[NOT YET SCHEDULED FOR ORAL ARGUMENT]

No. 19-5125

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

STATE OF NEW YORK, *et al.*,

Plaintiffs-Appellants,

v.

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

Defendants-Appellees.

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

FINAL REPLY BRIEF FOR APPELLANTS

Of Counsel:

KATE S. O'SCANNLAIN
Solicitor of Labor

G. WILLIAM SCOTT
Associate Solicitor

THOMAS TSO
MELISSA MOORE
ISIDRO MARISCAL
Attorneys
Office of the Solicitor
U.S. Department of Labor

JOSEPH H. HUNT
Assistant Attorney General

HASHIM M. MOOPPAN
Deputy Assistant Attorney General

MARK B. STERN
MICHAEL S. RAAB
MICHAEL SHIH
JENNIFER L. UTRECHT
Attorneys, Appellate Staff
Civil Division, Room 7268
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 353-6880

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs are the State of New York; the Commonwealth of Massachusetts; the District of Columbia; the State of California; the State of Delaware; the Commonwealth of Kentucky; the State of Maryland; the State of New Jersey; the State of Oregon; the Commonwealth of Pennsylvania; the Commonwealth of Virginia; and the State of Washington.

Defendants are the U.S. Department of Labor; Patrick Pizzella, in his official capacity as Acting Secretary of the U.S. Department of Labor; and the United States of America.

Amici before the district court included: (1) the Chamber of Commerce of the United States of America and the Society for Human Resource Management; (2) the States of Texas, Nebraska, Georgia, and Louisiana; (3) Nancy Pelosi, Steny H. Hoyer, James E. Clyburn, Joseph Crowley, Linda T. Sánchez, Robert C. Scott, Frank Pallone, Jr., Jerrold Nadler, and Richard E. Neal; (4) the Restaurant Law Center; (5) the American Medical Association and the Medical Society of the State of New York; and (6) the Coalition to Protect and Promote Association Health Plans.

Amici before this Court in support of appellants include: (1) the Chamber of Commerce of the United States of America, the National Federation of Independent

Business, the Texas Association of Business, the United Service Association for Health Care, the Alaska Chamber of Commerce, the Louisiana Association of Business and Industry, the Minnesota Chamber of Commerce, the State Chamber of Oklahoma, the Vermont of Chamber of Commerce, the Tennessee Chamber of Commerce & Industry, Wisconsin Manufacturers & Commerce, the Greater Fairbanks Chamber of Commerce (Alaska), the East Valley Chambers of Commerce Alliance (Arizona), the Tucson Metro Chamber (Arizona), the Greater Miami Chamber of Commerce (Florida), the Bolingbrook Area Chamber of Commerce (Illinois), the Carol Stream Chamber of Commerce (Illinois), Chamber630 (Illinois), the Elgin Area Chamber of Commerce (Illinois), the Elmhurst Chamber of Commerce & Industry (Illinois), the Heritage Corridor Business Alliance (Illinois), the Orland Chamber of Commerce (Illinois), the St. Charles Chamber of Commerce (Illinois), the West Suburban Chamber of Commerce and Industry (Illinois), the Wheaton Chamber of Commerce (Illinois), the Traverse City Area Chamber of Commerce (Michigan), the Northwest Chamber of Commerce (Missouri), the Boulder City Chamber of Commerce (Nevada), the Henderson Chamber of Commerce (Nevada), the Las Vegas Asian Chamber of Commerce (Nevada), the Las Vegas Latin Chamber of Commerce (Nevada), the Las Vegas Metro Chamber of Commerce (Nevada), the Reno + Sparks Chamber of Commerce (Nevada), the Urban Chamber of Commerce (Nevada), the Zebulan Chamber of Commerce (North Carolina), the Chester County Chamber of Business and Industry (Pennsylvania), the

Greater Lexington Chamber of Commerce and Visitor Center (South Carolina), the Allen Fairview Chamber of Commerce (Texas), the Cedar Hill Chamber of Commerce (Texas), the Chamber (Schertz-Cibolo-Selma Area) (Texas), the Colleyville Chamber of Commerce (Texas), the Denison Area Chamber of Commerce (Texas), the East Parker County Chamber of Commerce (Texas), the Frisco Chamber of Commerce (Texas), the Garland Chamber of Commerce (Texas), the Granbury Chamber of Commerce (Texas), the Grand Prairie Chamber of Commerce (Texas), the Grapevine Chamber of Commerce (Texas), the Greater Arlington Chamber of Commerce (Texas), the Greater Waco Chamber of Commerce (Texas), the Hurst Euless Bedford Chamber of Commerce (Texas), the Lake Cities Chamber of Commerce (Texas), the Lewisville Area Chamber of Commerce (Texas), the Longview Chamber of Commerce (Texas), the Lubbock Chamber of Commerce (Texas), the Melissa Area Chamber of Commerce (Texas), the Mansfield Area Chamber of Commerce (Texas), the Mesquite Chamber of Commerce (Texas), the North Texas Gay Lesbian Bisexual Transgender Chamber of Commerce (Texas), the Plano Chamber of Commerce (Texas), the Pottsboro Area Chamber of Commerce (Texas), the San Antonio Chamber of Commerce (Texas), the Rockwall Area Chamber of Commerce (Texas), the Rowlett Chamber of Commerce (Texas), the Wichita Falls Chamber of Commerce (Texas), the Wylie Chamber of Commerce (Texas), the Marshfield Area Chamber of Commerce & Industry (Wisconsin); (2) the States of Texas, Alabama, Georgia, Indiana, Kansas, Louisiana, Montana, North

Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, Governor Phil Bryant of Mississippi, and Kentucky, by and through Governor Matt Bevin; (3) the Oklahoma Insurance Department and the Montana State Auditor, Commissioner of Securities and Insurance; (4) The Restaurant Law Center; (5) the National Association of Realtors, the Baldwin County Association of Realtors, the Greater Las Vegas Association of Realtors, the Kansas City Regional Association of Realtors, Nevada Realtors, and the Tennessee Realtors; and (6) the Coalition to Protect and Promote Association Health Plans and AssociationHealthPlans.com.

