UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF LABOR *et al.*,

Defendants.

Civil Action No. 18-cv-1747 (JDB)

DEFENDANTS' REPLY IN SUPPORT OF THEIR MOTION TO DISMISS, OR, IN THE ALTERNATIVE, CROSS-MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

INTRODUCTION. 1

ARGUMENT 2

I. THE COURT SHOULD DISMISS THIS CASE FOR LACK OF JURISDICTION. 2

A. Plaintiffs' Claimed Proprietary Interests Do Not Confer Standing. 2

1. The Claimed Injuries Are Too Speculative to Confer Standing. 3

2. Any Alleged Increased Regulatory Burden Is Incidental to the Final Rule. 4

3. Any Alleged Decrease in Tax Revenue Is Incidental to the Final Rule. 5

4. Any Increase in the Cost to Plaintiffs of Uncompensated Care Is Incidental to the Final Rule 6

B. The Final Rule Does Not Impinge on the States' Sovereign Interests. 6

C. Plaintiffs' Interest in the Stability of Their Insurance Markets Cannot Confer Standing Against the Federal Government. 7

II. THE FINAL RULE IS A REASONABLE INTERPRETATION OF ERISA SECTION 3(5) AND FURTHERS ERISA'S OBJECTIVE OF ENCOURAGING THE CREATION OF EMPLOYEE BENEFIT PLANS. 8

A. The Department Permissibly Modified Its Sub-Regulatory Guidance Interpreting ERISA Section 3(5)'s Ambiguous Definition of "Employer." 8

B. The Department's Interpretation of Section 3(5) As Reflected in the Final Rule Is Not Foreclosed By Other Statutory Provisions. 11

1. Other ERISA provisions do not foreclose this interpretation of Section 3(5). **Error! Bookmark not defined.**

2. Nothing in the provisions of either the ACA or the IRC foreclose the Final Rule's interpretation of Section 3(5). 13

a. The ACA group market provisions incorporate ERISA Section 3(5)'s definition of "employer." 13

b. The relationship between the ACA group market provisions and AHPs was determined by HHS well before the Department of Labor's promulgation of the Final Rule and is unaffected by the Final Rule. 15

c. The ACA group market provisions allowing the aggregation of employers support the Final Rule's interpretation of Section 3(5). 17

d. The IRC does not foreclose the Final Rule. 18

III. THE FINAL RULE'S TREATMENT OF WORKING OWNERS IS A REASONABLE INTERPRETATION OF ERISA SECTION 3(5). 19

IV. THE FINAL RULE'S INTERPRETATION OF "A GROUP OR ASSOCIATION OF EMPLOYERS" IS NEITHER ARBITRARY NOR CAPRICIOUS. 21

A. The Department Adequately Explained The Basis For Its Decision To Add An Additional Pathway For Forming AHPs. 21

B. The Department Appropriately Weighed the Evidence On Both Sides. 22

C. The Department Relied On Factors Congress Intended It To Consider. 24

CONCLUSION ..... **Error! Bookmark not defined.** 25

TABLE OF AUTHORITIES

Cases

Alaska v. Dep't of Transp.,
868 F.2d 441 (D.C. Cir. 1989) 7

Arpaio v. Obama,
27 F. Supp. 3d 185 (D.D.C. 2014) 4, 5, 6

Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.,
467 U.S. 837 (1984) 8, 12

City of L.A. v. Lyons,
461 U.S. 95 (1983) 5

Clapper v. Amnesty Int'l USA,
568 U.S. 398 (2013) 3

Conkright v. Frommert,
559 U.S. 506 (2010) 26

Food & Water Watch, Inc. v. Vilsack,
808 F.3d 905 (D.C. Cir. 2015) 4, 8

Government of Province of Manitoba v. Zinke,
273 F. Supp. 3d 145 (D.D.C. 2017) 7

Gruber v. Hubbard Bert Karle Weber, Inc.,
159 F.3d 780 (3d Cir. 1998) 10

Home Care Ass'n of Am. v. Weil,
799 F.3d 1084 (D.C. Cir. 2015) 11

In re Union Pacific Railroad,
479 F.3d 936 (8th Cir. 2007) 11

Int'l Ass'n of Entrepreneurs of Am. Ben. Tr. v. Foster,
883 F. Supp. 1050 (E.D. Va. 1995) 10

Lindeen v. SEC,
825 F.3d 646 (D.C. Cir. 2018) 20, 21

Massachusetts v. EPA,
549 U.S. 497 (2007) 7

Massachusettes v. Mellon,
262 U.S. 447 (1923) 7

Md. People's Counsel v. FERC,
760 F.2d 318 (D.C. Cir. 1985) 7

MDPhysician & Assocs., Inc. v. State Bd. of Ins.,
957 F.2d 178 (5th Cir. 1992) 9, 10

N.L.R.B. v. SW Gen., Inc.,
137 S. Ct. 929 (2017) 19

Nat'l Wrestling Coaches Ass'n v. Dep't of Educ.,
366 F.3d 930 (D.C. Cir. 2004), *abrogated on other grounds, Perry Capital, LLC v. Mnuchin,*
864 F.3d 591 (D.C. Cir. 2017) 5

Natural Resources Defense Council v. NHTSA,
894 F.3d 95 (2d Cir. 2018) 5

Nat'l Cable & Telecomms. Assoc. v. Brand X Internet Servs.,
545 U.S. 967 (2005) 10

Pennsylvania v. Kleppe,
533 F.2d 668 (D.C. Cir. 1976) 6

Public Citizen, Inc. v. Nat'l Highway Traffic Safety Admin.,
489 F.3d 1279 (D.C. Cir. 2007) 2, 8

Renal Physicians Ass'n v. HHS,
489 F.3d 1267 (D.C. Cir. 2009) 4

Snapp & Son, Inc. v. Barez,
458 U.S. 592 (1982) 7

Susan B. Anthony List v. Driehaus,
573 U.S. 149 (2014) 3

Texas v. United States,
809 F.3d 134 (5th Cir. 2015) 7-8

United States Ass'n of Reptile Keepers, Inc. v. Jewell,
103 F. Supp. 3d 133 (D.D.C. 2015) 11

United States Telecom Ass'n v. FCC,
825 F.3d 674 (D.C. Cir. 2016) 25

West Virginia ex rel. Morrisey v. HHS,
827 F.3d 81 (D.C. Cir. 2016) 5

Yates v. Hendon,
541 U.S. 1 (2004) 21

Statutes

5 U.S.C. § 706(2)(A) 22

26 U.S.C. § 414(m) 20

26 U.S.C. § 4980H 20

29 U.S.C. § 1001(a) 27

29 U.S.C. § 1002(5) 9, 13

29 U.S.C. § 1002(40) 13

29 U.S.C. § 1002(40)(A) 22

29 U.S.C. § 1135 15

29 U.S.C. § 1144 7

29 U.S.C. § 1051 14

29 U.S.C. §§ 1061-1169 14

29 U.S.C. §§ 1081-1091c 14

29 U.S.C. § 1183(4) 11

29 U.S.C. § 1301 *et seq.* 14

42 U.S.C. § 300gg-91 ..... 15, 16, 22

42 U.S.C. § 18024(b) 16, 19

Regulations

26 C.F.R. § 54.4980H-1 20

28 C.F.R. § 2510.3-5(a) 9

29 C.F.R. § 2510.3-3 22

76 Fed. Reg. 54,969 (Sept. 6, 2011) 17, 18

83 Fed. Reg. 28, 912 (June 21, 2018)..... *passim*

Other Authorities

Congressional Research Service, R40906 (Nov. 10, 2009), Overview of Provisions in the Amendment in the Nature of a Substitute to H.R. 3962 Offered by Mr. Boehner of Ohio *available at* https://www.everycrsreport.com/files/20091110_R40906_0f669b179c4aa1e6cb7c69407920dd29c19268c1.pdf 10

