IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

DATA MARKETING PARTNERSHIP, LP and LP MANAGEMENT SERVICES, LLC	)	
Plaintiffs,	)	
UNITED STATES DEPARTMENT OF LABOR, et al.,	)	Civil Action File No. 4:19-cv-00800-O
Defendants.	)	

PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Pursuant to Fed. R. Civ. P. 65 and 29 U.S.C. §§ 1132(a)(3) and 1132(k), Plaintiffs Data Marketing Partnership, LP ("DMP") and LP Management Services, LLC ("LPMS") (DMP and LPMS collectively referred to as "Plaintiffs") respectfully request that this Court issue a temporary restraining order and preliminary injunction restraining the Defendants United States Department of Labor ("DOL"), Department of Labor Secretary Eugene Scalia, in his official capacity only (the "Secretary") and the United States of America ("USA") (DOL, the Secretary and USA collectively referred to as "Defendants") from taking any action that is contrary to ERISA.

DMP is a Texas limited partnership that specializes in the production, capture, segregation, aggregation, organization, and sale to third-parties of electronic data. DMP captures this electronic data through a proprietary software that DMP's individual limited partners install on the computers and/or mobile devices, which captures all of the electronic data that the limited partners generate as they use their devices and transmits the data to a secure, cloud-based "data bank" maintained by DMP. Once DMP captures a sufficiently large amount of electronic data from its limited partners, DMP will then market and sell the data to third-parties.

DMP's limited partners will receive income from DMP commensurate with the amount of electronic data that they generate and that DMP is able to sell to third parties. In addition to this monetary benefit, DMP's limited partners who contribute 500 or more hours of electronic data in a calendar year receive the added benefit, if they choose to use it, of participating in DMP's single-employer, self-insured, group health care plan (the "Plan") under the Employee Retirement Income Security Act ("ERISA"). *See* 29 U.S.C. § 1002 (1).

In this case, LPMS submitted a request for advisory opinion (the "AO Request") to DOL (at DOL's recommendation) seeking confirmation that DMP's business model and its Plan conform with ERISA's statutory requirements. Over 14 months later, DOL issued a fatally flawed, arbitrary and capricious advisory opinion (the "AO Response") in which it erroneously determined, among other things, that DMP's Plan does not qualify as a single-employer, group health care plan because its limited partners do not constitute "employees" under ERISA.[1]

Plaintiffs seek immediate injunctive relief from this Court to prevent the irreparable harm that Plaintiffs will suffer as a result of the AO Response. Specifically, Plaintiffs seek to enjoin the Defendants from taking any action with respect to the AO Response pending this Court's final adjudication of the issues Plaintiffs raise in Counts I and III of their First Amended Complaint for Declaratory and Injunctive Relief (the "FAC"), to compel Defendants to remove the AO Response from the DOL website, and to restrain Defendants from taking any action with respect to the

[1] DOL's advisory opinion was submitted to DOL on November 8, 2018, then revised as of January 15, 2019 and again February 27, 2019. A true and correct copy of the AO Request is attached to the FAC as Exhibit A. DOL's response on January 24, 2020 (the "AO Response"), was issued four hundred forty-two (442) days after LPMS's submitted the AO Request, one hundred twelve (112) days after Plaintiffs filed the original Complaint, and a mere eleven (11) days before Defendants answer to the original Complaint was due. A true and correct copy of the AO Response is attached to the FAC as Exhibit B.

Plaintiffs until a final ruling from this Court. Plaintiffs seek to enjoin Defendants from taking any action regarding DOL's defective AO Response.

As discussed in detail in Plaintiffs' Brief in Support of Motion for Temporary Restraining Order and Preliminary Injunction (the "TRO Brief"), Plaintiffs' TRO Motion meets all four (4) requirements for granting a temporary restraining order. First, Plaintiffs have a substantial likelihood of success on the merits because DOL's defective AO Response: (1) fails to follow DOL's own procedures set forth in DOL Procedure 76-1; (2) fails to comply with the Administrative Procedure Act ("APA") requirements of analyzing and citing to relevant, applicable law; (3) is based on speculative and distorted factual findings in violation of ERISA Procedure 76-1 and the APA; and (4) violates the APA by implying standards that are inconsistent with well-established law. Thus, Plaintiffs have a substantial likelihood of success on the merits of their case against Defendants.

Second, Plaintiffs face a substantial threat of immediate and irreparable harm for which they do not have an adequate remedy at law. As discussed in the TRO Brief, the success of DMP's business model, as well as the other limited partnerships managed by LPMS, largely depends on its ability to attract a sufficiently large number of limited partners to join the partnership and generate electronic data for DMP to market and sell to third parties. DOL's defective AO Response effectively renders DMP's ability to attract limited partners extremely difficult at best. Consequently, DMP is harmed every day by the uncertainty surrounding their novel business model and health care plan structure, and DMP's Plan participants are harmed because, if this Court fails to grant the TRO Motion, they could immediately lose the health coverage and access to affordable health care that was previously available to them as a partner of DMP. Thus,

Plaintiffs (and their Plan participants) will be immediately and permanently harmed if this Court fails to grant the TRO Motion.

