[NOT YET SCHEDULED FOR ORAL ARGUMENT]

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

STATE OF NEW YORK, *et al.*, Plaintiffs-Appellees, v. U.S. DEPARTMENT OF LABOR, *et al.*, Defendants-Appellants.	No. 19-5125

UNOPPOSED MOTION TO EXPEDITE APPEAL

The federal government respectfully requests that the Court establish an expedited schedule for briefing and argument in the above-captioned appeal. Plaintiffs do not object to the schedule proposed herein.

The district court vacated key provisions of a final rule the Department of Labor ("Department") issued to expand access to affordable, high-quality healthcare coverage, particularly for employees of small businesses and for some self-employed individuals. The rule—promulgated pursuant to the Department's authority to implement the Employee Retirement Income Security Act ("ERISA")—accomplishes this end by modifying restrictions on the creation of association health plans, and by allowing sole proprietors without any common-law employees to participate in association health plans.

The district court's ruling not only threatens significant impending harm to tens of thousands of small-business employees and self-employed individuals, but also rests on errors of law. Two of the rule's three applicability dates took effect before judgment was entered against the Department. Hundreds of employers joined new association health plans in reliance on the rule, and those plans are currently providing healthcare coverage to tens of thousands of people across the country.

As further detailed below, if this appeal is not considered expeditiously, the district court's judgment may create serious adverse effects. First, existing plans would be forced to cease operating at the end of the applicable plan year or contract term. The Department understands that these dates typically range from September 2019 to December 2019. Without the ability to retain coverage provided by an existing association health plan, employers and their employees would be forced to seek new coverage, in many cases before the plan year or contract term expires. This disruptive and costly process may create coverage gaps, during which individuals must either pay for medical expenses out of pocket or forgo medical treatment until new coverage is acquired and becomes active. Some individuals may even be priced out of the insurance marketplace entirely. Second, the judgment could cause plans to cease operations *before* the end of the plan year or contract term. Individuals who unexpectedly lose coverage in this manner would likewise be subject to coverage gaps, with the attendant damaging consequences. Finally, the judgment prohibits employers from joining plans created under the final rule so long as the judgment

remains in effect. During that time, hundreds of thousands of employees will be unable to take advantage of the rule's substantial benefits.

The Department of Labor, in conjunction with the Department of Health and Human Services ("the Departments"), has attempted to mitigate some of these harms by adopting a nonenforcement policy. Dep't of Labor, Statement Relating to the U.S. District Court Ruling in *State of New York v. United States Department of Labor*, https://go.usa.gov/xm5TQ (last accessed May 9, 2019). Under this policy, the Departments will not prevent employers participating in certain association health plans from maintaining their employees' health-insurance coverage until the end of the applicable plan year or contract term. However, the policy cannot address many of the harms the district court's judgment is likely to engender.

For these reasons, the government proposes the following briefing schedule:

05/31/19	Appellants' Opening Brief
06/07/19	Amici for Reversal
07/15/19	Appellees' Response Brief
07/22/19	Amici for Affirmance
07/25/19	Appellants' Reply Brief
08/01/19	Joint Appendices
08/08/19	Final Briefs with Joint Appendix Cites

We further request that the Court calendar the case for argument at the earliest possible time after the summer recess—and before many association health plans created under the final rule cease to be covered by the Departments' nonenforcement policy.

STATEMENT

1. ERISA is a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). For these purposes, an employee welfare benefit plan includes a "plan . . . established or maintained by an employer . . . to the extent that such plan . . . was established or is maintained for the purpose of providing [health coverage] for [the employer's employees] or their beneficiaries." 29 U.S.C. § 1002(1).

Even prior to ERISA's enactment, employers joined together to offer health coverage to their employees collectively, and they have continued to do so after ERISA's enactment. ERISA refers to any arrangement of multiple employers that offers some form of welfare benefits as a "multiple-employer welfare arrangement." 29 U.S.C. § 1002(40)(A). Health coverage sponsored by multiple employers is regulated as a single employee benefit plan—and not as an arrangement of separate plans sponsored by individual employers—only if the group or association of employers sponsoring the coverage qualifies as an "employer" under ERISA. The definition of "employer" under ERISA "means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association acting for an employer in such capacity." *Id.* § 1002(5). Thus, for purposes of ERISA's definition of an employee welfare benefit plan, a group or association of employers that acts "indirectly in the interest of an employer" is an "employer" capable of "establish[ing] or maintain[ing]"

such a plan. *Id.* § 1002(1). The Department of Labor characterizes these plans as "association health plans."