Washington Insurance Comissioner, *association health plan in the state* (May 7, 2018), *available at* https://www.insurance.wa.gov/news/kreidler-approves-largest-association-health-plan-state..... 15

Dep't of Health and Human Servs. Ctrs. For Medical and Medicare Servs., Insurance Standards, Bulliten Transmittal No. 02-02 (Aug. 2002), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_02_02_508.pdf 16

Oregon Ins. Bulliten No. 2013-3, 2013 WL 2419451 (OR INS BUL May 31, 2013) 16

INTRODUCTION

In June 2018, after a robust notice-and-comment period, the Department of Labor ("the Department") exercised its authority under ERISA to promulgate a rule that expands access to affordable, high-quality healthcare coverage, particularly for employees of small employers and some self-employed individuals. *See* Definition of 'Employer' under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 28,912 (June 21, 2018) (AR 1-53) ("the Final Rule"). The Final Rule reasonably interprets the term "employer" in ERISA Section 3(5) to clarify when employers may band together as a group or association of employers to sponsor an "association health plan" ("AHP"). The Final Rule preserves the original pathway for forming AHPs as set forth in the Department's prior sub-regulatory guidance ("Pathway 1"), and offers an additional pathway to affordable coverage using a similar framework ("Pathway 2").

Plaintiffs oppose this reasonable policy change, but their recycled prior arguments still fall short of demonstrating that they have standing to bring this challenge or that the Final Rule is an impermissible interpretation of ERISA Section 3(5). Indeed, Plaintiffs do not dispute that the term "employer" in ERISA Section 3(5) is ambiguous, that ERISA does not delineate what it means for "a group or association of employers" to "act" as an "employer" for the purpose of sponsoring a group health plan, or that Congress delegated broad, interpretative authority to the Department.

Instead, faced with the deference afforded to the Department's reasonable interpretation of an ambiguous provision for which it has rulemaking authority, Plaintiffs manufacture a conflict between the Final Rule and a different statute—the Patient Protection and Affordable Care Act ("ACA")—even though the Final Rule does not purport to interpret or modify the ACA in any way. The Final Rule does not change how AHPs are treated under the ACA; indeed, that treatment was set forth by the Department of Health and Human Services ("HHS") long before the promulgation of

the Final Rule. Thus, the ACA is unaffected by the Final Rule, and the ACA will treat new Pathway 2 AHPs the same way that it treats Pathway 1 AHPs that existed prior to the Final Rule.

Under Plaintiffs' theory that the ACA forecloses the Department's interpretation of Section 3(5), pre-existing associations of employers that sponsor Pathway 1 AHPs would not be able to operate under HHS guidance as they do now and as they have done since well before the Final Rule: they would be barred from operating as large employers for purposes of purchasing coverage in the large group insurance market. This outcome would have serious consequences for the health coverage of thousands of employees. Plaintiffs' remaining arguments are equally untenable. The agency's rulemaking process led to a reasonable interpretation of Section 3(5) that is not foreclosed by other statutory provisions or court decisions.

For these reasons, the Court should dismiss this case for lack of jurisdiction or, alternatively, uphold the Final Rule and enter summary judgment for the Department.

ARGUMENT

I. THE COURT SHOULD DISMISS THIS CASE FOR LACK OF JURISDICTION.

Plaintiffs' various claims to standing are meritless because the challenged rule does not regulate the states, does not require the states to do or refrain from doing anything, and does not restrict the states in any way. *Cf. Public Citizen, Inc. v. Nat'l Highway Traffic Safety Admin.*, 489 F.3d 1279, 1289 (D.C. Cir. 2007). Plaintiffs simply disagree with federal policy. But mere policy disagreements are insufficient to create an Article III case or controversy. *See Diamond v. Charles*, 476 U.S. 54, 62 (1986).

A. Plaintiffs' Claimed Proprietary Interests Do Not Confer Standing.

Plaintiffs assert three proprietary interests that they contend confer standing. First, they hypothesize that the new AHPs created in their states as a result of the Final Rule will be riddled with fraud and abuse, and that Plaintiffs will therefore incur additional regulatory, enforcement, and administrative costs. Pls.' Opp. to Defs.' Mot. to Dismiss, Or, In the Alternative, for Summary

Judgment, and Reply to Defs.' Opp. to Pls.' Mot. for Summ. J. at 3-7, Dkt. 53 ("Pls.' Opp."). Second, Plaintiffs speculate that once businesses offer AHPs, their employees will abandon insurance they already buy through exchanges to instead join the new AHPs, and the states will therefore collect fewer taxes from health plans sold on the exchanges. *Id.* at 7-9. Third, Plaintiffs suspect that only businesses with healthier employees will join AHPs and that the flight of healthy individuals from other insurance markets will cause premiums in those markets to rise, which in turn will price individuals out of those markets, who will require care they are unable to pay for, ultimately requiring Plaintiffs to pay. These alleged injuries are all too speculative, thus precluding standing.

1. The Claimed Injuries Are Too Speculative to Confer Standing.

Because most provisions do not begin to operate until 2019, Plaintiffs claim harms that they identify as "imminent" rather than "actual." Plaintiffs have not shown that their alleged injuries are "'certainly impending,' or [that] there is a 'substantial risk that the harm will occur.'" *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014) (citation omitted).

First, Plaintiffs' attenuated chain of hypotheticals demonstrates the remote and speculative nature of their claims. The Department acknowledged the *possibility* of certain effects of its rule, but that does not establish a "substantial risk" of harm. *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013) ("'[a]llegations of possible future injury' are not sufficient"). *See, e.g.*, 83 Fed. Reg. at 28,953 (AR 42) (noting "increased opportunities" for mismanagement); *id.* at 28,943 (AR 32) (noting that AHPs "sometimes may" avoid costs "including for example premium taxes"); *id.* at 28,950 (AR 39) (noting that the "Department lacks data to quantify the effect of the final rule on the uninsured population" and that historical studies on market rules indicated "little net effect on coverage").

Second, Plaintiffs wholly ignore the host of protections the rule implements to mitigate any risk of the three economic harms they claim. *E.g.*, 83 Fed. Reg. at 28,919 (AR 8) (the "control-test" provision reduces fraud); *id.* at 28,962 (AR 51) (the "substantial business purpose" requirement

reduces fraud); *id.* at 28,952 (AR 41) (the "organizational structure" requirement reduces risk of abuse); *id.* at 28,928 (AR 17) (nondiscrimination rules ensure that "there is less cause for concern about fraud."); *id.* at 28,939 (AR 28) (rule may lead to higher taxable pay and taxable consumption, potentially increasing state tax revenues); *id.* at 28,950-51 (AR 39-40) (the rule will likely *increase* coverage, reducing uncompensated care). To show a "substantial risk" of harm, a plaintiff must account for *all* aspects of the challenged conduct—including those aspects that mitigate the asserted risk. *See Food & Water Watch, Inc. v. Vilsack*, 808 F.3d 905, 917 (D.C. Cir. 2015) (plaintiffs failed to show a "substantial risk" when evidence did not account for the provisions aimed at reducing the same risk).