Amici before this Court in support of appellees include: (1) Health Care Policy History Scholars, Henry J. Aaron, Linda J. Blumberg, Andrea Louise Campbell, Daniel Carpenter, Sabrina Corlette, David Cutler, Steven Davidson, Doug Elmendorf, Judith Feder, Robert Field, Sherry Glied, Colin Gordon, Jacob S. Hacker, Mark A. Hall, John Holahan, David K. Jones, Timothy Stoltzfus Jost, Miriam Laugesen, Theodore Marmor, Rick Mayes, Jonathan Oberlander, Thomas R. Oliver, Dania Palanker, Mark Peterson, Harold Pollack, Sara Rosenbaum, William Sage, Mark Schlesinger, David Schactman, David Barton Smith, Michael Sparer, JoAnn Volk, Joseph White, Christen Linke Young, and Stephen Zuckerman; (2) Families USA, National Partnership for Women and Families, National Women's Law Center, National Employment Law Project, National Health Law Program, United Hospital Fund, and Public Citizen; (3) the Small Business Majority Foundation, Inc.;

(4) Former State Insurance Commissioners and Former State Insurance Regulators: Joel Airo, Brain Atchinson, Carrie Banahan, Elizabeth S. Berendt, Randy Blumer, Robert Brace, Katherine M. Clark, Jane Cline, Rick Diamond, Jack Ehnes, Allen Feezor, Alissa Fox, Jeffrey Gabardi, Christina Lechner Goe, Jorge A. Gomez, Suzette Green-Wright, Thomas E. Hampton, Jean Holliday, J. Robert Hunter, Alessandro Iuppa, Dave Jones, Christopher F. Koller, Leslie Krier, Steven B. Larsen, Monica Lindeen, Kevin Lucia, Kip May, Sally McCarty, Kent Michie, Lawrence Mirel, Alice A. Molasky Arman, John Morrison, Fred Nepple, John Oxendine, Karl Polzer, Earl Pomeroy, Sandy Praeger, Guenther Ruch, Elizabeth Sammis, Kathleen Sebelius, Georgia Alvarez Siehl, Matthew Smith, Karen Weldin Stewart, Susan Voss, and Barbara Yondorf; (5) the American Medical Association, Medical Society of the State of New York, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American College of Emergency Physicians, American College of Obstetricians & Gynecologists, and American Psychiatric Association; (6) Members of Congress: Representatives Nancy Pelosi, Steny H. Hoyer, James E. Clyburn, Ben Ray Lujan, Hakeem Jeffries, Katherine Clark, Robert C. "Bobby" Scott, Frank Pallone, Jr., Jerrold Nadler, and Richard E. Neal; and (6) Former United States Department of Labor Officials: Phyllis C. Borzi, M. Patricia Smith, Alan D. Lebowitz, Marc I. Machiz, and Daniel J. Maguire.

There are no intervenors.

B. Rulings Under Review

Appellants seek review of the district court's order and memorandum opinion entered on March 28, 2019 (Dkt. Nos. 78, 79). The rulings were issued by the Honorable John D. Bates in Case No. 1:18-cv-1747.

C. Related Cases

This case has not previously been before this Court. Counsel is not aware of any other related cases within the meaning of D.C. Circuit Rule 28(a)(1)(C).

/s/ Michael Shih
MICHAEL SHIH

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases: **Page(s)**

Statutes:

Regulations:

Legislative Material:

Other Authorities:

GLOSSARY

ACA	Patient Protection and Affordable Care Act
APA	Administrative Procedure Act
CMS	Centers for Medicare and Medicaid Services
ERISA	Employee Retirement Income Security Act of 1974
HIPAA	Health Insurance Portability and Accountability Act of 1996
IRS	Internal Revenue Service

SUMMARY OF ARGUMENT

The plaintiff States have challenged a rule issued by the Department of Labor to make it easier for employers to acquire affordable, high-quality healthcare coverage for their employees. The district court held that the States had standing; that the Department lacked authority under the Employee Retirement Income Security Act (ERISA) to adopt the rule's two principal provisions; and that the rule must be vacated nationwide. That judgment was erroneous in every respect, as our opening brief explained. And the States have failed to rehabilitate the court's reasoning.

With respect to standing, the States cannot dispute that the rule does not command any State to take, or to refrain from taking, any action. They argue only that the rule injures them by (1) depriving them of tax revenues, and (2) "forcing" them to spend resources because association health plans might engage in fraud and mismanagement. But, among other defects, those injuries are self-inflicted. The rule does not restrict the States' ability to tax association health plans if they choose, and the States are not required to choose to spend money to protect their citizens from the (speculative) possibility that yet-to-be-formed associations might behave improperly. Additionally, the States have articulated no reason why they fall within ERISA's zone of interests. ERISA regulates employee benefit plans to protect the interests of their participants and beneficiaries. Yet the States' asserted injuries can be remedied only by vacating the rule's expansion of affordable, high-quality healthcare coverage—relief that is unrelated to, and indeed inconsistent with, ERISA's purposes.

