), necessarily means than an organization *outside* the safe harbor could still satisfy the "substantial business purpose" test. The Final Rule thus would count as "substantial" a non-benefits business purpose that would not otherwise be enough to make an organization a "viable entity." That standard "sets such a low bar that virtually no association could fail to meet it." Mem. Op. 26(JA202). It imposes no meaningful enforcement of the requirement that a bona fide association have a purpose unrelated to the provision of benefits.

2. The "commonality of interest" standards in the Final Rule fail to ensure any meaningful ties between the employers in an association.

Like the purpose test, the Final Rule's new commonality-of-interest criteria do no work to limit the AHPs that would qualify as ERISA plans. Once again, the Department has rightly admitted that ERISA itself imposes a commonality-of-interest requirement, rejecting comments suggesting that ERISA § 3(5) does not require such commonality. Final Rule 28,916-17(JA226-227). But once again, the criteria that the Department adopted have nothing to do with requiring a meaningful tie unrelated to the provision of benefits.

Under the Final Rule, two or more employers will be deemed to have a commonality of interest based solely on geographical proximity—specifically, if each has "a principal place of business in the same region that does not exceed the boundaries of a single State or a metropolitan area (even if the metropolitan area includes more than one State)." 29 C.F.R. § 2510.3-5(c)(1). The district court correctly found that this geographical rule failed entirely to ensure commonality of interest under any reasonable understanding of that term. As the court aptly observed, the Final Rule would allow a California-wide association to be formed by

"a restaurateur in Oakland, a physicians practice group in the Hollywood Hills, an almond farmer in the Central Valley, an importer in Long Beach, a technology company headquartered in San Diego but doing business primarily in New York, and a Fresno fast-food franchise" Mem. Op. 29(JA205).

The district court rightly concluded that the geographic commonality test does nothing to "further[] the statutory requirement that associations act in the interest of employers," and that the Final Rule has never explained "why employers with a place of business in a state would be expected to share common interests." Mem. Op. 28(JA204). As the court correctly observed: "ERISA imposes a common *interest* requirement, not merely a something-in-common requirement." Mem. Op. 28(JA204). By contrast, the test the Department has adopted "permits unrelated employers in multiple, unrelated industries to associate and be deemed to act 'in the interest of' the employer members, notwithstanding the fact that the interests of these employer members may be very different or even conflicting." Mem. Op. 27(JA203).

The Department's brief on appeal barely attempts to explain how geographic proximity alone can possibly serve as a proxy for a common

interest, especially when the only proximity required is being in the same State. Its only argument is that employers in the same region have a shared interest because they "operate within the same regulatory environment." Br. 34. Setting aside the fact that an association spanning a multistate metropolitan area (and thus different "regulatory environment[s]") would also be permitted under the Final Rule, identifying a common interest in such a sweeping manner goes well beyond what the statute can reasonably bear. Indeed, even purely entrepreneurial plans that are concededly beyond the scope of ERISA would share this interest in "the same regulatory environment." ERISA requires more: an assurance that an association of employers be bound together by some common substantive interest. "[T]here is nothing intrinsic in common geography," without more, that creates such a bond. Mem. Op. 28(JA204).

The Department itself has long refused to recognize geography alone as sufficient to establish commonality of interest—even when the employers are much closer in proximity than across an entire State or major metropolitan area. As the Department rightly recognized in its opinion letter regarding the Bend Chamber of Commerce (see *supra* at

36), a shared "commitment to private business development in a common geographic area" does not bind an association's employer-members together in a way that distinguishes the association from any other entity in the "entrepreneurial arena." Dep't of Labor Op. 2008-07A.

As the district court correctly held, commonality of interest "most directly relates to the core concern of the statute: employers' interests." Mem. Op. 27(JA203). The Final Rule's failure to credibly require any commonality of interest at all requires its vacatur.

3. The Final Rule's control and non-discrimination requirements are insufficient to satisfy ERISA.

On appeal, the Department makes the extraordinary argument that it can effectively abandon the purpose and commonality-of-interest requirements entirely because the few limitations that the Final Rule imposes on qualifying associations are enough to satisfy ERISA. Specifically, the Department asserts that it is enough that the Final Rule requires any AHP to be "controlled by its employer members" and prohibited from "discriminating among its members based on their employees' health status." Br. 2. But the control and non-discrimination

requirements are not enough—either individually or in the aggregate—to ensure the nexus that ERISA requires.

As an initial matter, the Department's suggestion on appeal that it can dispense with the commonality test altogether (*see* Br. 33-34) directly contradicts the Final Rule itself. As discussed above (see *supra* at 37), several commenters argued that the commonality-of-interest test lacks a textual basis in ERISA § 3(5), but the Department expressly rejected that argument. Final Rule 28,916-17(JA226-227). Having determined during rulemaking that commonality is required by ERISA, the Department cannot now reverse course and abandon that requirement. *See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 50 (1983) ("an agency's action must be upheld, if at all, on the basis articulated by the agency itself," not on "appellate counsel's post hoc rationalizations for agency action").