2. Any Alleged Increased Regulatory Burden Is Incidental to the Final Rule.

Plaintiffs' claim that they might incur additional costs in enforcing their own laws cannot confer standing for the additional reason that such an injury is not fairly traceable to the challenged action. *See Renal Physicians Ass'n v. HHS*, 489 F.3d 1267, 1269 (D.C. Cir. 2009). Plaintiffs' claimed injury on this front is speculative—in large part because so much turns on what third parties choose to do in response to the new regulation. Plaintiffs' theory turns on (1) employers first choosing to join new AHPs, (2) employees choosing to enroll, (3) AHP management committing fraud and abuse, and (4) states choosing to police that abuse. The harm is realized only if two intervening actors (employers and individuals) first choose to use AHPs and if a third actor (AHP management) then chooses to violate the law. That tenuous chain of events is insufficient to confer standing.

There are only "two categories of cases where standing exists to challenge government action though the direct cause of injury is the action of a third party." *Renal Physicians*, 489 F.3d at 1275. To fit the first category, "the challenged government conduct must authorize the specific third-party conduct that causes the injury to the plaintiff." *Arpaio v. Obama*, 27 F. Supp. 3d 185, 204 (D.D.C. 2014). That category is plainly inapplicable here: There is no contention that the Final Rule authorizes AHPs to commit fraud or abuse. The second category is satisfied "where the record present[s]

substantial evidence of a causal relationship between the government policy and the third-party conduct, leaving little doubt as to causation and the likelihood of redress." *Nat'l Wrestling Coaches Ass'n v. Dep't of Educ.*, 366 F.3d 930, 941 (D.C. Cir. 2004)*, abrogated on other grounds*, *Perry Capital LLC v. Mnuchin*, 864 F.3d 591, 620 (D.C. Cir. 2017). Courts do not readily presume that individuals will violate the law. *See, e.g.*, *City of L.A. v. Lyons*, 461 U.S. 95, 101 (1983). While Plaintiffs rely on *Natural Resources Defense Council v. NHTSA*, 894 F.3d 95 (2d Cir. 2018), *see* Pls.' Opp. 6-7, that case is inapposite. There, the challenged policy was a penalty reduction intended to obtain compliance with the law: the link between the challenged policy and the third parties' compliance with the law was direct. *Nat. Res. Def. Council*, 894 F.3d at 104. Not so here, where the Final Rule simply expands the number of entities that can permissibly use AHPs.

Fundamentally, the state regulations Plaintiffs assert they will have to enforce are wholly within their own control. *See West Virginia ex rel. Morrisey v. HHS*, 827 F.3d 81, 84 (D.C. Cir. 2016) (state's decision whether to enforce a law did not establish standing to challenge federal regulation that invited decision); *Arpaio*, 27 F. Supp. 3d at 202 (rejecting standing premised on the claim that a "federal policy causes [the plaintiff's] office to expend resources in a manner that he deems suboptimal"). Any number of federal policies might alter the need for a state to enforce its own laws, but a state cannot sue to enjoin a shift in federal policy or priorities on that basis alone. Such logic leads to absurdity: if the federal regulation shifts resources from prosecuting nonviolent crimes to violent crimes, the state does not incur an Article III injury if it decides to shift its own resources to combat nonviolent crime. But that is just the type of "injury" Plaintiffs assert here.

3. Any Alleged Decrease in Tax Revenue Is Incidental to the Final Rule.

"[I]mpairment of state tax revenues should not, in general, be recognized as sufficient injury in fact to support state standing." *Pennsylvania v. Kleppe*, 533 F.2d 668, 672-73 (D.C. Cir. 1976). To overcome this barrier, a state must show *at least* "some fairly direct link between the state's status as a

collector and recipient of revenues and the legislative or administrative action being challenged." *Id.* Plaintiffs have not done so. Their claimed injury is wholly unrelated to their "status as a collector and recipient of revenues." Instead, their claim is simply that tax revenues from a specific revenue stream may decrease. Pls.' Opp. 7 & n.6. Changes in behavior occasioned by changes in federal policy do not confer standing on a State to challenge the federal policy simply because they might have incidental effects on a state's tax receipts. Some states, for example, tax rental income. But it cannot be—and is not—that every federal policy that encourages home ownership confers standing on a state simply because of any incidental effects on the rental market.

4. Any Increase in the Cost to Plaintiffs of Uncompensated Care Is Incidental to the Final Rule.

Just like the costs imposed by any increased regulatory burden, the costs of uncompensated care are not fairly traceable to the Final Rule. Even assuming that the regulation leads to an increase in uninsured or underinsured individuals—a speculative outcome, *see* 83 Fed. Reg. at 28,950-51 (AR 39-40)—nothing in the regulation requires the states to pick up the bill. *Cf. Arpaio*, 27 F. Supp. 3d at 202. Additionally, Plaintiffs are incorrect that Medicaid programs are one of the "other payers" who could suffer from a dilution of bargaining power due to new AHPs. Pls.' Opp. 12. The "other payers" in the preamble were payers that might lose membership in competition from AHPs, namely, individual and small group insurers—not Medicaid. 83 Fed. Reg. at 28,942 (AR 31) (describing the effect only as a possibility); *id.* at 28950 (AR 39) (describing the limited anticipated effect on Medicaid).

B. The Final Rule Does Not Impinge on the States' Sovereign Interests.

Plaintiffs also cannot challenge the Final Rule based on asserted injury to their sovereign interests. A state has standing to challenge certain federal action that interferes with the State's "sovereign interest" in "exercising 'the power to create and enforce a legal code'" through preemption of state law, *Alaska v. Dep't of Transp.*, 868 F.2d 441, 443 (D.C. Cir. 1989) (citation omitted), but a state does not have standing based on speculation about the number of people subject to valid federal or

state laws. *See* Pls.' Opp. 12. Here, Plaintiffs do not even argue that the Final Rule preempts state law, nor do they identify any specific preempted laws. Instead, they contend that under ERISA some unidentified "state non-insurance laws remain at risk of preemption." Pls.' Opp. 12. This is true: ERISA generally preempts state non-insurance laws related to ERISA-covered plans. *See* 29 U.S.C. § 1144. But this risk arises from ERISA itself, not from the Final Rule.

C. Plaintiffs' Interest in the Stability of Their Insurance Markets Cannot Confer Standing Against the Federal Government.

Finally, Plaintiffs assert an injury to their "quasi-sovereign interests in the stability of their insurance markets." Pls.' Opp. 13. It is well settled, however, that "[a] State does not have standing as *parens patriae* to bring an action against the Federal Government." *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*,, 458 U.S. 592, 610 n.16 (1982) (citing *Mass. v. Mellon*, 262 U.S. 447, 485-86 (1923)); *see also Md. People's Counsel v. FERC*, 760 F.2d 318, 320 (D.C. Cir. 1985); *Government of Province of Manitoba v. Zinke*, 273 F. Supp. 3d 145, 165 (D.D.C. 2017). Plaintiffs do not contend otherwise, but instead seek to reclassify their *parens patriae* claim as a free standing injury to quasi-sovereign interests.[1] The one case they cite for this novel theory of standing, *Texas v. United States*, 809 F.3d 134 (5th Cir. 2015), does not actually do so. That court did use the term "quasi-sovereign interests," but in context that term is best understood as referencing "near-sovereign" interests: the court explained that a state's interest in maintaining its current law was "analogous to" its sovereign interests in creating and enforcing a legal code. *Id.* at 153. Still more important: that court's ultimate injury-in-fact analysis rested only on the purported injury to Texas's proprietary interests, not to any quasi-sovereign interest. *See id.* at 155-56.

[1] Plaintiffs make no claim to the narrow exception set out in *Maryland People's Counsel v. FERC*, 760 F.2d at 322, and later acknowledged by the Supreme Court in *Massachusetts v. EPA*, 549 U.S. 497, 519-20 & n.17 (2007). Those cases recognized an exception that allows a state to maintain a *parens patriae* action against the federal government when a specific federal statute grants the state standing to challenge federal action.