As to the merits, the States have failed to demonstrate that the Department lacked statutory authority to adopt the rule's alternative criteria for establishing association health plans. In the most critical respects—the degree and nature of employer control of the association health plan—those criteria establish standards equally or more stringent than the indisputably lawful factors the Department has historically used to ensure that an association acts "indirectly in the interest of an employer," 29 U.S.C. § 1002(5). The States nevertheless argue that, because the remaining criteria do not prohibit an association from offering healthcare coverage as its principal purpose, the Department's interpretation of ERISA is unreasonable. But neither the text nor context of ERISA imposes such a requirement, let alone unambiguously. And although the States contend that the criteria fail to ensure that associations will act in their members' interests, the States' arguments merely second-guess the Department's expert judgment. The rule's reasonable construction of ERISA warrants *Chevron* deference.

The States next argue that the criteria conflict with the Patient Protection and Affordable Care Act (ACA). These arguments, which the district court did not adopt, lack merit as well. The relevant ACA provisions *incorporate* the very ERISA definitions the challenged rule construes, and thereby foreclose the States' suggestion that the ACA stripped the Department of its preexisting authority to interpret ERISA as it has. In any event, the challenged rule does not govern how the ACA applies to association health plans created under it. That responsibility resides in two other

agencies: the Centers for Medicare and Medicaid Services (CMS) and the Internal Revenue Service (IRS). Even if those agencies have applied the ACA incorrectly—which they have not—any such error would not justify vacating the Department's separate rule.

The States likewise have failed to demonstrate that the rule's working-owner provision unreasonably implements ERISA. The States acknowledge that a working owner can be both an employer and an employee for purposes of establishing and participating in an ERISA-covered benefit plan. *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004). Contrary to the States' contention, neither the Supreme Court's decision in *Yates* nor ERISA's text unambiguously forecloses the Department's reasonable conclusion that a working owner who has no other employees may participate in association health plans.

Finally, the States are not entitled to nationwide vacatur of the rule. Both Article III and foundational principles of equity establish that any vacatur must be no broader than necessary to provide full relief to the States the rule actually injures. In ordering otherwise, the district court has prevented the Department from maintaining the rule in the many States that support it—to the detriment of employers that would otherwise use it to obtain affordable, high-quality healthcare coverage for their employees.

ARGUMENT

I. The States Lack A Cognizable Injury Providing A Basis To Challenge The Rule.

A. The States' assertions of lost tax revenue do not provide a basis to challenge the rule.

Lost tax revenues are "generally not cognizable as an injury-in-fact for purposes of standing." *Arias v. DynCorp*, 752 F.3d 1011, 1015 (D.C. Cir. 2014) (citing *Pennsylvania ex rel. Shapp v. Kleppe*, 533 F.2d 668, 672 (D.C. Cir. 1976)); Br. 19-22. Standing will exist only when the State can allege a "fairly direct link between the state's status as a collector and recipient of revenues" and the "administrative action being challenged." *Kleppe*, 533 F.2d at 672. No such link exists here. By the States' own admission (Resp. Br. 29-30), the challenged rule does not directly mandate behavior that would reduce their tax revenues. The rule instead expands the healthcare-coverage options available to employers by making it easier for them to form association health plans. The rule will reduce States' tax revenues only because some States have voluntarily chosen not to tax coverage obtained through such plans. Such incidental injuries are insufficient to support standing. *Kleppe*, 533 F.2d at 670.

The States argue (Resp. Br. 30) that, under *Wyoming v. Oklahoma*, 502 U.S. 437 (1992), standing exists as long as they identify a "specific" revenue stream the rule will incidentally affect. But *Wyoming* reaffirmed *Kleppe*'s rejection of injuries based on incidental loss of tax revenues. *Id.* at 438 (explaining that *Kleppe* did not "involve[] a direct injury in the form of a loss of specific tax revenues—an undisputed fact here");

id. at 450 ("[Wyoming's] severance tax revenues are directly linked to the extraction and sale of coal and have been demonstrably affected by the Act."); *id.* at 451 ("[The challenged] Act . . . directly affects Wyoming's ability to collect severance tax revenues."). The direct link present in *Wyoming*—that the challenged law itself regulated the conduct of severance-tax-paying utility companies—is not present here. The challenged rule imposes no restrictions on the independent and unfettered choices of tax-paying third parties.

The States also argue (Resp. Br. 30-31) that *Kleppe* is inapposite because the asserted injury resulted from a natural disaster, not governmental action. That distinction is illusory. In assessing standing, courts must assume *arguendo* the merits of a plaintiff's legal claims. *Estate of Boyland v. USDA*, 913 F.3d 117, 123-24 (D.C. Cir. 2019). Accordingly, *Kleppe* assumed the plaintiff States' premise that the government's failure to remedy the disaster was unlawful; that conduct, of course, *itself* injured their businesses and, by extension, themselves. 533 F.2d at 671 & n.14. What mattered was not that the harm had originally been caused by the disaster, but that the incidental effect of the government's failure to remedy the disaster on the taxes collected was insufficient to confer standing.

The States next suggest (Resp. Br. 29-31) that a reduction in their tax revenues is not an incidental effect but the rule's intended consequence. They emphasize the preamble's observation that the rule would allow employers to avoid the "potentially significant cost to comply with State rules that apply to large group issuers," such as

premium taxes. 83 Fed. Reg. 28,912, 28,943 (2018). But the States omit the very next sentence, which confirms that States retain the authority to tax association health plans. *Id.*

In all events, therefore, the States fail to overcome the government's showing (Br. 22) that, because they retain control over their own tax policies, any reduction in tax revenue would be self-inflicted, and even more attenuated from the challenged rule than the injuries identified in *Kleppe*. There, no tax restructuring could have eliminated the harm allegedly inflicted on the States by the government's disaster-relief decisions. Similarly, in *Wyoming*, the State could not recoup lost tax revenues by imposing a different tax on out-of-State utility companies. Here, by contrast, the extent of the States' losses depends entirely on their own taxation decisions—thus supplying an independent ground to reject this assertion of injury. Br. 26-27.

