**[NOT YET SCHEDULED FOR ORAL ARGUMENT]**

**No. 19-5125**

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

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STATE OF NEW YORK, *et al.*,

Plaintiffs-Appellees,

v.

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

Defendants-Appellants.

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

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# BRIEF FOR APPELLANTS

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## 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; R. Alexander Acosta, in his official capacity as Secretary of the U.S. Department of Labor; and the United States of America.

Amici before the district court include: (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. No amici or intervenors are currently before this Court.

### 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

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|---|---|
| ACA | Patient Protection and Affordable Care Act |
| APA | Administrative Procedure Act |
| ERISA | Employee Retirement Income Security Act of 1974 |

## INTRODUCTION

This case concerns a rule issued by the Department of Labor to expand access to affordable and high-quality healthcare coverage. For decades, employers have banded together to provide health coverage for their employees by participating in association health plans established pursuant to the Employee Retirement Income Security Act ("ERISA"). Such plans are treated as a single employee benefit plan under ERISA because ERISA's definition of "employer" includes "a group or association of employers" that acts "indirectly in the interest of an employer." 29 U.S.C. § 1002(5). The rule, promulgated under the Department's authority to implement ERISA, makes it easier for employers—especially small businesses and working owners—to participate in association health plans. It does so in two ways. First, the rule provides a set of alternative criteria for employers to form association health plans, by adopting an alternative interpretation of the "employer" definition than the Department established through prior sub-regulatory guidance. Second, the rule allows working owners without common-law employees to participate in association health plans, which the Department's sub-regulatory guidance previously had rejected.

Eleven States and the District of Columbia ("the States") challenged the rule in district court. They argued that the rule violated the Administrative Procedure Act ("APA") because, as relevant here, it exceeded the Department's statutory authority. Although the district court rejected many of the States' arguments supporting their

standing to sue, the court held that at least some States had a basis to challenge the rule on two particular grounds. The court then held that the rule's principal components unreasonably implemented ERISA. That judgment was erroneous in every respect.

To begin, the district court erroneously held that the States have a judicially cognizable injury providing a basis to challenge the rule. The court incorrectly relied on allegations that the rule would reduce the States' tax revenue. Lost tax revenue is not generally cognizable as an Article III injury-in-fact, and regardless, any injury to the States' revenues from the rule's expansion of their citizens' healthcare-coverage options is entirely unrelated to, and positively inconsistent with, the zone of interests protected by ERISA for purposes of an APA action. The court also incorrectly relied on assertions that the States would incur heightened regulatory costs with respect to plans allowed by the rule. Any such costs are speculative, self-inflicted, or both.

Turning to the merits, the court further erred in concluding that the rule's alternative criteria for establishing association health plans unreasonably implement ERISA's ambiguous phrase "indirectly in the interest of an employer." Those criteria—which are derived from the Department's prior sub-regulatory guidance and which do not displace that guidance—are more stringent in some respects and more flexible in others. They require an association health plan created under them to be controlled by its employer members, and they prohibit the plan from discriminating among its members based on their employees' health status. The association must

also have some additional, non-benefit-related business purpose, and its members must share certain interests in common. The Department reasonably concluded that these criteria are more than sufficient to ensure that a group created under the rule acts "indirectly in the interest" of the group's employer members—a statutory requirement Congress enacted, in part, to exclude groups such as commercial insurance providers that represent not employers' interests but their own. The district court found these criteria unreasonable because their purpose and commonality requirements are less stringent than under the Department's prior sub-regulatory guidance, and do not exclude plans established by employers principally to offer healthcare benefits on better terms for themselves and their employees. The most fundamental flaw in that reasoning is that employers' interest in obtaining such benefits for their employees is entirely legitimate and reasonable under ERISA—and the court simply assumed otherwise without any explanation.

The court was also wrong to conclude that the rule's working-owner provision unreasonably implemented ERISA. The Supreme Court has held that the owner of a company can be both an employer and an employee for purposes of establishing and participating in an ERISA-covered benefit plan. *See Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004). The district court relied on a footnote in *Yates* that distinguished the question whether a working owner with no other employees could obtain an ERISA plan for himself. Mem. Op. 37(JA__) (citing *Yates*, 541 U.S. at 21 n.6). But that question is not the same as the one presented here:

Whether a working owner with no other employees can participate in an association health plan as an "employer." And regardless, *Yates*'s footnote is inapposite because it relied on cases decided on the basis of a regulation that the Department has altered in this very rule.

## STATEMENT OF JURISDICTION

The district court had jurisdiction over the States' APA challenge to the rule under 28 U.S.C. § 1331. The district court entered final judgment on March 28, 2019. Order 2(JA__). The government timely appealed. Notice of Appeal 1(JA__). This Court has jurisdiction under 28 U.S.C. § 1291.

## STATEMENT OF THE ISSUES

1. Whether the States have a judicially cognizable injury supporting a right to challenge the rule.

2. Whether the rule's criteria for creating association health plans reasonably implement ERISA.

3. Whether the rule's working-owner provision reasonably implements ERISA.

4. Whether nationwide vacatur of the challenged provisions was overbroad.

## PERTINENT STATUTORY AND REGULATORY PROVISIONS

Pertinent statutory and regulatory provisions are reproduced in the addendum to this brief.

## STATEMENT OF THE CASE

### A. Statutory and Regulatory Background

Congress enacted the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.*, to establish a "comprehensive" statutory regime "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); *see* 29 U.S.C. § 1001(b). ERISA defines an "employee welfare benefit plan" as any "plan . . . established or maintained by an employer . . . for the purpose of providing [certain benefits] for its participants or their beneficiaries, through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Because these benefits, including the provision of healthcare coverage, are employment-based, *id.*, an employee benefit plan established by an employer is regulated primarily by the Department of Labor under ERISA. By contrast, health insurance purchased from commercial insurance companies is regulated primarily by state insurance regulators under laws governing the health-insurance marketplace.

Since before ERISA's enactment, employers have joined together to offer healthcare coverage to their employees collectively. And employers have continued to do so after ERISA's enactment. ERISA refers to a group of multiple employers that offers some form of welfare benefits, including healthcare coverage, as a "multiple employer welfare arrangement." *See* 29 U.S.C. § 1002(40)(A). Healthcare coverage sponsored by such groups is regulated by the Department of Labor as a single employee benefit plan under ERISA if and only if the group satisfies ERISA's

statutory definition of "employer." That definition extends not only to "any person acting directly as an employer" but also to any person acting "indirectly in the interest of an employer[] in relation to an employee benefit plan," and "includes a group or association of employers acting for an employer in such capacity." *Id.* § 1002(5). A "group or association" of employers that acts "indirectly in the interest of an employer" is therefore an "employer" capable of "establish[ing] or maintain[ing]" an employee benefit plan under ERISA. *Id.* § 1002(1). The Department of Labor calls such plans "association health plans."

For decades, the Department in sub-regulatory guidance has examined three general criteria to determine when a group of employers is acting "indirectly in the interests of an employer." *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, are designed to distinguish such groups from arrangements that act not in their members' interests but their own—including arrangements that more closely resemble commercial insurance providers regulated not by ERISA but by state insurance regulators. *See* 83 Fed. Reg. 28,912, 28,913-14 (June 21, 2018). First, the group must be a "bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits." *Id.* at 28,914. Second, the group's employer members must "share some commonality and genuine organizational relationship unrelated to the provision of

benefits." *Id.* Finally, the group's employer members must "exercise control over the program, both in form and substance." *Id.*

The Department also has considered, again in sub-regulatory guidance, the separate question whether working owners—who not only own businesses but also work for the businesses that they own—can be "employers" capable of participating in an association health plan. The Department's prior advisory opinions concluded that working owners "without common-law employees are not eligible to be treated as 'employers' for purposes of participating" in an association health plan. U.S. Dep't of Labor, Advisory Opinion 2007-06A (Aug. 16, 2007), https://go.usa.gov/xmQeW; *see also, e.g.*, U.S. Dep't of Labor, Advisory Opinion 94-07A (Mar. 14, 1994), https://go.usa.gov/xmNBc. These opinions did not explain how the Department reached this conclusion. They were issued, however, against the backdrop of a regulation that excluded benefit plans established by working owners from ERISA Title I coverage if they and their spouses were the sole participants. *See* 29 C.F.R. § 2510.3-3(c)(1) (1976) (promulgated by 40 Fed. Reg. 34,526, 34,528, 34,532-33 (Aug. 15, 1975)).