In conclusion, Plaintiffs no doubt dispute the choices made by the Final Rule. But the speculative nature of the claimed injuries underscores that this remains a policy dispute, not a legal one. "[D]isputes about future events where the possibility of harm to any given individual is remote and speculative are properly left to the policymaking Branches, not the Article III courts." *Food & Water Watch*, 808 F.3d at 914 (quoting *Public Citizen, Inc.*, 489 F.3d at 1295).

II. THE FINAL RULE IS A REASONABLE INTERPRETATION OF ERISA SECTION 3(5) AND FURTHERS ERISA'S OBJECTIVE OF ENCOURAGING THE CREATION OF EMPLOYEE BENEFIT PLANS.

Plaintiffs do not dispute that ERISA Section 3(5)'s definition of "employer" is ambiguous or that Congress delegated interpretative authority to the Department to define that term. *See* Defs.' Mot. to Dismiss, Or, In the Alt., for Summ. J., and Opp. to Pls.' Mot. for Summ. J. at 25–28, Dkt. 49-1 ("Defs.' Mot."); Pls.' Opp. 2. Thus, under step two of *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 865–66 (1984), the question before the Court is whether the Department's interpretation of Section 3(5) is reasonable. Plaintiffs advance very few arguments as to why the Final Rule is unlawful under ERISA. Instead, they focus on arguments related to the ACA. Because the Final Rule only interprets ERISA, not the ACA, the controlling statute in this case is ERISA. As set forth below, the Department permissibly modified its sub-regulatory guidance interpreting "employer" in ERISA Section 3(5), and this interpretation is not foreclosed by other provisions of ERISA, the ACA, or the Internal Revenue Code ("IRC").

A. The Department Permissibly Modified Its Sub-Regulatory Guidance Interpreting ERISA Section 3(5)'s Ambiguous Definition of "Employer."

ERISA Section 3(5) defines "employer" to mean "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). Title I of ERISA does not define the terms "group" or "association" or delineate what it means for "a group or association of employers" to "act" for an "employer" in relation to sponsoring a group health

plan. *See MDPhysician & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 184 (5th Cir. 1992). Plaintiffs do not dispute that Congress left this gap in Section 3(5) to the Department to fill; they merely prefer the Department's prior sub-regulatory guidance. *See* Pls.' Opp. 26–35.

Plaintiffs' preference for the prior guidance is an acknowledgement that the Department has authority to interpret ERISA's definition of "employer." The Department reasonably exercised that authority when it created the original pathway for qualifying as an association capable of acting as an ERISA Section 3(5) "employer" to sponsor an AHP (*i.e.*, Pathway 1 AHPs), *see* Defs.' Mot. 1–2, and again in the Final Rule when it created an additional pathway—subject to nondiscrimination rules—for qualifying as an association of employers that can act as an "employer" to sponsor an AHP (*i.e.*, Pathway 2 AHPs). Plaintiffs' arguments are largely nonresponsive to this authority.[2]

Plaintiffs do not argue that ERISA limits the Department's discretion to modify its guidance, but instead rely on out-of-circuit cases to insist that the Department is precluded from defining "employer" as it did in the Final Rule. Pls.' Opp. 27–28; *see also* Pls.' Mot. for Summ. J. at 32–33, Dkt. 31-17 ("Pls.' Mot."). These out-of-circuit cases, however, do not purport to specify the outer limits of the "nexus" or "common economic tie" required to form "a group or association of employers" under Section 3(5), other than to observe that the "group or association of employers" must have some purpose other than the provision of benefits. The Final Rule is consistent with this interpretation. *See* Defs.' Mot. 31. Additionally, "[a] court's prior judicial construction of a statute trumps an agency construction otherwise entitled to *Chevron* deference only if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion." *See Nat'l Cable & Telecomms. Assoc. v. Brand X Internet Servs.*, 545 U.S. 967,

[2] Sub-regulatory guidance does not have the force or effect of law like a regulation. Plaintiffs challenge only the regulation: the Final Rule. The Final Rule incorporates by reference the Department's existing approach under the sub-regulatory guidance. *See* 83 Fed. Reg. at 28,916 ("[T]his final rule does not supplant the Department's previously issued guidance[.]"); 28 C.F.R. § 2510.3-5(a).

982 (2005). The cases cited by Plaintiffs acknowledge the ambiguity in Section 3(5) and the deference due to the Department. *See* Defs.' Mot. 31; *see also, e.g.*, *Gruber v. Hubbard Bert Karle Weber, Inc.*, 159 F.3d 780, 786–87 (3d Cir. 1998); *Int'l Ass'n of Entrepreneurs of Am. Ben. Tr. v. Foster*, 883 F. Supp. 1050, 1061 (E.D. Va. 1995); *MDPhysician*, 957 F.2d at 184. Thus, Plaintiffs' objections are meritless.

Plaintiffs also continue to maintain that Congress "reject[ed]" the "expansion of AHPs" and thus "never granted [the Department] authority" to adjust its interpretation of "employer." *See* Pls.' Opp. 27; Pls.' Mot. 25–26; *see also* Br. of Members of Congress as Amici Curiae in Support of Plaintiffs at 15–16, Dkt. 55-1. These arguments rest on the legislative history of Congresses after the Congress that enacted ERISA in 1974 and on their failed efforts to enact legislation. Such reliance is misplaced.[3] *See* Defs.' Mot. 31–32; *United States Ass'n of Reptile Keepers, Inc. v. Jewell*, 103 F. Supp. 3d 133, 153 (D.D.C. 2015); *Home Care Ass'n of Am. v. Weil*, 799 F.3d 1084, 1093 (D.C. Cir. 2015).

Moving away from the broader questions of authority, Plaintiffs contest the Department's decision to expand the "commonality of interest" test to include geography, arguing that "physical proximity alone does not provide ... a unifying connection[.]" Pls.' Opp. 29. But geography is a well-established link among common employers. For example, state and local chambers of commerce have long acted as organizations that represent members with common interests. *See, e.g.*, Michigan Chamber of Commerce Comment Letter (AR 4357); LABI Comment Letter (AR 6169); Plano Chamber of Commerce Comment Letter (AR 4461). Employers that share a common geography face

[3] Nor should the views of Amici Members of Congress be given any weight given a reasonable interpretation on the face of the statute. *See In re Union Pacific Railroad*, 479 F.3d 936, 942, 942 n.3 (8th Cir. 2007). Additionally, although the Boehner amendment discussed by these amici used the term "association health plan," it contained different requirements than those found in the Final Rule, as well as other provisions unrelated to health plans. *See* Overview of Provisions in the Amendment in the Nature of a Substitute to H.R. 3962 Offered by Mr. Boehner of Ohio, Congressional Research Service, R40906 (Nov. 10, 2009), *available at* https://www.everycrsreport.com/files/20091110_R40906_0f669b179c4aa1e6cb7c69407920dd29c19268c1.pdf. Thus, Congress's rejection of that amendment cannot be relied on as evidence of Congress's intent to prohibit AHPs or the Final Rule.

the same local and state health regulations, such as state benefit mandates, as well as common issues based on local and geographical differences. *See, e.g.*, 29 U.S.C. § 1183(4) ("plan is ceasing to offer any coverage in a geographic area"); Las Vegas Metro Chamber of Commerce Comment Letter (explaining challenges facing their employers due to changes in the state's health insurance market) (AR 6497).

