UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

STATE OF NEW YORK, et al.,	.	
	.	
Plaintiffs,	.	**CA No. 18-1747 (JDB)**
	.	
v.	.	
	.	
U.S. DEPARTMENT OF LABOR,	.	**Washington, D.C.**
et al.,	.	**Thursday, January 24, 2019**
	.	**9:35 a.m.**
Defendant.	.	
. . . . .		

TRANSCRIPT OF MOTIONS HEARING
BEFORE THE HONORABLE JOHN D. BATES
UNITED STATES DISTRICT JUDGE

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P R O C E E D I N G S

THE DEPUTY CLERK: Your Honor, we have civil action 18-1747, State of New York, et al., versus the United States Department of Labor. I would ask that lead counsel from both tables please approach the lectern and identify yourself and those at your respective tables.

MR. GRIECO: Good morning, Your Honor. My name is Matthew Grieco. I'm joined at counsel table with Sara Mark, who is special counsel in our office, and Stephen Vogel, who is from the Commonwealth of Massachusetts.

THE COURT: Good morning to all of you.

MS. CHEUNG: Good morning, Your Honor. My name is Ashley Cheung from the Department of Justice. Defendants plan to split the arguments, so I will be handling the standing arguments; and with me at counsel table is my colleague, Brad Rosenberg, who will be arguing the merits. At counsel table we also have Tamra Moore, Michael Knapp, Amy Turner, and Melissa Moore.

THE COURT: All right. Good morning to all of you. I think we will split the argument. And we have many people on the phone, and welcome to those people who are on the phone as well. Why don't we deal first with standing, and then complete that and move on to the merits rather than mix and match as we're going.

I would anticipate that we ought to be able to finish both

parts in less than an hour so that we can get out of here in well under two hours, but I understand that it will take some time. So if we deal first with standing, I guess that will put you up first, Ms. Cheung. Is that right?

MS. CHEUNG: That's fine.

THE COURT: Because it's your motion on standing, a motion to dismiss. So I'll hear first from you, then the states, and then I'll give you a moment or two to rebut, and then we'll move on to the merits in an opposite order.

MS. CHEUNG: Good morning, Your Honor, and may it please the Court.

THE COURT: Good morning again.

MS. CHEUNG: Ashley Cheung for defendants.

The Department of Labor promulgated the association health plan Final Rule to increase access to healthcare coverage for small employers and self-employed individuals who previously lacked affordable options.

Not only is the final rule consistent with the Affordable Care Act, but it is entirely within the Department's authority under ERISA to encourage the provision of employee benefit plans. Plaintiffs purport to challenge the final rule, but at bottom, what they're really attacking is the statutory scheme governing how association health plans are treated under the ACA. But this statutory scheme has existed since long before the final rule.

THE COURT: Isn't that what the final rule does, is attack somehow what the ACA has done? It's attempting changes that will impact the Affordable Care Act. Correct?

MS. CHEUNG: No, Your Honor. The final rule does not undermine the ACA or treat how the ACA affects association health plans, and my colleague, Mr. Rosenberg, can speak more to the merits of the plaintiffs' arguments. I'm hoping to just finish introducing --

THE COURT: But the executive order that was issued that started this whole ball rolling is pretty specific at the outset in saying that the reason for this particular portion of the executive order -- there are three parts of it -- but the reason for it is because of concerns about the Affordable Care Act. And it looks at inadequacies, if you will, with respect to the Affordable Care Act, and these definitional changes in ERISA are specifically to address Affordable Care Act concerns, not ERISA concerns. Isn't that correct?

MS. CHEUNG: Your Honor, I apologize --

THE COURT: That's the mandate that the Department of Labor had by virtue of the executive order.

MS. CHEUNG: Your Honor, my colleague Mr. Rosenberg can address this question.

THE COURT: Well, I'm just talking about the general tenor here as we start. I'm not going to get into the merits with you, but isn't that what this is all about?

MS. CHEUNG: No, Your Honor. This case is an ERISA case. It's about the Department of Labor's authority under ERISA to interpret and define the definition of "employer" under 3(5) and ERISA's definition of "employer." And that's squarely within the Department of Labor's authority, and any incidental effects it may have on the ACA markets --

THE COURT: All right. Let's not talk about authority or the merits. Let's talk about standing, because that's why you're standing here.

MS. CHEUNG: Yes, Your Honor.

THE COURT: So if the states don't have standing, who does, to challenge this fairly important, I think you would agree, and fairly consequential rule and its impact on the Affordable Care Act? If the states can't challenge it, who can?

MS. CHEUNG: Your Honor, plaintiffs would be able to challenge the final rule if they could show a concrete injury that is caused by the final rule.

THE COURT: But your view is that they can't challenge it. So if they can't challenge it, who can? Can anyone challenge it? Or is this an unchallengeable final rule that the Department of Labor has put into effect that has these pretty significant consequences?

MS. CHEUNG: Your Honor, I don't -- the Department of Labor does not purport to say that this rule is unchallengeable and could never be reviewed in court.

THE COURT: So how would it get reviewed in court? Who could bring that case if the states can't?

MS. CHEUNG: I suppose if there were individuals or other plaintiffs who could show concrete injury that was caused by the final rule and they could meet this high bar of Article III standing, then they could bring a challenge to this action. But --

THE COURT: I think in fairness that's not an answer to the question, to say that if there's someone who can show injury, then it can be challenged. Who is it who could show injury in your view? Anyone? Insurance companies? States? Individuals out there in the healthcare universe? Who is it who might be able to bring such a challenge?

MS. CHEUNG: Your Honor, there might at some point be individuals who lose their healthcare coverage because of changes to the state exchanges and the individual or smaller marketplace.

THE COURT: Wouldn't it be too late then, in terms of challenging the rulemaking? Wouldn't you be arguing -- let's say 18 months from now there were such an individual. Might the federal government not be arguing that it was too late to challenge the rulemaking then? If not on a technical, legal level, certainly on a practical level with everything that happened in the ensuing 18 months.

Well, anyway, let's move on. You go ahead.

MS. CHEUNG: Your Honor, the plaintiffs set forth three theories of standing. They argue that the final rule injures their sovereign interests, their quasi-sovereign interests, and their economic interests. I will address each theory in turn.

The plaintiffs argue that the final rule injures their sovereign interests in enforcing their own state laws, but the final rule does not preempt any state laws.

THE COURT: That's pretty clear in the language of the preamble, and that seems to be pretty much admitted in the materials from both sides.

MS. CHEUNG: And for that reason, since plaintiffs are not arguing that any state laws are currently preempted and they are only arguing that there is a risk of future preemption, a risk of future preemption cannot establish a concrete injury in fact sufficient to show standing.

The plaintiffs also assert that they have a quasi-sovereign interest in the stability of their insurance markets and the residents that may purchase health insurance coverage in these markets. However, it is well settled that states do not have standing to bring a *parens patriae* action against the federal government.

THE COURT: Ever?

MS. CHEUNG: Your Honor, there are exceptions to this general rule against states bringing *parens patriae* actions

against the federal government, but the plaintiffs do not attempt to take advantage of these narrow exceptions such as the exception in *Massachusetts v. EPA*. *Massachusetts v. EPA*, Congress had authorized states to bring suit against the federal government through the Clean Air Act, but in this case here, there's no similar congressional authorization of state standing to bring a *parens patriae* suit against the federal government.

Plaintiffs also argue that the final rule injures their economic interests, and they claim three types of economic injury. They argue that there will be increased regulatory burdens, a decrease in state tax revenue, and an increase in uncompensated care costs.

Turning first to the increased regulatory burden, the plaintiffs argue that the final rule will lead to an increase in fraudulent association health plans.

THE COURT: Won't it?

MS. CHEUNG: Your Honor --

THE COURT: Doesn't the final rule pretty much say that? I'll quote some language: "The Department anticipates that the increased flexibility afforded AHPs under this rule will introduce increased opportunities for mismanagement or abuse." And then it goes on to say as well that that will increase the oversight demands on the states, on state regulators.

Isn't that pretty much a concession, if you will, by the

Department of Labor that there are going to be increased opportunities, and therefore occasions of fraud and abuse, with respect to this multiplying volume of AHPs?

MS. CHEUNG: Your Honor, the Department did acknowledge the possibility of increased opportunities for increased mismanagement with an increase in association health plans.

THE COURT: I think it did more than acknowledge it. I mean, it's stated pretty clearly, and it even delayed implementation of the rule in order to allow the states to prepare for that, to increase their regulatory staff and training, looking at these things. What more can you ask for in terms of a regulatory burden showing than the rule itself acknowledging it?

MS. CHEUNG: But, Your Honor, the agency's projections that they make in their policymaking process are simply projections. And these uncertain projections --

THE COURT: But they're confirmed in the record, aren't they, by the affidavits and declarations from the states? Don't the states, in effect, say the same thing, looking at the historical track record with AHPs and what in addition they're going to have to deal with, particularly with AHPs from outside of the state coming into the state, if you will?

MS. CHEUNG: No, Your Honor. I don't think that the affidavits confirm that the states face a concrete injury in fraud and an increase in regulatory burdens, which is going back

quickly to what the Department did say in the final rule and --

THE COURT: But the problem with this area is the regulatory burden, when you're talking about a rulemaking like this, is always going to be somewhat in the future. It's not going to be something that has already happened and has already become fully concrete. So it sounds like the argument boils down to, well, if they can't show that it's already occurred, then they don't have standing.

But that wouldn't make sense. Because the regulatory burden that they have to show is not so concrete that it actually has occurred, but it's just sort of a reasonable, articulable, and demonstrable projection that it will occur. What more do they have to show for standing?

MS. CHEUNG: Your Honor, the plaintiffs also need to show that any increase in regulatory burden would be caused by the final rule.

THE COURT: The final rule says that. Doesn't the preamble say that? "This final rule will create increased opportunities for mismanagement or abuse." That sounds like it's pretty traceable.

MS. CHEUNG: Your Honor, I would like to respond to that question in two ways. First, the agency's policymaking projections are not held to the same standard as the plaintiffs' burden to establish Article III standing. Uncertain projections may be appropriate in the policymaking process, but the Court's

analysis of Article III standing is much more rigorous.

And second, plaintiffs' alleged injury here would not be caused directly by the final rule. It would be caused by the independent, unlawful acts of third parties who decide to break the law and to commit fraud. The final rule is not authorizing third parties to commit fraud.

THE COURT: But it's acknowledging that there will be more fraud committed by third parties.

MS. CHEUNG: Your Honor, it is acknowledging the possibility of increased risk of mismanagement, but I don't --

THE COURT: I'd say the language of the rule acknowledges the probability. Let's at least put it there. I don't think it's just acknowledging a possibility; I think it's acknowledging a probability.

MS. CHEUNG: But, Your Honor, even the probability of an increased risk of fraud is not enough to meet plaintiffs' burden to show Article III standing. Plaintiffs have to adduce specific facts by affidavit or other evidence to show that there's a substantial risk or that this fraud and the increased regulatory burden is certainly impending, and plaintiffs have not met that burden.

THE COURT: So you don't think the affidavits do that.

MS. CHEUNG: No, Your Honor. I think that plaintiffs' affidavits are pretty conclusory in that they don't adduce specific facts, and rather they're just general averments about

concerns about fraud. But I don't -- I don't think they --

THE COURT: Well, they -- I mean, some of the affidavits actually state specific past instances of AHP -- I'll use the term loosely -- "fraud" and explain why this same thing will be occurring in the future by virtue of the final rule in greater volume, and they specifically talk about that "transfer over state lines" issue. And I'm referring specifically to New York and New Jersey, and obviously, they're concerned about the metropolitan-area issue.

MS. CHEUNG: But, Your Honor, instances of past fraud with MEWAs does not mean that there will be future fraud with any new association health plans.

THE COURT: What does mean that there will be future fraud? How do you show that there will be future fraud other than to say, here's what happened in the past, here's what the final rule is going to mean with respect to increased AHPs, and here's the kind of fraud we anticipate? What more can you do to show future fraud?

MS. CHEUNG: Your Honor, I think the plaintiffs would need to take into full account the changes in the regulatory context and the enforcement tools that the Department of Labor has now to combat future fraud. The ACA granted the Department of Labor increased enforcement tools such as cease-and-desist authority and increased criminal penalties and new reporting requirements to combat fraud, and these are in addition to the

Department of Labor's previous and inherent authority to regulate and enforce in this area.

THE COURT: But notwithstanding that, the Department of Labor still acknowledges this probability that the state regulators will also have to face this increased risk of fraud.

MS. CHEUNG: Your Honor, the Department of Labor, through the final rule, is not regulating the states or mandating the states do anything. It's not mandating that they increase their enforcement efforts, and, in fact, the Department of Labor -- Department of Labor has a robust infrastructure in place to police and combat fraud. And there are some states that may choose to do nothing and not to enforce these laws at all, and in that situation, the Department of Labor believes that it will be able to step in and adequately police.

Plaintiffs also fail to sufficiently account for the provisions in the final rule itself that are intended to combat fraud, such as the organizational structure requirement and the control requirement. And for plaintiffs to meet their burden, they have to take into account not only possibilities of fraud, but the possibilities of these other mitigating factors and how that changes the overall interplay.