Third, much greater injury will result to Plaintiffs (and their Plan participants) if the Court denies the TRO Motion than any harm that might occur to Defendants or the general public if the Court grants the TRO Motion. As noted above, DMP's primary business purpose hinges on its ability to attract and maintain a broad assortment of partners to generate the electronic data that the company seeks to market and sell to third parties. Following DOL's erroneous AO Response, DMP has been forced to operate under a dark cloud of uncertainty concerning the viability of its business model and the legality of its Plan under ERISA. Thus, far greater injury will result to Plaintiffs (and their Plan participants) if the Court denies the TRO Motion than any injury that might occur to Defendants or the general public if the Court grants the TRO Motion.

Finally, the public interest will be served if the Court grants the TRO Motion because: (1) the general public will have clarity about how group health care plans provided by novel limited partnership business models, like DMP, are viewed under ERISA; and (2) all of DMP's over 50,000 Plan participants (including eligible spouses and dependents) will be able to maintain the current health coverage they have under the Plan (and similar plans maintained by the other LPMS-managed partnerships).

Thus, because Plaintiffs' TRO Motion meets all four (4) requirements for granting a temporary restraining order, this Court should grant the TRO Motion pending this Court's final adjudication of the issues Plaintiffs raise in their FAC concerning DOL's defective and misplaced analysis and erroneous conclusions about the viability of DMP's business model and Plan under ERISA.

Plaintiffs rely upon the Declaration of Randall Johnson, Declaration of Alexander Renfro, and its TRO Brief in filed concurrently herewith. Based upon the same, Plaintffs respectfully request that the Court provide for expedited treatment of the TRO Motion and issue the injunctive relief as noted above.

Respectfully submitted,

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CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that service of the foregoing *Plaintiff's Motion for Temporary Restraining Order and Preliminary Injunction* was made, this 3rd day of February, 2020, by the Court's Case Management/Electronic Files system upon the attorneys for the parties.

Respectfully submitted this 3rd day of February, 2020.

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FORT WORTH DIVISION

DATA MARKETING PARTNERSHIP, LP and
LP MANAGEMENT SERVICES, LLC,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF LABOR,
EUGENE SCALIA, *in his official capacity as Secretary of the United States Department of Labor,* and
UNITED STATES OF AMERICA,

Defendants.

Case Number 4:19-cv-00800-O

PLAINTIFF'S BRIEF IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

PLAINTIFF'S BRIEF IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Plaintiffs Data Marketing Partnership, LP ("DMP") and LP Management Services, LLC ("LPMS") (DMP and LPMS collectively referred to as "Plaintiffs"), file this Brief in Support of Motion for Temporary Restraining Order and Preliminary Injunction (the "TRO Motion") pursuant to Fed. R. Civ. P. 65 and 29 U.S.C. §§ 1132(a)(3) and 1132(k). In the TRO Motion, Plaintiffs seek a temporary restraining order and preliminary injunction against Defendants United States Department of Labor ("DOL"), Department of Labor Secretary Eugene Scalia, in his official capacity only (the "Secretary") and the United States of America ("USA") (DOL, the Secretary and USA collectively referred to as "Defendants"), respectfully showing the Court as follows:

I. INTRODUCTION

Plaintiffs seek immediate injunctive relief from this Court to correct the fatally flawed, arbitrary and capricious actions of the United States Department of Labor ("DOL"). DOL seeks to invalidate a legitimate and innovative business model offering the benefit of a group health plan to tens of thousands of self-employed Americans. Left unrestrained, its actions would have the practical effect of depriving over 50,000 participating Americans of their current health coverage, and potentially millions of others from gaining access to affordable healthcare.

The TRO Motion seeks a temporary restraining order and preliminary injunction barring Defendants from taking any action related to their invalid legal interpretation in the AO Response. Concurrently herewith, Plaintiffs filed their First Amended Complaint for Declaratory and Injunctive Relief (the "FAC") [ECF No. 9]. The LPMS advisory opinion was submitted to DOL on November 8, 2018, then revised as of January 15, 2019 and again February 28, 2019 (the "AO Request"). A true and correct copy of the AO Request is attached to the FAC as Exhibit A. DOL's response on January 24, 2020 (the "AO Response"), was issued four hundred forty-two (442) days

after submission of the AO Request, one hundred twelve (112) days after the filing of the original Complaint, and publicly posted a mere four (4) days before Defendants answer to the original Complaint was due. The AO Response may reasonably be viewed not as an advisory opinion at all, but rather as Defendant's poorly formed response to the initial Complaint. A true and correct copy of the AO Response is attached to the FAC as Exhibit B.

Plaintiffs seek to enjoin the Defendants from taking any action with respect to the AO Response while this case is pending, to compel Defendants to remove the AO Response from the DOL website, and to restrain Defendants from taking any action with respect to the Plaintiffs until a final ruling from this Court. Plaintiffs respectfully request that this Court issue such injunction at the earliest possible time in order to prevent continuing and irreparable harm to Plaintiffs as well as to more than 50,000 individual participants in group health plans whose coverage would terminate immediately absent said injunction. Plaintiffs further respectfully request the Court issue an injunction preventing Defendants from taking action that is contrary to this Court's finding on the merits with respect to Count I and III of the FAC.