In prior sub-regulatory guidance, the Department focused on three general criteria for determining whether a "group or association of employers" is acting "indirectly in the interests of an employer" under 29 U.S.C. § 1002(5) with respect to an employee welfare benefit plan. *See, e.g.*, U.S. Dep't of Labor, Advisory Opinion 94-07A (Mar. 14, 1994), https://go.usa.gov/xmNBc. These criteria, as set forth in the Department's advisory opinions, first require that the association be a "bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits." *See* 83 Fed. Reg. 28,912, 28,914 (June 21, 2018). Second, the association's members must share some commonality in the form of a sufficiently close economic or representational nexus to the employers and employees that participate in the plan, including a genuine organizational relationship unrelated to the provision of benefits. *Id.* Third, the association's participating employers must "exercise control over the [plan], both in form and substance." *Id.* The Department adopted these criteria to distinguish associations "acting . . . indirectly in the interest of an employer," 29 U.S.C. § 1002(5), from arrangements that more closely resemble insurance companies regulated primarily by state insurance regulators. 83 Fed. Reg. at 28,913.

The Department's past advisory opinions have separately precluded sole proprietors with no other employees from participating in a group or association of

employers that sponsors an association health plan. *See, e.g.*, U.S. Dep't of Labor, Advisory Opinion 94-07A (Mar. 14, 1994), https://go.usa.gov/xmNBc; U.S. Dep't of Labor, Advisory Opinion 07-06A (Aug. 16, 2007), https://go.usa.gov/xmQeW.

2. In 2017, the President signed an executive order urging agencies to "facilitate the purchase of insurance across State lines and the development and operations of a healthcare system that provides high-quality care at affordable prices for the American people." 82 Fed. Reg. 48,385 (Oct. 12, 2017). The order identified association health plans as a potential mechanism for expanding small businesses' access to insurance. Consistent with this directive, the Department of Labor published a notice of proposed rulemaking seeking comment on ways to "broaden the criteria . . . for determining when employers may join together" in an association health plan. 83 Fed. Reg. 614, 625 (Jan. 5, 2018). The Department finalized the rule in June 2018.

3. The final rule's two principal components are designed to make it easier for groups of small-business owners and sole proprietors to form association health plans.

First, the rule creates an "alternative basis for groups or associations [of employers] to meet the definition of an 'employer' under ERISA." 83 Fed. Reg. at 28,955. Under the rule, groups or associations of employers may continue to form association health plans on the basis of the Department's prior guidance. But groups

or associations of employers may also form association health plans on the basis of the criteria the rule sets forth.

These new alternative criteria are modeled on the Department's prior guidance. The final rule retains the requirement that "[t]he functions and activities of the association or group are controlled by its employer members," and that the arrangement's "employer members . . . control the plan." 29 C.F.R. § 2510.3-5(b)(4). However, the rule contains more flexible business-purpose and commonality-of-interest requirements. An association or group of employers can satisfy the rule's business-purpose requirement even if its primary purpose is to provide health coverage, as long as it has "at least one substantial business purpose" unrelated to the provision of health benefits. *Id.* § 2510.3-5(b)(1). And to satisfy the rule's commonality-of-interest requirement, it is sufficient that the association or group members are located in the same geographic area. *Id.* § 2510.3-5(c). The rule also imposes new nondiscrimination rules to prevent association health plans from charging members different premium rates based on the health status of their employees—a restriction that does not apply to association health plans formed under the Department's original criteria.

Second and separately, the rule allows sole proprietors without any common-law employees to participate in association health plans, which they previously could not do. 29 C.F.R. § 2510.3-5(d). The rule accomplishes this by treating a working

owner as an "employer" and "employee" for purposes of participation in and coverage by an association health plan.

The Department concluded that small businesses and self-employed individuals will benefit substantially from expanded access to association health plans. As the rule's preamble explains, the Congressional Budget Office projects that 400,000 uninsured individuals may become insured by 2023 as a result of the rule. 83 Fed. Reg. at 28,951. Another cited study estimates that, by 2022, the expansion of association health plans will lead to premiums that are $1,900 to $4,100 lower than the annual premiums in the small-group market, and $8,700 to $10,800 lower than the annual premiums in the individual market. *Id.* at 28,948.