THE COURT: If there weren't such, as you call them, increased measures for the Department of Labor to address fraud and abuse, would the states have standing?

MS. CHEUNG: No, Your Honor. I think, even without these increased enforcement tools, the Department already had other and inherent authority to enforce and regulate in this area as the Department of Labor has been doing.

THE COURT: This whole area historically has been recognized as an area where state insurance regulation is paramount, that the state regulators are essential. I don't think historically that we can look at this and say, ah, the federal regulators are paramount, and they're the ones who really take care of this. I thought that it was set up and acknowledged that state regulators are really the ones carrying most of the water.

MS. CHEUNG: Your Honor, although it is true that § 514 of ERISA does grant joint authority to both the Department of Labor and the states to regulate in this area, the Department of Labor does a lot of enforcement and policing on its own, and it does not rely solely on the states to regulate MEWAs and potential fraud in association health plans in this area.

The plaintiffs would also have to show that any potential fraud would be occurring in the plaintiff states themselves. Plaintiffs need to show that the injury affects them in a personal and individual manner. And although the final rule talks generally about aggregate concerns that the Department of Labor took into account during its policymaking process, these general concerns about fraud occurring somewhere doesn't at all

say that this fraud and the increased regulatory burdens will occur in the plaintiff states.

THE COURT: But we have affidavits on behalf of the various states that mirror, if you will, that concern expressed by the Department of Labor in general terms by saying what those state regulators foresee happening in those states. So doesn't that supply the state specificity that you say is necessary?

MS. CHEUNG: Your Honor, I think -- Your Honor, the Department of Labor's -- the affidavits of the plaintiff states speak in general concerns and general averments, but they do not adduce specific facts which are necessary at summary judgment for the plaintiffs to carry their burden of showing that fraud in their states is certainly impending or that there is a substantial risk of this fraud in their states. General concerns, even stated by the plaintiff states, are still general concerns, and that's not enough to meet their burden.

Plaintiffs also claim that they will be injured in the form of lost tax revenue paid to state agencies for small group and individual plans obtained on state insurance exchanges. The many federal policies affect the behavior of individuals, and changes in individual behavior indirectly can't confer standing on a state to challenge a federal policy simply because those changes may have incidental effects on a state's tax revenue. And for this reason, courts have generally declined to recognize the impairment of state tax revenues as a sufficient injury to

support standing.

THE COURT: So if the tax and administrative fee that the states say they will -- the losses in taxes and administrative fees that the states say they will suffer, if they produced a quantifiable estimate of those, would that be sufficient to give them standing? There is no such estimate here. There's no hard facts and figures. There is, as you have properly pointed out, more of a general-impact argument.

If they provided a monetary estimate, would that be sufficient? Because it is tagged to a specific tax loss. It's not tagged to just general revenues. But what's missing is some specificity with respect to the loss of revenues. If they had that, would that be enough on the tax revenue issue?

MS. CHEUNG: Your Honor, that would still not be enough, because almost all federal policies have downstream effects and could have some effect on a state's tax revenues. But that doesn't give states standing to challenge all of these federal policies with downstream effects.

THE COURT: But there are some tax revenue losses that are sufficient for standing. We know that from both Supreme Court cases and from some circuits. Correct?

MS. CHEUNG: That is correct, Your Honor, but --

THE COURT: So why is this not in this category, assuming for the moment that they were able to provide some specific estimate -- because it's a future year; it's not past

years -- a specific estimate of the amount of lost revenue, either from lost tax revenues or from lost administrative fees?

MS. CHEUNG: Your Honor, I think the plaintiff states would still need to show some fairly direct link between the state status as a collector and recipient of revenues and the final rule, and I don't think that they have shown that link here. I think cases like *Wyoming v. Oklahoma* are distinguishable for a couple of different reasons. In *Wyoming* there was unrebutted evidence of Wyoming's specific tax loss. So every year --

THE COURT: Acknowledged.

MS. CHEUNG: And in *Wyoming*, the challenged regulations mandated that Oklahoma utilities purchase some of their coal from Oklahoma and not from Wyoming. But here the final rule is not mandating that individuals or small employers form association health plans.

THE COURT: So it's an indirect result rather than a direct result? Is that the point?

MS. CHEUNG: Yes, Your Honor. I think it's the difference between a mandate and a choice. Here the final rule is providing an option; it's providing a choice. And it may have indirect effects on state tax revenues, but there is no direct link between the final rule and this alleged injury.

Finally, plaintiffs argue that they will become financially responsible for an increase in uncompensated care costs.

THE COURT: Won't they? Aren't there going to be some people, by virtue of this final rule -- and, indeed, the intent of the final rule -- aren't there going to be some people, as is acknowledged in the preamble, who will not have their care costs covered, and won't some of that burden fall on the states when people go to emergency rooms, for example? And this is particularly true because the essential health benefits that are required under the Affordable Care Act for individual and small employers will not be required as some of those people move into the AHPs that the final rule permits.

MS. CHEUNG: Your Honor, although there may be some individuals that do become uninsured, plaintiffs --

THE COURT: They don't even have to be uninsured. You could call it "underinsured," but less insurance, because it won't cover these essential health benefits that have previously been covered for them as long as they were in the individual and small-employer categories. So they'll have to get that care somehow, somewhere, not through the AHP insurance, and won't that burden fall somewhat on the states if people go to emergency rooms, for example?

MS. CHEUNG: Your Honor, there is a possibility of individuals becoming uninsured or underinsured, but the plaintiffs have to show that this is caused by the final rule. And health insurance markets are dynamic, and there are many intervening factors that could lead to similar changes in the

uninsurance rate or the rate of underinsured individuals.

THE COURT: Even though the preamble to the final rule acknowledges that will happen. The acknowledgement of the Department of Labor isn't enough; somehow the plaintiffs have to actually show that it's actually happened?

MS. CHEUNG: Your Honor, the preamble to the final rule also acknowledges that the Congressional Budget Office predicted that 400,000 people who would have previously been uninsured would now have access to health insurance through association health plans.

THE COURT: Is that an offsetting economic assessment that you're proposing, or is it just addressing whether there will or will not be more uninsured? Because I'm not focusing on how many uninsured there will be. I'm focusing more at the moment on the underinsured, as you put it a moment ago.

MS. CHEUNG: But, Your Honor, plaintiffs would need to look at the overall effects of the final rule and any changes that might result. So, although there may be an increase in the uninsured or the underinsured, there may also be an increase in individuals who were previously uninsured or underinsured who are now able to better access more affordable options for health insurance. And on balance, plaintiffs haven't shown that there's a substantial risk that --

THE COURT: Did the Department of Labor, in promulgating the final rule, undertake such an economic analysis

to determine whether, overall, with the consequences that you've indicated are possible, overall there would not be any increased burden on the states with respect to uncompensated care? Did the Department reach that conclusion?

MS. CHEUNG: Your Honor, in its policymaking process, the Department of Labor did look at certain projections for how the final rule would affect the uninsured population.

THE COURT: I'm talking about the effect on the states in terms of whatever would have to happen with respect to uncompensated health costs.

Did the Department make an assessment that the states would not have to pick up any additional financial burden there because of offsets from one population versus another population, or for whatever reason? I'm just asking was that assessment undertaken by the Department of Labor, if you know.

MS. CHEUNG: Your Honor, I'm not sure, but perhaps my colleague, Mr. Rosenberg, can speak to that.

THE COURT: He may be able to.

MS. CHEUNG: But even if the Department of Labor, in the final rule's preamble and regulatory impacts analysis, had made certain predictions or projections about the uninsured population or any uncompensated care costs, that may fall on the states or may fall on other actors. Again, these are just uncertain policymaking projections that are appropriate in the policymaking context but are not sufficient to show Article III

standing.

And the D.C. Circuit has made clear in *United Transportation Union v. ICC* that the court's inquiry on the constitutional requirement of Article III standing is much more rigorous and that the court cannot be bound by what Congress says in legislating or what an agency says in promulgating a final rule.

And finally, even if there are increased uncompensated care costs, there is nothing in the final rule that mandates that states will become financially responsible and have to foot the bill. For example, some of these uncompensated care costs may fall to the healthcare providers, who might in turn pass on these additional costs to other paying consumers of health care.

And the plaintiff states have not met their burden to show that even if there is an increase in uncompensated care cost this would be in the plaintiff states themselves and that the plaintiffs would become financially responsible.

And I would like to just turn back to Your Honor's first question very briefly. Even though I don't have a good example of what plaintiff could bring challenge to this suit today, *Clapper* makes clear that even if there is no other plaintiff that could bring a challenge to this suit, that is not a reason for the court to find standing for these plaintiff states. If the Court has no further questions...

THE COURT: Nothing further at this time, Ms. Cheung. Thank you.

MS. CHEUNG: Thank you.

THE COURT: Mr. Grieco.

MR. GRIECO: Good morning, Your Honor.

I will address two specific bases for standing, but of course I'm happy to answer any questions about anything in the brief. Every state has standing because, as the final rule itself recognizes, the states must bear the brunt of ensuring that newly created AHPs are free from fraud, abuse, and insolvency and do not appear in states that preclude them. At page 50 of the administrative record --

THE COURT: Don't the states have to show a little bit more than the Department just saying that there's going to be the possibility of increased fraud and abuse?

MR. GRIECO: Well, first of all, the Department has said that there's going to be a more than an increased possibility, and I want to point out that there is a -- there's a logical error in the Department of Labor's argument. They presume that the harm occurs when a fraudulent AHP forms. The principal injury to the states is the money that must be expended and resources that must be expended in advance in order to prevent fraudulent AHPs from entering into the states.

THE COURT: That's a choice that the state makes. There may be some states that decide, well, we're not really worried about more fraud, so we don't have to expend more money to get ready for additional fraud. They wouldn't have standing

then?

MR. GRIECO: It's not a choice, and there's two points that I would make in response to that. The first is that here -- the limiting principle here is that this is a case where the Department of Labor is expressly relying upon the states and counting on the states to prevent the increased risk of fraud and abuse that it says is going to be created by the rule.

And secondly, I would point Your Honor to cases such as the recent *Air Alliance Houston* decision from the D.C. Circuit, or also the *Texas v. United States* case from the Fifth Circuit. In the *Air Alliance* case, for example, the argument could have been made that states could simply choose to let these chemical discharges occur and not do anything about them, but it's not a real choice because it's something that's an acknowledged form of harm.

So when you have a case like this, where you have something that is an acknowledged form of harm such as fraud or abusive commercial behavior or insolvent companies offering health insurance, it's not really a choice to decide to do something about that. And even if there is an imaginable case where that would be true, it would not be true in this case where the Department of Labor relies upon the presumption of state enforcement to -- as one basis for their claim that the rule is rational.

THE COURT: But there's still something lacking in

terms of the specificity here, because it is dependent somewhat on the actions of third parties, those who would engage in fraud and abuse. Some of the costs, at least, are. Maybe not all. Maybe there's some preparatory cost that could be necessitated. And you don't really know that there's going to be increased fraud and abuse, do you?

MR. GRIECO: First of all, I think that we do, based on the historical record and the track record with AHPs. Every time that the -- that it has been made easier to form AHPs, the problem has gotten worse, we saw in the 1970s and '80s. And as Your Honor just said, there is, in any event, the main reason that fraud and abuse are going to be prevented is that the states are going to enforce their existing laws.

I would point you to example for -- to the declaration from my state, the declaration from Maria Vullo, the Superintendent of Financial Services for the State of New York, in which she explains that it's a problem of scale.

Now, in New York, many AHPs that would purportedly be legal under the final rule will nevertheless remain illegal in New York. But up until now, New York has been enforcing that requirement in a world in which AHPs of a national level are quite rare. And as the superintendent points out in her declaration, it's a problem of scale.

There are as many as 7,000 chambers of commerce nationwide, and the under the final rule's elusory commonality requirement

of saying that it's -- that two companies being simply in the same state is by itself a form of commonality, or even, as Your Honor alluded to earlier, across the New York tri -- New York, New Jersey, Connecticut tristate area would be a form of commonality.

If that passes for commonality, New York is going to have to be enforcing -- I don't think it requires the drawing of any inferences to conclude that New York is going to have to significantly ramp up enforcement to ensure that its own laws remain in force and that AHPs that are illegal under New York State law don't creep into New York's borders.

To get back to your earlier point about the role of third parties, the fact that third-party activity is involved does not preclude standing. I would point you to a couple of cases on this point. For example, in the --

THE COURT: It isn't precluded, but it makes it somewhat -- that somewhat stronger showing is necessary --

MR. GRIECO: I think the only -- I think the only --

THE COURT: -- would say.

MR. GRIECO: I think the only thing that changes is that you have to explain why the injury is traceable to government action. And here, in this case that exists, the first case that I would point Your Honor to is the *Renal Physicians* case from the D.C. Circuit in which the court affirmatively identified two kinds of cases in which standing

exists even though there is a role for third parties, even if the proximate cause of the injury is the action of a third party. And one of those is, and I'm quoting from the decision, "Standing exists where the challenged government action authorized conduct that would otherwise have been illegal. In such case, if the authorization is removed, the conduct would become illegal and therefore likely cease."