For the reasons that follow, Plaintiffs have established all elements necessary for issuance of a temporary restraining order and preliminary injunction. A preliminary injunction prohibiting Defendants from taking action on the AO Request or otherwise take actions against Plaintiffs contrary to ERISA is necessary to protect Plaintiffs from further unnecessary injury, and the issuance of such an injunction will not prejudice Defendants.

II. STATEMENT OF FACTS[1]

A. OVERVIEW OF LPMS AND DMP RELATIONSHIP AND BUSINESS

The primary business purpose of LPMS is to serve as General Partner of various limited partnerships and manage the day-to-day affairs of these partnerships, including DMP. Each of those limited partnerships, including DMP, has sponsored an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act ("ERISA"). 29 U.S.C. § 1002 (1). The primary business purpose of DMP is the production, capture, segregation, aggregation, organization, and sale to third-parties of electronic data generated by its partners. To succeed, this business model requires large numbers of partners contributing data to the partnership. DMP offers access to its group health plan in order to attract, retain and motivate partners. The plan is organized as a single-employer self-insured group health plan that provides health benefits to DMP's eligible employees, along with DMP's partners, eligible spouses, and dependents. Given the adverse impact of the Affordable Care Act a/k/a Obamacare ("ACA") on small business owners and the self-employed, DMP has targeted that group for recruiting partners.

DMP is duly registered and formed in the State of Texas. DMP's Partnership Agreement appoints LPMS as General Partner and delegates day-to-day business management decisions to LPMS, including but not limited to the execution of rental/office lease agreements, employment contracts, distribution of revenue producing agreements, and grantor decisions to form a group health plan. The limited partners of DMP are individuals who have obtained an ownership interest through the execution of a joinder agreement with DMP. Limited partners also participate in global management issues through periodic votes of all partners. Payments by DMP to limited partners

[1] The facts set forth in this section are derived from the Declarations of Alexander Renfro, attached hereto as Exhibit A, and Randall Johnson, attached hereto as Exhibit B.

for their revenue generating activities are reported to the IRS as guaranteed payments, and are subject to employment taxes.

In order to generate the necessary electronic data, participating partners install proprietary software for computers and mobile applications for mobile devices. This software captures the electronic data generated by the partner's use of their computer and/or mobile device and transmits it to a data bank maintained by the partnership. The aggregated electronic data is then anonymized and organized for marketing to third-party purchasers. Each limited partner participating in the Plan must contribute at least five hundred (500) hours of work per year through the generation, transmitting, and sharing of their electronic data. Partners control and manage the production, capture, segregation, aggregation, and sale of their own individual data, empowering partners in a manner not otherwise available to them.[2]

B. LPMS MEETINGS WITH DOL

Representatives of LPMS first met with DOL in October, 2018 (the "October Meeting"). In attendance and representing the interests of LPMS were its attorney Alexander Renfro and consultant Christopher Condeluci, among others. In attendance and representing the interests of DOL was Preston Rutledge, Assistant Secretary of Labor for the Employee Benefits Security Administration (EBSA), among others. EBSA has direct oversight of ERISA within DOL.

By all accounts, the October Meeting was constructive. LPMS representatives explained the plan structure to DOL representatives, and provided detail of the goals of the Plan and business structure. Assistant Secretary Rutledge explained that an Advisory Opinion Request was the best route to secure approval of the Plan by DOL. The AO Request submitted on November 8, 2018 was the response to this advice from DOL.

[2] While this is the primary business purpose, DMP also provides the partners opportunities to provide personal services to various third-parties as an additional revenue opportunity.

In the weeks and months that followed, informal conversations were had between representatives of LPMS and DOL. In a reversal of his previous position, Rutledge expressed to Condeluci that he did not see why DOL needed to issue an Advisory Opinion, because ERISA already allows partners to be treated as employees for purposes of plan eligibility. During this conversation, Rutledge told Condeluci that LPMS should "just do it," meaning implement the Plan, rather than wait for a DOL Advisory Opinion that might be a long time coming.

As a result of informal verbal questions and observations from DOL, the AO Request was slightly revised and resubmitted to DOL in early 2019, culminating in the final version of the AO Request submitted on February 27, 2019. Simultaneously, and in reliance on DOL's statements, LPMS began accepting limited partners into certain limited partnerships that it manages, and formed ERISA-subject health plans for them. As of January 15, 2020, more than 50,000 Americans are participants in the health plans offered by those partnerships. Joinders and plan enrollments were offered in reliance on the representations made by Rutledge and other DOL officials, and the assumption that DOL would follow its own published rules regarding AO requests, including asking any questions necessary to consider the request, and giving it timely and fair consideration.