The Department's attempt to rely on control and non-discrimination alone would not be enough to satisfy ERISA in any event. Judicial decisions, grounded in "the statutory language of ERISA and the intent of Congress," confirm that preserving employer-members' control over an association is not enough by itself to demonstrate the close

relationship that distinguishes a qualifying association under ERISA from any other association.[4] *See, e.g.*, *MDPhysicians*, 957 F.2d at 186 & n.6; *Gruber*, 159 F.3d at 787. As the district court noted, control depends on the assumption that "employer members' interests are *already* aligned"; once that predicate is established, then effective control ensures that employer-members' shared interests influence the association's decisions. Mem. Op. 31(JA207) (emphasis added). But standing alone, the control test neither ensures "that employer members are united in interest" nor guarantees that the association can resolve "opposed interests." Mem. Op. 31, 32(JA207-208).[5]

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[4] The Department's view that control alone is enough is also belied by the fact that insurance plans controlled by policyholders who share in their management have long been a feature of the state-regulated, commercial insurance market. *See, e.g., Christiansen v. Nat'l Sav. & Tr. Co.*, 683 F.2d 520, 526 (D.C. Cir 1982) (mutual insurance companies are cooperative enterprises controlled by their policy holders). Control thus cannot, standing alone, distinguish a health plan from a commercial venture.

[5] The Department argues (Br. 36) that the interests of an AHP's members are necessarily aligned because "they have freely elected to band together to acquire healthcare coverage" through an arrangement "they themselves control." But this characterization merely confirms the problem that the district court appropriately identified: the Final Rule requires no common interest beyond a desire to obtain health care coverage.

The Department's reliance on the Final Rule's non-discrimination requirement is also unavailing. As an initial matter, the Department overstates the effectiveness of the non-discrimination provision. While the Final Rule formally bars discrimination based on health status, it expressly permits discrimination based on other factors—endorsing, for example, AHP's charging higher premiums to employers in non-urban areas, in particular occupations, or in particular subsectors of an industry. Final Rule 28,963(JA273) (Examples 5, 7, 8, 9). Nothing would prevent AHPs from using these permissible discriminatory criteria as a proxy for health—for example, charging more for employees who work in more dangerous occupations.

In any event, even if the non-discrimination requirement were meaningful, the district court properly recognized that it simply does not address the core question of when an association acts in the interest of an employer. To the contrary, the non-discrimination provision merely prohibits one specific basis for discrimination in the cost of premiums after an association has *already* been deemed to act in the interest of an employer based on the Final Rule's other factors. The provision thus does

not "serve to limit which associations qualify as ERISA 'employers.'" Mem. Op. 30 n.17 (JA206).

C. The Final Rule's New Interpretation of ERISA Is Arbitrary and Capricious.

In addition to being unreasonable, the Final Rule's new interpretation of ERISA is also arbitrary and capricious.[6] When an agency fails to "display awareness" that it is abandoning a long-held policy, its action is arbitrary and capricious. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). Moreover, when there have been "decades of reliance on the Department's prior policy," the agency must offer a "reasoned explanation" for the policy change. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016).

Here, the Department claims that the Final Rule preserves the principle that "a group of employers fails to act in the interests of its

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[6] The States also raised several other arbitrary-and-capricious challenges to the Final Rule below. *See* Dkt. No. 31-17 (Mem. of Law) at 38-54; Dkt. No. 54-1 (Reply Mem. of Law) at 31-45. Because the district court had no need to resolve those challenges once it found that the rule was contrary to law, this Court should remand for the district court to address those challenges in the first instance if it does not affirm the judgment below.

members if it too closely resembles a commercial insurance-type venture." Br. 32. In fact, the Final Rule abandons that principle. The Final Rule thus lacks any acknowledgment that it eliminates what the Department has always agreed is a core principle of ERISA: a commercial venture created to market insurance products to employers *cannot* be an ERISA plan. The Department's failure to admit this change and to explain the reasons for it is inherently arbitrary and capricious, and an independent basis on which this Court may affirm the order setting aside the Final Rule.

POINT III

THE FINAL RULE VIOLATES THE ACA BY SEEKING TO EVADE ITS CRITICAL CONSUMER PROTECTIONS

As explained, Congress enacted the ACA to mandate robust consumer protections in health plans for individuals and employees of small employers, including essential health benefits and risk pooling. The Final Rule openly seeks to undo that considered policy judgment by authorizing the creation of AHPs exempt from many of the ACA's core protections. Final Rule 28,933(JA243); Alexander Acosta, *A Health Fix for Mom and Pop Shops*, Wall St. J. (June 18, 2018) (Secretary Acosta

announcing the Final Rule as "relief" from the ACA, which he describes as a "backward" statutory scheme because it places more requirements on small employers than large employers). Because Congress "has unambiguously foreclosed the agency's statutory interpretation," *Catawba Cty., N.C. v. EPA*, 571 F.3d 20, 35 (D.C. Cir. 2009), the Final Rule is contrary to law.

The district court recognized that "[t]he Final Rule is clearly an end-run around the ACA" but, in light of its ERISA ruling, did not reach the question of whether the Final Rule independently violates the ACA. This Court, however, may affirm on this alternative ground.

A. The Final Rule Improperly Disregards the ACA's Definitions of "Large" and "Small Employer" in Determining Applicable Consumer Protections.