And I would also point Your Honor to *Block v. Meese,* a D.C. Circuit decision from 1986 written by then Judge Scalia, in which he emphasized that only de facto causation, not proximate cause, is necessary to show standing.

And so the de facto cause of the state's injury is going to be the final rule because -- and this also goes to redressability. If Your Honor sets aside the rule, these new AHPs will not be able to spring up at the nation level, or anywhere, and states won't have to engage in this increased regulatory enforcement burden.

And there are other affidavits that support us in this as well. Other affidavits I would point you to in addition to the New York declaration --

THE COURT: Do I have to review all of the affidavits in order to determine that each state does have standing?

MR. GRIECO: No, you don't. Every state has standing. And, again, I would point you to the final rule's language itself. Particularly, I'd point Your Honor to page 50 of the

administrative record, which is where DOL lays out in great detail, not just that states are going to increase enforcement, but I can give you a couple of quotes from that page of the record.

That's where they acknowledge concerns about whether they have -- whether they -- DOL have, quote, the tools and capacity to adequately oversee an expanded AHP marketplace and protect the public from harms that have materialized in the past from fraudulent and poorly operated MEWAs, including many that were not AHPs, some that were AHPs or claimed to be AHPs.

And they point out then that, to the extent that they have not yet -- and of course they've reserved -- they've reserved this to some extent. To the extent that the rule does not currently preempt any state law, they say, "This decision was deliberate in recognition by the Department of the vast expertise of the states in combating MEWA, fraud, and mismanagement," unquote.

And then here's the kicker. They say, "Even more so than in the past," unquote, the Department is going to partner with states to increase enforcement to prevent fraudulent activity that is an operational risk that they acknowledge that the final rule is creating.

So on that basis alone, page 50 of the administrative record, without more, would give every state standing. But certainly the declarations do set forth specific instances. To

give you another example, I would point you to the declaration from Delaware.

THE COURT: But do I have to find that each state has standing?

MR. GRIECO: You don't have to find that each --

THE COURT: You say the record will support it, but do I have to --

MR. GRIECO: Look, under the *Rumsfeld* case, one plaintiff with standing is sufficient.

THE COURT: Do I have to find that some plaintiff has standing on each of the claims that you have made?

MR. GRIECO: In this particular case, I don't see how there would be a difference in the basis for standing for any particular claim, because it's either the rule is contrary to law or that it's arbitrary and capricious.

There is the requirement that there be standing for each individual claim, but in this case, that would be satisfied because the only relief that any state is seeking is for the rule -- either the rule to be set aside or for Your Honor to issue the types of declarations set forth in our prayer for relief.

But just to give you quickly those examples, I would point to the Navarro declaration, paragraphs 11 and 12, in which Delaware explains how that it's already reassigned and reprioritize assignments to police AHPs in preparation for the

final rule. They anticipate a 35 percent increase in work for the staff who specifically work on licensing in oversight enforcement -- enforcement actions.

Then there's, as I said before, the Vullo declaration from New York, paragraphs 20 and 21, and I would also point you to the Gasteier declaration from Massachusetts, paragraphs 7 and 8, in which they discuss the time and resources being expended to ensure that AHPs that may be legal under the final rule but illegal under Massachusetts law don't start to appear in the state.

So in view of the fact that the Department of Labor's principal argument for the -- that -- that the rule will ultimately not lead to an increase in fraud is simply the fact that they're saying, don't worry, the state's got this, they'll take care of it. That premise in itself gives standing to every state, and the Court doesn't need to go any further or reach any other standing -- um -- standing argument because the harm is occurring on the front end. The one other basis --

THE COURT: What case do you think is the best case for you on that regulatory burden question, that that regulatory burden is the injury in fact that is traceable to the Department of Labor's rule and redressable by the relief sought here?

MR. GRIECO: The two best cases on that would be *Air Alliance Houston* from the D.C. Circuit, decided this past fall, and *Texas v. United States* from the Fifth Circuit.

That was the case involving driver's licenses being issued by the state. So unless Your Honor has further questions about the regulatory burden standing argument, the one other standing argument that I wanted to discuss specifically --

THE COURT: Does that mean that you're abandoning --

MR. GRIECO: I'm not abandoning any. I -- I'd be happy to answer questions about any of the others -- is the lost tax revenue standing.

THE COURT: There's nothing concrete in terms of any monetary impact that is in the affidavits. Is that correct?

MR. GRIECO: The affidavits don't put a dollar figure on what would be lost. However, there's no requirement --

THE COURT: Or even any kind of estimate?

MR. GRIECO: There's no requirement of a specific estimate. All Your Honor has to assure yourself of is that it is -- I -- that a specific tax has been identified with a nexus to the injury and you can assure yourself that the loss is going to be greater than zero. And there's several state affidavits from which you can assure yourself of that.

So first of all, I would say that first of all, there's five states that could potentially lose revenue. Those states are New Jersey, Delaware, California, Washington, and Massachusetts. And these states operate in different ways.

To give you two examples, Washington State would be one example of this. Washington State levies a 2 percent tax on

premiums, plus a per-member, per-month assessment on carriers. And they use that tax to fund their exchange, which is not just the qualifying health plans exchange under the Affordable Care Act, but also their Medicaid portal. And that specific -- that specific tax would inarguably be lost if the final rule achieves its stated goal of driving people off of the ACA exchanges and onto qualifying health plans -- onto AHPs.

And the -- in this case, because the very purpose of the rule is to do that, to take people off of ACA exchanges and move them onto AHPs, it is clear that some meaningful dollar amount will be lost to the State of Washington. There's no requirement in the standing analysis that there be a definable number. You just have to assure yourself that it's going to be greater than zero, because any degree of injury satisfies standing, and it could be significant if the final rule is as successful as the DOL evidently hopes it is.

But the only separate nexus that's required is that there be a connection between a specific tax and that the injury relate to the taxing power. As Your Honor alluded to earlier, in the multiple cases involving Wyoming, it's been clearly recognized that lost tax revenue is a form of standing for states. And here, because it is a rule that relates to the Affordable Care Act exchanges and is intended to drive people off those exchanges and will damage a specific tax in a specific state that is used specifically to fund healthcare exchanges and

actually is a tax on that exchange, that nexus exists perhaps more clearly here than even in the precedents that we rely upon.

THE COURT: But the principal *Wyoming* case, the *Wyoming-Oklahoma* case, did have specific dollar amounts with respect to loss of revenues.

MR. GRIECO: There were specific dollar amounts --

THE COURT: Here we don't have that.

Do you have any case that supports the principle that you just articulated that you don't need to have any specific figure in mind in terms of lost tax revenues, that it's enough just to have the assurance that there will be some impact on the tax revenues? What case supports that?

MR. GRIECO: So I don't have a case for that as specifically as you just stated it. I'm relying on the well-settled principle that, with respect to any injury given to confer standing, it has to be a particular -- it has to be greater than -- it has to be some modicum of injury. There's not a requirement it has to be grave injury. It --

THE COURT: I'm not saying that it has to be -- my question is not that it has to be a plus or a minus in this instance.

MR. GRIECO: Right.

THE COURT: My question is does there have to be something specific with respect to the loss of revenue rather than just, well, there's going to be some loss of revenue.

MR. GRIECO: I do think some loss of revenue is -- what has to be specific is a specific tax, and there has to be -- you have to show the causal chain leading to the injury to that specific tax.

THE COURT: That's not what the Tenth Circuit said in a subsequent case. They said it's not enough to identify the type of tax, the specific tax involved, but you need some specific loss of revenue.

MR. GRIECO: You need -- but I don't -- but I don't think that they -- I don't think that they, by that, they meant a dollar amount. I know that in the cases where tax -- uh, tax revenue standing has not been found, it's been because of a failure to show a nexus between the injury in a specific tax.

That, as I understood it, was the problem in the *Wyoming v. Department of Interior* case, that it was sort of a generalized fear that if you reduced the use of snowmobiles that fewer people are going to come to our state. That was extremely generalized.

This is not that case. This is a rule that targets -- that has a laser-light focus on damaging ACA exchanges and is intended -- its intended effect is the exact thing that will reduce Washington's tax revenue. And not just Washington. I'm using them as an example. But Delaware, it's also the case that they have a tax that goes into their general coffers, and there are other examples set forth in the affidavits.

I do want to say that although Washington has not -- has said that they can't calculate the exact amount of the enrollment loss, they pointed out that any decline in enrollment would reduce the exchange of revenue.

And they have provided, in paragraph 17 of the MacEwan Declaration, Washington has explained the specific dollar amounts of their existing revenue, and they've given examples of how -- how that would be reduced in the event the final rule succeeds in driving people off of the ACA exchanges.

They pointed out that in -- that their fiscal year 2018 exchange revenues related to QHP premiums and assessments were $36.7 million, and their projected revenue for fiscal year 2019 are $39.1 million. So that gives Your Honor exact numbers as to the amount of revenue that they're currently getting, and it's a sizeable sum of money.

And, remember, they're exchange because it has to be self-sustaining. Any amount of money that they lose out of that pot is going to have to be made up for somewhere else, either -- presumably by the Washington State legislature. So that is sufficient to give the state standing.

And although Your Honor is correct that I'm not aware of a case that speaks specifically to the dollar-amount question, I'm also not aware of a case that has ever specifically held you have to quantify a dollar amount. And based on the general principle that any amount of injury is sufficient to

confer standing, if this were a case of first impression on that point, then the correct ruling would be to say that what the Court needs to assure itself of is that there's a specific tax with a specific nexus to the injury that is going to be affected in some greater-than-zero way.

THE COURT: So is there any other alleged injury that you want to focus on before we move on to get to the merits?

MR. GRIECO: No. If Your Honor has any other questions about other bases for standing, I would be happy to answer them --

THE COURT: I suppose I'd ask you, in one or two sentences, to tell me why this uncompensated care issue gives the states standing.

MR. GRIECO: Sure. As Your Honor alluded to earlier, there's essentially two different sets of harms associated with uncompensated care. There's the people who will buy association health plans who won't have essential health benefits and will be underinsured.

And I agree with something you said earlier, that that is the clearest basis to find standing under uncompensated care costs, because of the direct link between the rule's intended effect and the injury to the states. And when people find out that the care that they need is not covered by the regular insurance they have, they're going to turn to --

THE COURT: They're going to turn to what? And what

is the state going to have to pick up?

MR. GRIECO: They going to turn --

THE COURT: Pick one of the essential health benefits if you want, whether it be mental health or substance abuse or maternity care, whatever you want, and tell me how is that going to result in the state's coffers having to pick up for that care.

MR. GRIECO: Well, mental health could be a great example. When people don't have mental health care, they may find themselves having to go to a state mental health facility. There are -- if my answer is broad, it's simply because the category of essential health benefits is quite broad, and it's very easy to imagine how this could happen in any one of those individual categories.

THE COURT: And these would be lowering some people, and therefore they won't be able to pay -- if they don't have the insurance coverage, but they need the care and they get it from a state facility, they won't be able to pay for it.

MR. GRIECO: Exactly. And there is also the separate form of harm that is caused by the segmentation of the risk pools that -- as DOL has acknowledged, AHPs are likely to pull healthier people off of the ACA exchanges, leaving a less healthy risk pool, one of the key principles that Congress had in mind.

THE COURT: It increases the premiums, but how does that impact the state --

MR. GRIECO: Oh, because some of those people are going to --

THE COURT: -- compensated care?

MR. GRIECO: Because some of those -- and we lay this out in our brief. Some of those people will choose to forego insurance entirely.

THE COURT: But the figures that the Department of Labor relies on sort of go two different directions with respect to whether there will be an increase in the uninsured population.

MR. GRIECO: They do -- they go do -- they do go in two different directions.

THE COURT: Do I have to resolve that? Do I have to decide there will be in order to find standing?

MR. GRIECO: No, you don't, particularly because of the underinsurement problem you mentioned earlier. That by itself, DOL resolutely predicts, will increase. And on that basis alone, the uncompensated care costs would give standing to all of the states.

THE COURT: All right. Anything further?

MR. GRIECO: Unless you have further questions, I would simply refer the Court to the arguments in our briefs on the other standing points.

THE COURT: All right. Thank you, Mr. Grieco.

Ms. Cheung, five minutes?

MS. CHEUNG: Thank you, Your Honor. I have a few

points on rebuttal on the increased regulatory burden and on the tax revenues. So first, plaintiffs' counsel said that the harm they're alleging is not the fraud that might occur but the monetary expenditures that the states would have to incur to combat this fraud.

THE COURT: Right. It's a regulatory burden.

MS. CHEUNG: Right. But the D.C. Circuit has made clear in *Food and Water Watch,* and the same in *Clapper,* that expenditures based on fear of hypothetical harm that's not certainly impending can't establish standing. So unless plaintiffs --

THE COURT: True enough. Do we have something more than a hypothetical harm here when the rulemaking itself acknowledges that there is this -- what did I say before? -- a probability of increased fraud and abuse?

I mean, it doesn't seem to me that we're in the speculative chain that *Clapper* had with ten things that -- it wasn't ten; I think it was six -- that really aren't very well established, where here we have something that's pretty well established. It's established not just through the affidavits of the various states, but it's established through the acknowledgement of the probability in the rulemaking itself.