### B. The Challenged Rule

In 2017, the President signed an executive order urging agencies to "facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people." 82 Fed. Reg. 48,385, 48,385 (Oct. 12, 2017). The order identified

association health plans as a potential mechanism for expanding small businesses' access to healthcare coverage. 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" to offer an association health plan. 83 Fed. Reg. 614, 633 (Jan. 5, 2018). The Department finalized the rule in June 2018. 83 Fed. Reg. at 28,912. The rule is designed to make it easier for groups of small-business owners and sole proprietors to form association health plans, and accomplishes these ends in two principal ways.

First, the rule adopts several criteria as an "alternative basis for groups or associations [of employers] to meet the definition of an 'employer' under ERISA." 83 Fed. Reg. at 28,955; *see* 29 C.F.R. § 2510.3-5(b). These criteria are modeled on the three criteria described in the Department's prior sub-regulatory guidance, which the Department has historically examined to determine whether a group of employers is acting "indirectly in the interest of" its employer members. Under the rule, a group of employers is still permitted to meet the definition of "employer" as implemented by the Department's prior guidance. This case concerns only the rule's new alternative criteria.

The new criteria retain the requirement that "[t]he functions and activities of the group or association are controlled by its employer members," and that the association's "employer members . . . control the plan." 29 C.F.R. § 2510.3-5(b)(4). Such "[c]ontrol must be present both in form and in substance." *Id.* But the new

criteria are more flexible than the Department's prior guidance because, under these criteria, a group of employers can satisfy the business-purpose requirement even if the group's primary purpose is to provide healthcare coverage, so long as the group has "at least one substantial business purpose" unrelated to the provision of healthcare benefits. *Id.* § 2510.3-5(b)(1). Similarly, a group of employers may satisfy the commonality-of-interest requirement under the new criteria if its employer members are located in the same State or geographic area, such as the "Washington Metropolitan Area of the District of Columbia and portions of Maryland and Virginia." *Id.* § 2510.3-5(c); *see* 83 Fed. Reg. at 28,924.

In one significant respect, the new criteria are more stringent than the Department's prior guidance. They include a fourth, wholly new criterion under which "[t]he group or association and health coverage offered by the group or association [must] compl[y] with" strict nondiscrimination rules designed to prevent association health plans from charging employer members different premium rates based on the health status of their employees. 29 C.F.R. § 2510.3-5(b)(7), (d). This restriction is intended, in part, to ensure that the group is distinguishable from commercial insurance-type arrangements, which lack the requisite connection to the employment relationship and whose purpose is, instead, principally to identify and manage risk on a commercial basis. 83 Fed. Reg. at 28,929. The restriction does not apply to association health plans operating under the Department's prior guidance. *Id.*

Second and separately, the rule allows working owners without common-law employees to participate in association health plans. 29 C.F.R. § 2510.3-5(e). The rule accomplishes this by amending the Department's regulations to clarify that a working owner may be both an "employer" and "employee" for purposes of participating in, and being covered by, an association health plan. *Id.*; *see id.* § 2510.3-3(c).

The Department concluded that small businesses and working owners will benefit substantially from expanded access to association health plans. The Department found that, by participating in such plans, some employers can take advantage of "increased bargaining power vis-à-vis . . . benefit providers," "economies of scale," "administrative efficiencies," and "a more efficient allocation of plan responsibilities." 83 Fed. Reg. at 28,912. 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. *Id.* at 28,951. Another cited study estimates that, by 2022, the expansion of association health plans will lead to annual 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.

### C. Prior Proceedings

In July 2018, eleven States and the District of Columbia sued the Department of Labor in district court. They argued that the rule violated the Administrative

Procedure Act, 5 U.S.C. § 551 *et seq.*, because it exceeded the Department's statutory authority and was arbitrary or capricious.

The court entered summary judgment for the States. Although the court rejected most of the States' theories of standing, the court ruled that at least some States had standing to sue on two particular theories. Mem. Op. 14-15(JA__-__). The court then ruled that the rule's principal components unreasonably implemented ERISA. Mem. Op. 42(JA__). The court remanded the rule to the Department without addressing the question whether the rule was arbitrary or capricious. Mem. Op. 42(JA__).

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 healthcare coverage to tens of thousands of small-business employees and working owners.[1]

[1] The rule was published in the Federal Register on June 21, 2018. The Department has informed us that, after examining annual regulatory filings, approximately 104 new multiple 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. From these data and other publicly available information, the Department believes that many of these new arrangements are association health plans that began operating in response to, and in reliance upon, the rule.

## SUMMARY OF ARGUMENT

**I.** The district court's judgment should be reversed because plaintiffs—eleven States and the District of Columbia—lack judicially cognizable injuries supporting a right to challenge the rule. The rule does not regulate state behavior or directly injure the States in any other cognizable way. Although the court correctly rejected most of the States' theories of standing, it erroneously concluded that at least some States could establish standing based on two asserted injuries to their economic interests.

First, the district court incorrectly held that some States had standing because the rule's expansion of self-insurance options might reduce their tax revenues. Those States suggested that employers who previously paid state taxes on health insurance premiums would opt to obtain healthcare coverage for their employees through association health plans that those States do not currently tax. But lost tax revenues are "not cognizable as an injury-in-fact for purposes of standing" in circumstances such as these. *Arias v. DynCorp*, 752 F.3d 1011, 1015 (D.C. Cir. 2014). Even if they were, any financial injury the States may suffer from the rule's expansion of healthcare coverage options for their citizens falls well outside "the zone of interests to be protected or regulated by" ERISA. *See Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians v. Patchak*, 567 U.S. 209, 224 (2012).

Second, the district court incorrectly held that some States had standing because they would incur regulatory costs to combat potential fraud and

mismanagement by association health plans. As the challenged rule does not task States with taking any oversight actions, any such burden on the States is their own self-inflicted choice. Moreover, they "cannot manufacture standing merely by inflicting harm on themselves based on their fears of hypothetical future harm." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 416 (2013); *see Pennsylvania v. New Jersey*, 426 U.S. 660, 664 (1976) (per curiam) ("No State can be heard to complain about damage inflicted by its own hand."). The States' speculation that these self-inflicted costs are necessary to protect against the hypothetical misconduct of third parties only underscores that the States cannot show that their threatened injury is both "certainly impending" and fairly traceable to the challenged rule. *See Clapper*, 568 U.S. at 410.

**II.** Reversal is warranted even assuming that the States have a basis to challenge the rule. The rule's alternative pathway to forming an association health plan reasonably implements ERISA's ambiguous definition of an "employer" as including "a group or association of employers" that acts "indirectly in the interest of an employer." 29 U.S.C. § 1002(5).

The Department of Labor has long interpreted the limiting phrase "indirectly in the interest of an employer" to exclude arrangements such as "commercial insurance-type arrangements," which act not in employers' interests but their own. 83 Fed. Reg. 28,912, 28,914 (June 21, 2018). Neither the district court nor the States dispute that general approach, which the rule does not alter. The rule simply adopts alternative criteria for determining whether a given entity too closely resembles such

commercial arrangements. Although these criteria are in some respects more flexible than the criteria set forth in the Department's prior advisory opinions, they are just as (if not more) restrictive in the most critical respects, and as a whole accomplish the same objective.

In particular, the new criteria retain a rigorous control requirement under which an association's employer members must control both the association and the plan "in form and in substance." 83 Fed. Reg. at 28,955. And the criteria include a wholly new requirement prohibiting association health plans from conditioning eligibility for membership, offering coverage, or charging differential premiums to employer members based on the health status of their employees in violation of the rule's stringent nondiscrimination provisions. *Id.* at 28,957. This new requirement further ensures that commercial insurance-type arrangements do not operate under the guise of the rule as a group or association acting indirectly in the interest of employers. *Id.* The Department reasonably concluded that an association meeting these control and nondiscrimination requirements—and that further meets the rule's business-purpose and commonality requirements—acts "indirectly in the interest of" its employer members, even though the business-purpose and commonality standards under these criteria are relaxed compared to the Department's prior sub-regulatory guidance.