Under the ACA, a "small employer" is any "employer who employed an average of at least 1 but not more than 50 employees" in the prior year, 42 U.S.C. § 300gg-91(e)(4), and a large employer is any "employer who employed an average of at least 51 employees" in the prior year, *id.* § 300gg-91(e)(2). As discussed (see *supra* at 10-13), the ACA provides more robust consumer protections for employees of small employers than for employees of large employers. Congress deliberately chose stricter

protections for employees of small employers because the market for such employees (*i.e.*, the small group market) has historically had less comprehensive coverage and more volatility than the large group market. See *supra* at 10-11; *see also* Compl. ¶¶ 3-5, 52, 54-58(JA20-21, 38-40).

In conflict with these requirements, the Final Rule would authorize small employers that "band together" into associations to offer their employees health plans that violate the ACA's consumer protections for small group plans. Final Rule 28,912(JA222). The rule accomplishes this impermissible effect by allowing the market size applicable to an AHP to be determined by aggregating "the total number of employees of all the member employers participating in the AHP." Final Rule 28,915(JA225). In other words, a small employer whose health plans would otherwise be subject to the ACA's essential benefits requirements and other consumer protections for small group plans could evade those protections by joining an association (whose members collectively employ more than fifty individuals) and offering an AHP to its employees.

The plain terms of the ACA prohibit this outcome. The Final Rule appears to assume that, once an association is an "employer" under

ERISA, the association's size for ACA purposes is determined by counting all of the employees of the association's employer-members. But that assumption is incorrect. While the term "employer" in the ACA is borrowed from ERISA, the distinction between a "large" and "small" employer appears only in the ACA. It is thus not enough that an association may qualify as an "employer" under ERISA—it must further satisfy the ACA's distinct definition of a "large employer" if it is to be subject to the more lenient rules that apply to the large group market. And that definition in turn requires that the association "employ[]" the requisite number of "employee[s]." 42 U.S.C. § 300gg-91(e)(2) or (e)(4).

As the district court recognized, the Supreme Court has interpreted the terms "employ" and "employee" in several federal statutes—including ERISA—to incorporate the common law of agency, meaning that an employee is someone who stands in a master-servant relationship with the relevant employer. *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 319 (1992); *see also Community for Creative Non-Violence v. Reid*, 490 U.S. 730, 739 (1989) ("a court must infer, unless the statute otherwise dictates, that Congress means to incorporate the

established meaning of these terms").[7] Under that common-law test, one is an "employee" of a given "employer" only if the employer controls "'the manner and means'" in which the employee does her job. *Darden*, 503 U.S. at 323 (quoting *Reid*, 490 U.S. at 751). An association of employers simply does not stand in that relationship to the employees of its employer-members, and thus cannot be the "employer who employed" the "employees" for purposes of the ACA's market-size definitions.

Indeed, the Department's own ERISA compliance handbook has adopted this common-law understanding of the employer-employee relationship in the context of associations. MEWA Handbook, *supra*, at 22(JA303). The handbook explains that even though "employer" in ERISA may include an association of employers, the term "employee" has a more restrictive meaning requiring a common-law employer-

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[7] *See also Clackamas Gastroenterology Assocs., P.C. v. Wells*, 538 U.S. 440, 449–50 (2003) (applying common-law test under the Americans with Disabilities Act, which applies to an employer who "has 15 or more employees for each working day in each of 20 or more calendar weeks in the preceding calendar year"); *Weary v. Cochran*, 377 F.3d 522, 525 (6th Cir. 2004) (applying common-law test to Age Discrimination in Employment Act, which applies to an employer who "has twenty or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year").

employee relationship between the individual and the entity counting that individual as its employee. *Id.* at 23(JA304). The handbook concludes that individuals covered by an association's health plan "are not 'employed' by the group or association and, therefore, are not 'employees' of the group or association." *Id.* at 22(JA303). "Rather, the covered individuals are 'employees' of the *employer-members* of the group or association." *Id.*(JA303). And the relevant consumer protections applicable to such employees thus depends on the size of their direct (small) employer, not on the size of the association.[8]

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[8] A 2011 guidance document issued by the Centers for Medicare & Medicaid Services and cited in a footnote in the Final Rule does not say otherwise. *See* Final Rule 28,915 n.8(JA225). To the contrary, the guidance confirmed the general rule that, for purposes of determining market size under the ACA, the size of the association is immaterial, and it is "the size of each *individual employer* participating in the association [that] determines whether that employer's coverage is subject to the small group market or the large group market rules." Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs. Ins. Stds. Bulletin Series at 3 (Sept. 1, 2011)(JA277). While the guidance further posited, without explanation, that "rare" exceptions to this principle might exist, it did not address the statutory language discussed here and provided no reasoning for its assertion. That stray suggestion merits no deference. *See Fogo De Chao (Holdings) Inc. v. DHS*, 769 F.3d 1127, 1136-37 (D.C. Cir. 2014).