MS. CHEUNG: Your Honor, even setting aside that point, plaintiffs classify this harm as mitigation costs, and mitigation costs can only establish injury in fact if they're

mitigating harm to the plaintiff states themselves. But here, the states are attempting to mitigate harm that would be caused to the residents in their states, and that is just a *parens patriae* action. The states cannot bring suit against the federal government to protect their citizens from harm, and we've already discussed the theories of *parens patriae*.

I'd also like to point out that many states are not concerned with the final rule and don't think that they will have to increase their enforcement efforts as demonstrated by the amicus briefs filed by other states in support of defendants' position.

THE COURT: Well, so? We do have states that arguably have different perspectives with respect to the impact on them. But just because states A, B, and C don't think that there will be fraud and abuse impact, if states D, E, and F think that there will be, isn't that enough for standing for them? Why does it matter that some states feel otherwise? For standing purposes.

MS. CHEUNG: That the plaintiff states think there will be injury to them is not enough. Again, the final rule talks in levels of generality, that there may be some fraud somewhere, and there may be some states that might want to increase their enforcement efforts somewhere; but it does not point directly to these plaintiff states, and the affidavits don't make concrete, specific facts that show that the fraud

will happen in their states as opposed to elsewhere.

Turning to the concern about association health plans existing across state lines and how that might increase the plaintiff states' enforcement burden, association health plans could always operate across state lines. This is the case under Pathway 1.

THE COURT: But this is a specific aspect of the rule that increases the likelihood because of this particular rule change focused on that issue.

MS. CHEUNG: No, Your Honor. The allowance of geography to be part of Pathway 2 doesn't increase the likelihood that there will be nationwide association health plans. It was always the case that --

THE COURT: Well, we're not talking about nationwide necessarily. We're talking about region-wide.

MS. CHEUNG: But, Your Honor, there could always be region-wide association health plans, even under Pathway 1, where associations could form based on small businesses banding together on commonality of industry.

THE COURT: Right. There could always be region-wide, and now there are going to be, by virtue of this rule, more region-wide. And that's why the volume, if you will, of the AHPs is a relevant factor with respect to the regulatory burden, because a given state, instead of dealing with 12 region-wide AHPs, now will have to deal with 120. And that's an increase in

volume that leads to an increased risk of fraud and abuse that they'll have to prepare for. What's wrong with that assessment that I just gave?

MS. CHEUNG: I think that's a hypothetical of a possible chain of events, but I don't think plaintiffs have met their burden to adduce specific facts that there will be an increase in association health plans that do span state lines.

THE COURT: Well, that returns me to the same question I asked earlier. If a given state shows that there has been that fraud and abuse in AHPs in the past and shows, by virtue of the final rule and the intent of the final rule that there will be an increase in the AHPs, why does it not follow logically, as said in the affidavits, that that means an increase in the regulatory oversight that the state will have to engage in as more AHPs that are just as likely to have fraud and abuse as the old AHPs, at least, and therefore there's more of a regulatory burden? It just seems logical. It doesn't seem really that speculative; it seems more logical.

MS. CHEUNG: Plaintiffs need to do more than rely on future events that logically could happen. They have to bring evidence showing specific facts that this will happen in their states. And they can't rely on the Department --

THE COURT: I'm not sure I agree with the "will happen." It seems to me, for standing purposes, they need to show that it is likely to happen. Do you think they need to

show with certainty that it will happen?

MS. CHEUNG: Your Honor, I'm not arguing that they have to show that it certainly will happen, but they do have to show that it is certainly impending, that there is a substantial risk. And "probably" and "possibility" aren't the same as "certainly impending" or "substantial risk."

THE COURT: All right. Fair enough.

MS. CHEUNG: And just finally one last point on taxes. It has always been the case that employers could self-insure, which means that there would be no state premium taxes collected on tax revenue, or individuals could always go without coverage, in which case the states would not be collecting premiums on these individuals. And the final rule allows association health plans to expand coverage. So there may be some new association health plans that are now purchasing insurance and doing so on the state exchanges, which would increase the tax revenues for the states.

THE COURT: Economic offset, if you will, meaning that there won't really be a loss in revenue by virtue of the rule.

MS. CHEUNG: Yes, Your Honor.

THE COURT: And did the Department of Labor undertake that economic assessment to determine that there wouldn't be a loss of revenue to states by virtue of the final rule in terms of tax revenues or administrative fees? Is that something that the Department assessed?

MS. CHEUNG: I don't know the answer to that, Your Honor.

THE COURT: Fair enough. Thank you very much.

MS. CHEUNG: Thank you.

All right. We will proceed with the merits. Mr. Grieco?

MR. GRIECO: I'll begin by explaining why the final rule is contrary to the Affordable Care Act. The Court can and should strike the final rule down on that basis alone without needing to reach any other merits issue, but I will also address several other reasons why the rule isn't valid.

A core principle of the ACA is that the small-group and individual markets must be subject to stronger formal requirements than the large-group market because of the historic problem with the small-group markets. The final rule defies that judgment. The ACA unambiguously requires the consumer protections applicable to a particular employee's health plan be determined by reference to the size of the employee's direct employer.

The controlling terms here are "large employer" and "small employer" as those terms are defined in the ACA, not merely the term "employer." Under the ACA, a large employer is any employer -- or, quote, employer who employed an average of at least 51 employees in the prior year.

Under settled interpretations of ERISA from both -- from the Supreme Court and from DOL itself, the word "employee" has a narrower meaning under ERISA than the word "employer" does.

As most recently in the 2013 MEWA manual, which is in the administrative record and which is cited in our papers, DOL recognized that when a statute uses the ERISA definition of "employee," it means a person who has a common-law, direct employment relationship with the entity counting its individual as its employee.

So under the Affordable Care Act, even if Your Honor decides that DOL has rationally interpreted the word "employer" under ERISA itself -- and I'll address that a little later. Even if you come to that conclusion, the final rule must still be set aside as contrary to law under the Administrative Procedure Act because even an association that qualifies as an employer can never qualify as a large employer under the ACA because it will never be the employer who employed the employees of the association's member employers.

Furthermore, in addition to the plain text of the statute and the settled interpretation of the word "employee," there are several other textual clues in the ACA that this sort of aggregation that the final rule is attempting to impose is illegal.

First and foremost, I would point Your Honor to the aggregation principles that follow the market size definitions in the ACA 's text. There is a section that is actually called "Rules for Determining Employer Size," and in that section there are several enumerated references, mostly to the Internal

Revenue Code in certain traditional ways under the tax code that employers have been allowed to aggregate. And under those circumstances --

THE COURT: How does the final rule, in its interpretation of ERISA statutory provisions, change the meaning of larger employer or smaller employer?

MR. GRIECO: The answer is that --

THE COURT: Because neither of those two terms is really specifically discussed in the final rule.

MR. GRIECO: That is correct, and that would be a good question to ask the Department of Labor, because they should have been. If they really believed that by --

THE COURT: Well, I asked you, but --

(Laughter.)

MR. GRIECO: And here's my answer. If they really believed that they had the authority to do this, they would have addressed the definitions of "large employer" and "small employer" in the ACA, and they didn't do so.

And, of course, to take the point Your Honor just made a little bit further, the actual text of the final rule is conspicuous for what it doesn't discuss. It only references ERISA. And yet the very lengthy preamble makes clear that the only purpose of this entire regulation is to change the word "employer" just for purposes of changing market size definitions under the Affordable Care Act.

How can it be that the -- that it has that effect and never addresses the definitions of "large employer" or "small employer" or account for the words "employer who employed" or account for the much narrower meaning that the word "employee" has under ERISA than the word "employer" does? Long story short, even if they quali -- even if an association qualifies as an employer, DOL needed to at least explain that particular part of the statutory definition under the Affordable Care Act, and they made no attempt to do so.

So, in addition to the -- in addition to the aggregation rules and the *expressio unius* argument that we've made that if Congress had intended to allow aggregation through an association that it would have said so explicitly in the subsection actually titled "Rules for Determining Employer Size," another textual clue is -- or maybe this wasn't of a textual clue than another error and incompatibility in the final rule itself is the conspicuous refusal of the final rule to apply this redefinition of "employer" to the employer mandate, which is also known as the shared responsibility payment, it uses the same language, the same "employer who employed" language --

THE COURT: What's wrong with it having different meaning in those two places?

MR. GRIECO: Well, a couple of things. First of all, there's the ordinary principle that a word used twice in the same statute is usually meant to be used the same way,

particularly when it's in the same exact phrase. And secondly, there's actually a clause in the ACA itself saying that a statute -- that a word used in one place that's also used in the Affordable Care Act shall be read the same in multiple places.

It's a tripartite scheme. I mean, for the last several decades, whenever Congress has engaged in any form of health care reform, they've done it by amending three preexisting statutes: ERISA, the PHSA, and the Internal Revenue Code. And the long pattern that Congress has shown amending those three statutes shows that a word, when in the healthcare context, should be read the same way across those statutes unless there's a good reason not to. So the other point --

THE COURT: So here you have -- do we have the Department of Labor acting alone here?

MR. GRIECO: We do. They say that they consulted with Treasury and with HHS, but there is precedent --

THE COURT: What more do they have to do than consult?

MR. GRIECO: Well, Your Honor has actually had --

THE COURT: ERISA, after all, is the their stat -- is Department of Labor's statute to apply and interpret.

MR. GRIECO: Well, there is the option of tripartite rulemaking, and I believe Your Honor had a case in which there was actually a rule that was jointly promulgated by those three departments that I just mentioned, and, furthermore, even if they weren't going to do that, they should have at the very

least, if the rule is going to be rational, explain this inconsistency. But the rule actually goes beyond that. It goes beyond just saying, we consulted with Treasury. It actually affirmatively states that the shared responsibility payment is only going to be applied to individual member employers who have more than 50 employees.

So they're actually going to -- they're actually going to place the employees of small employers who are part of large associations in a worse position than even the employees of large employers, because they will have neither of the protections that Congress intended for the small-group market, nor the protections that Congress intended for the large-group market.

And to address specifically the question you just asked, it's not just a matter of consulting with Treasury. They've actually gone further and affirmatively represented --

THE COURT: You say Treasury. You mean HHS as well.

MR. GRIECO: Well, I --

THE COURT: Treasury with respect to the Internal Revenue Service, HHS with respect to the Affordable Care Act.

MR. GRIECO: That's right. The reason I'm referring to Treasury right now is that I'm talking about the employer mandate, which is enforced by Treasury.

So, at a minimum, they should have done a tripartite rulemaking, but even that couldn't have cured this rule because

-- first because of the plain text of the "large employer" definition, and even if they got past that, they would have to explain this complete inconsistency between applying this new definition of "employer" just to the market size definitions only when it helps to get people out of the small-group market and not when it would put people into the large-group market. That is also a basis on which Your Honor could declare the rule to be arbitrary and capricious.

THE COURT: So does the Department of Labor get *Chevron* deference here?

MR. GRIECO: They do not.

THE COURT: Why not?

MR. GRIECO: Under *King v. Burwell,* this is a case where it's simply implausible that Congress, when it adopted the ACA, would have intended to delegate to the agency the authority to completely rework the specific market size definitions that were so central to the ACA's reforms. As I mentioned at the beginning of my argument --

THE COURT: *King v. Burwell* is a little different in that part of what the Supreme Court relied on was the lack of any expertise in the healthcare arena by the Internal Revenue Code. Of course, the Department of Labor has some substantial expertise dealing with ERISA and benefit plans.

MR. GRIECO: Well, by that rationale, so would the IRS because, of course, the employer mandate that we were just

discussing. I mean -- but even if there were some degree of expertise, it is implausible that any agency -- I mean, the *King v. Burwell* made two points. It made a point that it's not plausible that any agency had this -- this delegated authority, and then that particularly the agency there, the IRS, didn't have the authority. And here, those same two same principles apply.

Yes, it's particularly implausible that DOL has that authority, but it's also implausible that any agency could rework the ACA's market size definitions just by interpreting a statute that is 40 years older than the ACA and is much less specific on the particular point at issue. The ACA is the more recently enacted statute. It is the more specific statute because it's the one that actually relies upon the market size definitions for its central healthcare reforms.

As I mentioned at the beginning of my argument, one of the key problems that Congress was trying to resolve when it adopted the Affordable Care Act is the lower quality of health insurance often available to the employees of small employers, and it affirmatively chose to place stronger requirements on that particular market.

Now, DOL may disagree or agree with that policy choice, but it is an unambiguous policy choice made by Congress. And under *King v. Burwell* and also *Brown & Williamson*, it is implausible that Congress would have intended DOL, or any agency, to have

the authority to change these very specifically enumerated market sizes via a regulatory interpretation, certainly of a much older statute, a statute which, by the way, meaning ERISA, was adopted for the purpose of protecting employees. And to reinterpret that statute in a way that deprives employees of consumer protections is unambiguously contrary to the will of Congress.

Unless Your Honor has further questions about the large employer/small employer definition part of the argument, I'm happy to move on to the --

THE COURT: I assume you're going to address other aspects of the Affordable Care Act definitional scheme.

MR. GRIECO: Oh, yes. I am. I just wanted to make sure we were done with the large-employer/small-employer definitions.

THE COURT: All right.