Plaintiffs also argue that the Final Rule is unreasonable because it permits the formation of AHPs for the primary purpose of providing health care coverage, which Plaintiffs contend make these AHPs "barely distinguishable from" "commercial insurance arrangements." Pls.' Opp. 30. This contention is belied by the text of the Final Rule, which imposes nondiscrimination and control requirements and also ensures that AHPs are employer-based by requiring "at least one substantial business purpose" unrelated to the provision of benefits. 83 Fed. Reg. at 28,918, 928, 952, 956 (AR 7, 17, 41, 45); Defs.' Mot. 12, 28. To further preserve this distinction, the Final Rule also prohibits health insurance issuers from sponsoring an AHP. *See* 83 Fed. Reg. at 28,918, 928, 962 (AR 7, 17, 51).

Finally, Plaintiffs retreat to arguing that the Final Rule does not further ERISA's purpose because it eliminates protections for some consumers and "open[s] the door" to "increased opportunities" for abuse. Pls.' Opp. 20–31. But Plaintiffs again fail to account sufficiently for provisions in the rule intended to protect AHPs against mismanagement and abuse. *See* 83 Fed. Reg. at 28,952 (AR 41); Defs.' Mot. 51–52. They similarly fail to account for the other protections in the rule, such as the viable entity safe harbor and substantial business purpose requirement, and changes in the regulatory environment since past instances of fraudulent multiple employer welfare arrangements, including states' own legislative efforts and the federal government's increased statutory powers. *See* Defs.' Mot. 52; 83 Fed. Reg. 28,951–52 (AR 40-41); *supra* at 3–4.

B. The Department's Interpretation of Section 3(5) As Reflected in the Final Rule Is Not Foreclosed By Other Statutory Provisions.

Finding no basis in ERISA Section 3(5)'s text to bar the Department's interpretation of "employer" under ERISA, Plaintiffs focus their arguments on alleged conflicts between the Final Rule

and the ACA, other provisions of ERISA, and the IRC. However, under *Chevron*, these other statutory provisions are relevant only to the extent they prove that the Final Rule's interpretation of ERISA Section 3(5) is (1) unambiguously foreclosed, or (2) unreasonable. *See Chevron*, 467 U.S. at 837; Defs.' Mot 34–44. As explained below, these statutory provisions neither speak to the issue addressed in the Final Rule, nor show that the Department's interpretation of ERISA is unreasonable.

1. Other ERISA provisions do not foreclose this interpretation of Section 3(5).

Plaintiffs argue that the Department's interpretation of "employer" is foreclosed or unreasonable because of ERISA Section 3(40), Pls.' Opp. 41, which defines, in relevant part, the term "multiple employer welfare arrangement" (MEWA) as "an employee welfare benefit plan . . . which is established or maintained for the purpose of offering or providing any benefit [described in § 1002(1)] to the employees of two or more employers (including one or more self-employed individuals)[.]" 29 U.S.C. § 1002(40). Plaintiffs begin with the mistaken premise that common law controls the definition of the term "employer" as used in Section 3(40) and then leap to the unfounded conclusion that the common law must also control the definition of "employer" in Section 3(5), as well as the definition of "large employer" in the ACA group market provisions. Pls.' Opp. 16–17. But the meaning of the term "employer" in Section 3(40)'s MEWA definition is not limited to the common law meaning. To be sure, the term "employer" in Section 3(40)'s MEWA definition *includes* common law "employers," but also extends beyond them to include, for example, unincorporated "self-employed individuals." § 1002(40); *see also* Defs.' Mot. 47. Similarly, as explained further below, Section 3(5)'s definition of "employer" includes the common law meaning of the term, but also extends beyond the common law meaning to include "a group or association of employers," § 1002(5), and the ACA incorporates Section 3(5)'s expanded definition of "employer." *See infra* at 14, 18.

Plaintiffs also take issue with the fact that the Final Rule's interpretation of "employer" is currently limited to health benefits and AHPs, arguing that "[t]he disparate treatment of functionally

indistinguishable products is the essence of the meaning of arbitrary and capricious." Pls.' Opp. 42 (citation omitted). Plaintiffs' argument incorrectly assumes that "*different* types of ERISA-covered" benefit plans are "functionally indistinguishable," *id.* at 41–42 (emphasis added), when in reality, health plans are distinct from other types of plans covered by ERISA, such as life insurance benefits, pension plans, and apprenticeship plans, and Section 3(5) defines "employer" "in relation to" a sponsored plan. Differences between the various types of ERISA plans are reflected in the statutory scheme. For example, Part 7 of ERISA Title I imposes requirements unique to health plans, and Parts 2 and 3 of Title I, Title IV of ERISA impose requirements on certain pension plans. *See, e.g.*, 29 U.S.C. §§ 1051, 1081, 1161-1169, 1181-1191c; 29 U.S.C. § 1301 *et seq*. Thus, the Final Rule is not foreclosed by other ERISA provisions and the treatment of other types of ERISA plans.

2. Nothing in the provisions of either the ACA or the IRC foreclose the Final Rule's interpretation of Section 3(5).

Unable to demonstrate that the Final Rule is unlawful under ERISA, Plaintiffs attempt to manufacture a conflict between the Final Rule and the ACA and IRC.[4] Their attempt fails because: (1) the ACA group market provisions incorporate ERISA Section 3(5)'s definition of "employer"; (2) the relationship between the ACA group market provisions and AHPs was determined by HHS well before the Final Rule and remains unaffected by the Final Rule; (3) the ACA group market provisions allowing the aggregation of employers support the Final Rule's interpretation of "employer"; and (4) the IRC's employer shared responsibility provision does not foreclose the Final Rule.

a. The ACA group market provisions incorporate ERISA Section 3(5)'s definition of "employer."

Plaintiffs' assertion that the Final Rule overrides the ACA's market structure is meritless. Pls.' Opp. 16. Plaintiffs argue that the Final Rule is unreasonable because whether an employer is a "large

[4] These arguments evaporate if the ACA is unconstitutional. *See Texas v. United States*, No. 4:18-cv-00167 (N.D. Tex. Dec. 14, 2018) (Dkt. 211) (declaring ACA unconstitutional).

employer" or "small employer" under the ACA group market provisions must, in their view, be determined for each employer-member in an AHP by the number of "common law" employees who work for each employer-member, not by the total number of employees of the association's employer-members in an AHP. Pls.' Opp. 17–18; Pls.' Mot. 15–16. That interpretation misreads the ACA and ignores the ACA's statutory structure and context. *See* Defs.' Mot. 38–39.

Because the ACA must be read as a whole, the definition of "large employer" in its group market provisions must be read in light of the ACA's incorporation of the definitions in 42 U.S.C. § 300gg-91—section 2791 of part C of Title XXVII of the Public Health Service Act ("PHSA").[5] As Plaintiffs acknowledge, the ACA group market provisions incorporate the PHSA's definition of "employer," which adopts ERISA Section 3(5)'s definition of "employer." 42 U.S.C. § 300gg-91(d)(6); *see also* Pls.' Opp. 17; Br. Cong. Amici 12, 14. Accordingly, Congress made the relationship between employers and employees in the ACA group market provisions turn on how that relationship is defined in *ERISA*. *See* Defs.' Mot. 36-37, 39.

Plaintiffs' reliance on common law also cannot be squared with their preference for the Department's prior guidance, which also interprets Section 3(5) as broader than the common law meaning of "employer." *See* Defs'. Mot. 32; *see also*, *e.g.*, Adv. Op. 2001-04A (AR 3919). Limiting "employer" to its common law meaning would render meaningless Section 3(5)'s reference to "a group or association of employers." *See* Defs'. Mot. 39. Plaintiffs never respond to this point.

Plaintiffs' argument that "Congress did not delegate to [the Department] any authority to alter the ACA's market structure," Pls.' Opp. 21–22, Pls.' Mot. 23–25, is thus beside the point. The Department did not alter that structure. *See supra* at 2; Defs.' Mot. 41 n.15. The Final Rule interprets only ERISA, a statute that Congress authorized the Department to administer. *See* 29 U.S.C. § 1135.