The ACA's specific provisions for aggregating multiple employers further preclude the Final Rule's attempt to create an additional aggregation rule for associations. In a provision titled "Rules for determining employer size," the ACA provides specific circumstances when two or more employers are to be treated as a single employer with common employees: for example, where one employer owns the other, or where both employers share a corporate parent. 42 U.S.C. § 18024(b)(4); 26 U.S.C. § 414(b), (c), (m), (o). When Congress enacts an "express exception" to a statute's general rule, it excludes other exceptions not listed. *Jennings v. Rodriguez*, 138 S. Ct. 830, 844 (2018). This list of exceptions, moreover, is placed in the statutory text adjacent to the definitions of "large employer" and "small employer." 42 U.S.C. § 18024(b)(1), (2), (4). The text, placement, and title of the ACA's specific aggregation rules thus provide further confirmation that, absent a statutorily enumerated exception, an employer's size for ACA purposes must be determined by counting its common-law employees.[9] The Final

[9] This principle does not prohibit small employers from forming associations. But if they do, the consumer protections applicable to such

Rule's attempt to evade this principle—by treating the employees of employer-members as employees of the association itself—is unlawful.

B. The Final Rule Independently Violates the ACA by Interpreting the Word "Employer" Inconsistently with Respect to the ACA's Employer Mandate.

The Final Rule's expanded interpretation of "employer" as applied to associations also conflicts with the ACA's employer mandate. Under the employer mandate, any "applicable large employer" must offer its employees "minimum essential coverage" or else pay a tax known as a "shared responsibility payment." 26 U.S.C. § 4980H(a). The term "applicable large employer" means "an employer who employed an average of at least 50 full-time employees" in the prior year, *id.* § 4980H(c)(2)(A)—language that parallels the ACA's market-size definition of "large employer," and "small employer," *see* 42 U.S.C. § 300gg-91(e)(2).

Despite this parallel language, the Final Rule unlawfully treats associations differently under these two provisions. Specifically, the

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an association's health plan will turn on the size of the individual employers, not on the size of the association.

Final Rule permits associations to aggregate the employees of their employer-members for purpose of the market-size definitions—thereby allowing small employers in an association to evade application of the ACA's consumer protections—but it does *not* aggregate the same employees for purposes of the employer mandate. Instead, the employer mandate will apply only to an individual employer-member of an association that independently satisfies the definition of "applicable large employer." Final Rule 28,933 & n.54(JA243).

This dichotomy flatly contradicts Congress's intent as expressed in the ACA. Not only did Congress use materially identical language in both the employer mandate and the market-size definitions, but it further expressly provided that "[a]ny term" used in the employer mandate "which is also used in [other provisions of] the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act."[10] 26 U.S.C. § 4980H(c)(6). The district court correctly held that this provision "foreclose[s]" the Final Rule's attempt

[10] The employer mandate was enacted as part of the ACA but codified in the Internal Revenue Code.

to selectively apply its expanded definition of "employer." Mem. Op. 9 n.6(JA185); *see also Independent Petroleum Ass'n of Am. v. Babbitt*, 92 F.3d 1248, 1260 (D.C. Cir. 1996) (a regulation cannot treat two similarly situated cases differently where the same legal rationale applies equally to both).

The Department's approach would also lead to perverse results. Congress intended to give employees of small employers the *strongest* consumer guarantees under the ACA. But under the Department's approach, these employees would have *fewer* protections than anyone—including employees of large employers—because they would benefit from neither the consumer protections applicable to the small group market nor the employer mandate applicable to the large group market. There is no indication whatsoever that Congress intended to endorse such a result.

C. Congress Did Not Delegate to the Department the Authority to Alter the ACA by Reinterpreting ERISA.

The Final Rule's attempt to alter the application of the ACA's consumer protections is also unlawful because it is not plausible that Congress intended to delegate such sweeping power to the Department

when it enacted the ACA—let alone to allow the Department to do so by reinterpreting the decades-old definition of "employer" in ERISA. The ACA's protections for the individual and small group markets, and the employer mandate for the large group market, are some of the statute's "key reforms," affecting "millions of people" previously subject to inadequate or discriminatory health plans. *King*, 135 S. Ct. at 2489. Whether and how those protections apply is thus "a question of deep 'economic and political significance' that is central to this statutory scheme; had Congress wished to assign that question to an agency, it surely would have done so expressly." *Id.* And it is particularly unlikely that Congress intended these questions to be resolved through a reinterpretation of ERISA, a statute that predates the ACA by four decades. "When an agency claims to discover in a long-extant statute an unheralded power to regulate a significant portion of the American economy . . . we typically greet its announcement with a measure of skepticism." *Utility Air Regulatory Grp.*, 573 U.S. at 324 (quotation marks omitted).

The Department's attempt to substitute its policy views for those of Congress is even more remarkable because the agency freely concedes

that an association of small employers *will not* have the same incentive to provide quality coverage that large employers do. Final Rule 28,944(JA254). The Department admits that although a true large employer has economic incentives to provide comprehensive coverage, AHPs will favor "risk differences between, for example, genders, age groups, and industries, and more tailored, often less comprehensive benefits." *Id.*(JA254). The Department thus cannot even argue that its regulatory approach here is consistent with Congress's aim of providing quality coverage to employees of small employers. It is implausible that Congress intended to delegate to an agency the authority to directly undermine the ACA's statutory goals. *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (a court "must be guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency.").