In February 2019, seven sitting state Attorneys General sent a letter (the "State AG Letter") to then-DOL Secretary Alexander Acosta, stressing the urgency of the public health problem that the LPMS working partner model addressed, and requesting expedited consideration of the AO Request (see State AG Letter attached as Exhibit C to the FAC). DOL made no response at all to the State AG Letter, and, while it saw fit to reference this litigation in the AO Response, DOL did not so much as mention the State AG Letter.

During a meeting on March 6, 2019, then DOL Chief of Staff Nicholas Geale told a group of representatives from LPMS and interested states, including Renfro, Condeluci, and Louisiana Attorney General Jeff Landry (the lead signatory to the State AG Letter) that although the LPMS structure was "ingenious" and that he "wished he'd thought of it," DOL could not respond to the AO Request due to perceived conflict with litigation around DOL's new Association Health Plan (AHP) rule. At one point during the meeting, representatives from DOL became animated and said that if the LPMS group disagreed about DOL's priorities, they should "take it up with the White House."

In a subsequent meeting that Condeluci had with Geale at DOL, Geale proposed that if LPMS would withdraw its AO request (and/or cease pressing for an answer to it), Geale would "look [LPMS representatives] in the eye" and promise that DOL would not investigate or otherwise interfere with any LPMS-managed partnership plans. This represented an abdication of DOL's responsibility to interpret ERISA and provide guidance in an area over which only DOL and the federal courts have jurisdiction. Absent an official opinion from DOL, over fifty separate State insurance regulators could pose significant and indefinite regulatory burdens on LPMS-managed partnership plans through investigations and rulings of their own. It simply was not practical or advisable to rely on handshake promises, with the threat of politically motivated investigations by individual States in the absence of a DOL determination.

C. DMP PLAN SUMMARY AND NEED FOR AO REQUEST

In an effort to attract, retain, and motivate talent in service of DMP's primary business purpose, DMP established a single-employer self-insured group health plan (the "Plan"). The Plan reflects the substantial commitment that DMP makes to its eligible plan participants, comprised solely of DMP's employees and limited partners (as well as eligible spouses and dependents). Since this Plan is formed and sponsored only by DMP – and not in concert with any other employer

– the Plan is a single-employer self-insured group health plan. DMP serves as the Named Fiduciary and Plan Administrator of the Plan.

The Plan is designed to be a "single employer plan" covered by ERISA. 29 U.S.C. § 1002(41). An ERISA plan that is not a multiple employer plan welfare arrangement ("MEWA") is a single employer plan. 29 U.S.C. § 1002(40). Plans like the Plan that are maintained by partnerships could be found to be MEWAs if partners of the partnership maintaining a plan are found to be separate employers. For example, if partners in a partnership are found to be a collection of independent contractors, a plan maintained by that partnership might be treated as a MEWA. With respect to MEWAs, in 2003, DOL first issued written guidance on addressing questions about MEWA status entitled *MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): Guide to Federal and State Regulation*, U.S. Dept. of Labor, Employee Benefits Administration (2013) (the "Guide").[3] As part of the *Guide*, DOL addressed when advisory opinion requests are "necessary." See *Guide*, pp. 35-36. This guidance made clear that "interpretive" determinations, as opposed to factual ones, meet the "necessary" standard and such determinations are conducted by DOL through the process set forth in ERISA Proc. 76-1.

III. ARGUMENT AND CITATION TO AUTHORITY

A temporary restraining order and preliminary injunction preserve the status quo and prevent irreparable harm just so long as is necessary to hold a hearing, and no longer. *Granny Goose Foods, Inc. v. Bd. of Teamsters & Auto Truck Drivers*, 415 U.S. 423, 439 (1974). To be entitled to a temporary restraining order, a party must demonstrate it meets a four-prong test: (1) a

[3]See https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf. Accessed 3 Feb. 2020.

substantial likelihood of success on the merits; (2) a substantial threat of immediate and irreparable harm for which it has no adequate remedy at law; (3) that greater injury will result from denying the temporary restraining order than if it is granted; and (4) that a temporary restraining order will not disserve the public interest. *Daniels Health Scis., LLC v. Vascular Health Scis., LLC,* 710 F.3d 579, 582 (5th Cir. 2013). "The decision to grant or deny a preliminary injunction is discretionary with the district court." *Miss. Power & Light Co. v. United Gas Pipe Line Co.,* 760 F.2d 618, 621 (5th Cir. 1985).

Before determining whether a temporary restraining order and preliminary injunction are warranted in this instance, DMP first establishes the authority of this Court to hear their claims and award the relief they request.