4. In July 2018, eleven States and the District of Columbia sued the Department of Labor, arguing that the final rule violated the Administrative Procedure Act ("APA") because it exceeded the Department's statutory authority and was arbitrary or capricious. On March 28, 2019, the district court entered summary judgment for plaintiffs. The court ruled that plaintiffs had standing to challenge the rule, and that the Department lacked authority under ERISA to promulgate the principal components of the rule. The court vacated those portions of the rule and remanded the rule to the Department to consider whether anything remained of the rule after the court's judgment.

Two of the rule's three applicability dates took effect before the district court issued its judgment. *See* 83 Fed. Reg. at 28,956 (discussing the three applicability dates

of September 1, 2018, January 1, 2019, and April 1, 2019). Many new association health plans were formed in reliance on the rule, and are now providing health coverage to tens of thousands of small business employees and working owners.[1]

ARGUMENT

The government respectfully asks this Court to adopt the proposed expedited schedule in light of the importance of the issues presented, and the significant costs and disruption that will be occasioned by the district court's judgment in the absence of expedition.

1. Many groups of employers have formed new association health plans in reliance on the rule. Those plans are currently providing health coverage to tens of thousands of small-business employees and working owners. The district court's judgment, if left to stand, will cause plans to cease operating entirely at the end of the applicable plan year or contract term. The Department of Labor understands that some plans may end as soon as September of this year, while others may continue through December 2019.

[1] The final rule was published in the Federal Register on June 21, 2018. The Department has informed us that, after examining annual regulatory filings, a total of 104 new multi-employer welfare arrangements were established between July 1, 2018 and March 31, 2019. This averages to 11.6 new arrangements each month—more than double the average of 4.5 new arrangements created each month in the preceding 36 months. These 104 arrangements cover approximately 40,000 enrollees. The Department believes that many of these new arrangements are association health plans that began operating in response to, and in reliance upon, the final rule.

Without the ability to renew their coverage under their existing association health plan, both employers and employees would be forced to undertake the costly and disruptive process of seeking new coverage in anticipation of plan termination. This transition may not be seamless. The Department of Health and Human Services' regulations provide that insurers may permissibly restrict enrollment to open- or special-enrollment periods. 45 C.F.R. § 147.104(b). If an existing association health plan terminates, before the next open-enrollment period in the individual market (which will run from November 1, 2019 through December 15, 2019), an individual could purchase new insurance on the individual market during the open enrollment period if that individual can afford to do so. However, coverage purchased during the open-enrollment period generally would not become effective until January 1, 2020. *See id.* §§ 155.410(e)(3), (f)(2). An individual may qualify for a special-enrollment period in the individual market, and obtain coverage without having to wait for the open-enrollment period. But that new coverage may not take immediate effect either.[2] During these coverage gaps, individuals would be required to shoulder the full cost of their medical expenses or to forgo medical care.

[2] Under the special-enrollment period that is triggered when an individual loses minimum essential coverage, new coverage can become effective as soon as the first day of the month following the date the association health plan coverage terminates, if the enrollee selects a new plan before the association health plan coverage terminates. However, the effective date of new coverage could be as late as fifteen to forty-five days after the enrollee selects a new plan, if the enrollee cannot select new coverage before the association health plan coverage terminates. *See* 45 C.F.R. §§ 147.104(b)(2),

Small-business employers could likewise be unable to offer new coverage to their employees in a seamless fashion. For example, an employer that cannot satisfy applicable minimum-participation requirements would be barred from offering new coverage to employees outside of the small-group-market open-enrollment period, which extends from November 15 to December 15 each year. *See* 45 C.F.R. § 147.104(b)(1)(i)(B). This would result in a coverage gap extending through January 1, 2020, when new coverage would become effective.

Additionally, whatever new coverage individuals or employers obtain is unlikely to be identical to the coverage their existing association health plan is providing. The new plan may cover different benefits, have higher administrative expenses, include different networks of healthcare providers, or feature higher premiums. These differences will be particularly disruptive for individuals who are receiving a course of treatment. Furthermore, both employers and employees may pay more for coverage as a result of having to change coverage—and some may be unable to afford coverage entirely.