Finally, the States have failed to explain how this self-inflicted injury brings them within the zone of interests of ERISA—or even of the ACA, insofar as that statute is purportedly relevant to their claim (*but see infra* pp. 17-18). The States believe (Resp. Br. 31-32) that, because ERISA and the ACA "preserve[] the States' historic role in regulating traditional insurance," they fall within both statutes' zones of interests. But the rule does not disturb the States' regulatory role. The States' complaint is that the rule may reduce the tax revenue they collect, and they seek to preserve this revenue at the expense of depriving employees of the expanded access to affordable, high-quality healthcare that the rule enables. This injury is "so

marginally related to"—indeed, "inconsistent with"—the interests protected by ERISA and the ACA "that it cannot reasonably be assumed that Congress intended to permit the suit." *Clarke v. Securities Indus. Ass'n*, 479 U.S. 388, 399 (1987).

The States attempt (Resp. Br. 31) to preclude consideration of the zone-of-interests issue on forfeiture grounds. But the issue is entwined with the government's argument, indisputably preserved, that States cannot complain about the incidental revenue effects of regulatory action. Br. 19-25. Indeed, *Kleppe*—the case on which the government primarily relied in district court—rested principally on its holding that state tax-revenue losses fall outside the zone of interests of the Small Business Act. 533 F.2d at 672-73. In any event, this Court has long exercised its discretion to address forfeited zone-of-interests arguments, including even *sua sponte*. *Association of Battery Recyclers, Inc. v. EPA*, 716 F.3d 667, 675, 678 & n.6 (D.C. Cir. 2013) (Silberman, J., concurring) (citing cases); *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 127 (2014) (agreeing with Judge Silberman's characterization of the zone-of-interests requirement, but not addressing when an appellate court may excuse the requirement's forfeiture in district court).

B. The States' assertions of increased regulatory costs do not provide a basis to challenge the rule.

The States' allegation that they have been harmed by the rule's "direct imposition of an increased regulatory burden" (Resp. Br. 23) is equally meritless. Their voluntary decision to expend resources to mitigate the (speculative) possibility

of fraud is a self-inflicted injury that cannot fairly be attributed to the challenged rule, and therefore is insufficient to satisfy Article III. Br. 25-30.

The States' reliance (Resp. Br. 25-27) on *Air Alliance Houston v. EPA*, 906 F.3d 1049 (D.C. Cir. 2018) (per curiam), is misplaced. The Court there held that certain States had standing to challenge EPA's decision to delay the effective date of a regulation issued to prevent the accidental discharge of hazardous substances. The Court did so because the States possessed "independent proprietary interests in avoiding chemical releases in their territory" sufficient to support standing. *Id.* at 1059-60.

Unlike *Air Alliance Houston*, the States do not seek to prevent or mitigate harms to themselves. Instead, the States suggest that association health plans might harm their citizens, and that money must be expended because they desire to prevent such harm. But States do not "have standing as *parens patriae* to bring an action against the Federal Government" on behalf of the health and well-being of their residents. *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 610 n.16 (1982). Just as plaintiffs generally may not "manufacture standing" by expending resources to guard against speculative injuries that themselves are insufficient to support standing, *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 416 (2013), States here may not rely on voluntary budgeting choices to convert an invalid *parens patriae* action into a direct proprietary injury.

The States' claim to standing fails for the independent reason that the fraud and mismanagement they seek to prevent is speculative. As explained (Br. 28-30), the States have not identified adequate evidence that such misconduct is likely to occur in the future. The States attempt to overcome that deficit by arguing (Resp. Br. 23, 27) that the rule's preamble "recognizes" that the rule will "increase the risk of fraud and mismanagement," and that the Department's own policing efforts will be insufficient to prevent against this risk. The preamble, however, makes no such finding. It acknowledges that the "increased flexibility" the rule affords could introduce "increased opportunities for mismanagement" by association health plans in the future, which would in turn increase "oversight demands on the Department and State regulators." 83 Fed. Reg. at 28,953. But the preamble never states that the Department's efforts will be inadequate to address fraud and mismanagement. To the contrary, it repeatedly emphasizes that the Department has made progress in combating abuse, and that the rule's criteria were designed to mitigate such abuse. *Id.* at 28,939, 28,951-53.

The States observe (Resp. Br. 23-24) that associations have committed misconduct in the past. But it does not follow that newly formed associations are equally likely to engage in misconduct, particularly when those associations will be operating under a more robust federal regulatory and enforcement regime. *Cf. City of Los Angeles v. Lyons*, 461 U.S. 95, 101 (1983). The Supreme Court's decision in *Department of Commerce v. New York*, 139 S. Ct. 2551 (2019), does not alter this

conclusion. That case held that States had standing to challenge the inclusion of a citizenship question on the federal census because the States had proven, after a trial, that noncitizen households would likely not respond to a census form that included the question. *Id.* at 2565-66. Here, however, the States have proffered no nonspeculative evidence to support their conclusion that the challenged rule would increase illegal behavior by associations—let alone that the States' voluntary choice to respond is anything other than a self-inflicted policy choice that cannot confer standing to sue.

II. The States Have Failed To Show That The Rule's Alternative Criteria For Creating Association Health Plans Unreasonably Implement ERISA.

The States also fail to rehabilitate the district court's merits holdings. The lawfulness of the rule's alternative criteria for creating association health plans turns on the meaning of ERISA's definition of "employer," which includes a "group or association of employers" that acts "indirectly in the interest" of its members. 29 U.S.C. § 1002(5). This definition clearly excludes groups, such as commercial insurers, that act in their own interest rather than that of their members. But the definition is otherwise ambiguous, and the Department has both authority and discretion to interpret it. *Id.* § 1135. The Department's exercise of that discretion warrants *Chevron* deference so long as its interpretation falls "reasonably within the compass of [the agency's] delegated authority." *Agape Church, Inc. v. FCC*, 738 F.3d 397, 408 (D.C. Cir. 2013). And an interpretation is "reasonable" if it "comes within

the zone of ambiguity the court has identified after employing all its interpretive tools." *Kisor v. Wilkie*, 139 S. Ct. 2400, 2415-16 (2019).