The Department's fundamental justification for the Final Rule is that it wishes to "level[] the playing field between small employers in AHPs, on the one hand, and large employers, on the other." Final Rule 28,933(JA243). But to the extent that the rules are different for small

and large employers, it is because *Congress* decided to make them different in response to the small group market's history of inadequate benefits, premium discrimination, and risk segmentation. See *supra* at 11-13. Whatever the merits of the Department's preferred policy approach, "it was not the idea Congress enacted into law." *MCI Telecomms. Corp. v. AT&T*, 512 U.S. 218, 231 (1994). The Final Rule does not merely adjust the scope of the ACA, but utterly transforms it—changing it from a scheme with a principal goal of protecting individuals and small employers' employees into a scheme that gives them fewer protections than the employees of large employers.

POINT IV

THE FINAL RULE'S TREATMENT OF "WORKING OWNERS" IS CONTRARY TO BOTH ERISA AND THE ACA

The district court also correctly vacated the Final Rule's provision allowing a working owner without employees—i.e., a sole proprietor—to qualify as an "employer" under ERISA. *See* 29 C.F.R. § 2510.3-5(e)(1). The rule deems sole proprietors to be "employers," despite having no employees, in order to allow them to aggregate to form associations that will themselves be considered employers under ERISA § 3(5) because

they are "association[s] *of employers*." (Such aggregation would in turn allow such associations to offer health plans that fail to comply with the individual-market protections that would otherwise apply to sole proprietors.) This portion of the Final Rule cannot be squared with either ERISA or the ACA. *See* Mem. Op. 33-42(JA209-218).

A working owner without employees is not an employer because he neither acts "directly as an employer" or "indirectly in the interest of an employer." 29 U.S.C. § 1002(5). The word "employee," moreover, can refer only to "an individual employed by an employer," *id.* § 1002(6). As the district court observed, this statutory text "clearly anticipates a relationship between two parties." Mem. Op. 35(JA211). And as the Department conceded at oral argument below, ERISA's statutory text cannot be read to apply to an individual who "is offering only [herself] a plan"; "that plan offered only to that individual falls outside the scope of ERISA." Tr. of Oral Arg. at 74(JA172). This position accords with decades of guidance from the Department, including regulations that expressly exclude sole proprietors from the scope of ERISA. *See* 29 C.F.R. § 2510.3-3(b), (c)(1).

The Final Rule nonetheless treats an *association* of two or more working owners as an employer under ERISA. This position fails for a basic reason: an association can be an "employer" for ERISA purposes only if it is an "association *of employers*." 29 U.S.C. § 1002(5) (emphasis added). As the district court correctly recognized, "[a]n association of two working owners without employees has *no* employers or employees" at all. Mem. Op. 41(JA217) (emphasis added). The Department previously adhered to this precise interpretation for decades. *See* Dep't of Labor Op. Letter 07-06A (Aug. 16, 2007) ("[T]he Department has previously concluded that sole proprietors without common-law employees are not eligible to be treated as 'employers' for purposes of participating in a bona fide group or association of employers within the meaning of ERISA section 3(5).").[11] Its abrupt change of course, as the district court correctly recognized, "is pure legerdemain." Mem. Op. 41(JA217).

[11] *See also* Dep't of Labor Op. Letter 03-13A (Sept. 20, 2003); Dep't of Labor Op. Letter 95-01A (Feb. 13, 1995); Dep't of Labor Op. Letter 94-07A (Mar. 14, 1994); Dep't of Labor Op. Letter 77-75A (Sept. 21, 1977); Dep't of Labor Op. Letter 75-19 (Oct. 10, 1975).

The Department attempts to find support for the Final Rule's treatment of "working owners" in *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004). *See* Br. 40-41. But *Yates* undermines rather than supports the Department's position. The Court there squarely held that "[p]lans that cover *only* sole owners or partners and their spouses . . . fall outside [ERISA] Title I's domain." 541 U.S. at 21 (emphasis added). And the Court further held that "if a benefit plan covers *only working owners*, it is *not* covered by Title I" of ERISA. *Id.* at 21 n.6 (emphasis added). To be sure, the Court held that ERISA did cover the particular plan at issue in *Yates*, but only because the "plan cover[ed] one or more employees *other than the business owner and his or her spouse*." *Id.* at 6, 21 (emphasis added). By contrast, as both *Yates* and subsequent decisions have made clear, a "sole proprietorship[] without employees" cannot "logically be considered an 'employer'" because it has no employees; thus, the "plain language of [ERISA] would . . . seem to preclude finding" that an association of sole proprietors qualifies as an "association of *employers*" under ERISA's definition. *Marcella v. Capital Dist. Physicians' Health Plan, Inc.*, 293 F.3d 42, 48 (2d Cir. 2002)

(Sotomayor, J.) (emphasis added).[12] Moreover, because, as the district court also correctly recognized, Mem. Op. 37 n.19(JA213), *Yates* and its progeny based their holdings on ERISA's statutory text—not just the Department's past regulations—it is irrelevant that the Department has altered its prior regulations, *cf.* Br. 41.

Finally, even if the Final Rule's "working owner" provision could be squared with ERISA's text, it would be foreclosed by the ACA. The ACA generally adopts ERISA's definition of "employer" with an important qualifier—"except that such term shall include only employers of two or more employees." 42 U.S.C. § 300gg-91(d)(6). Thus, even if a working owner could be an "employer" under ERISA, she would still have only one employee—herself—and would not qualify as an "employer" under the ACA.