[5] The PHSA's market definitions were added by the Health Insurance Portability and Accountability Act ("HIPAA") in 1996 and were unchanged by the ACA.

b. The relationship between the ACA group market provisions and AHPs was determined by HHS well before the Department of Labor's promulgation of the Final Rule and is unaffected by the Final Rule.

Plaintiffs contend that the Final Rule seeks to "undo" the policy judgments of the ACA by "authorizing the creation of AHPs exempt from many of the ACA's core protections." Pls.' Opp. 16. But that characterization of the Final Rule suffers from two fatal flaws. First, Plaintiffs do not, and cannot, dispute that AHPs are longstanding organizations that have existed since before the enactment of the ACA and the Final Rule. *See* Defs.' Mot. 5–7. Second, the Final Rule does not interpret the ACA or change how AHPs are treated under the ACA.

In general, under the ACA group market provisions, the "association of employers" that sponsors an AHP acts as a single "employer," and if the AHP is sponsored by an association of employers that collectively employed 50 or fewer employees in the prior year, the "association of employers" is considered a "small employer" (and may purchase coverage in the small group market). If the AHP is sponsored by an association of employers that collectively employed at least 51 employees in the prior year, the "association of employers" is considered a "large employer" under the ACA group market provisions (and may purchase coverage in the large group market). 42 U.S.C. § 300gg-91(e)(2), (4); 42 U.S.C. § 18024(b).[6] This was the case for Pathway 1 AHPs prior to the Final Rule, and it remains the case for both Pathway 1 and Pathway 2 AHPs that form under the Final Rule. *See* Dep't of Health & Human Services Centers for Medicare & Medicaid Services Insurance Standards Bulletin, "Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations," September 1, 2011 (AR 2211) ("2011 CMS Bulletin")[7]; "Rate Increase Disclosure and Review: Definitions of 'Individual

[6] States may expand the definition of small employer to 100 employees. 42 U.S.C. § 300gg-91(e)(7).
[7] Notably, numerous States, including some Plaintiffs, explicitly endorsed the 2011 CMS Bulletin. *See, e.g.*, "Kreidler approves largest association health plan in the state," Washington Insurance Commissioner, May 7, 2018, *available at* https://www.insurance.wa.gov/news/kreidler-approves-

Market' and 'Small Group Market,'" 76 Fed. Reg. 54,969, 54,971 (Sept. 6, 2011) ("CMS Rate Setting Rule"); Dep't of Health & Human Services Centers for Medicare & Medicaid Services, Insurance Standards. Bulletin, Transmittal No. 02-02 (August 2002), *available at* https://www.cms.gov/CCIIO/Resources/ Files/Downloads/hipaa_02_02_508.pdf ("2002 CMS Bulletin"); Defs.' Mot. 40–41, 41 n.14. The relationship between the ACA group market provisions and AHPs was set forth by HHS well before the promulgation of the Final Rule, *see* 2011 CMS Bulletin (AR 2211), and the Final Rule does nothing to alter that longstanding relationship.

The 2011 CMS Bulletin indicates that whether an AHP is a "small employer" or "large employer" under the ACA group market provisions is determined by the total number of employees of all of the AHP's employer-members. Plaintiffs repeat their unsupported attack on the 2011 CMS Bulletin, making much of its statement that it is a "rare instance[]" in which "the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the 'employer.'" However, the underlying legal guidance does not change based on the alleged "rarity" of its application. Defs.' Mot. 40–41. Indeed, AHPs have long operated under this established market structure. *See* 83 Fed. Reg. at 28,917 (AR 6). Additionally, Plaintiffs never address the preamble to the CMS Rate Setting Rule, which states that, "if an association is, in fact, sponsoring a group health plan subject to ERISA, the association coverage should be considered to be one group health plan and the number of employees covered by the association would determine the group size for purposes of determining whether the group health plan is sponsored by a small employer" or a large employer.[8] CMS Rate Setting Rule, 76 Fed. Reg. at 54,971; *see also* Defs.' Mot. at 41 n.14.

largest-association-health-plan-state; Oregon Ins. Bulletin No. 2013-3, 2013 WL 2419451 (May 31, 2013); "Federal and State Policy Toward Association Health Plans in Oregon" (AR 311) (Nevada and Montana, among other states, endorsed CMS interpretation); *see also* Defs.' Mot. 41 n.14.

[8] Plaintiffs are incorrect that the 2002 CMS Bulletin is irrelevant because it predates the ACA. *See* Pls.' Opp. 19. Associations of employers sponsoring ERISA-covered AHPs have been treated as single

Moreover, accepting Plaintiffs' arguments would overturn this longstanding relationship between AHPs and the ACA group market provisions and bar pre-existing Pathway 1 AHPs from participating in the large group insurance market, as they have since before the Final Rule. This would have serious consequences for thousands of participants that rely on pre-existing AHPs. For example, the American Council of Engineering Companies Health Plan ("ACEC Health Plan") is an AHP that has existed since 1965, operates in all fifty states, and "provides insurance for more than 91,500 members working for more than 1750 employers" of various sizes. ACEC Comment Letter at 1, (AR 5404). In its comment letter, the ACEC Health Plan explains how it meets ERISA Section 3(5)'s definition of "employer" under Pathway 1 sub-regulatory guidance and is thus treated as a single large employer under the ACA group market provisions. *Id.* at 3 (AR 5406). Pursuant to the 2011 CMS Bulletin, "the number of employees covered by the entire [AHP] determines the group size." *Id.* But under Plaintiffs' incorrect interpretation of the relationship between the ACA group market provisions and AHPs, the ACEC Health Plan would no longer be able to determine its status under the ACA group market provisions by counting the total number of employees of the AHP's employer-members, and the association would no longer be able to operate as a large employer under the ACA group market provisions. Thus, accepting Plaintiffs' position would disrupt the ACEC Health Plan, other pre-existing associations sponsoring AHPs and operating as large employers, and the health care coverage of their participants. *See also* BIAW Comment Letter (AR 4469).

c. The ACA group market provisions allowing the aggregation of employers support the Final Rule's interpretation of Section 3(5).

Next, Plaintiffs repeat their argument that the ACA's "aggregation rules" in § 18024(b)(4)(A) set forth the *only* circumstances under which employees of separate employers can be aggregated to

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employers for purposes of insurance market definitions in the PHSA since 1996, and CMS reaffirmed this approach after the passage of the ACA. *See supra* at 14 n.5; *see also, e.g.*, Timothy Jost Comment Letter ("Congress established the structure for three markets under HIPAA in 1996.") (AR 4730); 2011 CMS Bulletin (AR 2211); CMS Rate Setting Rule, 76 Fed. Reg. at 54,971.

be treated as a single employer. Pls.' Opp. 19–21; Pls.' Mot. 18. But this reliance on the canon of *expressio unius* must fail because "[t]he *expressio unius* canon applies only when circumstances support[ ] a sensible inference that the term left out must have been meant to be excluded." *N.L.R.B. v. SW Gen., Inc.*, 137 S. Ct. 929, 940 (2017). Nothing of the kind exists here: Section 18024(b)(4)(A) sets forth particular circumstances under which separate but related entities must be treated as one employer for purposes of the ACA group market provisions. Logic dictates that the circumstances on this list cannot be exclusive; otherwise, all AHPs, including long-standing Pathway 1 AHPs, would be prohibited from constituting single employer plans. *See* Defs.' Mot. 37-38.