As our opening brief explained (Br. 30-35), the rule's alternative criteria easily clear this bar. The States nonetheless contend that the rule falls outside ERISA's zone of ambiguity because it does not prohibit employers from forming associations for the principal purpose of offering healthcare coverage. But ERISA does not mandate such a prohibition, much less unambiguously. Accordingly, the Department's conclusion—that associations formed for this purpose still act in their members' interests if they satisfy the rule's criteria, including that the associations remain controlled by their members—is a reasonable interpretation of ERISA that warrants *Chevron* deference.

A. ERISA does not prohibit associations acting in the interest of their member employers from being formed principally to provide healthcare coverage.

The States' primary argument (Resp. Br. 33) is that a group of employers can never act indirectly in the interest of its members if it was "formed principally for the purpose of marketing health insurance." This principal-purpose requirement is not compelled, much less unambiguously, by ERISA's text. Nothing in the phrase "indirectly in the interest of . . . employer[s]," 29 U.S.C. § 1002(5), prohibits the Department from concluding that an association formed principally for the purpose of providing healthcare coverage is capable, in some circumstances, of acting in its members' interests. Other courts of appeals (and the district court) have concluded

that the phrase is broad enough to include a variety of entities and relationships. Mem. Op. 20-21(JA196-97); *e.g.*, *MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178, 184 (5th Cir. 1992) (explaining that, by not defining the phrase, Congress "inject[ed] ambiguity into the statute"). And none of the cases cited by the States held that ERISA *unambiguously* incorporates a principal-purpose requirement. *Compare* Resp. Br. 33, *with National Cable & Telecommc'ns Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 982 (2005).

The States argue (Resp. Br. 36) that their interpretation is compelled by the Department's recognition that ERISA's definition of "employer" focuses on "employment-based arrangements," not "commercial insurance-type arrangements." 83 Fed. Reg. at 28,914. That distinct principle flows naturally from ERISA's text. A commercial insurer is a private enterprise that sells a product to employers, and acts not in its customers' interests but its own. It does not follow that an association of employers cannot act in its members' interests because it exists principally to provide healthcare coverage to its members' employees. Where an association is controlled by its employer members themselves, and was created so that its members could offer their employees more affordable, high-quality healthcare coverage than could have been provided individually, such an association *does* act in employers' interests. *Id.* at 28,912.

The States' reliance on a post-enactment committee report, *see Activity Report of the Comm. on Educ. & Labor*, H.R. Rep. No. 94-1785, at 48 (1977), is similarly inapt.

Even assuming that such material may ever overcome *Chevron* deference, *cf. Bruesewitz v. Wyeth LLC*, 562 U.S. 223, 241-42 (2011), the report demonstrates only that Congress did not intend ERISA to cover entrepreneurial ventures selling insurance for a profit to unrelated entities. The report does not equate that distinction with the States' atextual reading of the phrase "indirectly in the interest of . . . employer[s]," 29 U.S.C. § 1002(5), let alone forbid associations of the type at issue here.

B. The alternative criteria reasonably exclude arrangements that do not act in the interest of employers.

The States also argue (Resp. Br. 36-48) that the Department lacked authority to adopt the challenged criteria because, as a policy matter, those criteria cannot ensure that an association acts in its member employers' interests. These arguments are irrelevant to the question presented on appeal: whether, as a legal matter, the Department's rule falls within the zone of permissible ambiguity established by ERISA's definition of "employer." ERISA does not require the Department to adopt any particular test for ensuring that a group of employers acts "indirectly in the interest" of its members. 29 U.S.C. § 1002(5). ERISA certainly does not compel the Department to adopt the specific criteria the States demand. The Department's interpretation of ERISA thus warrants deference notwithstanding the States' policy objections. Those objections might be relevant to whether the rule is arbitrary or capricious under the Administrative Procedure Act (APA). But the States agree

(Resp. Br. 48 n.6) that, with one exception, those claims should be decided by the district court in the first instance.

The States' conceptual confusion is highlighted (Resp. Br. 48-49) by the single arbitrary-or-capricious argument they *do* advance on appeal: that the Department failed to "display awareness" that the rule "abandon[ed] the principle" that commercial-insurance-type ventures cannot satisfy ERISA's definition of "employer." The Department did not abandon that principle at all. The rule prohibits commercial insurers from sponsoring association health plans. 83 Fed. Reg. at 28,914, 28,962. And the Department explained why the rule's criteria are sufficient to exclude commercial-insurance-type arrangements while including associations that, in the Department's judgment, act in their member employers' interests despite falling outside the Department's prior guidance. *Id.* at 28,915. Indeed, the rule's requirement that a group be controlled by its members in form and substance—especially when combined with the rule's new nondiscrimination requirement—may be enough to distinguish between groups that act in employers' interests and groups that do not. Br. 32-34.

Apart from repeating the district court's flawed critique of the control requirement's efficacy, *but see* Br. 36-38, the States suggest (Resp. Br. 46 n.4) that control cannot be the only criterion ERISA requires because mutual insurance companies might then be able to sponsor association health plans. The States, however, have failed to explain how such a company (which is not comprised solely

of employers) could be a "group or association *of employers*," as ERISA requires. 29 U.S.C. § 1002(5) (emphasis added). The States also observe (Br. 33-34) that other courts of appeals have suggested, in dictum, that ERISA requires an entity sponsoring an association health plan to have some common interest unrelated to healthcare coverage. But that suggestion—which has no basis, much less an unambiguous basis, in ERISA's text, *supra* pp. 11-14—would imply at most that control by itself is insufficient to ensure that associations act in the interest of their members. Control, of course, is not the rule's only requirement.