The Department argues that the "ACA at no point constrains" the "interpretive authority" that the Department has over ERISA. Br. 42.

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[12] *See also, e.g.*, *Dahl v. Charles F. Dahl, M.D., P.C. Defined Benefit Pension Tr.*, 744 F.3d 623, 629 (10th Cir. 2014); *House v. American United Life Ins. Co.*, 499 F.3d 443, 450 (5th Cir. 2007); *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102, 1105 (11th Cir. 1999); *In re Watson*, 161 F.3d 593, 597 (9th Cir. 1998).

But any agency interpretation of ERISA is necessarily limited, in the ACA context, by the ACA's express terms. And the Department's brief at no point acknowledges, let alone explains away, the qualifier that the ACA places on its incorporation of ERISA's definition of "employer." *See* Br. 42-43.

POINT V

VACATUR OF THE FINAL RULE WAS APPROPRIATE

The Department's contention that the district court issued overly broad relief is both unpreserved and meritless. The Department did not argue below that more limited relief than vacatur was appropriate, and even if the agency was "surprised—which may be doubtful—by the scope of the judge's order," the Department was required to "preserve [the] issue for appeal even if the only opportunity was a post-judgment motion." *Arias*, 752 F.3d at 1016.

In any event, it is the settled law of this Court "that '[w]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.'" *National Mining Ass'n v.*

U.S. Army Corps of Engineers, 145 F.3d 1399, 1409 (D.C. Cir. 1998) (quoting *Harmon v. Thornburgh*, 878 F.2d 484, 494-95 & n.21 (D.C. Cir. 1989)). The district court's vacatur was a straightforward application of *National Mining* and the APA.

The Department objects to *National Mining* and asks to "preserve the issue for further review" (Br. 45), but its objections draw on arguments that have no application here. The Department's reliance on principles of equity and Article III standing to contest vacatur invokes arguments it has made in other cases against the issuance of nationwide injunctions by individual district courts. *See* Office of the Attorney General, *Litigation Guidelines for Cases Presenting the Possibility of Nationwide Injunctions* (Sept. 13, 2018). But those arguments are inapposite here because the district court did not grant injunctive relief, and because the "less drastic remedy" of vacatur is expressly authorized by the APA, 5 U.S.C. § 706(2)(A). *Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 165-66 (2010); *see also American Bioscience, Inc. v. Thompson*, 269 F.3d 1077, 1084 (D.C. Cir. 2001) (distinguishing vacatur from injunctive relief).

Among other distinctions, the standard APA remedy of vacatur and remand—unlike an injunction—does not place the agency under any ongoing order or court supervision; once the court vacates a rule as unlawful and returns the matter to the agency, "the court's inquiry is at an end." *Palisades Gen. Hosp., Inc. v. Leavitt*, 426 F.3d 400, 403 (D.C. Cir. 2005) (quotation marks omitted). And as courts have long recognized, the practice of vacating and remanding an illegal rule is "in keeping with the fundamental principle that agency policy is to be made, in the first instance, by the agency itself—not by courts, and not by agency counsel." *Harmon*, 878 F.2d at 494.

CONCLUSION

This Court should affirm the district court's judgment.

Dated: New York, New York
August 8, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(a) of the Federal Rules of Appellate Procedure, Megan Chu, an employee in the Office of the Attorney General of the State of New York, hereby certifies that according to the word count feature of the word processing program used to prepare this brief, the brief contains 12,914 words and complies with the typeface requirements and length limits of Rule 32(a)(5)-(7).

/s/ *Megan Chu*

Addendum

TABLE OF CONTENTS

Except for the following, all applicable statutes, etc., are contained in the Brief for Appellants.

PAGE

5 U.S.C.
United States Code, 2017 Edition
Title 5 - GOVERNMENT ORGANIZATION AND EMPLOYEES
PART I - THE AGENCIES GENERALLY
CHAPTER 7 - JUDICIAL REVIEW
Sec. 706 - Scope of review
From the U.S. Government Publishing Office, www.gpo.gov

§706. Scope of review

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

(Pub. L. 89–554, Sept. 6, 1966, 80 Stat. 393.)

HISTORICAL AND REVISION NOTES

Derivation	*U.S. Code*	*Revised Statutes and Statutes at Large*
	5 U.S.C. 1009(e).	June 11, 1946, ch. 324, §10(e), 60 Stat. 243.

Standard changes are made to conform with the definitions applicable and the style of this title as outlined in the preface of this report.

ABBREVIATION OF RECORD

Pub. L. 85–791, Aug. 28, 1958, 72 Stat. 941, which authorized abbreviation of record on review or enforcement of orders of administrative agencies and review on the original papers, provided, in section 35 thereof, that: "This Act [see Tables for classification] shall not be construed to repeal or modify any provision of the Administrative Procedure Act [see Short Title note set out preceding section 551 of this title]."

26 U.S.C.
United States Code, 2017 Edition
Title 26 - INTERNAL REVENUE CODE
Subtitle A - Income Taxes
CHAPTER 1 - NORMAL TAXES AND SURTAXES
Subchapter D - Deferred Compensation, Etc.
PART I - PENSION, PROFIT-SHARING, STOCK BONUS PLANS, ETC.
Subpart B - Special Rules
Sec. 414 - Definitions and special rules
From the U.S. Government Publishing Office, www.gpo.gov

§414. Definitions and special rules

. . .