Plaintiffs' reliance on these "aggregation rules" in the ACA also undermines their argument that the common law employer-employee relationship must control whether an employer is a "large employer" or "small employer" under the ACA group market provisions. *See supra* at 14; Pls.' Opp. 17–18. Although the definition of "large employer" in the ACA group market provisions uses the phrase "who employed" to define the threshold number of employees employed by the "employer," the aggregation rules demonstrate that the phrase "who employed" is *not* restricted to a common law definition. The entities listed in § 18024(b)(4)(A)'s aggregation rules are not common law employers of their aggregated employees, yet each one is nevertheless treated as one employer to determine whether it is a "large employer" or "small employer" under the ACA group market provisions. *See, e.g.*, 26 U.S.C. § 414(m) ("[A]ll employees of the members of an affiliated service group shall be treated as employed by a single employer."); Defs.' Mot. 29. Thus, the phrase "who employed" does not refer only to common law employers, but also to entities deemed a single "employer."

d. The IRC does not foreclose the Final Rule.

Finally, Plaintiffs again argue that the Final Rule is unreasonable because it creates an inconsistency between the term "employer" in ERISA Section 3(5) of and the term "applicable large employer" in Section 4980H of the IRC, 26 U.S.C. § 4980H (the "employer shared responsibility"

provision). Pls.' Opp. 22–24; Pls.' Mot. 54. But the operative term in the employer shared responsibility provision is "applicable large employer," which is a term of art different from the term "employer" in ERISA Section 3(5) and the term "large employer" in the ACA. Notably, the definitions of "employer" in ERISA Section 3(5) and "large employer" in the ACA group market provisions specifically speak to the "employer" "in relation to" or "in connection with" a plan, but similar language is not found in the definition of "applicable large employer" in Section 4980H. Thus, Plaintiffs' reliance on the text of Section 4980H(c)(6)[9] is inapposite. The Department of the Treasury and the Internal Revenue Service ("IRS") the term "applicable large employer" to refer to the common law definition of employer, as the common law definition is generally used for purposes of the IRC, as well as for a number of administrative and structural reasons. *See* 26 C.F.R. 54.4980H-1(a)(5) and (a)(16). IRC Section 4980H is separate from ERISA Section 3(5), under the jurisdiction of the Department of the Treasury and the IRS, and has its own purposes, rules and definitions. It does not limit the Department's ability to interpret ERISA through the Final Rule, nor does it change the fact that the ACA group market provisions explicitly incorporate ERISA's definition of "employer."

III. THE FINAL RULE'S TREATMENT OF WORKING OWNERS IS A REASONABLE INTERPRETATION OF ERISA SECTION 3(5).

Relying on inapposite case law, Plaintiffs argue that Section 3(5) bars the inclusion of a working owner who has no other employees as an employer member of "an association or group of employers." *See* Pls.' Opp. at 24. But this argument ignores that under *Chevron* the "'starting point for our interpretation of a statute is always its language.'" *Lindeen v. SEC*, 825 F.3d 646, 653 (D.C. Cir. 2016) (citation omitted). The relevant question is whether Section 3(5) forecloses the inclusion of a working owner who has no other employees as an employer member of an association or group of employers. *See* Defs.' Mot. at 44. Because the answer to that question is "no," *see id.*, the Court must

[9] Section 4980H(c)(6) states that "[a]ny term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act."

defer to the Department's interpretation where Congress granted the Department rulemaking authority to fill "gaps" in Section 3(5). *See Lindeen*, 825 F.3d at 655.

Plaintiffs' recycled arguments do not compel a different conclusion. As an initial matter, *Yates v. Hendon* held that, for purposes of an ERISA-covered pension plan, a sole proprietor may have *dual status* as both an "employer" and an "employee" to qualify as a plan "participant" so long as "*the plan* covers one or more employees other than the business owner and his or her spouse." 541 U.S. 1, 6 (2004) (emphasis added). *Yates* does not purport to interpret Section 3(5), but instead focuses on the scope of ERISA's definition of "employee benefit plan" in Section 3(3). And in the context of interpreting the scope of "employee benefit plan" in Section 3(3), the Supreme Court observed that it "need not look outside ERISA itself to conclude with security that Congress intended working owners to qualify as plan participants." *Id.* at 17; *see also id.* at 26 (Thomas, J., concurring). *Yates*' reasoning for including working owners as "participants" in an ERISA-covered plan applies to the Department's interpretation of Section 3(5) as permitting a working owner to participate as an employer member of "a group or association of employers" for purposes of obtaining group health insurance coverage.[10] *See* Defs.' Mot. at 45. Indeed, other ERISA provisions expressly contemplate the inclusion of the self-employed as "employers" in MEWAs, such as AHPs. *See* 29 U.S.C. § 1002(40)(A) ("employees of two or more employers (including one or more self-employed individuals)").

Equally misguided is Plaintiffs' insistence that the ACA forecloses the Department's interpretation that Section 3(5) of ERISA permits working owners to participate in AHPs. *See id.* at 25; Defs.' Mot. at 40. The ACA does no such thing. *See* Defs.' Mot. at 40. The parties at least agree that the ACA's definition of "employer" incorporates Section 3(5) by reference. *See* Pls.' Opp. at 25.

[10] For the reasons set forth in the Department's opening brief, the Department's regulation defining the scope of employee benefit plans, 29 C.F.R. § 2510.3-3, does not support Plaintiffs' strained interpretation of Section 3(5). *See* Defs.' Mot. at 45 & n.17. Nothing in § 2510.3-3 bars sole proprietors (or working owners) from participating in AHPs as one of many employer members.

Where the parties diverge is the meaning of the second clause, "*except that such term* [that is, Section 3(5)'s employer definition] *shall include only employers of two or more employees*" in the ACA's definition of employer. 42 U.S.C. § 300gg-91(d)(6); *see also* Pls.' Opp. at 25; Defs.' Mot. at 40. Plaintiffs insist that this phrase unambiguously bars "working owners" because "*under the ACA* . . . there would be only one purported employee—the 'working owner' herself." Pls.' Opp. at 25 (emphasis in original). But this argument fails as a matter of statutory interpretation by not interpreting the two clauses harmoniously. *See* Defs.' Mot. at 39-40, 46-47.

IV. THE FINAL RULE'S INTERPRETATION OF "A GROUP OR ASSOCIATION OF EMPLOYERS" IS NEITHER ARBITRARY NOR CAPRICIOUS.

A. The Department Adequately Explained The Basis For Its Decision To Add An Additional Pathway For Forming AHPs.

Plaintiffs do not meet their burden to demonstrate that the Final Rule is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). The Department explained the basis for its decision to add an additional pathway for forming AHPs: Small employers purchasing health coverage have long faced economic disadvantages compared to large employers and have also faced more rigorous regulatory requirements, which led to limited choices in health insurance and increased premiums. *See* Defs.' Mot. 48–50; 83 Fed. Reg. at 28,912–13 (AR 1-2), 28,940 (AR 29); Pls.' Opp. 31–35. The Final Rule addresses these problems by providing opportunities for more small employers to gain access to new, affordable employment-based health coverage options. *See* Defs.' Mot. 48–49; 83 Fed. Reg. at 28,940 (AR 29).