The States' argument (Resp. Br. 47) that the rule's nondiscrimination requirement is too lax seeks impermissibly to substitute their judgment for the Department's. The Department reasonably determined that the requirement is sufficient to ensure that health status—the key factor that might drive employers to use association health plans as substitutes for commercial-insurance-type enterprises—cannot serve as the basis for associations to charge employers different premiums. 83 Fed. Reg. at 28,925. ERISA does not require the Department to go further, particularly when the rule prohibits associations from using factors such as "industry or geography as a subterfuge" for discrimination based on health status. *Id.* at 28,925 n.34.

Because control and nondiscrimination are likely sufficient to ensure that associations act in their members' interests, the States' remaining arguments are immaterial. The rule—which contains additional criteria—is *a fortiori* reasonable,

regardless of the States' policy-based objections to those additional criteria. And those criteria are more meaningful than the States' caricature of them admits. For example, the rule continues to require that an association possess a "substantial business purpose" apart from offering healthcare coverage. 83 Fed. Reg. at 28,918. Associations that would be viable entities absent their coverage-providing function presumptively satisfy this requirement. *Id.* But this presumption does not imply, as the States suggest (Resp. Br. 40), that trivial business purposes would suffice. A business purpose must be "sufficiently substantial," within the ordinary meaning of "substantial," to qualify. 83 Fed. Reg. at 28,918.

Similarly, the rule continues to require that an association's members possess certain common features—a requirement that can be satisfied if the members share a "common geographic location," defined as "a single State or a metropolitan area." 83 Fed. Reg. at 28,941. The States denigrate this requirement (Resp. Br. 40-44) because they believe employers in different industries and cities lack a sufficiently meaningful connection. But the States fail to recognize that employers have long chosen to organize on the basis of common geography—as is the case with state chambers of commerce—despite having no other connection apart from working within a similar regulatory environment. Such employers have done so presumably because they recognize the commonality of interest that flows from operating within that environment.

The States suggest (Resp. Br. 35-36) that the Department recognized, in prior guidance, that it could not deviate from how that guidance assessed business purpose and commonality. But the cited advisory opinions do not state that those factors were compelled unambiguously by ERISA. In any event, nonbinding guidance could not foreclose the Department from adopting a different reasonable interpretation through a notice-and-comment regulation to which deference is owed. *Brand X*, 545 U.S. at 982-83; *Kisor*, 139 S. Ct. at 2420. The States' reliance on the preamble to the challenged rule (Resp. Br. 45) is even harder to fathom. The preamble explained that, for policy reasons, the Department had retained the business-purpose and commonality requirements in altered form, and rejected arguments that doing so was textually foreclosed by ERISA. 83 Fed. Reg. at 28,916-17. The Department never stated that retention of those factors, in their prior form, was textually required by ERISA.

Ultimately, the States' attack on the Department's predictive judgment regarding the efficacy of its criteria will not even support the arbitrary and capricious challenge that they may assert in district court. It certainly fails to establish in this Court that the Department lacked authority to promulgate the rule under ERISA.

C. The ACA does not render the alternative criteria unreasonable.

The States' alternative contention—that the ACA eliminates the Department's authority to issue the rule—is illogical. The ACA *incorporates* ERISA's definitions of

"employer" and "employee," 42 U.S.C. § 300gg-91(d)(5)-(6), and responsibility for implementing ERISA's definitions remains with the Department, 29 U.S.C. § 1135. The States are thus wrong to contend (Resp. Br. 58-61) that the ACA's incorporation of ERISA's definitions stripped the Department of its preexisting authority to interpret ERISA's terms, merely because the challenged interpretation allegedly undermines the ACA. The Department's congressionally delegated power to interpret ERISA's definitions also distinguishes this appeal from cases such as *King v. Burwell*, 135 S. Ct. 2480 (2015). Those cases concerned whether Congress had delegated to an agency authority to adopt the challenged interpretation of a statute in the first instance. Here, nobody disputes that the Department possesses interpretive authority over ERISA, Mem. Op. 20(JA196), and the Department's new interpretation would have been valid before the ACA's enactment, *supra* Subsections II.A-B. For these reasons, the States' ACA-related arguments are irrelevant to whether the Department had statutory authority to promulgate the challenged rule.

Even taken on their own terms, the States' ACA-related arguments lack merit. They misconstrue the ACA, and they misunderstand the relationship between the Department's interpretation of ERISA and separate interpretations of the ACA by CMS and IRS.

1. The rule is consistent with the ACA's group-market provisions.

The States argue (Resp. Br. 50-55) that the rule is inconsistent with the ACA's group-market provisions. Those provisions govern "group health plan[s]," defined as "employee welfare benefit plan[s] (as defined [by ERISA])" that "provide[] medical care." 42 U.S.C. § 300gg-91(a)(1). Group health plans sponsored by large employers must comply with different rules than those sponsored by small ones. As relevant here, a "large employer" is generally one "who employed an average of at least 51 employees," *id.* § 300gg-91(e)(2), while a "small employer" is generally one "who employed an average of at least 1 but not more than 50 employees," *id.* § 300gg-91(e)(4). The terms "employer" and "employee" "ha[ve] the meaning[s] given such term[s] under [ERISA]." *Id.* § 300gg-91(d)(5)-(6).