A. THE COURT'S AUTHORITY AND JURISDICTION OVER PLAINTIFFS' CLAIMS

ERISA provides,

> Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, ***to restrain the Secretary from taking any action contrary to the provisions of this Act***, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

29 U.S.C. § 1132(k) (emphasis added). ERISA also provides,

> (a) Persons empowered to bring a civil action — A civil action may be brought—
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan…

29 U.S.C. § 1132(a)(3).

29 U.S.C. § 1132(k) constitutes an express waiver of sovereign immunity by the federal government and authorizes proper plaintiffs to bring certain claims directly against the Secretary

of the Department of Labor. *Simon v. Kaiser Permanente Hosps.,* 2006 U.S. Dist. LEXIS 85281 * 7. The claims available under § 1132(k) are broken up into three separate and distinct categories: "(1) actions to review a final order of the Secretary; (2) actions to 'restrain the Secretary from taking any action contrary to the provisions of this Act'; and (3) actions to compel the Secretary to take action 'required under this subchapter.'" *Id.*

The AO Response is a final order. For this purpose, "order" means the "whole or a part of a final disposition, whether affirmative, negative, injunctive, or declaratory in form, of an agency in a matter other than rule making…" See 5 U.S.C. § 551(6). Pursuant to ERISA Proc. 76-1, once DOL issues a response, it may not be withdrawn and it is binding on the parties to the request. Moreover, ERISA Proc. 76-1 does not provide for an administrative appeal. *Cf. Virginia Beach Policemen's Benevolent Ass'n v. Reich,* 881 F. Supp. 1059, 1064 (1995) Under the Administrative Procedures Act ("APA"), "[o]nly after a party clears the 'final agency action' and 'committed to agency discretion' hurdles of judicial review, may a reviewing court 'compel agency action unlawfully withheld or unreasonably delayed.'" 5 U.S.C. § 706(1).

Having established subject matter jurisdiction over their claims, DMP now turns to consider the issues presented on the merits.

B. SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS.

As further discussed in this Section, Plaintiffs are entitled to and can establish a substantial likelihood of success on the merits of its claims. The statutory authority provided by ERISA and subsequent federal cases expounding thereon clearly demonstrate that the Plan is a single-employer group health plan covered by ERISA. The AO Request provides a thorough and detailed assessment of the applicable statutes, regulations and case law supporting this assertion. Rather than restate that analysis here, Plaintiffs incorporate by reference the AO Request as if fully restated herein.

Given the substance (or lack thereof) of the AO Response, it is clear that Plaintiffs have a substantial likelihood of success on the merits. Even on a cursory reading, it is clear that the AO Response is arbitrary and capricious in many regards. First, the AO Response violates the APA by implying standards that are inconsistent with applicable law. See, 5 U.S.C. §706. Second, DOL failed to comply with Administrative Procedure Act ("APA") requirements of analyzing and citing to relevant, applicable law. *Motor Vehicle Manufacturers Association v. State Farm Auto Mutual Insurance Co*., 463 U.S. 29, 43 (1983) (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)). Third, DOL failed to follow its own procedures set forth in ERISA Procedure 76-1 by failing to assume the accuracy of material facts presented in the AO Request, substituting its own speculative and distorted factual findings instead. See ERISA Proc. 76-1, §10. Finally, proper legal analysis of the facts presented concludes that DMP's partners are working owners entitled to participate in the Plan.

1. AO RESPONSE VIOLATES APA BY IGNORING SUPREME COURT PRECEDENCE AND PRIOR DOL ADVISORY OPINIONS

In order to make its determination, DOL must cite to *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004) and by implication Advisory Opinion 99–04A ("99-04A"). In *Yates*, the Supreme Court addressed the very issue posed by LPMS – is a "working owner" eligible to participate as an "employee" in a single employer plan governed by ERISA.

The Supreme Court held

> The answer, we hold, is yes: If the plan covers one or more employees other than the business owner and his or her spouse, the working owner may participate on equal terms with other plan participants. Such a working owner, in common with other employees, qualifies for the protections ERISA affords plan participants and is governed by the rights and remedies ERISA specifies. In so ruling, we reject the position, taken by the lower courts in this case, that a business owner may rank only as an "employer" and not also as an "employee" for purposes of ERISA-sheltered plan participation. *Yates*, at 6.

In reaching its decision, the majority of the Court determined that the statutory terms set forth in ERISA mandated this result and there was no reason to look to common-law employment factors like those set forth in *Nationwide Mut. Ins. Co. v Darden*, 503 US 318 (1992) which it had previously determined must occur to define the term "employee" for purposes of ERISA.

It is critical to note that the majority very intentionally set aside a common law employment test by holding that ERISA provides "specific guidance" on which to rely obviating the *Darden* common law analysis. *Yates,* at 12. ("In sum, because the statute's text is adequately informative, we need not look outside ERISA itself to conclude with security that Congress intended working owners to qualify as plan participants."). In further support of this point, in Footnote 5 of the majority opinion, the Court explained its position as follows: "We do not suggest that each provision described supra, at 13-15 in isolation, would compel the Court's reading. But cf. post, at 25-26 (Thomas, J., concurring in judgment). In combination, however, the provisions supply "specific guidance" adequate to obviate any need to expound on common law. See *Darden*, 503 US, at 323…"). *Yates*, at FN 5.This position taken by the majority occurred to directly rebut Justice Thomas' concurring opinion, wherein he advocated for a common law employment test to also be applied to working owners. In fact, in Thomas' opinion, he held that the majority made all working owners employees for purposes of ERISA without exception. ("The Court does not clearly define who exactly makes up this class of 'working owners,' even though members of this class are now considered categorically to fall under ERISA's definition of "employee.") *Id*. at FN, Thomas, J. concurring opinion.