The regulatory uncertainty created by the district court's judgment may even encourage employers to cease current coverage unexpectedly *before* the end of the plan or contract year. For similar reasons, employees affected by this unanticipated loss of

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(b)(5); 155.420(b)(1), (b)(2)(iv), (d)(1). For individuals exercising a special-enrollment right in a group health plan (such as a spouse's plan or a parent's plan), coverage must be made effective no later than the first day of the first month following the date of the request. 29 C.F.R. § 2590.701-6(a)(4).

coverage would likely be subject to gaps in coverage, *supra* p. 10, during which they would be required to shoulder the full cost of their medical expenses or to forgo medical care. Even if affected employees *were* able to obtain new insurance coverage seamlessly, any deductibles they paid under their prior plan would likely not count toward out-of-pocket-spending limits under their new plan. The current out-of-pocket spending maximum is $7,900 for individual coverage and $15,800 for family coverage. *See* 83 Fed. Reg. 16,930, 17,022 (Apr. 17, 2018). An individual or family who has already reached their out-of-pocket spending maximum under their preexisting plan could therefore be exposed to an additional $7,900 or $15,800 in medical expenses simply by virtue of being required to obtain new coverage after their existing coverage terminates prematurely.

Finally, for as long as the district court's judgment remains in effect, the judgment will prevent new association health plans from being formed under the rule. This may preclude hundreds of thousands of individuals from accessing the affordable and high-quality coverage the rule was intended to create. As noted, the Congressional Budget Office estimates that up to 400,000 uninsured individuals may become insured by the year 2023 as a result of the rule. 83 Fed. Reg. at 28,951. Another study estimates that currently insured individuals may save thousands of dollars in lower premiums by the year 2022. *Id.* at 28,948.

The Department of Labor and the Department of Health and Human Services have attempted to mitigate some of these harms through the nonenforcement policy

cited above. But if the district court's judgment remains in effect when association health plans created under the rule reach the end of their applicable contract term or plan year, the Departments will be unable to prevent them from shutting down. Similarly, the Departments cannot prevent employers from voluntarily dropping coverage offered through an association health plan before that plan's scheduled termination date. And the Departments cannot prevent States from attempting to enforce insurance laws against coverage sold to plans created under the final rule on the assumption that the plans would be regulated as association health plans under ERISA.

2. Expedition is also warranted because the district court's rulings rest on substantial errors of law. As a threshold matter, the court incorrectly ruled that plaintiffs had standing to challenge the final rule based on allegations that the rule would reduce their "tax revenue or administrative fees paid to state agencies for small group and individual plans obtained on a state insurance exchange." Op. 14. "Lost tax revenue is 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 v. Kleppe*, 533 F.2d 668 (D.C. Cir. 1976)). And even assuming that lost tax revenue were a cognizable injury, APA lawsuits such as this one "may not proceed unless the interest asserted by the plaintiff is arguably within the zone of interests to be protected or regulated by the statute that [plaintiff] says was violated." *Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians v. Patchak*, 567 U.S. 209, 224 (2012). ERISA was enacted to

establish uniform standards to "protect the interest of participants in employee benefit plans and their beneficiaries," 29 U.S.C. § 1001(b), and to encourage employers to offer employee benefit plans to their employees, *Conkright v. Frommert*, 559 U.S. 506, 517 (2010). Plaintiffs' asserted injury thus falls outside the zone of interests regulated by ERISA.

The district court also erred in finding standing based on plaintiffs' allegations that the final rule will increase the likelihood that association health plans will engage in fraud, leading them to incur regulatory costs in response. Op. 17-19. It is unclear why association health plans in any particular state should be deemed likely to commit fraud, notwithstanding the safeguards present in the final rule and the prospect of enforcement by the Department of Labor. That "highly attenuated chain of possibilities" fails to "satisfy [Article III's] requirement that threatened injury must be certainly impending." *See Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 410 (2013). Moreover, to the extent that plaintiffs wish to provide enforcement in addition to that provided by the Department, that injury would result exclusively "from decisions by their respective state" enforcement divisions. *See Pennsylvania v. New Jersey*, 426 U.S. 660, 664 (1976) (per curiam). "[S]elf-inflicted injuries" of this sort "are not fairly traceable to" the final rule. *See Clapper*, 568 U.S. at 418.

With respect to the merits, the district court erred in concluding that the final rule is an unreasonable interpretation of ERISA's ambiguous definition of "employer." That provision defines "employer" to include a "group or association of

employers" acting "indirectly in the interest of an employer." 29 U.S.C. § 1002(5). The limiting phrase "indirectly in the interest of an employer" plainly excludes associations that represent not the employers' interests but their own. In enacting ERISA, Congress intended to distinguish between employee welfare benefit plans (which are governed by ERISA) and entrepreneurial ventures selling insurance for a profit to unrelated entities (which are governed by state insurance regulators). *See Report of the Committee on Educ. & Labor*, H.R. Rep. No. 1785, at 48 (1977). But neither ERISA's text nor its purpose restricts the Department's discretion to set criteria for determining whether a given association adequately acts in employers' interests. As to that question, the "touchstone of the Department's analysis has long been whether the . . . association has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan." 83 Fed. Reg. at 28,928.