Plaintiffs dispute the Department's conclusion that in the years following its sub-regulatory AHP guidance, there have been significant changes in the "law, market dynamics, and employment trends" affecting the ability of many workers to access affordable, quality health coverage from their employers. Plaintiffs wrongly focus on (1) coverage offers between 2014-2016 when coverage slightly declined but did not meaningfully change, and (2) the "rise in small business offer rates in some small

business categories." Pls.' Opp. 34. This focus on a two-year period does not contradict the long-term trend of significantly declining offer rates that the Department observed over the course of sixteen years (2000–2016) or the fact that offer rates for small employers continues to hover around 30 percent. 83 Fed. Reg. at 28,947 n.113 (AR 36). Additionally, the Department considered trends across multiple market sectors, which included the trend that certain local markets face sharp premium increases and scarcity of health coverage choices, *id.* at 28,953 (AR 42), and that the structure of certain small employers, such as franchises and farms, makes it difficult for these employers to provide affordable health coverage for employees, *see* Defs.' Mot. 9. Plaintiffs' focus on the minor change in offer rates in two small business categories over the course of one year, Pls.' Opp. 34; Pls.' Mot. 51 n.57, does not render the Final Rule unsupported by data. *See* Defs.' Mot. 57 n.25.

Next, Plaintiffs assert that the Department has not adequately addressed threats of fraud and insolvency, arguing that the Final Rule's nondiscrimination requirements are not enough. Pls.' Opp. 32. These requirements are not the Department's sole response to comments concerning the potential threat of fraud or insolvency. Plaintiffs fail to account for changes in the regulatory environment, *see* Defs.' Mot. 52–53, or respond to the Department's other points. *See* Defs.' Mot. 51–54.

B. The Department Appropriately Weighed the Evidence On Both Sides.

Plaintiffs next press their argument that the Department ignored evidence that (1) demonstrated a "tendency of AHPs to succumb to fraud, abuse, and insolvency," and (2) showed that "damage would be done to the ACA marketplace if AHPs are not required to cover essential health benefits ("EHBs") or follow community-rating requirements." Pls.' Opp. 35–28; Pls.' Mot. 43; *see also id.* at 42–49. Plaintiffs assert that their two concerns are supported by comments submitted during the notice and comment period and that the Department "does not contend otherwise." Pls.' Opp. 35. But the Department considered those comments, modified the proposed rule in response,

and ultimately made a balanced policy choice supported by other comments. Defs.' Mot. 51–52; *see e.g.*, 83 Fed. Reg. at 28,918 (AR 7). This is exactly the decision-making process that the APA requires.

Plaintiffs also argue that the Department ignored evidence that "damage would be done to the ACA marketplace if AHPs are not required to cover essential health benefits ("EHBs") or follow community-rating requirements." Pls.' Opp. 35. Once again, Plaintiffs' claim is belied by the record. The Department considered whether to subject AHPs to individual and small group market rules, including EHBs and community-rating requirements. It simply reasoned that "AHPs' flexibility to offer products and premiums that more closely align with their members' preferences is a significant benefit to those members." 83 Fed. Reg. 28,955 (AR 44); *see also id.* at 28,933 (AR 22). And it also recognized that states can apply benefit mandates and rating rules to AHPs under state laws. *Id.* at 28,934 (AR 23). Mere disagreement with the Department's decision does not render that decision arbitrary or capricious. *See U.S. Telecom Ass'n v. FCC*, 825 F.3d 674, 697 (D.C. Cir. 2016).

Plaintiffs also fault the Department for purportedly advancing the "mistaken belief that there is little difference between the benefits required for large group, small group, and individual market plans." Pls.' Opp. 36. But the Department is not arguing that the significant benefit mandates and requirements affecting AHPs constitute a one-for-one substitution for EHBs. *See* Defs.' Mot. 54–55. Rather, the Department reasoned that these mandates "place significant constraints on AHP benefit designs, but leave ample room for AHPs to offer more tailored, less comprehensive, and more affordable health coverage." *Id.* at 28,942 (AR 31); Defs.' Mot. 54. And the Department imposes nondiscrimination requirements on Pathway 2 AHPs to limit risk segmentation in the individual and small group markets. *See* Defs.' Mot. 51; 83 Fed. Reg. 28,946 (AR 35).

Plaintiffs also over-read the Department's statement that it agreed with "commenters who asserted that AHPs are not likely to offer relatively low levels and scope of benefits, which could jeopardize their relationship with their members and because other federal and State coverage

requirements may apply."[11] Defs.' Mot. 55 (citing 83 Fed. Reg. at 28,933 (AR 22)). Plaintiffs rely on this statement to argue that the Department's decision to not mandate EHBs and community-rating requirements rests "not on evidence in the record, but on hope and speculation" about market forces. Pls.' Opp. 37. The record does not support that claim. The decision not to mandate EHBs and community-rating requirements was based not only on commenters indicating that they "did not believe that legitimate membership organizations would risk their goodwill and reputation by offering" AHPs with inadequate benefits. 83 Fed. Reg. at 28,933 (AR 22); *see also* ACEC Comment Letter at 1, (AR 5404) (example of a pre-existing Pathway 1 AHP operating as a large employer that is not subject to an EHB mandate yet offers "comprehensive essential health benefits."). The Department also considered the fact that AHPs are often subject to other significant benefit mandates and that an EHB mandate "could reduce AHPs' flexibility to tailor coverage to the particular needs of the members of the group or association offering the benefits, and thereby reduce access to AHPs by making them less attractive options for providing affordable coverage." 83 Fed. Reg. at 28,933 (AR 22). The Department made a measured decision to balance affordability and comprehensiveness of coverage.

C. The Department Relied On Factors Congress Intended It To Consider.

Plaintiffs suggest that ERISA requires the Department to ignore the affordability of the health insurance options, *see* Pls.' Opp. 38–41; Pls.' Mot. 50–52, but nothing in ERISA so requires. *See* Defs.' Mot. 55–56. Plaintiffs do not dispute that in enacting ERISA, Congress sought to ensure that "employers, employee organizations, and other entities" continued to "establish[] and maintain[]" employee benefit plans, which "have become an important factor affecting the stability of employment and the successful development of industrial relations." 29 U.S.C. § 1001(a); *see* Defs.' Mot. 29–30, 55–56. By including associations of employers as recognized sponsors of employee benefit plans

[11] *See* American Benefits Council Comment Letter (AR 6269); American Society of Association Executives Comment Letter (AR 4195); National Retail Federation Comment Letter (AR 6196).

under ERISA, Congress reasonably determined that the formation of AHPs is one way in which "to induce employers to offer benefits" to their employees, *Conkright v. Frommert*, 559 U.S. 506, 517 (2010), (citation omitted). *See* Defs.' Mot. 29–30. The Final Rule simply establishes another pathway to create AHPs, which will expand access to affordable healthcare coverage.

Finally, Plaintiffs incorrectly state that the Department conceded that the Final Rule does not reduce administrative costs. Pls.' Opp. 39. In addition to economic advantages associated with economies of scale and increased negotiating power, *see* 83 Fed. Reg. 28,942 (AR 31), the Department pointed to possible savings in distribution costs where associations and members have existing ties, *see id.* at 28,943 (AR 32), and potential transactional cost savings for self-insured AHPs, *see id.* These economic advantages, along with the savings from offering more tailored benefits and actuarially fair prices, will expand access to affordable health coverage.[12] *See id.* at 28, 948-949 (AR 37-38).

CONCLUSION

For the foregoing reasons, Plaintiffs lack standing and the Court should dismiss this action for lack of jurisdiction. Alternatively, the Court should uphold the Final Rule as a permissible and reasonable interpretation of ERISA, grant summary judgment in the Department's favor, and deny Plaintiffs' motion for summary judgment.

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Respectfully Submitted,

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[12] Plaintiffs do not challenge the Final Rule's severability provision, which states that if any of the provisions is found to be invalid or stayed pending agency actions, the remaining portions of the rule would remain operative. *See* 83 Fed. Reg. 28,961 (AR 50). Accordingly, even if one aspect of the Final Rule is not upheld, vacatur of the entire rule would be inappropriate. *See* Defs.' Mot. 57.

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