MR. GRIECO: So the rule is also invalid on several additional bases. One is its attempt to redefine working owners. It's -- and the working owner portion of the rule is contrary to both ERISA and the Affordable Care Act.

The reason it's contrary to ERISA is because of the years of case law, including the *Yates* v. *Hendon* from the Supreme Court, interpreting ERISA to say that a person must have an employee other than herself to be an employer, and even if it were okay under ERISA, it would be contrary to the ACA because

the ACA doesn't import the definition of "employer" from ERISA unadulterated. It says -- it has the text of "employer" -- the "employer" definition from ERISA Section 3(5).

And then it says, except that it shall only include employers of two or more employees. And you can't aggregate to get there because, if you want to be an employer, you have to be a group or association of employers. So simply aggregating people who aren't already employers does not make them into employers or an association of employers. Furthermore --

THE COURT: So what does that mean if you're right with respect to that particular point? Does that mean that the rule falls, or does it just mean that the rule doesn't do what they're trying to do with respect to the Affordable Care Act?

MR. GRIECO: Well, that's the reason that in the prayer for relief in our complaint, we believe that the entire rule should be set aside as illegal and as contrary to law and as arbitrary and capricious, but we've also noted that Your Honor could issue declaratory relief.

It is a very unusual form of rulemaking for the agency to adopt a rule that only talks about one statute, ERISA, and to be preceded by a lengthy preamble that does nothing but cabin, cabin, using language that doesn't appear in the text of the rule itself, cabin it to one piece of one other much later enacted and specific statute.

THE COURT: It also cabins it, to some extent, with

respect to ERISA, doesn't it? The changes in the final rule, do they apply in all circumstances?

MR. GRIECO: No, that's right. You're exactly right. It is cabined to doing one specific thing, which is one of -- which ought to be one of the chief hallmarks that they're trying to do through regulation, something that years of AHP proponents, trying to get AHPs adopted into legislation, were unable to do. And it is another basis on which the rule is arbitrary and capricious.

So, as I said earlier, we believe that the redefinition of "employer" is illegal as contrary to ERISA. But even if Your Honor is not persuaded by that, it is also, at a minimum, arbitrary and capricious in the explanation that DOL has given for its attempted redefinition of "employer." At a minimum, the rule fails to justify its sweeping departure from a decades-long interpretation upon which regulators, including states and many other stakeholders, have relied.

Any reasonable interpretation of ERISA Section 3(5) must include a meaningful requirement that an association qualifying as an employer act, quote, in the interest of the direct employer who's employees are the beneficiaries. The final rule fails that test.

And this is not just based -- contrary to DOL's argument, this is not just based on the fact that there are these advisory opinions that they've issued in the past. Assuming for the

sake of argument that they have the same degree of authority to revisit those advisory opinions, they need to do so in a way that is rational as opposed to arbitrary and capricious, and they fail to do that here because they have not built a meaningful control requirement into the regulation.

The chief case law we'd point Your Honor to on this point would be the *Wisconsin Education Association* case from the Eighth Circuit, the *MDPhysicians* case from the Fifth Circuit, and the *Gruber* case from the Third Circuit. And I would like to talk in particular about an amicus brief that DOL itself filed in the *MDPhysicians* case. That's the Fifth Circuit one, and footnote 7 of the final rule actually mentions this amicus brief.

And in that amicus brief, the Department of Labor explained in 1991 that if an association is to be an employer for purposes of ERISA, the association has to be a true product of a close, concerted effort by those employers. And you can't have that with the final rule where every employer can subscribe to a chamber plan.

THE COURT: That amicus brief is close to 30 years ago.

MR. GRIECO: It is, but it is based on more than just the advisory opinions that the court had at that time. All of the case law says something similar, which is that the words "in the interest of" in ERISA Section 3(5) mean something.

And what DOL is attempting to do through this final rule is that they're trying to take those words "in the interest of,"

meaning that the employer is standing, to a certain extent, in the shoes of its employees, and because there's a close relationship between the employer and the association, a very close relationship under the existing advisory guidelines, which is why bona fide associations have been so rare in the past, that nexus is the irreducible minimum of what is required to ensure that an association is truly an alter ego of an employer, which is what would -- the minimum that would be required even if DOL were going to reduce -- to revisit its definitions.

What they're really trying to do through this rule is to take those words "in the interest of" out of ERISA Section 3(5) and change it to basically mean "instead of" to basically say that anytime an association does something on behalf of, they were instead of an employer and offers a plan, that that would be sufficient to have an association and to have the association qualify as an employer under ERISA 3(5).

And again, to reiterate, it's not just -- they have tried to portray this case as us saying that they can't revisit the role of advisory opinions, and Your Honor does not need to come to that conclusion to conclude that the rule is arbitrary and capricious. It's enough to say that every case that -- every circuit case that has looked at this statute has concluded that the control and the commonality requirements are meaningful and robust ones, and there is no meaningful or robust commonality or control requirement in this regulation. And I'll explain why

the safeguards for -- the alleged safeguards --

THE COURT: Have they changed the language of the control requirement?

MR. GRIECO: Come again?

THE COURT: Have they changed the language of the control requirement?

MR. GRIECO: They have not. However, if you look in particular at those circuit cases that I just referred to, the courts have made clear -- and this I think particularly is the *Gruber* case -- that you need both the commonality and the control requirement, because the control requirement is simply a conclusory statement about control, and the courts have concluded that you need these other indicators including a true common business purpose and a true form of commonality.

THE COURT: It's the commonality and purpose --

MR. GRIECO: Yes.

THE COURT: -- requirements that have been changed here.

MR. GRIECO: That is -- that is correct. But before I leave the -- I'll get to that later, actually.

The geographic commonality requirement, it makes a mockery of a commonality requirement. It says that if what two employers have in common is that they both exist in the state of Delaware, they are common for purposes of --

THE COURT: Well, let's make it a little more stark. Both exist in the state of California.

MR. GRIECO: Exactly. I picked a state at random, but yes. The fact that two employers exist in the same state is enough for it to be common. And there is no way to swear a commonality requirement that broad, if it's even a requirement, because it can also be across state lines, metropolitan areas, the entire New York, New Jersey, Connecticut tristate area. That's not commonality. And the -- and given the case law interpreting the commonality requirement to be there is an important check on the control -- on the bare control requirement --

THE COURT: What if I found that the only problem here was this commonality by region, and I struck that? And there's a severability clause here in this rule. What would that mean if that's all that I found was troublesome?

MR. GRIECO: Well, just severing that one clause would make things even worse, because then you wouldn't have the -- you wouldn't have -- you would have even the elusory protection that they claim to put in there. If the --

THE COURT: But there --

MR. GRIECO: The severability clause --

THE COURT: But there are two parts to the commonality under the final rule, so you'd have the other part of the commonality.

MR. GRIECO: Are you referring to the common-purpose requirement? The -- or you're referring to the single-trade

option to --

THE COURT: Right.

MR. GRIECO: But that is also -- that would allow nationwide associations as long as it was the same business. It's unimaginable that in a large, nationwide association that employers would be able to meaningfully control the association.

The reason that the bona fide association test that DOL has relied upon in the past has worked as well as it has is that it requires -- you're never going to be able to satisfy it unless you have meaningful control of the association by the employer so that to satisfy the statute, the association actually asks in the interest of the employers, and it doesn't mean just in place of the employers, and we'd be moving to that regime if all participants in a single trade nationwide could participate in a single association.

I also want to talk about the primary purpose requirement. So DOL itself recognizes in the final rule that the risk of fraud is greater when the purpose an association forms for is offering insurance as opposed to having been formed for some other organic purpose. And so the rule purports to deal with this by saying that if they have at least one substantial business purpose, that they then have a purpose other than insurance. But then --

THE COURT: That is not related to health coverage.

MR. GRIECO: That's right. But then there's a safe

harbor that says that they will satisfy that substantial business purpose test if the, quote -- or if the agency -- if the entity, quote, would be a viable entity in the absence of sponsoring, unquote, a healthcare plan.

Much like the geographic commonality requirement, that is so broad that it is meaningless. You could have an organization whose only function other than offering health care would be to offer, you know, once-a-month CLEs, or the equivalent of CLEs in some other profession, and that would qualify as a substantial purpose under this rule. It would not under the past interpretations that the courts have given to the rule in which there's actually entities that are closely related in terms of their actual business and then formed for that purpose.

And it's important to remember why the primary purpose test arose. It's not because there's some sort of box that needs to be checked off that says, okay, you're not just a health insurance company. It's to ensure that the association has arisen organically; it is truly a representative of its employers, because the employers stand in the shoes of their employees and are responsible for protecting their employees.

And if there is not an actual control requirement, then that disappears. And although there are words in the regulation that purport to create control requirements, when you look behind the curtain, there's absolutely nothing there. The bottom line is that the final rule would no longer serve ERISA's

key purpose of protecting employees --

THE COURT: Why are the commonality of interest test and the purpose test, as previously formulated, why are they necessary to the congressional intent here?

MR. GRIECO: Well, as I allowed earlier, there is arguably -- for the sake of argument, DOL may have some authority to revisit those guidances. I would qualify this by saying that when Congress adopted the Affordable Care Act, it was acting against the backdrop of this long interpretation and would have understood "employer" not to mean anything nearly as broad as what DOL is attempting to --

THE COURT: That usually requires some express acknowledgement by Congress.

MR. GRIECO: The centrality of the market size definitions provides evidence that they would not have intended this to be so easily rewritten. And as a matter of -- to borrow from *Brown & Williamson*, common sense, it's implausible that Congress intended such a revision this extensive.

The bare minimum that needs to exist in any regulation that would rationally reinterpret the term "employer" under ERISA -- and, again, subject to my caveat earlier that even if it does, it's still illegal under the ACA itself -- the bare minimum would have to be a robust control requirement that guarantees true control of an association by its member employers, and this rule doesn't come close to doing that.

I wanted to say one more thing about severability, which you raised earlier. Although there is a severability clause in the regulation, everything in the rule that relates to satisfying the definition of "employer," it's difficult for me to imagine how any of those parts could be severed from one another because, although they are extremely weak protections, the main texts are these protections.

So because they are insufficient, if Your Honor concluded the protections in the rule to ensure actual control are insufficient, which is what you should conclude, then the entire redefinition of the word "employer" would have to be set aside. It wouldn't be severable because it's the same nexus of operational law.

And, finally, there are a couple of other bases on which the rule is also arbitrary and capricious. In addition to not providing adequate justification for the dramatic change to satisfy the reliance interests of the states, the agency also disregarded the weight of the evidence in front of it.

It did not do it -- many commenters submitted letters explaining the history of fraud, abuse, and insolvency associated with association health plans, and the agency has not built in meaningful safeguards to prevent that from recurring, other than, as it said and as we discussed in the standing discussion, saying, don't worry, the states will take care of it. And furthermore, they've never really accounted for

the damage that will happen to the markets.

Nearly every medical group that commented on this rule opposed it. The American Medical Association appeared as an amicus in this case, supporting our position, and explained that the market segmentation that occurs when you withdraw healthy people out of the market is one of the principal harms that Congress intended to remedy when it created the Affordable Care Act.

And so the agency here relied upon factors that Congress did not intend to consider, which is the independent basis for holding it arbitrary and capricious, because Congress would not have intended the agency to intentionally create market segmentation as a basis for interpreting the law when in fact that's the harm they were trying to remedy.

THE COURT: In the AMA's amicus brief, they cite and quote a news article for the point that not a single group representing patients, physicians, nurses, or hospitals voiced support for the proposed rule. Does your reading of the proposed rule and the comments confirm that?

MR. GRIECO: I can't -- I can't swear to there being zero. I know that the -- I think it's the *L.A. Times* article that you're referring to gave an overwhelming number. I think that that -- that was a quote from the former insurance commissioner I think that you're referring to. I don't know if I can swear to it being zero.

I can tell you that it is overwhelming and that most of the prominent organization -- every prominent organization that I'm aware of that deals with the field of health care -- the AMA, the American Hospital Association, the Academy of Pediatrics, and the Association of Obstetricians -- all of these organizations have firmly come out against this rule, principally because of the risks of fraud and because of the risks of market segmentation.

THE COURT: I interrupted. You were about to go on to --

MR. GRIECO: Yes.

THE COURT: -- the final point, I think.

MR. GRIECO: And the final point that I would make on arbitrary and capricious is that the agency has relied on plainly inconsistent statutory interpretations, that in addition to showing that the rule is contrary to law, a rule is arbitrary and capricious when it fails to account for needing to read statutory language consistently.

And because the rule specifically targets ACA market sizes and affirmatively rejects the application of its own logical principles to other areas, including but not limited to the employer mandate, the rule has illogically interpreted the same words in different ways in different places and should be set aside as arbitrary and capricious on that ground.

THE COURT: Within ERISA itself or only with respect

to Affordable Care Act provisions?

MR. GRIECO: Also anywhere else in ERISA that the word "employer" is used other than the ones we've discussed here. If they're going to redefine what "employer" means, then they would need to be redefining -- either redefining it for all purposes or giving a rational explanation for how -- not just that they have a policy desire to have it apply to this one particular context, but to show how it is actually rational to read the statute having that mean something different in different places, and they haven't done that.

THE COURT: All right. Thank you, Mr. Grieco. Mr. Rosenberg. Good morning.