The majority looked to both ERISA and the Internal Revenue Code (the "Code") to find its specific guidance. In relevant part, the majority pointed to 26 U.S.C. § 401(c)(1)((A) which defines "employee" to include a "self-employed individual" and 26 U.S.C. §§ 401(c)(1)(B) and

401(c)(2)(A)(i) which define "'a self-employed individual' to cover an individual with 'earned income' from "a trade or business in which personal services of the taxpayer are a material income-producing factor.'" *Yates*, at 14. The majority then offered up the following assessment "This definition no doubt encompasses working sole proprietors and partners." *Id.* emphasis added. The majority also relied heavily on DOL's analysis and conclusions in 99-04A which, in relevant part, the Court restated in its opinion:

> In its regulation at 29 C. F. R. 2510.3-3, the Department clarified that the term 'employee benefit plan' as defined in section 3(3) of Title I does not include a plan the only participants of which are '[a]n individual and his or her spouse . . . with respect to a trade of business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse' or '[a] partner in a partnership and his or her spouse.' The regulation further specifies, however, that a plan that covers as participants 'one or more common law employees, in addition to the self-employed individuals' will be included in the definition of 'employee benefit plan' under section 3(3). The conclusion of this opinion, that such 'self-employed individuals' are themselves 'participants' in the covered plan, is fully consistent with that regulation." Advisory Opinion 99-04A, at 561, n 7." emphasis added.

In addition to this express reliance on self-employed status in the above quote, an even closer look at 99-04A is also instructive to understand the majority's willingness to collectively read ERISA and Code provisions as dispositive. In Footnote 3 of 99-04A, DOL expressly defines working owner for purposes of its opinion in 99-04A.

> By the term "working owner," you apparently mean any individual who has an equity ownership right of any nature in a business enterprise and ***who is actively engaged in providing services to that business***, as distinguished from a "passive owner," who may own shares in a corporation, for example, but is not otherwise involved in the activities in which the business engages for profit." (Emphasis added).

Albeit informally, less than a year after *Yates* was decided, DOL went even further in its support of 99-04A and the *Yates* holding when it cited this very precedence in a response it gave

to the American Bar Association Standing Committee on Employee Benefits (the "ABA Committee").[4] The timing of DOL's interpretation is particularly relevant because it closely followed in time not only the *Yates* opinion but also the issuance of the final regulations it issued concerning 29 U.S.C. § 1191a(d) (discussed *infra*). The ABA Committee very directly asked for DOL's opinion on the following hypothetical fact pattern: If partners, as self-employed individuals, participate in a partnership health plan alongside of employees of the partnership, does that cause the health plan to be a multi-employer welfare arrangement[5] ("MEWA") because employees of two or more employers participated in the plan.[6] DOL's response to the ABA Committee's question was a definitive "No." ("A plan sponsored by a single partnership covering only partners of the partnership and common law employees of the partnership would not be a MEWA for purposes of section 3(40) of ERISA.") The Department explained that "a self-employed partner in a partnership should be treated as an 'employee' of the partnership." Citing *Yates*, the Department reasoned that its regulations did not preclude partners from being treated like employees for all purposes under ERISA. Also importantly, like the Supreme Court holding in *Yates* and consistent with its conclusions in 99-04A, the Department did not establish in its response to the ABA Committee minimum requirements to be qualified as a "working owner" partner for these purposes. At least by implication, this silence leaves intact the working owner

[4] Periodic meeting between ABA Committee and representatives of the Department held on May 18, 2005, Q&A 16.

[5] ERISA Section 3(40). *See also,* FN 6, AO Response. The significance of MEWA status in the context of ABA Committee's question is that each partner would be considered to be a separate employers maintaining partnership health plan. Consequently, this status then throws the health care plan and the partners into an additional and complex set of statutory and regulatory requirements both at the Federal level and also the state level.

[6] It is fair to say that the question by the ABA was both an academic one and a practical one. Given that groups of lawyers commonly form together in partnerships and lawyers give advice to clients who are partnerships, getting clarification regarding the question of MEWA status of a partnership health plan was of paramount importance.

definition it set forth in 99-04A and adopted by the Supreme Court in *Yates*. Moreover, by expressly basing its opinion to the ABA Committee on the partners "self-employed" status, DOL embraced the Code's concept of self-employment as being dispositive.

In 2007, the Fifth Circuit adopted and expanded the reasoning of the Supreme Court in *Yates*, stating that a disability benefits plan offered to partners and common law employees was a single-employer plan despite the fact that partners paid 100% of the premiums while the partnership covered 100% of the premiums on behalf of common law employees. *House v. American United Life Insurance Company*, 499 F. 3d 443 (5th Cir. 2007).

In the AO Response, in addition to inserting employment classification requirements that cannot apply, DOL also takes the liberty to re-write other standards set forth in its regulations in manner wholly inconsistent with *Yates* and 99-04A. In this regard, DOL conjures up the following standards for limited partners that if met creates a scenario where "… it would be plausible to treat them as employed by the partnership in the relevant sense." AO Response, p. 5. Emphasis added. DOL states that limited partners can only be "bona fide" if "the limited partners worked for or through the partnership, had a material ownership interest in the partnership, and earned income for work that generated material income for the partnership …" *Id*. (Emphasis added.)