CMS has long interpreted these definitions to provide that an association health plan—to repeat, an employee benefit plan sponsored by a "group or association of employers" acting "indirectly in the interest of" its members under ERISA, 29 U.S.C. § 1002(5)—is a group health plan sponsored by a single employer: the association itself. As CMS has explained, the ACA's group-market definitions incorporate "ERISA['s] definitions of employee welfare benefit plan and employer." CMS, *Application of Individual and Group Market Requirements* 2 (Sept. 1, 2011), https://go.usa.gov/xyv7c (*Bulletin*). Association health plans are plans sponsored by an ERISA "employer." In CMS's view, such plans must be treated as sponsored by

single "employers" under the ACA's group-market provisions, with their size determined by the total number of their members' employees. *Id.*

This interpretation predates the ACA. The relevant definitions originated in the Public Health Service Act, Pub. L. No. 78-410, as amended by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA). A 1997 regulation explained that the term "employer," as used in those definitions, "has the meaning given the term under [ERISA]." 45 C.F.R. § 144.103 (adopted by 62 Fed. Reg. 16,894 (1997)). In 2002, CMS concluded that, under HIPAA, association health plans should be treated as sponsored by single employers. CMS, Insurance Standards Bulletin No. 02-02 (Aug. 2002), https://go.usa.gov/xyvfu. CMS reaffirmed that interpretation after the ACA's enactment and before the challenged rule was issued. *Bulletin* 2; 76 Fed. Reg. 54,969, 54,971 (2011). Many States, including some plaintiffs, have adopted the same view. Dkt. No. 66, at 15 n.7.

The States respond (Resp. Br. 52) that an association acting "indirectly in the interest of" its members under ERISA, 29 U.S.C. § 1002(5), cannot be an "employer" under the ACA's group-market provisions with respect to its members' "employees" because the association does not stand in a common-law employment relationship with them. But the States overlook the fact that those provisions incorporate ERISA's definition of "employer." As CMS has concluded, this incorporation means that "reference to ERISA is needed when . . . determining the identity of the 'employer' sponsoring the plan." *Bulletin* 3. The States note (Resp. Br. 53-54) that the

Department has "adopted [a] common-law understanding of the employer-employee relationship" in other ERISA contexts. But the Department has never adopted that understanding in *this* context, and reasonably so. Many groups of employers that act "indirectly in the interest" of their members do not have a common-law employment relationship with their members' employees—yet ERISA defines "employer" to include such groups. 29 U.S.C. § 1002(5).

The States' arguments are further undermined by the fact that the ACA's group-market provisions treat other groups of employers as single employers whose size is determined by the number of employees that their members employ. These groups also do not have a common-law employment relationship with their members' employees. For example, the ACA provides that a group of service organizations "shall be treated as 1 employer." 42 U.S.C. § 18024(b)(4)(A) (citing 26 U.S.C. § 414(m)). This exception and others confirm that the term "employer," as used in the group-market provisions, encompasses non-common-law employers that are deemed employers by operation of law.

The States assert (Resp. Br. 55-56) that § 18024(b)(4) authorizes deviating from the common law only for the groups specified, which do not include associations sponsoring association health plans. But their invocation of the *expressio unius* canon fails because "circumstances" do not support "a sensible inference that the term left out must have been meant to be excluded." *NLRB v. SW Gen., Inc.*, 137 S. Ct. 929, 940 (2017). Such associations did not need to be included among the entities

specified in § 18024(b)(4) because, unlike those entities, they were already included under the ACA's incorporation of ERISA's definition of "employer." That definition, again, was understood to cover associations sponsoring association health plans for decades before the ACA was enacted. Indeed, the States do not seriously dispute that associations satisfying the factors examined by the Department's prior guidance are employers under ERISA and, therefore, under the ACA's group-market provisions. That CMS adopted its interpretation of the ACA when such associations were comparatively "rare," *see* Resp. Br. 54 n.8, does not make its interpretation unlawful now that the Department has expanded access to them.

2. The rule is consistent with the ACA's shared-responsibility provisions.

The States' argument (Resp. Br. 56-58) that the rule conflicts with the ACA's shared-responsibility provisions is similarly flawed. Those provisions apply only to "applicable large employers." 26 U.S.C. § 4980H. Section 4980H defines that term of art as "an employer who employed an average of at least 50 full-time employees." *Id.* § 4980H(c)(2)(A). In 2014, IRS—the agency responsible for enforcing § 4980H—defined the term "employer," in this context, to mean "the employer of an employee under the common-law standard." 26 C.F.R. § 54.4980H-1(a)(16) (adopted by 79 Fed. Reg. 8544 (2014)). IRS has applied this definition to conclude that status as an "applicable large employer" is determined not based on the aggregate size of an association deemed an "employer" under ERISA, but based on the individual size of

each of that association's respective employer members. IRS, Q&A on Employer Shared Responsibility Provisions, No. 18 (last updated Mar. 26, 2019), https://go.usa.gov/xmY7y.

The States argue (Resp. Br. 56) that IRS's interpretation is inconsistent with CMS's interpretation of the ACA's group-market provisions. But the States do not appear to contest that IRS's interpretation of § 4980H—which follows from the definition IRS adopted before the Department issued the challenged rule—is lawful as applied to association health plans created under the Department's prior guidance. And again, there is no basis to conclude that IRS's interpretation has now become unlawful because the criteria for achieving association-health-plan status have changed. Regardless, IRS's interpretation of § 4980H is reasonable. The States suggest (Resp. Br. 57-58) that the word "employer" in the term "applicable large employer" must mean the same thing as the word "employer" in the ACA's group-market provisions. But courts need not "require uniformity when resolving ambiguities in identical statutory terms . . . in different provisions of the same statute," especially when those terms are not defined identically. *Environmental Def. v. Duke Energy Corp.*, 549 U.S. 561, 575-76 (2007). IRS's interpretation reasonably gives effect to Congress's differential choice.