Like the criteria established by the Department's prior advisory opinions, the final rule requires that an association health plan be controlled "in form and in substance" by the employers that created the sponsoring association, and that the member employers participate in the plan and control the association itself. 83 Fed. Reg. at 28,955. As the rule explains, this "control test is necessary" to ensure that an association is responsive to the demands of the employers it serves. *Id.* It is "also necessary to prevent formation of commercial enterprises that claim to be [association health plans] but, in reality, merely operate similar to traditional insurers selling insurance in the group market." *Id.* Indeed, meeting this rigorous condition may by

itself be sufficient to satisfy ERISA's requirement that the association sponsoring an association health plan act "indirectly in the interest of an employer." That the employers creating that association may operate in different sectors or different cities arguably is not necessary to resolve the statutory question as to whether the association acts "indirectly in the interest of an employer." The same is arguably true even if the association created by those employers has no purpose other than providing health coverage. As long as the bona fide association and plan remain in the employers' control in form and in substance, the association is acting "indirectly in the interest of" the employers that are its members.

In any event, the final rule still requires that an association satisfy substantial-purpose and commonality-of-interest requirements. As the Department explained, these requirements—even as altered by the rule—may continue to "assist substantially in drawing the line between traditional health insurance issuers" and bona fide associations that sponsor employment-based arrangements. *See* 83 Fed. Reg. at 28,918. (For precisely this reason, the final rule prohibits insurance issuers and related entities from sponsoring association health plans. *Id.* at 28,921-22.) Additionally, the Department imposed new nondiscrimination requirements on association health plans created under the new alternative criteria which forbid associations from "condition[ing] individual employer members' eligibility for benefits or premiums on their respective employees' health status." *Id.* at 28,957. These requirements further

"ensure that [a] group or association" created under the final rule "is distinguishable from commercial-insurance-type arrangements." *Id.*

The district court nonetheless vacated the final rule's alternative criteria on the theory that the revised substantial-purpose and commonality-of-interest requirements failed to "place reasonable constraints on the types of associations that act 'in the interest of' employers under ERISA." Op. 25. But nothing in ERISA unambiguously compels the Department to retain the constraints on association health plans favored by the district court as a policy matter. The Department reasonably concluded that groups or associations formed under the final rule's terms still bear "a sufficiently close economic or representational nexus to the employers and employees that participate in the plan" to be regulated as ERISA plans. *See* 83 Fed. Reg. at 28,928. That judgment warrants deference.

The district court also erroneously vacated the final rule's working-owner provisions. In *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004), the Supreme Court recognized that "a working owner may have dual status [under ERISA], *i.e.*, he can be an employee entitled to participate in a plan and, at the same time, the employer . . . who established the plan." *Id.* at 16. As the district court acknowledged, *Yates* "opens the door for any sole proprietor . . . to qualify as dual-status employee and employer under ERISA." Op. 36. The court attempted to limit this holding to plans with at least one other participant who is not a working owner, relying on dictum in *Yates* to that effect. Op. 37 & n.19 (discussing *Yates*, 541 U.S. at

21 n.6). But *Yates*'s suggestion that plans covering working owners without employees categorically fall outside ERISA was premised on a Department of Labor regulation containing that prohibition. 541 U.S. at 21. In this final rule, the Department altered the very regulation on which *Yates* relied. The district court's reliance on *Yates*'s dictum is therefore inapposite. *See National Cable & Telecommc'ns Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 982 (2005).

In sum, because the district court's judgment rests on substantial legal errors, and because the general public has an unusual and strongly compelling interest in the prompt disposition of this appeal, expedited briefing and argument is warranted.

3. The government has conferred with counsel for plaintiffs, who do not oppose the proposed schedule.

CONCLUSION

For these reasons, the expedition motion should be granted.

Respectfully submitted,

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MAY 2019

CERTIFICATE OF SERVICE

I hereby certify that on May 9, 2019, I electronically filed the foregoing document with the Clerk of this Court by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and will be served through the CM/ECF system.

/s/ Michael Shih
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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing motion complies with the requirements of Fed. R. App. P. 27(d) because it has been prepared in 14-point Garamond, a proportionally spaced font. I further certify that this motion complies with the type-volume limitation of Fed. R. App. P. 27(d)(2) because it contains 4,247 words according to the count of Microsoft Word.

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