MR. ROSENBERG: Good morning, Judge Bates. Brad Rosenberg from the Department of Justice Civil Division on behalf of the United States.

Your Honor, this is a case about ERISA, and we wouldn't know that based on much of the argument over the last few minutes. The final rule challenge to this lawsuit was promulgated by the Department of Labor --

THE COURT: You might not know it by the executive order that gave rise to this rule change either, which talks frequently about the Affordable Care Act, and I think only mentions ERISA in directing the Secretary of Labor to consider the very rule changes that now have been enacted by the Secretary of Labor.

That's the only place that is a reference to ERISA, is a reference to the specific definition of "employer." Everything else in that executive order is talking about the Affordable Care Act and wanting to make these changes because of concerns with respect to the Affordable Care Act. So I don't see how we can divorce this from the Affordable Care Act.

MR. ROSENBERG: I'm not advocating that we --

THE COURT: That is what is driving this.

MR. ROSENBERG: No, I'm not advocating that we divorce the analysis from the Affordable Care Act, but I think that there are actually four steps that this court should consider in evaluating whether or not the rule is lawful.

The first step is to consider whether or not the rule as promulgated is in conflict with the ERISA statute itself, and plaintiffs in their arguments have set forth several broadside arguments against the rule. We don't think any of them have merit based on the definition of "employer" under Section 3(5).

The second aspect of analysis that the Court would need to conduct is what effect, if any, does the Affordable Care Act have on the question of whether or not this rule is lawful under ERISA. In other words, even if this court were to decide that this rule is lawful under ERISA, is there anything in the ACA that would change this court's mind and thus make it unlawful? And as I'll speak to in a few minutes, there's nothing at all unlawful about this rule in the context of the ACA. In fact,

the ACA explicitly cross-references ERISA's definition of "employer" as well as "employee" --

THE COURT: It doesn't just cross-reference it. It adopts it.

MR. ROSENBERG: Yes. Exactly.

THE COURT: Except that it changes it a little bit with respect to "employer" because it adds on an "except" clause.

MR. ROSENBERG: It does change it a little bit, and as I'll get to when I address working owners, Your Honor, that argument -- then that modification actually supports our argument on working owners.

And so the third aspect of the analysis -- the third analysis that the Court has to conduct relates to the three specific provisions that are within the rule, and those three specific provisions are the purpose of providing health insurance benefits, the geography requirement as an alternative basis for commonality, and the -- you know -- and the working owner provision. Has to decide whether those are lawful or unlawful.

And then the last step is whether or not the rule's arbitrary and capricious, and much of the arbitrary and capricious analysis, we would submit, is straightforward because the rule carefully considered comments that were submitted to the agency. Now --

THE COURT: So does the Department of Labor get

deference here? Your briefs ask for *Chevron* deference. How can I give *Chevron* deference to the Department of Labor when the specific purpose, coming first from the executive order and then traceable through the rule, is to change things for the Affordable Care Act? How can I give deference to the Department of Labor in its interpretation of these provisions of ERISA? Isn't this just like the *King v. Burwell* case?

MR. ROSENBERG: No, it's not, Your Honor, for a couple of reasons. And I'm going to take issue with the premise that's baked into your question, and it really infects much of plaintiffs' argument on this point that the rule does something to change the Affordable Care Act, and plaintiffs have repeatedly made the statement that the rule attempts to rework the markets and the way that those markets function under the ACA. The rule does nothing of the kind.

Post rule, small market still exists --

THE COURT: Doesn't the rule -- isn't one of the intents and purposes of the rule to -- by expanding access to these AHPs, isn't the intent to permit small businesses particularly, individuals secondarily, to avoid some of the requirements of the Affordable Care Act? That's the intent of this rule, isn't it?

MR. ROSENBERG: No.

THE COURT: Even though the President said, and I quote, "Expanding access to AHPs will also allow more small

businesses to avoid many of the Affordable Care Act's costly requirements." That's what the President said in directing you to do this.

MR. ROSENBERG: The President also said in the executive order in paragraph 1 --

THE COURT: Well, just stick with that which the President said, and then you can go on to what else he said. So why isn't that true?

MR. ROSENBERG: A small business need not necessarily -- a small business could make the decision not to provide health benefits, and individuals could still choose, even in the presence of an AHP that might provide access to a large-group market, to purchase health insurance benefits on the small-group market and have all of the essential health kind of benefits and community rating standards that are available in that market.

And those markets themselves don't change. The reason that there are regulations that are specific to the small-group market is not because of the individuals that participated in that market; it's because of the nature of the market itself.

THE COURT: But the intent of the rule is that there will be fewer entities and individuals in the individual market and the small-employer market. They will move to large-employer through the AHP process. Isn't that the intent of the rule?

MR. ROSENBERG: I would frame it a little bit differently, Your Honor. The intent of the rule is to provide

access to individuals who are currently stuck in a small-group or individual market to a large-group market.

THE COURT: Okay. The intent it to provide access which they will then undertake.

MR. ROSENBERG: Well, if --

THE COURT: If they provide access but nothing's going to happen, that's not what the rule is hoping for.

MR. ROSENBERG: Well, the rule contemplates that many people will make the decision to participate in an AHP and therefore have access to a large-group market. It doesn't mean that everybody will do that. People will have the choice about whether or not they want to do that --

THE COURT: -- the case that everyone would do that. I agree with that.

MR. ROSENBERG: Exactly. And the point of the rule is that it provides people with access to the different markets. And, notably, the ACA does not purport to favor one market over another. They're just different.

The large-group market has fewer requirements on it because, historically, it's functioned and operated in a different way than the small-group market. Nothing in the rule changes any of that. All that the rule does is provide people with more opportunities to access those different markets.

And in terms of the interrelationship between the ACA and the Department of Labor's rule here, the ACA itself, as the

Court has noted, cross-references ERISA's definition of "employer." And that's critical because it indicates that these two statutory schemes are meant to work together.

THE COURT: So why wouldn't you be reading out that additional reference to the definition of "employer" in the ACA that "employer," referencing ERISA, has the meaning given to the term under 3(5) of ERISA except that such term shall include only employers of two or more employees? You say that supports your working owner argument. How so?

MR. ROSENBERG: Yeah. I can step through the working owner argument. I'm jumping a little bit ahead, but I'm happy to do that. I think the starting point of the analysis, there really -- one threshold issue that I think everybody here has to agree upon is that ERISA's definition of "employer" under Section 3(5) includes associations. That's clear as -- whatever else can be said about --

THE COURT: There's no question about that --

MR. ROSENBERG: That's crystal clear.

THE COURT: -- everybody agrees.

MR. ROSENBERG: And so the ACA's cross-reference to ERISA has to also include associations. Now --

THE COURT: And I haven't seen anything in the briefing or the argument that would disagree with that.

MR. ROSENBERG: Okay. So now the starting point for the Court's analysis should be the Supreme Court's decision in

Yates. *Yates* held that, under ERISA, a working owner can have dual status. They can be both an employer and an employee.

THE COURT: Or a participant.

MR. ROSENBERG: Yes. Well, dual status. For purposes of ERISA, an employee is a participant.

THE COURT: Right.

MR. ROSENBERG: Now, plaintiffs have relied upon some of the language in *Yates* to argue that the Supreme Court's holding is not quite as broad as I've just described it, but in making their argument, that omit relevant language and mischaracterize the nature of the Supreme Court's analysis.

So in plaintiffs' brief, they say the Supreme Court stated the plans to cover only sole owners or partners and their spouses, ellipsis, fall outside of ERISA Title I domain. But what was omitted from the ellipsis are the three words "the regulation instructs." So the language that plaintiffs rely upon is not the holding in *Yates*. It's just a statement of then-current ERISA regulations.

THE COURT: But the holding in *Yates* doesn't get you anywhere. Just because an owner can be an employee, i.e., dual, a participant, that doesn't answer any question for you, really. And why isn't *Yates* really best read as follows: that ERISA deals with employment relationships. Right? I think we can all agree with that. So working owners, without any employees, aren't covered by ERISA at all, are they?

If you have a working owner who has no employees, how is that -- how is there any employment relationship that makes that covered by ERISA at all? And if a working owner does have employees, which was the fact situation in *Yates* and was pointed out by the Supreme Court, so if you have a working owner that does have employees, that working owner can be both an owner and an employee/participant in the plan; and that seems to make perfect sense, and that seems to be what *Yates* is saying.

MR. ROSENBERG: So I think that there's a gap that I'd like to fill in that analysis, because I don't think that we're all that far apart here, Judge Bates. But I think the first step in filling that gap is to look at what the regulation that is cited in *Yates* and in all of the decisions the plaintiffs have relied upon says, and that regulation is at 29 C.F.R. 2510.3-3(b), and essentially it says an employee benefit plan excludes plans that cover only sole owners or partners.

So now going back to the Court's example, you have a working owner and does ERISA apply to the working owner, really the question is, does ERISA apply to a plan that the working owner is providing to himself? And the answer to that question is -- on that question alone is, no, because it falls outside the scope of the regulation. And indeed --

THE COURT: And outside of the scope of the statute.

MR. ROSENBERG: And you have to look at the purpose of the statute, because the purpose of ERISA is to protect

employees from --

THE COURT: Relationship. The employer-employee relationship.

MR. ROSENBERG: The relationship, and it protects against issues like self-dealing, for example, or imprudent investment or misappropriation. And if somebody is offering only themselves a plan, they're presumably not going to engage in those practices against themselves. So that's why that individual falls outside the scope of -- that plan offered only to that individual falls outside the scope of ERISA.

But let's take a step back and look at the definitional cross-reference again, because as the Court is aware, the ACA's reference includes associations, and associations, therefore, act as the employer for purposes of ERISA.

And this, by the way -- and I'll speak to this in more detail in a few moments. This has nothing to do with the rule that's been promulgated here. Under Pathway 1, there have been associations that have acted as employers for a very long time, and one can look at the *American Council of* --

THE COURT: But heretofore not with working owners who have no employees being those employers within an association.

MR. ROSENBERG: Right. But here's why -- and that's a change of the rule. But here's why that's consistent with *Yates*, with the ERISA statute, with the regulation, and indeed with all of the cases that plaintiffs have cited here. Because

if the association is the employer, which we know it to be from the statutory definition as well as all of the precedent under Pathway 1, that regulation still applies to the employer.

THE COURT: But if the working owner without any employees is not an employer, then the association language gets you nowhere because the language is "includes a group or association of employers." And if a working owner is not an employer...

MR. ROSENBERG: But that's where the working owner, according to *Yates*, can wear the two hats. The Court has to resolve whether that working owner -- for example, perhaps that working owner is a court reporter. Maybe the court reporter is a solo proprietor.

THE COURT: The owner wears the two hats if it's a working owner who has employees.

MR. ROSENBERG: But what the Supreme Court held in *Yates* is that that working owner -- well, let me back up. I think what the Court is asking about is again the regulation which says that you have to have an employee other than the working owner. Am I understanding the Court -- the premise of the Court's question correctly?

THE COURT: Mm-hmm.

MR. ROSENBERG: And if that's the case, that analysis applies to the association, because the association is the employer for purposes of the ACA's cross-reference.

Now, the association may have many working owner employees who are pooling their resources and taking advantage of the health benefits that the association could provide, and they are still employers, because as the Supreme Court noted in *Yates*, those individuals can have two hats. And the regulation takes -- that would normally take those individuals outside the scope of ERISA doesn't apply to those individuals because they're not at the plan level. The plan is being offered by the association.

And so with that analysis, that squares everything regarding working owners into one very neat package. The ACA includes the cross-reference, indicates that you have to have an individual other than the employer. That would apply to the association. In other words, you can't have an association of one. The association can have -- as long as the association has at least two individuals to whom it is providing benefits, be it individuals, be it small companies, it doesn't matter.

The regulation would apply to that association to prevent the association from engaging in any sort of self-dealing or improper practices, and those individuals can participate in the health plan offered by the association because they can wear the two hats as noted by the Supreme Court in *Yates*. And notably, when you take a step back --

THE COURT: So if we combine the language of 3(5) and the language in the Affordable Care Act with respect to

employer, we have the following definition. The term "employer" means any person acting directly as an employer, except that that term "employer" does not include employers of less than two or more employees, or indirectly in the interest of an employer, modified by the ACA language, and includes an association of employers, modified by the ACA language.

And I don't see how you get to your -- to the new working owner inclusion that you say *Yates* supports given that statutory language in the combination of ERISA and the Affordable Care Act.

MR. ROSENBERG: So looking at Section 3(5), says the term employer means -- and I'm going to take out the irrelevant language. "The term 'employer' means any person acting indirectly in the interest of an employer including an association of employers acting for an employer in such capacity." So that --

THE COURT: And every time that term "employer" is used, it has an except that the term shall include only employers of two or more people by virtue of the Affordable Care Act language.

MR. ROSENBERG: Right. But the Affordable Care Act language references two or more -- if the employer is the association, that means that the employer has to have two or more people. It doesn't mean that the individuals to whom the association provides benefits have to themselves have employees of two or more.

THE COURT: Well, we'll see. I'll look at the language closely.