3. In all events, the States' ACA arguments do not supply a basis for invalidating the Department's rule.

Finally, regardless of their merit, the States' ACA-based arguments do not supply a basis for holding that the Department lacked statutory authority to issue *its* rule. The Department issued that rule by exercising its undisputed authority to interpret ERISA's definitions for purposes of ERISA itself—authority the ACA does not restrict merely by incorporating ERISA's definitions. The States object to the application of established interpretations of the ACA, by CMS and IRS, to associations created under the rule. That is not a challenge to the Department's rule at all. At most, it is an argument that, because of the rule, CMS and IRS must alter their interpretations with respect to associations authorized by the Department's new rule, if not *all* associations (including those recognized by the Department's prior guidance). *Cf. Clark v. Martinez*, 543 U.S. 371, 380-81 (2005). Such a claim would be meritless, and importantly, the States have not even brought it.

III. The States Have Failed To Show That The Rule's Working-Owner Provision Unreasonably Implements ERISA.

The rule's working-owner provision also reasonably implements ERISA. The States do not dispute that, in *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 6 (2004), the Supreme Court acknowledged that a working owner can be both an employer and employee under ERISA. The States instead argue (Resp. Br. 64) that *Yates* does not allow treating a working owner who employs no one but himself as an "employer" who may participate in an association health plan, relying on

dictum from a footnote. 541 U.S. at 21 n.6. But that dictum does not establish that a working owner without any other employees cannot be an "employer." It establishes only that such an individual cannot create his own ERISA plan because the plan would not have sufficient "participants." This is consistent with the Department's conclusion that a working owner can be an "employer" who is one of many "participants" in an association health plan. At a minimum, this means that the Department's reasonable conclusion is foreclosed neither by *Yates*'s footnote nor the cases cited by that footnote and by the States. *Brand X*, 545 U.S. at 981-83.

The States separately argue (Resp. Br. 65) that the working-owner provision is inconsistent with the ACA's definition of "employer" in the group-market context, which incorporates ERISA's corresponding definition "except that such term shall include only employers of two or more employees." 42 U.S.C. § 300gg-91(d)(6). Again, however, the States cite no authority holding that the ACA's group-market provisions—which incorporate ERISA's definitions—constrain the Department's interpretive authority over ERISA. Thus, the States could not prevail even if they were correct that a working owner with no other employees cannot be an "employer" under the ACA's group-market provisions. Under *Yates*, such a working owner can still qualify as an "employer" under ERISA for purposes of joining a "group or association of employers" acting "indirectly in the interest" of its members, 29 U.S.C. § 1002(5), as the Department's rule reasonably concludes.

Finally, even if this Court were to conclude that the working-owner provision unreasonably implements ERISA or the ACA, vacatur of the entire rule would be inappropriate. The rule provides that any invalidated "provision shall be severable from [the rule] and shall not affect the remainder thereof." 29 C.F.R. § 2510.3-5(g).

IV. The States Are Not Entitled To Nationwide Relief.

At a minimum, the district court's judgment should be reversed to the extent it purports to vacate the rule nationwide. That sweeping relief is inconsistent with fundamental requirements of Article III standing and basic principles of equity. Br. 43. The States attempt (Resp. Br. 67-68) to distinguish these principles as applying only to nationwide injunctions. But their proposed distinction—that, when a rule is vacated as opposed to enjoined, an agency is not subject to a court order enforceable by contempt—is irrelevant to the constitutional, equitable, and statutory reasons why relief should be no broader than necessary to redress a plaintiff's own injuries. The States also suggest (Resp. Br. 68) that nationwide vacatur is "in keeping with the fundamental principle that agency policy is to be made . . . by the agency itself." *Harmon v. Thornburgh*, 878 F.2d 484, 494 (D.C. Cir. 1989). But that principle supports the Department. By vacating the rule nationwide, the district court has eliminated it in *all* States—including the many that, unlike the plaintiffs here, support the rule's facilitation of healthcare coverage for their citizens—notwithstanding the rule's severability provision. The order thus prevents the Department from making the

policy choice to maintain the rule in other States, even absent any challenge by any injured party there.

Finally, the States argue (Resp. Br. 66) that the government has forfeited any objection to the scope of the relief entered. But this objection is not susceptible to forfeiture, because it implicates both a court's Article III jurisdiction to enter the relief it ordered, *Simpkins v. District of Columbia Gov't*, 108 F.3d 366, 371 (D.C. Cir. 1997), and the scope of an injunction, *ACORN v. Edgar*, 56 F.3d 791, 797-98 (7th Cir. 1995). Regardless, any forfeiture should be excused. Whether the district court's judgment swept too broadly is a "straightforward legal question" akin to those this Court has addressed in the first instance. *E.g.*, *Lesesne v. Doe*, 712 F.3d 584, 588 (D.C. Cir. 2013). Doing so would be particularly appropriate here because the court's overbroad order affects not merely the Department but employers in States that support the rule, whose ability to acquire affordable and high-quality healthcare coverage for their employees under the rule has improperly been eliminated.

CONCLUSION

For these reasons, the judgment of the district court should be reversed in whole or in part.

Respectfully submitted,

Of Counsel:

KATE S. O'SCANNLAIN
Solicitor of Labor

G. WILLIAM SCOTT
Associate Solicitor

THOMAS TSO
MELISSA MOORE
ISIDRO MARISCAL
Attorneys
Office of the Solicitor
U.S. Department of Labor

JOSEPH H. HUNT
Assistant Attorney General

HASHIM M. MOOPPAN
Deputy Assistant Attorney General

MARK B. STERN
MICHAEL S. RAAB
MICHAEL SHIH
JENNIFER L. UTRECHT
Attorneys, Appellate Staff
Civil Division, Room 7268
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 353-6880
michael.shih@usdoj.gov

August 2019

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 6,495 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Michael Shih
MICHAEL SHIH

CERTIFICATE OF SERVICE

I hereby certify that, on August 8, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Michael Shih
MICHAEL SHIH