(b) Employees of controlled group of corporations

For purposes of sections 401, 408(k), 408(p), 410, 411, 415, and 416, all employees of all corporations which are members of a controlled group of corporations (within the meaning of section 1563(a), determined without regard to section 1563(a)(4) and (e)(3)(C)) shall be treated as employed by a single employer. With respect to a plan adopted by more than one such corporation, the applicable limitations provided by section 404(a) shall be determined as if all such employers were a single employer, and allocated to each employer in accordance with regulations prescribed by the Secretary.

(c) Employees of partnerships, proprietorships, etc., which are under common control

(1) In general

Except as provided in paragraph (2), for purposes of sections 401, 408(k), 408(p), 410, 411, 415, and 416, under regulations prescribed by the Secretary, all employees of trades or businesses (whether or not incorporated) which are under common control shall be treated as employed by a single employer. The regulations prescribed under this subsection shall be based on principles similar to the principles which apply in the case of subsection (b).

(2) Special rules relating to church plans

(A) General rule

Except as provided in subparagraphs (B) and (C), for purposes of this subsection and subsection (m), an organization that is otherwise eligible to participate in a church plan shall not be aggregated with another such organization and treated as a single employer with such other organization for a plan year beginning in a taxable year unless—

(i) one such organization provides (directly or indirectly) at least 80 percent of the operating funds for the other organization during the preceding taxable year of the recipient organization, and

(ii) there is a degree of common management or supervision between the organizations such that the organization providing the operating funds is directly involved in the day-to-day operations of the other organization.

. . .

(m) Employees of an affiliated service group

(1) In general

For purposes of the employee benefit requirements listed in paragraph (4), except to the extent otherwise provided in regulations, all employees of the members of an affiliated service group shall be treated as employed by a single employer.

(2) Affiliated service group

For purposes of this subsection, the term "affiliated service group" means a group consisting of a service organization (hereinafter in this paragraph referred to as the "first organization") and one or more of the following:

(i) is a shareholder or partner in the first organization, and

(ii) regularly performs services for the first organization or is regularly associated with the first organization in performing services for third persons, and

. . .

(o) Regulations

The Secretary shall prescribe such regulations (which may provide rules in addition to the rules contained in subsections (m) and (n)) as may be necessary to prevent the avoidance of any employee benefit requirement listed in subsection (m)(4) or (n)(3) or any requirement under section 457 through the use of—

(1) separate organizations,

(2) employee leasing, or

(3) other arrangements.

The regulations prescribed under subsection (n) shall include provisions to minimize the recordkeeping requirements of subsection (n) in the case of an employer which has no top-heavy plans (within the meaning of section 416(g)) and which uses the services of persons (other than employees) for an insignificant percentage of the employer's total workload.

26 U.S.C.
United States Code, 2017 Edition
Title 26 - INTERNAL REVENUE CODE
Subtitle D - Miscellaneous Excise Taxes
CHAPTER 43 - QUALIFIED PENSION, ETC., PLANS
Sec. 4980H - Shared responsibility for employers regarding health coverage
From the U.S. Government Publishing Office, www.gpo.gov

§4980H. Shared responsibility for employers regarding health coverage

(a) Large employers not offering health coverage

If—

(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

. . .

(2) Applicable large employer

(A) In general

The term "applicable large employer" means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

. . .

(C) Rules for determining employer size

For purposes of this paragraph—

(i) Application of aggregation rule for employers

All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(ii) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

29 U.S.C.
United States Code, 2017 Edition
Title 29 - LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF EMPLOYEE BENEFIT RIGHTS
Subtitle B - Regulatory Provisions
part 5 - administration and enforcement
Sec. 1144 - Other laws
From the U.S. Government Publishing Office, www.gpo.gov

§1144. Other laws

. . .

(b) Construction and application

. . .

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

. . .

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A - PUBLIC HEALTH SERVICE
SUBCHAPTER XXV - REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE
Part A - Individual and Group Market Reforms
Subpart I - General Reform
Sec. 300gg - Fair health insurance premiums
From the U.S. Government Publishing Office, www.gpo.gov

§300gg. Fair health insurance premiums

(a) [1] Prohibiting discriminatory premium rates

(1) In general

With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg–6(c) of this title); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) Rating area

(A) In general

Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this subchapter.

(B) Secretarial review

The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this subchapter. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) Permissible age bands

The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) Application of variations based on age or tobacco use

With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) Special rule for large group market

If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 18032(f)(2)(B) of this title), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A - PUBLIC HEALTH SERVICE
SUBCHAPTER XXV - REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE
Part A - Individual and Group Market Reforms
Subpart I - General Reform
Sec. 300gg-6 - Comprehensive health insurance coverage
From the U.S. Government Publishing Office, www.gpo.gov

§300gg–6. Comprehensive health insurance coverage

(a) Coverage for essential health benefits package

A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title.