The district court acknowledged both that the provision of ERISA at issue is ambiguous, and that the Department has authority to interpret it. The court nevertheless vacated these alternative criteria on the theory that they might still allow

"groups that closely resemble entrepreneurial, profit-driven commercial insurance providers to qualify for ERISA's protections." Mem. Op. 33(JA__). The court believed that, as a policy matter, the Department's prior guidance more effectively policed the line between employee benefit plans and commercial insurance-type arrangements. But the Department reasonably found that an association that (1) is controlled by its employer members, (2) is forbidden from discriminating among its members based on the health status of their employees, and (3) satisfies the rule's other requirements, is not akin to a commercial insurance-type arrangement for these purposes and is acting "in the interest of" its employer members. In concluding otherwise, the court wrongly substituted its policy preferences for the Department's judgment that association health plans formed under the rule still bear "a sufficiently close economic or representational nexus to the employers and employees that participate in the plan" to be regulated under ERISA. *See* 83 Fed. Reg. at 28,928. That expert judgment warrants deference.

**III.** The district court was likewise wrong to vacate the rule's working-owner provision. 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 . . . can be an employee entitled to participate in a plan and, at the same time, the employer . . . who established the plan." *Id.* at 16. The district court relied on a footnote in *Yates* that distinguished the question whether the same can be said for a working owner with no other employees. Mem. Op. 37(JA__) (citing *Yates*, 541 U.S. at 21 n.6). But the

question addressed by that dictum is not the same as the question presented here: Whether a working owner with no other employees can participate in an association health plan as an "employer." And even if the footnote's analysis were relevant, its conclusion would be inapposite because it relied on cases decided on the basis of the very regulation altered by this rule. 83 Fed. Reg. at 28,961 (amending 29 C.F.R § 2510.3-3(c)); *see National Cable & Telecommc'ns Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 982-83 (2005).

**IV.** At a minimum, the district court erred by vacating the rule nationwide. Any vacatur should be no broader than necessary to provide full relief to the plaintiff States actually injured by the rule, and the States have not demonstrated the need for nationwide relief.

## STANDARD OF REVIEW

This Court reviews a grant of summary judgment de novo. *See Silver State Land, LLC v. Schneider*, 843 F.3d 982, 989 (D.C. Cir. 2016). The challenged rule may be set aside only if it was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). The Department of Labor's interpretation of an ambiguous statutory provision must be upheld if it is reasonable. *Chevron U.S.A. Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-44 (1984).

## ARGUMENT

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

To establish standing under Article III of the Constitution, plaintiffs must prove that they have "(1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016) (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992)). The injury alleged must be "concrete, particularized, and actual or imminent[.]" *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013).

Moreover, even where plaintiffs have Article III standing, they must also establish that they fall "within the class of persons whom Congress has authorized to sue." *Mendoza v. Perez*, 754 F.3d 1002, 1016 (D.C. Cir. 2014). To do so, plaintiffs must demonstrate that their alleged injury comes within the "zone of interests to be protected or regulated by the statute." *Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians v. Patchak*, 567 U.S. 209, 224 (2012); *see also Mountain States Legal Found. v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996). Under the APA, a plaintiff falls outside this zone when its interests "are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit." *Clarke v. Securities Indus. Ass'n*, 479 U.S. 388, 399 (1987).

Plaintiffs in this case—eleven States and the District of Columbia—have failed to make the requisite showing here. As the district court recognized, the rule regulates employers seeking to form association health plans, not States. *See* Mem. Op. 7-8(JA__-__). The rule interprets ERISA's "employer" definition; it does not command any State to take or to refrain from taking any action.

The district court nevertheless ruled that at least some States could establish standing on the basis of two alleged injuries to their economic interests. First, the court determined that the rule's "intended expansion of self-insured [association health plans]" would "decrease state tax revenues." Mem. Op. 15(JA__). According to the court, increased access to self-insured association health plans would make traditional insured plans less desirable. Mem. Op. 16(JA__). This, in turn, might cause employers to join self-insured or out-of-state insured association health plans, which would reduce state tax revenues collected on in-state insured plans. The court identified only three States—Delaware, New Jersey, and Washington—who could establish this injury. Mem. Op. 15(JA__). Second, the court held that many States had adequately demonstrated injury in the form of increased regulatory costs. For example, Delaware asserted that it has "begun expending regulatory resources to answer 'multiple inquiries' about" the rule's regulatory requirements. Mem. Op. 17(JA__). And several other States asserted that they anticipated needing to hire staff to combat potential fraud and mismanagement by association health plans. Mem. Op. 17-18(JA__). Both rulings were erroneous.

### 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)). Only where a State can allege some "fairly direct link between the state's status as a collector and recipient of revenues and the legislative or administrative action being challenged" can the reduced revenue be sufficient to support Article III standing. *Kleppe*, 533 F.2d at 672. Standing does not exist "where diminution of tax receipts is largely an incidental result of the challenged action." *Id.*; *see also Wyoming v. Oklahoma*, 502 U.S. 437, 448 (1992).

This Court first explained the need for a clear "direct link" between the allegedly unlawful conduct and a specific revenue source in *Kleppe*. There, several States affected by a hurricane were dissatisfied with the disaster assistance offered by the Small Business Administration. *Kleppe*, 533 F.2d at 670. They alleged that the inadequacy of the loans provided by the Small Business Administration would cause a reduction in the States' tax revenues. *Id.* at 671. This Court concluded that the reduction in tax revenues was "largely an incidental result" of the Small Business Administration's decision. *Id.* at 672. "[V]irtually all federal policies" will have "unavoidable economic repercussions" on state tax revenues, and accordingly, complaints about such losses typically amount to "the sort of generalized grievance

about the conduct of government, so distantly related to the wrong for which relief is sought, as not to be cognizable for purposes of standing." *Id.* Because the challenged action did not directly target state fiscs, any reduction in state tax revenues was insufficient to support standing. *Accord Iowa ex rel. Miller v. Block*, 771 F.2d 347, 354 (8th Cir. 1985) (holding that there was an insufficiently direct link between reduced tax revenue and disaster relief decisions to support standing).

This Court reached a similar conclusion in *Arias*. There, several Ecuadorian provinces alleged that they were injured by an anti-drug herbicide-spraying operation conducted by an American company because the herbicide damaged local crops property, resulting in a measurable loss of the provinces' tax revenue. *Arias*, 752 F.3d at 1013-14. This Court held that this incidental effect on the tax revenue was not cognizable as injury in fact, and in any event, that the decreased revenue was not fairly traceable to the herbicide spraying. *Id.* at 1015.

Here as in *Kleppe* and *Arias*, any reduction in tax revenue caused by the challenged rule is incidental to the challenged rule. The direct effect of the rule is to expand employers' access to association health plans. The availability of health coverage through such plans could potentially make state-taxed plans less desirable and reduce a State's tax revenue. *See* Mem. Op. 16(JA__); *see also* 83 Fed. Reg. at 28,943 (noting that self-insured association health plans "sometimes *may* avoid the potentially significant cost to comply with State rules that apply to large group issuers, including for example premium taxes") (emphasis added). But this reduced revenue is

neither a certain nor direct result of the rule—just like the general harms to a State's tax-revenue stream that this Court found insufficient to support standing in *Kleppe* and *Arias*.

The facts of *Wyoming*, *supra*, on which the district court relied, stand in stark contrast to the facts of this case. *Wyoming* concerned a law enacted by Oklahoma that required Oklahoma utility companies "to blend ten percent Oklahoma coal with their present use of Wyoming coal." 502 U.S. at 443-44. Prior to the law's enactment, Oklahoma utility companies used nearly 100% Wyoming coal, for which Wyoming charged a severance tax. *Id.* at 445. In enacting the law, the Oklahoma legislature noted that, as a result of that tax, Oklahoma ratepayers were paying Wyoming $9 million per year, and that the law was intended to allow a significant portion of that money to remain in Oklahoma. *Id.* at 443. After the law's enactment, Oklahoma businesses purchased less Wyoming coal, reducing Wyoming's tax revenues accordingly. *Id.* at 446-48. The Supreme Court held that the direct link between Oklahoma's law and a specific stream of tax revenue was sufficient to support Wyoming's standing to sue. *Id.* at 447.