MR. ROSENBERG: Okay. That's all we can ask, Your Honor. Let me take a step back. So we've addressed working owners, but I think the threshold question for this court is whether or not -- whether or not the rule as promulgated is contrary to ERISA.

THE COURT: What about the fact that the rule is coming up with an interpretation that only applies in part of ERISA and doesn't -- it's an interpretation of a statutory term and saying that the statutory term in this one aspect of ERISA will mean such-and-such, but it doesn't change its meaning in other aspects of ERISA. Do you agree that that's true or not?

MR. ROSENBERG: I'm not sure I understand the premise of the question. In what way --

THE COURT: I thought the final rule was intended to change -- to give an interpretation with respect to "employer" -- let's just simplify it that way -- but only with respect to certain parts of ERISA, not with respect to all parts of ERISA.

MR. ROSENBERG: It gives --

THE COURT: But the definition, the statutory definition, is for all parts of ERISA.

MR. ROSENBERG: Yes. But I think what --

THE COURT: And this rule has said, okay, there's a statutory definition for all parts of ERISA, but we're going to

interpret that to mean such-and-such for this one part of ERISA.

MR. ROSENBERG: And is the one part of ERISA the associations? Is that -- I guess that's where I'm a little bit confused as to the Court's question. I mean, obviously, the final rule is limited to defining --

THE COURT: I thought it only applied for certain kinds of plans, not for other kinds of plans.

MR. ROSENBERG: Well, it applies for association health plans, but my understanding --

THE COURT: Association health plans.

MR. ROSENBERG: Yes.

THE COURT: But does it apply -- does this rule come up with an interpretation that applies for other welfare or benefit plans covered by ERISA?

MR. ROSENBERG: My understanding is that the Department of Labor is actually in the process of --

THE COURT: Oh, but it hasn't done it yet.

MR. ROSENBERG: Not yet, but --

THE COURT: It's done its reinterpretation of the statute only for a portion of the statute.

MR. ROSENBERG: Well, I think "aspect of the statute" is a better way to frame it than "portion" because --

THE COURT: Okay.

MR. ROSENBERG: -- different aspects of the statute have different purposes and goals. And so the Department of

Labor identified --

THE COURT: Can you cite some case law that supports, within a single statute, a statutory term having different meanings?

MR. ROSENBERG: Well, I can cite for the Court the fact that the definition --

THE COURT: I asked for cases, but go ahead.

MR. ROSENBERG: Well, I can do better than cases, Your Honor. The definition of "employer" itself -- statutory definition of "employer" varies depending upon --

THE COURT: But that's not what we have here. We have a definition of employer for purposes of ERISA that is being interpreted one way for a particular part of ERISA but not for other parts of ERISA, at least today. Can you tell me what cases would support a statutory term having different meaning within that statute?

MR. ROSENBERG: I don't have a case that I could cite to you standing here now --

THE COURT: Doesn't that seem at odds with normal principles of statutory interpretation?

MR. ROSENBERG: No.

THE COURT: No?

MR. ROSENBERG: No.

THE COURT: Why not?

MR. ROSENBERG: Because, as I started to discuss,

different aspects of ERISA, be it health plans or employee benefit plans, have different requirements, different purposes, different goals. You don't have questions or concern -- there's some common concerns that are going to arise, obviously, with issues of self-dealing that might occur across all sorts of different plans, but there are also unique aspects of different types of plans that the Department of Labor has to address.

And so I don't think -- there is nothing improper about tailoring a definition to a particular need within an aspect of a statutory scheme that an agency is regulating, nor do I necessarily know that there would be any inconsistency between the definition of "employer" as being used in the final rule here versus any final rule that the Department is in the process of promulgating for purposes of benefit plans.

And, indeed, it might even be the case that there would never be an inconsistency because the terms themselves might be used in fundamentally different ways depending on where in the statutory scheme those terms are being applied. And if it were the case otherwise that an agency had to apply the term consistently, regardless of the actual nature of the problem the agency is addressing, it wouldn't be able to --

THE COURT: But you can cite me to no case that would support the proposition that an agency can give a statutory term different meaning in different parts of the statute.

MR. ROSENBERG: I don't have a case standing here

today, but I think there's a fundamental flaw in -- baked into the premise of the question, which is when the Court uses the word "different meaning," it's not necessarily that the terms as used in different aspects of a statutory scheme have conflicting meanings; it's that the terms are applied to the circumstances that the agency is addressing in the context of a particular rule.

THE COURT: Well, let's step back and say, whether you use the term "meaning" or "interpretation," for years and years ERISA has given a certain interpretation to these statutory terms. It is now changing that interpretation for one aspect of the statute.

MR. ROSENBERG: Well, I don't think that's -- I don't think that's an accurate characterization of what --

THE COURT: Well, then the final rule doesn't do anything --

MR. ROSENBERG: No, the --

THE COURT: Don't interrupt, please.

MR. ROSENBERG: Sorry.

THE COURT: If it doesn't change things, then why have the final rule? It certainly is changing things for that one particular application within the statute.

MR. ROSENBERG: And my apologies, Judge Bates, for interrupting. What I'm trying to say is that prior to this rule, there was no rule to compare the final rule against. All

that there was was subregulatory guidance, the equivalent of --

THE COURT: That's fine. But that's what the agency was -- how the agency was interpreting the statutory term. Now it's interpreting it in one aspect, as you put it, of the statute differently.

MR. ROSENBERG: The subregulatory guidance applies, though, to the same aspect. The subregulatory guidance regarding association health plans applied only to association health plans.

THE COURT: Well, do you know whether there was any inconsistent subregulatory guidance, then, with respect to other aspects of the statute for other welfare and benefit plans?

MR. ROSENBERG: I am not aware of any. I cannot cite any. And the nature --

THE COURT: I mean, there is general law that says a statutory term should have the same meaning throughout the statute. There is general law that supports that proposition, and you're able to point me to no case that would be inconsistent with that.

MR. ROSENBERG: Well, I actually can point you to a case. I don't have it right at my fingertips, Your Honor, but I know that we cited a case in our briefs that says that that general proposition yields when circumstances warrant. And I'm not sure that it necessarily even needs to --

THE COURT: And you support that with an authoritative

case?

MR. ROSENBERG: I know that we did cite a case for that in our briefs, and if you give me just one moment, I might be able to --

THE COURT: Well, I can find it. If it's in your brief, I can find it.

MR. ROSENBERG: No, it is in our briefs. Give me just one moment, Your Honor. Obviously, we cited *Ferring Pharmaceuticals, Inc.* and *Brand X* for the proposition that an initial agency's interpretations are not carved in stone.

THE COURT: That a different proposition. That just says the agency can change the uniform interpretation throughout the statute.

MR. ROSENBERG: Yes. So in our opening brief, on page 43, we cited *Helvering v. Stockholms,* 293 U.S. 84, for the proposition that, although there is a presumption that identical words used in different parts of the same act are intended to have the same meaning, the presumption readily yields if the circumstances demonstrate that the words were used with different intent.

THE COURT: And do you have something that would demonstrate that Congress used the term with different intent throughout ERISA?

MR. ROSENBERG: Well, I don't think that there necessarily --

THE COURT: It's not the Department of Labor's intent that that quotation is talking about. It's Congress's intent. Do you have something that demonstrates that Congress was using the term "employer" as it's defined in ERISA with a different meaning for different parts of ERISA? I doubt that you have that, but let's move on.

MR. ROSENBERG: Okay. But I don't have a case at hand, Your Honor, but I think the question for the Court -- and the relevant question for the Court is, in light of the definition of "employer" under ERISA, is this rule unlawful under that statute?

And many of the arguments that plaintiffs have made, going back to the harms that they allege will take place on the healthcare markets and the way the healthcare markets will be modified -- as we've discussed, it doesn't modify those markets in any way -- but many of those issues have existed for a long time under Pathway 1. The rule -- all that rule 2 does is change, in measured ways --

THE COURT: An additional pathway to AHPs.

MR. ROSENBERG: Yeah. Additional pathway while preserving the initial pathway. Now, one of the key issues going to the question of how does the ACA impact the Court's analysis and how do the two statutes play together, plaintiffs have made arguments that the ACA, I think in their view, is set in stone, that it's a statutory scheme with certain requirements.

But the issue that the Court has to grill in on is how does the definition of "employer" interact with those requirements? And I'd point -- and this is very important, Your Honor. I'd point the Court specifically to CMS guidance, in a final rule that it issued in 2011. And this was cited in our briefs as well, but I'll give the Court the cites again.

In the administrative record on page 2211, there was a CMS guidance document that was issued that acknowledged situations in which association coverage is considered to be a single group health plan. And we know that's the case because there are organizations like the American Council of Engineering Companies that have been association health plans under Pathway 1 for a long time.

So it's already the case, it has been the case, and will continue to be the case that associations provide health benefits on a group basis, allowing those individuals participating in those health plans to participate in the large-group market, where but for that Pathway 1 association, they would be in the small-group market. So that doesn't change. The rule doesn't do anything to modify that. All the rule does is modify some of the standards to determine whether or not an association can in fact be an association.

But just as important in that guidance document is some language from CMS reflecting their belief -- and plaintiffs have harped on this a bit, but reflecting CMS's belief, and CMS uses

that word, "belief" -- that there aren't many association health plans that would meet, you know, what was then the Pathway 1 standard, although it was not known as Pathway 1 because it was the only pathway.

Now, the reason a lot of the associations may not be able to meet the Pathway 1 standard is because of the control test, which, by the way, as the Court noted, still exists in Pathway 2. There is still a check on associations. But what that guidance document tells us is that CMS, in 2011, in the past administration, was deferring to the Department of Labor on how to interpret whether or not an association is providing benefits at group level.

But if that's not clear enough, five days later, CMS issued a final rule, and in the preamble to the final rule, it restated these terms in even more explicit language. And the final rule is available at -- I'm going to give the Court the pinpoint cite -- 76 Federal Register 54971. And in the final rule, in the preamble, CMS noted that if an association is in fact sponsoring a group health plan subject to ERISA, the association health coverage should be considered to be one group health plan.

Everything that plaintiffs have argued about, virtually everything in this case, would undercut the ability of associations under Pathway 1 to be able to count their members on a group basis. But more to the point, in that final rule, CMS specifically deferred to the Department of Labor on whether

or not an association operates at the group level.

And I'm going to quote language from that Federal Register preamble: CMS acknowledged that DOL has jurisdiction over ERISA group health plans and for private sector entities the determination of whether the group health plan exists at the association level or the employer level is made under ERISA.

So what does that tell us? That tells us that it has long been the practice not only of DOL but also of CMS -- not under only this administration, but under the prior administration -- to look to the Department of Labor and to ERISA to determine whether or not an association health plan operates at a group level.

Again, the final rule doesn't do anything to change the interplay between those two statutes, just as the final rule doesn't do anything to define the markets that exist under the ACA. In fact, by cross-referencing ERISA's definition of "employer," Congress acknowledged implicitly, if not explicitly, that it is the role for the Department of Labor to define whether or not an association health plan exists, and that's why this is really --

THE COURT: Why did Congress go to the trouble of cross-referencing the definitional section of ERISA but changing it by adding on this "except that such term shall include only employers of two or more employees"? Why did Congress go to that trouble?

MR. ROSENBERG: Well, we think that, as going back to the working owner issue, would prevent an association of one from existing. It would prevent -- let's say that John Bates is an individual proprietor and -- no. As an individual proprietor, he can't participate in any market other than the individual market under the ACA. But John Bates could presumably create an association of John Bates and then --

THE COURT: Of John Bateses, you mean?

MR. ROSENBERG: John Bates Association. And the John Bates Association consists only of John Bates. So the John Bates Association now is out of the individual market and is in the group market because it's an association, except that can't be the case.

THE COURT: Are you really advocating that that can be the case?

MR. ROSENBERG: No. That can't be the case, and that's the point of the language. It prevents the John Bates Association that consists only of John Bates. That association has to have another member. It can't be an association of one. And that gives --

THE COURT: But it can be Judge Bates and Brad Rosenberg, both individual proprietors, forming an association and becoming thereby, under the final rule, an AHP that is in the large market. Correct?

MR. ROSENBERG: If they meet all of the other elements

of the Pathway 2 test.

THE COURT: Assume that they meet those other elements.

MR. ROSENBERG: Yes. That is correct.

THE COURT: Just because we are here in the Metropolitan Washington area and you have a proprietorship that provides software help by fixing individuals' computers, and I have a liquor store that I own and operate myself.

MR. ROSENBERG: Well, I'm not sure that we would -- well, I'm not sure that we would necessarily meet that test because we'd still need to meet the control requirement, and our association would have to have a substantial business purpose other than the provision of healthcare benefits. So something would need to be identified, consistent with ERISA, that provides that business purpose.

And the elegance of that interpretation, Judge Bates, is that the ERISA regulation that we discussed earlier would apply to prevent Brad Rosenberg, who might be running the plan, from self-dealing, thus harming John Bates. I would never do that, of course.

But that's why that regulation exists. And that regulation need not exist if it's just the John Bates Association of John Bates, but that's also precluded by the statute. So the statute, the regulation, *Yates*, and all of the cases that plaintiffs cited regarding working owners can all be raised consistently with that interpretation of the statute.

THE COURT: All right. You need to wrap it up in the next two or three minutes.