By comparison, according to *Yates* and 99-04A, for a partner, any partner, to be a working owner he/she has "an equity ownership right of any nature in a business enterprise and [who] is actively engaged in providing services to that business." 99-04A, FN3. (Emphasis added.) On its face, DOL's requirement of a "material ownership interest" is inconsistent with law. The "any

nature" standard established by *Yates* and 99-04A in no way implies a materiality requirement nor can it. Partnership and partner status is determined by state and not Federal law.[7]

Moreover, with respect to DOL's standard that "earned income" must derive from "work that generated material income for the partnership," there is again no legal basis. Under the IRC, earned income is defined in Code Section 911(d)(2)(A) as compensation for personal services, not distributive shares, evidenced by compensation or guaranteed payments for services rendered as opposed to mere equity ownership. Further, the actual test regarding self-employment status is set forth in 26 U.S.C. §§ 401(c)(1)(B) and 401(c)(2)(A)(i) which define "'a self-employed individual' to cover an individual with 'earned income' from 'a trade or business in which personal services of the taxpayer are a material income-producing factor.'" *Yates*, at 14. Here, DOL seeks to require an economic threshold to be achieved even though the law requires none. In DOL's version, material income must be generated but the law requires only that the income result from services that are a material factor or "input."[8] Therefore, in the AO Response, DOL plainly changes the standards articulated in *Yates* and 99-04A and thereby impermissibly abandons the Supreme Court's carefully considered analysis and its own prior guidance.

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[7] As a starting point, DOL must recognize what is an acceptable partner/partnership construct. As the Tax Court explained in *Renkemeyer Campbell &Weaver LLP v. Commissioner,* 136 T.C. 137, 148-149 (2011), States, not the Federal government, determine and then directly regulate hybrid corporate structures like limited partnerships. Therefore, DOL must defer to the States to determine this threshold element. Assuming, state partnership law requirements are met, what remains is a general review of facts and circumstances for compliance with other applicable requires. .*See generally* IRC § 469. [26 U.S.C. § 469] (With respect to limited partner status, this occurs when the terms of a partnership agreement stipulate owners as such in compliance with the laws of the state under which the limited partnership is organized or upon the satisfaction of a federal standard of limited liability tie to a fixed liability standard. 26 CFR § 1.469-5T(e)(3). Notably, the regulations endorse state determinations of qualifying limited partnership status, *Id*.)

[8] *Merriam-Webster* defines a "factor" in this context to be an input into a greater process as "one that actively contributes to the production of a result." See "Factor." Merriam-Webster.com Dictionary, Merriam-Webster, http://www.merriam-webster.com/dictionary/factor?src+search-dict-box. Accessed 29 Jan. 2020.

In the AO Response, DOL also attempts to re-write its long standing regulation defining the scope of the meaning of the "employee benefit plan" in 29 U.S.C. § 1002(3) and this too must be rejected. In relevant part, this regulation states:

> Plans without employees. For purposes of title I of the Act and this chapter, the term "employee benefit plan" shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so called "Keogh" or "H.R. 10" plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under title I.

29 CFR § 2510.3-3(b). Emphasis added.

In the AO Response, DOL indicates that a ratio percentage test must be met to satisfy the "one or more" requirement.

> You argue, by implication, that the limited partnership benefit program can be treated as a single ERISA-covered plan because it would cover at least one common law employee of the partnership itself, … even if the single common law employee is outnumbered by thousands or tens of thousands of "limited partners" who obtain health coverage through the arrangement.

In the first instance, as already discussed *infra*, to the extent DOL attempts to require through its Opinion satisfaction of a *Darden* common law employment test, this must be rejected because the Supreme Court determined in *Yates* that the *Darden* test was not applicable to owner employee status. Secondly, DOL has no authority to establish requirements in a final order that must be obtained through rule making or, in this case, the reversal of *Yates* by the Supreme Court. By requiring compliance with a ratio percentage test, DOL is not merely interpreting 2510.3-3(b), it is changing the entire calculus. DOL would have the rule be "one or more" and least some percentage of partners. In fact, as a practical matter, DOL's newly articulated requirement begs the question of what percentage is compliant. This determination cannot be made through interpretation. Therefore, any such attempt to establish such a requirement through a final order is

a violation of the APA. *Christopher v. SmithKline Beecham Corp*., 132 S. Ct. 2156, 2166 (2012) (*Auer* deference does not apply "when the agency's interpretation is plainly erroneous or inconsistent with the regulation."). If DOL wants to introduce these completely new standards, to be compliant with the APA, at a minimum it should do so through rule making and not through the issuance of final orders under ERISA Proc. 76-1.