Unlike the law challenged in *Wyoming*, the challenged rule does not mandate a reduction of state-taxed plans or require employers to abandon insurance they already buy through the small-group market to instead join newly formed association health plans. *See* 502 U.S. at 446-48. To the contrary, employers (including working owners) remain free to choose between an association health plan and other types of

healthcare coverage, including plans that are taxed by States. Thus, any lost tax revenues a State might sustain are "directly linked" not to the challenged rule but to the unfettered choices of third parties. *See id.* at 450; *cf. Lujan*, 504 U.S. at 562 (explaining that standing "is ordinarily 'substantially more difficult' to establish" when an alleged injury turns on the conduct of third parties).

Furthermore, nothing in the rule prevents States from imposing similar taxes on self-insured association health plans. 83 Fed. Reg. at 28,943 ("Under this final rule, . . . States retain authority to extend [rules such as premium taxes] to self-insured [association health plans]."); U.S. Dep't of Labor, Advisory Opinion 2005-18A (Aug. 1, 2005) (advising that ERISA does not preempt States from taxing self-funded multiple employer welfare arrangements), https://go.usa.gov/xmsSk; *see also* Mem. Op. 11(JA__) (noting the parties' agreement that the rule "does not directly preempt state law" because the rule expresses the Department of Labor's intention to retain state regulation of association health plans). Because States remain free to impose similar taxes and fees on insurance policies that association health plans purchase and on association health plans that self-insure, any alleged loss in premium tax revenue is a self-imposed harm insufficient to support standing. *See infra* pp. 26-27.

Even if the States' allegations of lost tax revenue were sufficient to support Article III standing, the purported injury is well outside "the zone of interests to be protected or regulated by [ERISA]." *See Patchak*, 567 U.S. at 224. "The fundamental, and unexceptionable, idea behind" the zone-of-interests rule "is a presumption that

Congress intends to deny" a right to sue "to 'those plaintiffs whose suits are more likely to frustrate than to further statutory objectives.'" *Hazardous Waste Treatment Council v. Thomas*, 885 F.2d 918, 922 (D.C. Cir. 1989) (quoting *Clarke*, 479 U.S. at 397 n.12). A plaintiff is not a "suitable challenger" of agency action under the zone-of-interest test if its interests are "so marginally related to or inconsistent with the purposes implicit in the statute [the agency allegedly violated] that it cannot reasonably be assumed that Congress intended to permit the suit." *Clarke*, 479 U.S. at 399; *see also Kleppe*, 533 F.2d at 671 (concluding that States' interest in protecting their tax revenue did "not satisfy the requirement of being arguably within the zone of interests protected by the Small Business Act").

As this Court held in *Kleppe*, a State's allegations of lost tax revenues fall outside the zone of interests where, as here, any diminution to the fisc is the result of a statute Congress enacted to promote particular objectives without regard to the States' financial interests. 533 F.2d at 671-72. The *Kleppe* case, as noted, arose from loan decisions made by the Small Business Administration in the aftermath of a hurricane. In rejecting the States' allegations of reduced tax revenue as outside the zone of interests protected by the Small Business Act (the Administration's enabling statute), this Court explained that Congress enacted that statute "for the narrow purpose of assisting small businesses" and preserving a "freely competitive economy." *Id.* The Act's substantive provisions authorized "various forms of assistance running directly from the [Administration] to the business concerns themselves," but did not authorize

any aid to be channeled "through state agencies or coordinated with state programs." *Id.* at 672. And neither the substantive provisions nor the legislative history of the Act "indicate[d] any concern for the well-being of the states as distinct political units." *Id.* Accordingly, this Court determined that a State's interest in protecting its tax revenues "d[id] not satisfy the requirement of being arguably within the zone of interests protected by the Small Business Act." *Id.* at 671.

These principles, which the district court did not address, foreclose reliance on plaintiffs' fiscal injury. Congress enacted ERISA to create "adequate" and nationally uniform "safeguards . . . with respect to the establishment, operation, and administration" of employee benefit plans, and to protect the "interests of employees and their beneficiaries." 29 U.S.C. § 1001(a). And the substantive provision of ERISA at issue—its definition of "employer" as including a "group or association of employers" that acts "indirectly in the interest of an employer," *id.* § 1002(5)—was enacted to recognize and regulate employee benefit plans sponsored by bona fide groups of employers as opposed to commercial insurance-type arrangements. *See infra* pp. 31-32. Nowhere in ERISA's text, purposes, or history did Congress indicate that this definition was even arguably intended to protect State fiscs.

Thus, just as in *Kleppe*, the States' fiscal interests are so marginally related to ERISA's purposes that they fall outside the zone of interests that ERISA protects. *See* 533 F.2d at 671-72; *see also Calumet Indus., Inc. v. Brock*, 807 F.2d 225, 229 (D.C. Cir. 1986) (holding that companies were not within OSHA's zone of interest because they

"do not come before [the Court] as protectors of worker safety, but instead as entrepreneurs seeking to protect their competitive interests"). Indeed, the interests asserted here are not just unrelated to ERISA's purposes, but "inconsistent with" those purposes. *See Clarke*, 479 U.S. at 399. Far from protecting employees, the States' quest to preserve their tax revenues would deprive employees of expanded access to affordable, high-quality healthcare that the rule enables by making it easier for employers to participate in association health plans.

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

The district court also erred in holding that some States had standing due to regulatory costs they have incurred or would incur as a result of the rule. The rule does not require States to undertake any regulatory action; indeed, it does not require States to take—or to refrain from taking—any action at all. The States nevertheless assert they have standing because they will voluntarily hire additional staff and reprioritize their employees' assignments in order to police association health plans for mismanagement and fraud. *See* Mem. Op. 17-18(JA__-__). These allegations are precisely the sort of alarmist and "self-inflicted" allegations that the Supreme Court and this Court have routinely rejected as being insufficient to satisfy the basic requirements of Article III. *See, e.g.*, *Clapper*, 568 U.S. at 418; *National Treasury Emps. Union v. United States*, 101 F.3d 1423, 1428 (D.C. Cir. 1996) (*NTEU*).

As noted, standing may not be predicated on resources expended by a would-be plaintiff to fend off some speculative future harm. Were this not so, States would be able to challenge any number of federal policies on the basis that the existence of federal law alters States' incentives to dedicate resources to passing or enforcing its own laws. These choices, however, remain entirely within the discretion of each State. And these States may not sue to enjoin a shift in federal policy on this basis alone. *See Pennsylvania v. New Jersey*, 426 U.S. 660, 664 (1976) ("The injuries to the plaintiffs' fiscs were self-inflicted, resulting from decisions by their respective state legislatures. . . . No State can be heard to complain about damage inflicted by its own hand.").

This Court's decision in *NTEU* is illustrative. There, a union claimed that it had been injured by Congress's enactment of the Line Item Veto Act. 101 F.3d at 1428-30. The union alleged that the President's potential use of the line-item veto on an appropriations bill would negatively affect government workers, requiring the union to expend funds to further its organizational mission of improving the terms of government workers' employment. This Court rejected that argument because it was impossible to tell whether the union's "additional expenditure of funds is truly necessary to improve the working conditions of government workers or rather is unnecessary alarmism constituting a self-inflicted injury." *Id.* at 1430. In *Fair Employment Council of Greater Washington, Inc. v. BMC Marketing Corp.*, 28 F.3d 1268 (D.C. Cir. 1994), this Court likewise rejected a fair-employment organization's claim

that it had been injured by an employment agency engaging in discrimination because the organization's choice to divert resources to test for discrimination "result[ed] not from any actions taken by [the agency], but rather from the [organization's] own budgetary choices." *Id.* at 1276. Here as in those cases, the States allege they have made budgetary decisions to mitigate harm that has not yet occurred and may never occur. Those decisions are insufficient to support standing.

In holding to the contrary, the district court reasoned that any regulatory costs the States might incur would not be self-inflicted, since the costs would be necessary to mitigate fraud that newly formed association health plans might perpetrate. Mem. Op. 17-18(JA__-__). But this is doubly wrong. To begin, the court's conclusion does not follow from its premise. That hypothetical fraud might encourage States to incur costs in the future does not render those costs any less self-inflicted. No law or principle requires States to prevent or restrain fraud. The States remain free to decide whether the benefits of doing so are worth the costs—and their independent decision that intervention is warranted cannot fairly be attributed to the challenged rule.