MR. ROSENBERG: Two or three minutes. Well, I would defer to the Court if it has any particular questions.

I think in addressing the substantial business purpose, under the rule as well as geography, we think that both of those are consistent with the ERISA statutory scheme, but for both of those aspects of the rule, which, again, are measured changes to the rule that don't affect in any way the interplay between the ACA and ERISA, while the Department modified and arguably loosened some of those standards in some aspects, in other aspects it added new restrictions such as the nondiscrimination provisions in order to ensure that the final rule was consistent with ERISA's purposes and -- in order to ensure the final rule was consistent with ERISA's purposes.

And by the way, just to be clear, the John Bates and Brad Rosenberg Association, if it were to ever come into existence, would not be in the large market, obviously. It would be in the small market because there would only be two of us. But perhaps if we could band all the people in the courtroom together, it would be in the large market.

THE COURT: With your persuasive advocacy, you'd be able to do that, I'm sure.

(Laughter.)

MR. ROSENBERG: I try my best, Your Honor.

Finally, just on arbitrary and capricious -- actually, one note that my colleague passed, going back to an issue that the Court raised regarding the application of the definition of employer, in October the Department of Labor did issue a proposed rule to bring pension plans in line with the AHP rule for the definition of "employer," and if the Court would like additional briefing on that, we'd be happy to submit it.

Finally, I'd just like to note --

THE COURT: Unless there's some concern raised by your adversaries, I'll accept your representation on that.

MR. ROSENBERG: Finally, I'd just like to briefly address the arbitrary and capricious. I think the Court could look to the preamble to the rule itself to understand that this is not an arbitrary and capricious rule. The Department of Labor considered many aspects in evaluating the rule. It was responsive to the many comments it had received. It acknowledged that there would be --

THE COURT: Do you agree -- and I'll change it slightly. In the -- too many papers up here now, but I mentioned to Mr. Grieco that there was this reference in the AMA brief that not a single group representing patients, physicians, nurses, or hospitals voiced support for the proposed rule. Let's say -- well, is that true from your reading of the proposed rule?

MR. ROSENBERG: Court's indulgence for just one moment?

THE COURT: Sure.

(Counsel conferring.)

MR. ROSENBERG: I'm not in a position to make a clear representation on that. I will note that there were many, many individuals in other organizations that wrote in, some in favor of the rule --

THE COURT: In favor of the rule, and probably predominantly small businesses.

MR. ROSENBERG: Chambers of commerce --

THE COURT: Chambers of commerce representing small businesses, certainly.

MR. ROSENBERG: All of whom would be affected and impacted by the rule perhaps in different ways but no less substantial ways --

THE COURT: Sure.

MR. ROSENBERG: -- than medical organizations.

THE COURT: I'm not faulting that. The reason for my question is to ask this: Does the preamble to the proposed rule and the discussion and the comments ever point out that it was overwhelmingly -- I'll modify the language that the AMA used -- "overwhelmingly opposed" by all the medical universe -- patients, physicians, nurses, or hospitals -- does it ever point that out?

MR. ROSENBERG: I believe that the preamble acknowledges that there were comments that were submitted in opposition.

THE COURT: Oh, there's no question that there is occasional acknowledgement of comments in opposition. But does it ever point out that it was "overwhelmingly opposed" by those parts of the healthcare universe?

MR. ROSENBERG: I don't know that it does, Judge Bates, and I'm not sure that that's necessarily relevant to the question of whether or not it's arbitrary and capricious, because whatever those comments may have been, the question is how does the agency respond to those comments.

THE COURT: And you would agree, or would you not agree, that the purpose of the rule is to undercut provisions of the Affordable Care Act, to change the Affordable Care Act's application?

MR. ROSENBERG: Absolutely not. I would not agree with that.

THE COURT: If not, then why did the Secretary of Labor, when the rule was promulgated, do an opinion piece -- in *The Wall Street Journal*, I think it was -- saying that "Obamacare is the problem. That's why the Trump administration is expanding access to affordable health plans, or AHPs, beginning Tuesday. Obamacare is a backwards statute, and Obamacare's problems can't all be fixed through regulatory changes. But expanding AHPs is an example of such action, and it will help."

Why did he say that if the purpose of the rule that he

was in charge of promulgating wasn't to change Obamacare? How can you say it wasn't when he says it was?

MR. ROSENBERG: So perhaps let me end on this, because I think it's really -- the Court has identified one of the key disputes between the parties. And it involves -- it involves the fundamental nature of what a statute is.

Plaintiffs in this lawsuit, and, admittedly, many people view the ACA as having a particular -- a particular nature, that it does things based on what's in the statutory language. Indeed, that's why some people, not just the Secretary of Labor, but others have called it "Obamacare." They have personalized the statute, in a way. But the statute is what it is. It is a set of provisions that apply to markets and have statutory goals, and also, those statutory provisions cross-reference other statutes such as the Internal Revenue Code and such as ERISA.

Different people can have reasonable views on how best to achieve the ACA's goal. One of the ACA's goals and one of the issues that the Department of Labor has tried to address is the fact that, even years after the ACA was enacted, there are still fundamental flaws in the individual and small-group markets that years of experience have shown that the ACA has not been able to address.

This rule, the Department of Labor believes, will help to solve some of those flaws with the ACA by allowing individuals

and small groups better access to health insurance that they don't currently have access to. And going back to the executive order that the President issued, that executive order is entirely consistent with that goal. One can be critical of what the statute has achieved, and that criticism in fact can spur an agency to try to solve some of the problems with that statute that have continued to exist, and that's what's happened here.

THE COURT: That's true, but it leads me to the following observation; and you can comment on it if you wish, and that will be your last comment. In your briefing, there's a frequent reference to, this is a policy dispute between the states and the administration, the administration acting through this final rule. That's said with some frequency.

It seems to me that the policy dispute is really between Congress, in enacting the Affordable Care Act, and the administration in now taking steps, like this step, to change in some ways the application of the Affordable Care Act. That seems to me to be the policy dispute. Seems to be a current Executive dispute with a former Congress in enacting the Affordable Care Act much more than it is a policy dispute between the states and the current administration. That's an observation on my part, and you can comment on it if you wish.

MR. ROSENBERG: And my observation, Judge Bates, is that there's nothing inconsistent between the rule and the statutory scheme. And, indeed, the President's executive order,

in the very first sentence, notes that these actions can be taken to the extent consistent with law.

Now, ultimately, that's a question, whether this is consistent with law, that this Court will of course resolve, but we would argue that because of the interplay between these statutes, and because of the fact that most of plaintiffs' arguments really would apply equally to association health plans that have long existed even before this rule, there really is no conflict. This is the Department of Labor trying to resolve a market failure post-ACA in a manner that takes advantage of the flexibility that's built into the ACA through its cross-reference to ERISA.

THE COURT: Thank you very much, Mr. Rosenberg.

Mr. Grieco, five minutes.

MR. GRIECO: Thank you, I'll be brief. I'll begin where you ended and agree with the closing observation that you made that the states stand here doing no more than defending the policy that Congress has chosen, and the policy disputed in this case is indeed between the administration and the congress that enacted the Affordable Care Act.

And, furthermore, you don't have to look past the text and structure of the ACA to come to that conclusion. The centrality of the market size definitions, the great attention that Congress gave to defining down to a specific number who goes into which market, and the direct connection between stronger requirements

including essential health benefits as well as others that apply only to the small-group market demonstrates that without any recourse to legislative history or politics or anything else, that Congress made a specific policy choice that Labor is now trying to contradict.

THE COURT: Aren't there problems with how the Affordable Care Act is operating in certain markets?

MR. GRIECO: So if --

THE COURT: And I'm not going to ask you to identify what they are, but would you agree that there's some improvements that could be made to the Affordable Care Act?

MR. GRIECO: Every statute has operational challenges that arise as years go by.

THE COURT: And this is among the most complicated statutes. Can't the administration take some steps, even without Congress having to do it, to make some improvements? Didn't the Obama administration indeed take some steps to improve the operation of the Affordable Care Act without going through Congress to change the statute?

MR. GRIECO: Your Honor, it's absolutely the role of administrative agencies to further the operation of statutes and to, to some extent, deal with unforeseen eventualities. What an agency may not do is adopt a regulation that is actually contrary to the statute.

I do want to address my counterpart's observation that

the large-group markets and the small-group markets are just different, and the administration is doing nothing more than moving a few people out of one basket and into another. Two points on that.

First of all, a lot of people who are covered by AHPs aren't even going to be getting the protections of the large-group markets because the employer mandate is not going to apply. So the suggestion that the agency is doing no more than a reallocation is not true. It is pulling some people entirely out of the statute's protections.

Secondly, they are more than merely different. Because Congress has spoken with such specificity to the protections that go to each individual category of market, it is contrary to law for the rule to move people in a way that violates the large employer/small employer definition.

I also want to address my counterpart's observation that the statute brings in the word "employer" from ERISA. I would ask the Court to bear in mind that it didn't just incorp -- that "employer" is not the only term from ERISA that the statute brought in. It brought in the word "employees" as well. And that is the word that appears in the -- along with "employer" in the market size definitions.

And that is the word that the Supreme Court in *Nationwide Insurance Company v. Darden* and DOL itself in the past, in the 2013 MEWA manual, has given a much narrower reading. And to

reiterate, that because of that textual conflict, everything else that we've discussed during this merits stage of today's argument could be decided in DOL's favor, and the rule would still need to be set aside because of that context of the Affordable Care Act.

I would also want to address my counterpart's observation that they're only changing an aspect of ERISA. The aspect that they're referring to is actually not in ERISA. It's in the Affordable Care Act. They are challenging one aspect of a different statute.

And my counterpart's observation that -- attempts to make this case not about the Affordable Care Act, even if that were an accurate observation, it would be a reason to set aside the rule, not a reason to uphold it, because DOL has acted both contrary to law and in an arbitrary and capricious fashion by issuing a rule that on its face talks about ERISA, and then in a preamble, purports to address -- to limit that rule only to one specific part of another statute that is much more specific and was adopted 40 years later.

Unless the Court has further questions, I would close there.

THE COURT: Thank you, Mr. Grieco, and thank you all for your arguments today and for the briefing. It's most helpful. But there's a lot to go through, and I'll be going through it for more than another day. I will try to get this out as quickly as I can.

But let me ask a question. Is there a timeline that's important here? Does the April 1st date mean something? I mean, to some extent, some dates have already passed. What should I be bearing in mind in terms of any urgency to a decision?

MR. GRIECO: So, from our perspective, a couple of things. One is, my understanding is that, notwithstanding the government shutdown, that the Department of Labor has funding for some time.

THE COURT: They do. That is correct.

MR. GRIECO: And, therefore, this will continue to be implemented apace unless the Court sets it aside. And so -- and as the final rule recognizes, the -- and as Your Honor alluded to earlier, the danger level ramps up with each new successive date that we hit in the implementation phase, culminating in the April 1st with the new self-insured AHPs, which DOL itself has contended will be the primary abuser.

So the closer we get to that date, the more and more that state agencies are going to have to start spending money, and as I explained earlier, those expenditures have already begun to occur. But it will only increase, and if we actually pass the April 1st date and the rule is still in effect, I think it would get even more intense because the states will have to --

THE COURT: So as of April 2nd, new AHPs, self-insured or self-funded, can be created and be --

MR. GRIECO: They can start operating. I'm assuming that there are already people starting to develop such AHPs, and obviously there's an amicus brief that was filed in this case by people who'd want to --

THE COURT: Can start operating and -- there's no time schedule for health plans' operations that is relevant here?

MR. GRIECO: I don't know -- I mean, different states may have different rules about when --

THE COURT: What a term year is.

MR. GRIECO: Right. Exactly. That could vary from state to state. So the bottom line, though, is -- and this goes back to my very first argument on standing -- that the harm -- the biggest harm to the states for now is happening on the front end because of the need to police.

Again, I would go back to the superintendent's declaration from New York that what the states are principally worried about right now is new AHPs forming that aren't going to be valid under state law, but making sure that they don't come into the state is going to require expenditure of revenue. And the sooner that the rule can be set aside and the states know that they don't have to worry about a glut of new AHPs --

THE COURT: Expenditure of revenues or loss of revenues.

MR. GRIECO: Right. Right. Or -- yes. So in terms of there being a specific deadline, we would simply say as quickly as Your Honor feels is practicable, bearing in mind that

DOL has the funding to continue implementing this rule, and so it would presumably keep going at the current rate.

THE COURT: Thank you, Mr. Grieco.

Mr. Rosenberg or Ms. Cheung, did you want to say anything on that particular point?

MR. ROSENBERG: Judge Bates, I don't think that from the government's perspective there's a particular urgency. Obviously, we would appreciate a decision sooner rather than later, because my understanding is that there are AHPs that are in the process of performing. So the sooner the Court --

THE COURT: All right. Thank you. And, again, thanks to all for the quality of the briefing and the arguments, and the matter is under consideration. Thank you.

(Proceedings adjourned at 12:01 p.m.)

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CERTIFICATE

I, BRYAN A. WAYNE, Official Court Reporter, certify that the foregoing pages are a correct, verbatim transcript from the record of proceedings in the above-entitled matter.

Bryan A. Wayne
BRYAN A. WAYNE