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A - PUBLIC HEALTH SERVICE
SUBCHAPTER XXV - REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE
Part C - Definitions; Miscellaneous Provisions
Sec. 300gg-91 - Definitions
From the U.S. Government Publishing Office, www.gpo.gov

§300gg–91. Definitions

. . .

(5) Employee

The term "employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(6)].

(6) Employer

The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(5)], except that such term shall include only employers of two or more employees.

. . .

(e) Definitions relating to markets and small employers

For purposes of this subchapter:

(1) Individual market

(A) In general

The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) Treatment of very small groups

(i) In general

Subject to clause (ii), such terms [2] includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) State exception

Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) Large employer

The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) Large group market

The term "large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) Small employer

The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees [3] on the first day of the plan year.

(5) Small group market

The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) Application of certain rules in determination of employer size

For purposes of this subsection—

(A) Application of aggregation rule for employers

all [4] persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 shall be treated as 1 employer.

(B) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) Predecessors

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(7) State option to extend definition of small employer

Notwithstanding paragraphs (2) and (4), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(July 1, 1944, ch. 373, title XXVII, §2791, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1972; amended Pub. L. 110–233, title I, §102(a)(4), May 21, 2008, 122 Stat. 890; Pub. L. 111–148, title I, §1563(b), (c)(16), formerly §1562(b), (c)(16), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 264, 269, 911; Pub. L. 114–60, §2(b), Oct. 7, 2015, 129 Stat. 543; Pub. L. 114–255, div. C, title XVIII, §18001(c)(1), Dec. 13, 2016, 130 Stat. 1344.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a)(1), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§1320d et seq.) of subchapter XI of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 2701, referred to in subsecs. (a)(3) and (d)(15)(A), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1,

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 157 - QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III - AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part A - Establishment of Qualified Health Plans
Sec. 18022 - Essential health benefits requirements
From the U.S. Government Publishing Office, www.gpo.gov

§18022. Essential health benefits requirements

. . .

(b) Essential health benefits

(1) In general

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 157 - QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III - AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part A - Establishment of Qualified Health Plans
Sec. 18024 - Related definitions
From the U.S. Government Publishing Office, www.gpo.gov

§18024. Related definitions

(a) Definitions relating to markets

In this title: [1]

(1) Group market

The term "group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) Individual market

The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) Large and small group markets

The terms "large group market" and "small group market" mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) Employers

In this title: [1]

(1) Large employer

The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) Small employer

The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) State option to extend definition of small employer

Notwithstanding paragraphs (1) and (2), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(4) Rules for determining employer size

For purposes of this subsection—

(A) Application of aggregation rule for employers

All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 shall be treated as 1 employer.

(B) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) Predecessors

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) Continuation of participation for growing small employers

If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subchapter for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) Secretary

In this title,[1] the term "Secretary" means the Secretary of Health and Human Services.

(d) State

In this title,[1] the term "State" means each of the 50 States and the District of Columbia.

(e) Educated health care consumers

The term "educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(Pub. L. 111–148, title I, §1304, title X, §10104(d), Mar. 23, 2010, 124 Stat. 171, 900; Pub. L. 114–60, §2(a), Oct. 7, 2015, 129 Stat. 543.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a) to (d), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

AMENDMENTS

2015—Subsec. (b)(1). Pub. L. 114–60, §2(a)(1), substituted "51" for "101".

Subsec. (b)(2). Pub. L. 114–60, §2(a)(2), substituted "50" for "100".

Subsec. (b)(3). Pub. L. 114–60, §2(a)(3), amended par. (3) generally. Prior to amendment, text read as follows: "In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting '51 employees' for '101 employees' in paragraph (1) and by substituting '50 employees' for '100 employees' in paragraph (2)."

2010—Subsec. (e). Pub. L. 111–148, §10104(d), added subsec. (e).

[1] *See References in Text note below.*

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 157 - QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III - AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part B - Consumer Choices and Insurance Competition Through Health Benefit Exchanges
Sec. 18031 - Affordable choices of health benefit plans
From the U.S. Government Publishing Office, www.gpo.gov

§18031. Affordable choices of health benefit plans

. . .

(b) American Health Benefit Exchanges

(1) In general

Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title [1] as an "Exchange") for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title [1] referred to as a "SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 157 - QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III - AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part B - Consumer Choices and Insurance Competition Through Health Benefit Exchanges
Sec. 18032 - Consumer choice
From the U.S. Government Publishing Office, www.gpo.gov

§18032. Consumer choice

. . .

(c) Single risk pool

(1) Individual market

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) Small group market

A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) Merger of markets

A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) State law

A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

42 U.S.C.
United States Code, 2017 Edition
Title 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 157 - QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
SUBCHAPTER III - AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS
Part C - State Flexibility Relating To Exchanges
Sec. 18041 - State flexibility in operation and enforcement of Exchanges and related requirements
From the U.S. Government Publishing Office, www.gpo.gov

§18041. State flexibility in operation and enforcement of Exchanges and related requirements

. . .

(b) State action

Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

. . .

(d) No interference with State regulatory authority

Nothing in this title [1] shall be construed to preempt any State law that does not prevent the application of the provisions of this title.[1]

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the accompanying Brief for Appellees by using the CM/ECF system on August 8, 2019.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: August 8, 2019
New York, NY

/s/ *Matthew W. Grieco*