Moreover, the court's premise underscores the speculative nature of the States' asserted injury. For that injury to occur at all, employers must choose to form association health plans in a given State under the rule, those plans must then behave in illegal ways, and the Department's own policing efforts must be insufficient to combat such fraud. Yet the States can only point to past illegal behavior (taking place under less robust state and federal regulatory and enforcement regimes than exist

today) to speculate that yet-to-be-formed association health plans in any particular State should be deemed likely to commit fraud in the future. This Court should not readily presume that these association health plans will violate the law. *See, e.g.*, *City of Los Angeles v. Lyons*, 461 U.S. 95, 101 (1983); *Arpaio v. Obama*, 797 F.3d 11, 31-22 (D.C. Cir. 2015). Nor have the States supplied any reason to believe that the Department will be incapable of combating fraud with the particularly robust enforcement tools created by the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010). *See generally* 83 Fed. Reg. 28,951-52 (discussing the enforcement mechanisms that the Department may use to combat fraud and abuse). Accordingly, any expenditures the States have made or might make are fairly traceable not to the challenged rule but to their own choices. *See Clapper*, 568 U.S. at 416.

On this score, the States' claimed injury suffers from an additional and independent flaw: The decision of a hypothetical association health plan to engage in unlawful conduct "lack[s] any legitimate causal connection to the challenged" rule. *See Arpaio*, 797 F.3d at 20. Standing "is ordinarily 'substantially more difficult' to establish" when an alleged injury turns on the conduct of third parties. *Lujan*, 504 U.S. at 562. This Court has identified only "two categories of cases where standing exists to challenge government action though the direct cause of injury is the action of a third party." *Renal Physicians Ass'n v. HHS*, 489 F.3d 1267, 1275 (D.C. Cir. 2007). First, standing exists "where the challenged government action authorized conduct

that would otherwise have been illegal." *Id.* Second, standing has been found "where the record presented substantial evidence of a causal relationship between the government policy and the third-party conduct, leaving little doubt as to causation and the likelihood of redress." *Id.* (citing *National Wrestling Coaches Ass'n v. Department of Educ.*, 366 F.3d 930, 941 (D.C. Cir. 2004); *see Arpaio*, 797 F.3d at 20.

The States have not made either showing here. They do not contend that the rule authorizes association health plans to commit fraud. They simply note that the rule's preamble acknowledges that the rule might introduce increased opportunities for fraud or mismanagement. *See* Mem. Op. 18(JA__) (citing 83 Fed. Reg. at 28,960). But the criteria set out in the rule were designed with knowledge of the possibility of fraud and were calibrated to mitigate such abuse. *E.g.*, 83 Fed. Reg. at 28,919 (control requirement); *id.* at 28,962 (business-purpose requirement); *id.* at 28,952 (organizational-structure requirement); *id.* at 28,928 (nondiscrimination requirement). And the States have provided nothing other than "unadorned speculation" to suggest that expanding the number of entities that can permissibly use association health plans will increase the likelihood of fraud, notwithstanding the protections in the rule. *See Renal Physicians*, 489 F.3d at 1275. It is likewise not sufficient to establish standing that, as the preamble also notes, the States have a number of regulatory tools that could be used to provide oversight to newly formed association health plans. Mem. Op. 18-19(JA__-__) (citing 83 Fed. Reg. at 28,953). The fact that States may well

incur costs by deploying these tools does not mean those costs were caused by the rule rather than by the independent conduct of third parties.

## II. The Rule's Alternative Criteria For Creating Association Health Plans Reasonably Implement ERISA.

Even assuming that the States have a basis to challenge the rule, the district court's judgment should be reversed on the merits. In concluding that the rule unreasonably implements ERISA's ambiguous definition of "employer" as including a "group or association of employers" that acts "indirectly in the interest of an employer," 29 U.S.C. § 1002(5), the court impermissibly substituted its policy preferences for the Department of Labor's expert judgment.

### A. The alternative criteria reasonably distinguish between employee benefit plans and commercial insurance-type arrangements.

The challenged rule establishes alternative criteria under which employers may band together to establish an employee benefit plan under ERISA. As noted, ERISA defines an "employer" not only as "any person acting directly as an employer" but also as "a group or association of employers" acting "indirectly in the interest of an employer, in relation to an employee benefit plan." 29 U.S.C. § 1002(5). However, ERISA does not define the limiting phrase "indirectly in the interest of an employer." This phrase plainly excludes groups or associations of employers that act not in their employer members' interests but their own. But as other courts of appeals have held and as the district court acknowledged, the phrase is capable of encompassing a

variety of different relationships. Mem. Op. 20-21(JA__-__); *see, e.g.*, *Meredith v. Time Ins. Co.*, 980 F.2d 352, 356 (5th Cir. 1993); *Greenblatt v. Delta Plumbing & Heating Corp.*, 68 F.3d 561, 575 (2d Cir. 1995).

For decades, the Department of Labor has interpreted ERISA's definition of "employer" in a manner "designed to ensure that the Department's regulation of employee benefit plans is focused on employment-based arrangements, as contemplated by ERISA, rather than merely commercial insurance-type arrangements that lack the requisite connection to the employment relationship." 83 Fed. Reg. at 28,914. The "touchstone" of this inquiry has always been "whether [a given] group . . . has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan." *Id.* at 28,928. The Department's prior sub-regulatory guidance implemented this approach by examining three general criteria: (1) the group's "business/organizational purposes and functions unrelated to the provision of benefits"; (2) the extent to which the group's employer members "share some commonality and genuine organizational relationship unrelated to the provision of benefits"; and (3) the extent to which the group's employer members "exercise control over the program, both in form and substance." *Id.* at 28,914.

There is no dispute that the Department's general approach to determining which groups are acting "indirectly in the interests of an employer" is a reasonable construction of the statutory text. Mem. Op. 23-24(JA__-__). It is consistent with the purposes of ERISA, which Congress enacted to regulate employee benefit plans

and not entrepreneurial ventures selling insurance for a profit to unrelated entities. *See Report of the Committee on Educ. & Labor*, H.R. Rep. No. 94-1785, at 48 (1977). It is also consistent with cases interpreting this language to require "some cohesive relationship between the provider of benefits and the recipient of benefits under the plan so that the entity that maintains the plan and the individuals who benefit from the plan are tied by a common economic or representational interest." 83 Fed. Reg. at 28,913-14.

The rule does not alter the Department's historical understanding that a group of employers fails to act in the interests of its members if it too closely resembles a commercial insurance-type venture. Indeed, the rule does not even depart from the Department's prior approach of considering business purpose, commonality, and control. The rule merely establishes an alternative method for determining the side of the line on which a given group falls.

Most importantly, and just like the criteria set forth in the Department's prior advisory opinions, the rule continues to require that an association health plan be controlled "in form and substance" by the employers that created the sponsoring association, and that only employer members are allowed to participate in the plan and to control the association itself. 83 Fed. Reg. at 28,914, 28,955. The Department adopted this requirement because, in its view, the "control test is necessary" to ensure that an association is responsive to the employers it serves. *Id.* The control test 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.*

Moreover, the rule added an entirely new requirement—the nondiscrimination requirement. Under this requirement, "groups or associations that condition[] . . . eligibility for benefits or premiums" in violation of the rule's nondiscrimination provisions cannot "qualify" as association health plans. 83 Fed. Reg. at 28,957. This ensures that plans do not make their "individual employer members' eligibility for benefits or premiums" contingent "on their respective employees' health status." *Id.* The requirement was adopted to prevent association health plans created under the rule from "too closely resembl[ing] medically-underwritten individual or small employer market commercial-type insurance coverage." *Id.* at 28,929. Many commenters criticized the requirement when initially proposed "as an undue obstacle to [association health plans'] proliferation and growth." *Id.* at 28,957. But the Department nonetheless incorporated the requirement into the rule because the Department deemed the requirement warranted to prevent "commercial insurance-type arrangements" from qualifying as an ERISA-covered plan under the guise of a group acting indirectly in the interest of employers. *Id.* at 28,914, 28,929.

The control and nondiscrimination requirements alone are arguably sufficient to ensure that the Department has reasonably excluded groups of employers that do not act "indirectly in the interests of an employer, in relation to an employee benefit plan." Commercial insurance-type arrangements cannot satisfy these requirements

because, despite selling health insurance to employers, they act not in the employers' interests but in their own. By contrast, a group and plan that are controlled by employers in form and substance, and that do not discriminate among the employers based on their employees' health status, can reasonably be said—for these reasons only—to act "indirectly in the interest of" employers. That the employers who have created an association satisfying those requirements may not have any other commonalities, or may have associated only for the purpose of sponsoring a plan, does not in any way foreclose a conclusion that such association still acts "indirectly in the interest of an employer, in relation to an employee benefit plan."

The Department's decision to retain the commonality and business-purpose requirements, albeit in relaxed form, underscores the reasonableness of the rule. Under the modified commonality requirement, a group that sponsors an association health plan must still have a "common employment-based nexus" evinced by their "products, services, . . . or lines of work" or by their "regions." 83 Fed. Reg. at 28,926. The term "region" extends only to a State or metropolitan area, as the employers within such regions often share common interests arising from the fact that they operate within the same regulatory environment. *See id.* at 28,925. And under the modified business-purpose requirement, a group that sponsors an association health plan must still have an independent business purpose that is "sufficiently substantial," *id.* at 28,918—that is, a purpose of "qualitative importance" or of "quantitatively large size," *cf. Life Techs. Corp. v. Promega Corp.*, 137 S. Ct. 734, 739-40

(2017). The Department explained that these modified requirements will continue to "assist substantially in drawing the line between traditional health insurance issuers" and bona fide associations that sponsor employment-based healthcare coverage. 83 Fed. Reg. at 28,918. They further diminish the likelihood that an association that satisfies the rule's control and nondiscrimination requirements nevertheless might somehow not be acting indirectly in the interests of its employer members.

In sum, the rule reflects the Department's considered determination that its historical criteria for obtaining association health plan status were not the only means by which the Department could ensure that an association health plan acts "indirectly in the interest of an employer." The Department's alternative pathway is more flexible than those historical criteria in some respects, and equally or more stringent in the most critical respects for reasonably interpreting the statutory standard. In the Department's judgment, these alternative criteria—taken together—are sufficient to distinguish between health plans that resemble employee benefit plans and health plans sponsored by commercial insurance-type providers, and ultimately, to exclude associations that fail to act indirectly in the interests of their employer members. That reasonable conclusion warrants deference under *Chevron*.

### B. In deeming the criteria unreasonable, the district court impermissibly substituted its atextual policy preferences for the agency's expertise.

The district court acknowledged that "ERISA's definition of 'employer' is ambiguous," Mem. Op. 20(JA__), and that the Department has authority to interpret

that definition, Mem. Op. 20(JA__). The court also acknowledged that, to determine whether a group is acting in the interests of its employer members, the Department could reasonably adopt criteria to distinguish between "ordinary commercial insurance relationships existing outside of the employment context" and "benefit plans arising from employment relationships." Mem. Op. 22-23(JA__-__). The court nonetheless vacated the rule on the theory that the rule failed to "place reasonable constraints on the types of associations that act 'in the interest of' employers under ERISA," meaning that "groups that closely resemble entrepreneurial, profit-driven commercial insurance providers [would] qualify for ERISA's protections." Mem. Op. 25, 33(JA__, __).

At the outset, the district court wrongly downplayed the Department's emphasis on the importance of the rule's control requirement, which may itself be sufficient to exclude commercial insurance-type arrangements from the ambit of the rule. The court posited that the requirement "is only meaningful if employer members' interests are already aligned." Mem. Op. 31(JA__). But the court never explained how any misalignment might occur, given that the interests of employers in an association health plan are already aligned in the relevant sense. They have freely elected to band together to acquire healthcare coverage on better terms for themselves and their employees, in an association that (quite unlike a commercial insurer) they themselves control.

The court speculated that an association with disparate interests "might further the interests of some—perhaps those that are most powerful or most numerous—but not all employers." Mem. Op. 32(JA__). But even assuming that the control requirement cannot prevent an association health plan from becoming captured in this manner, the plan's fiduciaries still remain obliged to ensure that the plan is administered equitably and in the interests of all employer members and their employees. 83 Fed. Reg. at 28,937-38 (discussing responsibility of plan sponsors to ensure compliance with ERISA's fiduciary requirements); *see Summers v. State St. Bank & Trust Co.*, 104 F.3d 105, 108 (7th Cir. 1997) (explaining that "picking and choosing among beneficiaries" would be a "violation of the traditional duty imposed by trust law of impartiality among beneficiaries"). The Department has authority to pursue enforcement actions against fiduciaries who violate their ERISA obligations. *See* 29 U.S.C. § 1132(a)(2), (5).

Moreover, the court failed to give weight to the Department's determination that any favoritism concerns would be adequately resolved by the rule's nondiscrimination requirement. *See* 83 Fed. Reg. at 28,928. Indeed, the court declined to "weigh" the requirement "in [its] analysis" at all because the court mistakenly believed that it "only limits how qualifying associations may structure their premiums" without "constrain[ing] which associations qualify." Mem. Op. 30 n.17(JA__ n.17). That is incorrect. *See* 29 C.F.R. § 2510.3-5(b)(7) (explaining that groups or associations that violate the rule's nondiscrimination provisions cannot

qualify as association health plans under the rule). The court similarly disregarded the fact that the rule bars health-insurance issuers from sponsoring association health plans. *Id.* § 2510.3-5(b)(8). The Department adopted this additional categorical prohibition to further police the boundary between associations created under the rule and commercial insurance-type arrangements. 83 Fed. Reg. at 28,918, 28,928, 28,962.

Importantly, the district court further assumed that a group or association can only act "indirectly in the interest of an employer" if "employee[s] of an employer" "have real ties to that association" capable of "provid[ing] inherent limits on the activities of the association with respect to its employer members or their employees." Mem. Op. 33(JA__)). Relying on that assumption, the court faulted the rule for relaxing the Department's prior commonality and business-purpose requirements, because the court believed the modified requirements no longer meaningfully excluded groups created "for the primary purpose" of allowing their controlling employers to band together to obtain better healthcare coverage for their employees. Mem. Op. 25, 29(JA__, __).

The court's implicit premise that such associations must be excluded lacks any basis in ERISA's text. That text speaks only in terms of an employer's interest in relation to an employee benefit plan (and not an employee's). 29 U.S.C. § 1002(5). The limiting phrase "indirectly in the interest of an employer"—as previously explained and as the district court elsewhere acknowledged—requires the Department to "distinguish[] employer associations that stand in the shoes of an 'employer' for the

purpose of sponsoring an ERISA plan" from entities that act in their own interests, such as commercial insurance ventures. Mem. Op. 23(JA__). The rule's alternative criteria reasonably implement that goal. And the court erred in setting aside the rule based on its atextual policy view about what types of associations acting in the interests of employers should be treated as employers under ERISA.

Finally, the district court attempted to buttress its analysis with decisions by the Fifth and Eighth Circuits. Mem. Op. 32-33(JA__-__) (citing *Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd. of Pub. Instruction*, 804 F.2d 1059 (8th Cir. 1986); *MDPhysicians & Assocs., Inc. v. State Bd. of Ins.*, 957 F.2d 178 (5th Cir. 1992)). But as the court acknowledged and as the rule's preamble explains, these cases simply reflect the proposition that "a plan is not an ERISA plan unless the entity providing benefits and the individuals receiving the benefits demonstrate the 'economic or representation[al]' ties . . . that characterize[] an employment relationship." *See* Mem. Op. 24(JA__) (first alteration in original); *accord* 83 Fed. Reg. at 28,913-14. The rule accounts for employees' interests by ensuring that their actual *employers*—with whom such nexus indisputably exists—retain control both over the association as an organization and over the association health plan itself. 83 Fed. Reg. at 28,920.

## III. The Rule's Working-Owner Provision Reasonably Implements ERISA.

The district court also erroneously vacated the provision of the rule that allows working owners to participate in association health plans even if they have no other employees. 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 government explained below, *Yates* "opens the door for any sole proprietor," even one with no other employees, "to qualify as dual-status employee and employer under ERISA," and thus to participate in an association health plan. *See* Mem. Op. 36(JA__).

The district court attempted to limit *Yates* to plans with at least one other participant who is not a working owner, relying on a footnote suggesting in dictum that plans established by working owners in which they and their spouses are the sole participants are not covered under ERISA. Mem. Op. 37 & n.19(JA__ & n.19) (discussing *Yates*, 541 U.S. at 21 n.6). That dictum does not speak to the question presented here: whether a working owner with no other employees may nevertheless participate in an association health plan.

The district court's reasoning cannot be sustained even if the cited footnote were relevant to the question presented. The *Yates* footnote relied on cases decided under a Department of Labor regulation excluding employee benefit plans established

by working owners from ERISA Title I coverage if they and their spouses were the sole participants. *See* 29 C.F.R. § 2510.3-3(c)(1) (1976) (promulgated by 40 Fed. Reg. 34,526, 34,533 (Aug. 15, 1975)). In prior advisory opinions, issued against the backdrop of that regulation, the Department concluded without explanation that working owners "without common-law employees are not eligible to be treated as 'employers' for purposes of participating" in an association health plan. U.S. Dep't of Labor, Advisory Opinion 2007-06A (Aug. 16, 2007), https://go.usa.gov/xmQeW. But the Department altered that view in the rule challenged here, which amended the regulation that was then in force. 83 Fed. Reg. at 28,929-31, 28,961; *see* 29 C.F.R. § 2510.3-3(c). Cases decided before this rule are therefore inapposite. *See National Cable & Telecommc'ns Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 982 (2005).

This conclusion is amplified by the government's amicus brief in *Yates*, on which the *Yates* Court relied. *See* 541 U.S. at 21 n.6. That brief explained that "whether a plan is covered under" ERISA's three substantive titles "may depend on the extent to which working owners are participants" as mediated through the governing statute or regulation. Amicus Br. of United States, *Yates v. Hendon*, No. 02-458 (U.S.), 2003 WL 21953912 at *18 n.9. The brief further explained that plans established by working owners in which they and their spouses are the sole participants are "excluded from Title I" of ERISA solely by operation of the regulation discussed above. *Id.*

The district court separately deemed the working-owner provision unreasonable because it believed that the provision creates "absurd results" under the Patient Protection and Affordable Care Act. Mem. Op. 39(JA__). The district court also suggested that the working-owner provision is inconsistent with the ACA's definition of "employer." Mem. Op. 40(JA__) (citing 42 U.S.C. § 300gg-91(d)(6)). But the relevant provisions of the ACA, which Congress enacted well after ERISA, are expressly tied to ERISA and thus cannot foreclose the Department from exercising its authority to adopt an interpretation of ERISA that would have been permissible before the ACA.

The ACA imposes requirements on group health plans and on health-insurance coverage, which may vary depending on whether the coverage is offered in the individual market, small-group market, or large-group market. "[G]roup health plan[s]" are defined as employee benefit plans created under ERISA to the extent they "provide[] medical care." 42 U.S.C. § 300gg-91(a)(1). For the purposes of group health plans, Congress provided that the terms "employer" and "employee" "ha[ve] the meaning given such term[s] under" ERISA, over which the Department of Labor possesses interpretive authority that the ACA at no point constrains. *See id.* § 300gg-91(d)(5)-(6); 29 U.S.C. § 1135 (vesting the Department with authority to "prescribe such regulations as [it] finds necessary or appropriate to carry out" ERISA's provisions). Congress could easily have linked the ACA's group-health-plan provisions to a different statute or to entirely new definitions. Instead, Congress

deliberately chose to link those provisions to ERISA. Accordingly, any speculation about the working-owner provision's implications for other provisions in the ACA do not undermine the reasonableness of the Department's interpretation of ERISA—an entirely separate statute.

## IV. The District Court Compounded Its Errors By Issuing Overly Broad Relief.

The district court exacerbated the impact of its errors by vacating the rule wholesale. The Supreme Court has recently reaffirmed that, under fundamental principles of Article III standing, a court's "constitutionally prescribed role is to vindicate the individual rights of the people appearing before it," and "[a] plaintiff's remedy" accordingly "must be tailored to redress the plaintiff's particular injury." *Gill v. Whitford*, 138 S. Ct. 1916, 1933, 1934 (2018); *see also Town of Chester v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) ("[S]tanding is not dispensed in gross," and "a plaintiff must demonstrate standing . . . for each form of relief that is sought.") (citations omitted). The Supreme Court has likewise held that basic principles of equity prohibit remedies that are "more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979).

To the extent that any of the plaintiff States is injured by the rule, that injury would arise solely as a result of association health plans established under the rule by employers within one of those States. The application of the rule to employers within

the plaintiff States injured by the rule is thus the only proper subject of judicial review, *see Lujan v. National Wildlife Fed'n*, 497 U.S. 871, 891 (1990), and enjoining that application marks the outer limit of any relief, *see Whitford*, 138 S. Ct. at 1930, 1933-34. Because prohibiting application of those requirements to employers within those plaintiff States would fully redress their asserted injuries, the district court was precluded both by Article III and by equitable principles from imposing a broader remedy.

The district court instead assumed that, if the challenged provisions of the rule were invalid, they must be vacated and "set aside[] pursuant to" the APA. *See* Mem. Op. 42(JA__) (citing 5 U.S.C. § 706). But although § 706 provides that an unlawful agency action be set aside, it does *not* provide that such action be set aside facially, as opposed to solely with respect to those applications that actually injure plaintiffs. Accordingly, § 706 is not properly construed to displace the general rule that equitable remedies—including vacatur of agency rules under the APA, *see* 5 U.S.C. § 703—may go no further than necessary to redress plaintiffs' own injuries. *See Weinberger v. Romero-Barcelo*, 456 U.S. 305, 313 (1982) ("[W]e do not lightly assume that Congress has intended to depart from established [equitable] principles.").

Unlike in *National Mining Association v. U.S. Army Corps of Engineers*, 145 F.3d 1399 (D.C. Cir. 1998), this is not a case where granting appropriately limited relief under § 706 will lead to "a flood of duplicative litigation" in this Circuit. *See id.* at 339. Unlike plaintiffs, who are eleven States and the District of Columbia, most States have

not attempted to invalidate the rule's expansion of affordable and high-quality healthcare coverage just so they can obtain more tax revenue or decrease the amount they spend on regulatory oversight. And some States have indeed indicated that they support the rule. *See* Amicus Br. of Texas, Nebraska, Georgia, and Louisiana, *New York v. U.S. Dep't of Labor*, No. 1:18-cv-1747, Dkt. No. 52; Montana Comm'r of Sec. & Ins., Comment No. 678 (Mar. 6, 2018), https://go.usa.gov/xmsuH; North Dakota Ins. Dep't, Comment No. 645 (Mar. 6, 2018), https://go.usa.gov/xmsu6. Moreover, *National Mining Association* itself recognized that a court's decision to grant the equitable relief of vacatur is discretionary rather than mandatory under § 706, *id.* at 338, and there is thus no basis to conclude that vacatur if granted must always be nationwide. To the extent *National Mining Association* suggests otherwise, we respectfully disagree and preserve the issue for further review.

## CONCLUSION

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

Respectfully submitted,

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May 2019

## CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(a). This brief contains 11,022 words.

*/s/ Michael Shih*
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## CERTIFICATE OF SERVICE

I hereby certify that, on May 31, 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*
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# ADDENDUM

# TABLE OF CONTENTS

**Page:**

**29 U.S.C. § 1002**

**§ 1002. Definitions.**

For purposes of this subchapter:

**(1)** The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

. . . .

**(5)** The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

**(6)** The term "employee" means any individual employed by an employer.

**(7)** The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

**(8)** The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

**(9)** The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

. . . .

**(40)(A)** The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more

employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained--

**(i)** under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

**(ii)** by a rural electric cooperative, or

**(iii)** by a rural telephone cooperative association.

**(B)** For purposes of this paragraph--

**(i)** two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

**(ii)** the term "control group" means a group of trades or businesses under common control,

**(iii)** the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 1301(b) of this title, except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

**(iv)** the term "rural electric cooperative" means--

**(I)** any organization which is exempt from tax under section 501(a) of Title 26 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

**(II)** any organization described in paragraph (4) or (6) of section 501(c) of Title 26 which is exempt from tax under section 501(a) of Title 26 and at least 80 percent of the members of which are organizations described in subclause (I), and

**(v)** the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of Title 26 which is exempt from tax under section 501(a) of Title 26 and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

. . . .

**29 C.F.R. § 2510.3-3.**

**§ 2510.3-3 Employee benefit plan.**

**(a)** General. This section clarifies the definition in section 3(3) of the term "employee benefit plan" for purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit plans within the meaning of section 3(3) of the Act. Under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I.

. . . .

**(c)** Employees. For purposes of this section and except as provided in § 2510.3–5(e):

**(1)** An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and

**(2)** A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

. . . .

**29 C.F.R. § 2510.3-5.**

**§ 2510.3-5 Employer.**

**(a)** In general. The purpose of this section is to clarify which persons may act as an "employer" within the meaning of section 3(5) of the Act in sponsoring a multiple employer group health plan. Section 733(a)(1) defines the term "group health plan," in relevant part, as an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents through insurance, reimbursement, or otherwise. The Act defines an "employee welfare benefit plan" in section 3(1), in relevant part, as any plan, fund, or program established or maintained by an employer, employee organization, or by both an employer and an employee organization, for the purpose of providing certain listed welfare benefits to participants or their beneficiaries. For purposes of being able to establish and maintain a welfare benefit plan, an "employer" under section 3(5) of the Act includes any person acting directly as an employer, or any person acting indirectly in the interest of an employer in relation to an employee benefit plan. A group or association of employers is specifically identified in section 3(5) of the Act as a person able to act directly or indirectly in the interest of an

employer, including for purposes of establishing or maintaining an employee welfare benefit plan. A bona fide group or association shall be deemed to be able to act in the interest of an employer within the meaning of section 3(5) of the Act by satisfying the criteria set forth in paragraphs (b) through (e) of this section. This section does not invalidate any existing advisory opinions, or preclude future advisory opinions, from the Department under section 3(5) of the Act that address other circumstances in which the Department will view a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan that is a group health plan.

**(b)** Bona fide group or association of employers. For purposes of Title I of the Act and this chapter, a bona fide group or association of employers capable of establishing a group health plan that is an employee welfare benefit plan shall include a group or association of employers that meets the following requirements:

**(1)** The primary purpose of the group or association may be to offer and provide health coverage to its employer members and their employees; however, the group or association also must have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees. For purposes of satisfying the standard of this paragraph (b)(1), as a safe harbor, a substantial business purpose is considered to exist if the group or association would be a viable entity in the absence of sponsoring an employee benefit plan. For purposes of this paragraph (b)(1), a business purpose includes promoting common business interests of its members or the common economic interests in a given trade or employer community, and is not required to be a for-profit activity;

**(2)** Each employer member of the group or association participating in the group health plan is a person acting directly as an employer of at least one employee who is a participant covered under the plan,

**(3)** The group or association has a formal organizational structure with a governing body and has by-laws or other similar indications of formality,

**(4)** The functions and activities of the group or association are controlled by its employer members, and the group's or association's employer members that participate in the group health plan control the plan. Control must be present both in form and in substance,

**(5)** The employer members have a commonality of interest as described in paragraph (c) of this section,

**(6)(i)** The group or association does not make health coverage through the group's or association's group health plan available other than to:

**(A)** An employee of a current employer member of the group or association;

**(B)** A former employee of a current employer member of the group or association who became eligible for coverage under the group health plan when the former employee was an employee of the employer; and

**(C)** A beneficiary of an individual described in paragraph (b)(6)(i)(A) or (b)(6)(i)(B) of this section (e.g., spouses and dependent children).

**(ii)** Notwithstanding paragraph (b)(6)(i)(B) of this section, coverage may not be made available to any individual (or beneficiaries of the individual) for any plan year following the plan year in which the plan determines pursuant to reasonable monitoring procedures that the individual ceases to meet the conditions in paragraph (e)(2) of this section (unless the individual again meets those conditions), except as may be required by section 601 of the Act.

**(7)** The group or association and health coverage offered by the group or association complies with the nondiscrimination provisions of paragraph (d) of this section.

**(8)** The group or association is not a health insurance issuer described in section 733(b)(2) of the Act, or owned or controlled by such a health insurance issuer or by a subsidiary or affiliate of such a health insurance issuer, other than to the extent such entities participate in the group or association in their capacity as employer members of the group or association.

**(c)** Commonality of interest—

**(1)** Employer members of a group or association will be treated as having a commonality of interest if the standards of either paragraph (c)(1)(i) or (c)(1)(ii) of this section are met, provided these standards are not implemented in a manner that is subterfuge for discrimination as is prohibited under paragraph (d) of this section:

**(i)** The employers are in the same trade, industry, line of business or profession; or

**(ii)** Each employer has a principal place of business in the same region that does not exceed the boundaries of a single State or a metropolitan area (even if the metropolitan area includes more than one State).

**(2)** In the case of a group or association that is sponsoring a group health plan under this section and that is itself an employer member of the group or association, the group or association will be deemed for purposes of paragraph (c)(1)(i) of this section to be in the same trade, industry, line of business, or profession, as applicable, as the other employer members of the group or association.

**(d)** Nondiscrimination. A bona fide group or association, and any health coverage offered by the bona fide group or association, must comply with the nondiscrimination provisions of this paragraph (d).

**(1)** The group or association must not condition employer membership in the group or association on any health factor, as defined in § 2590.702(a) of this chapter, of any individual who is or may become eligible to participate in the group health plan sponsored by the group or association.

**(2)** The group health plan sponsored by the group or association must comply with the rules of § 2590.702(b) of this chapter with respect to nondiscrimination in rules for eligibility for benefits, subject to paragraph (d)(4) of this section.

**(3)** The group health plan sponsored by the group or association must comply with the rules of § 2590.702(c) of this chapter with respect to nondiscrimination in premiums or contributions required by any participant or beneficiary for coverage under the plan, subject to paragraph (d)(4) of this section.

**(4)** In applying the nondiscrimination provisions of paragraphs (d)(2) and (3) of this section, the group or association may not treat the employees of different employer members of the group or association as distinct groups of similarly-situated individuals based on a health factor of one or more individuals, as defined in § 2590.702(a) of this chapter.

. . . .

**(e)** Dual treatment of working owners as employers and employees—

**(1)** A working owner of a trade or business without common law employees may qualify as both an employer and as an employee of the trade or business for purposes of the requirements in paragraph (b) of this section, including the requirement in paragraph (b)(2) that each employer member of the group or association participating in the group health plan must be a person acting directly as an employer of one or more employees who are participants covered under the plan, and the requirement in paragraph (b)(6) that the group or association does not make health coverage offered to employer

members through the association available other than to certain employees and former employees and their beneficiaries.

**(2)** The term "working owner" as used in this paragraph (e) of this section means any person who a responsible plan fiduciary reasonably determines is an individual:

**(i)** Who has an ownership right of any nature in a trade or business, whether incorporated or unincorporated, including a partner and other self-employed individual;

**(ii)** Who is earning wages or self-employment income from the trade or business for providing personal services to the trade or business; and

**(iii)** Who either:

**(A)** Works on average at least 20 hours per week or at least 80 hours per month providing personal services to the working owner's trade or business, or

**(B)** Has wages or self-employment income from such trade or business that at least equals the working owner's cost of coverage for participation by the working owner and any covered beneficiaries in the group health plan sponsored by the group or association in which the individual is participating.

**(3)** The determination under this paragraph must be made when the working owner first becomes eligible for coverage under the group health plan and continued eligibility must be periodically confirmed pursuant to reasonable monitoring procedures.

**(f)** Applicability dates—

**(1)** This section is applicable on September 1, 2018, for employee welfare benefit plans that are fully insured and that meet the requirements for being an association health plan sponsored by a bona fide group or association of employers pursuant to paragraphs (b) through (e) of this section.

**(2)** This section is applicable on January 1, 2019, for any employee welfare benefit plan that is not fully insured, is in existence on June 21, 2018, meets the requirements that applied before June 21, 2018, and chooses to become an association health plan sponsored by a bona fide group or association of employers pursuant to paragraphs (b) through (e) of this section (e.g., in order to expand to a broader group of individuals, such as working owners without employees).

**(3)** This section is applicable on April 1, 2019, for any other employee welfare benefit plan established to be and operated as an association health plan sponsored by a bona fide group or association of employers pursuant to pursuant to paragraphs (b) through (e) of this section.

**(g)** Severability. If any provision of this section is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this section and shall not affect the remainder thereof.