2. AO RESPONSE VIOLATES APA BY FAILING TO ANALYZE AND CITE RELEVANT, APPLICABLE LAW

The omission of any citation to or analysis by DOL with respect to the advisory opinion requested by LPMS is inexplicable. For example, when DOL previously issued an advisory opinion addressing facts that also raised issues concerning the status of a working owner as an eligible participant for purposes of ERISA, DOL cited to 99-04A in order to makes its determination. See DOL Op. No. 2006-04A.[9] Moreover, DOL often cites to both *Yates* and *Darden* when it addresses an issue concerning "employee" status in an advisory opinion it issues. This procedure makes sense because the *Darden* test covers those instances where the common law employee issues are present and *Yates* covers those instances where a working owner analysis is required. Therefore, together, the two cases address all circumstances concerning employee status, yet neither are considered by DOL in its AO Response. Said differently, DOL does not simply cite to *Darden* as the test for all determinations of "employee" status under ERISA, because the majority in *Yates* declined to adopt that approach with respect to working owners.

[9] In fact, if you conduct a search on DOL's website under the EBSA tab and then go to the sub-tab offering "Law & Regulations" and then go to sub-tab "Guidance," DOL provides access to all prior advisory opinions it has issued. Using DOL's search engine, if you seek advisory opinions designated by DOL as applicable to the term "working owner" and also "participant" which is defined in ERISA Section 3(7), the only hit you get is DOL Op. No. 2006-04A which in turn cites to and analyzes 99-04A. Yet DOL omitted that citation and accompanying analysis in the AO Response as well.

Unconstrained by *Yates* and 99–04A, DOL takes the liberty to engage in a robust common law employment analysis to determine whether the limited partners described in LPMS's advisory opinion application are eligible to participate as ERISA "employees" and "participants" in a health plan sponsored by the partnership. For example, DOL calls out and expressly relies on the following employment related factors in the AO Response:

> According to the representations you have provided in support of your request, limited partners do not appear to report to any assigned "work" location or otherwise notify the partnership that they are commencing their work; and they are not required to possess any particular work-related skills.[10] AO Response, p. 2.
>
> These provisions, like the title of the law itself— the Employee Retirement Income Security Act (emphasis added) — are replete with references to the employment relationship, and ERISA's coverage expressly turns on the provision of benefits in the employment context, As the above quoted language demonstrates, ERISA covers employee welfare benefit plans sponsored by an employer or employee organization for the benefit of plan participants who are themselves employees or former employees. The arrangements proposed by LP Management meet none of these criteria, inasmuch as the partnership is not the limited partners' employer, and the partners are neither employees nor employers with respect to the partnership. *Id.*, p. 3
>
> The fact that one common law employee participates in a purported partnership program does not mean that everyone covered by the arrangement is participating in an ERISA plan. Rather, the regulation must be read in light of the Department's authority under ERISA to regulate the provision of employee benefits offered in the context of a genuine employment relationship. *Id.*, p. 4

None of these employment related factors, however, can be relied on by DOL based on the Supreme Court's holding in *Yates* because this very test was specifically rejected. Instead, in relevant part, the Supreme Court directs us to 26 U.S.C. §§ 401(c)(1)((A), 401(c)(1)(B) and 401(c)(2)(A)(i) and 99-04A as the "specific guidance" that makes owner employees ERISA employees. By rejecting the application of *Darden*, the Supreme Court intentionally treats owner

[10] Pursuant to 26 U.S.C. § 469 discussed *infra*, the pertinent consideration is activity undertaken for a profit not a common law employment test. In this regard, what limited partners are doing is intentionally downloading software, using the device dedicated to partnership use, signing in, creating data through use of the device and ultimately helping to manage the data's end use. Therefore, the creation of data is not happenstance, rather it is an intentional and dedicated activity.

employees differently recognizing that it is the Internal Revenue Code that actually defines the terms "self-employed individuals" and "owner employees," whereas ERISA does not. The majority very directly supports its position by pointing out that ERISA itself requires that it be harmonized with the Code. *Yates*, at 13. Therefore, the Supreme Court comfortably concludes it is both appropriate and consistent with ERISA to recognize the different attributes of owner employees and relies on the Code to establish the relevant standards. Therefore, DOL's reliance on common law employment factors to make its determination in the AO Response is contrary to law. In short, DOL inexplicably engaged in the wrong analysis in reaching its conclusions – an analysis it had previously engaged in without difficulty.

3. AO RESPONSE VIOLATES DOL PROCEDURES BY BASING CONCLUSIONS ON SPECULATIVE AND DISTORTED FACTUAL FINDINGS

Even if DOL had a basis to undertake an employment type analysis, DOL's approach is fatally flawed in its own right. Specifically, DOL relied on speculative facts even though ERISA Procedure 76-1 bars such reliance. Specifically, ERISA Proc. 76-1 § 10 states "The opinion assumes that all material facts and representations set forth in the request are accurate, and applies only to the situation described therein." It the AO Response, however, DOL does not accept as accurate even the most basic facts present by LPMS. These inaccuracies and mischaracterizations by DOL are legion. A table summarizing these repeated violations of its own procedure is attached hereto and incorporated herein as Exhibit C. In no way did LPMS characterize the partners' services as mindless, unintentional and inconsequential to the partnerships' business. Rather, it is simply DOL's erroneous opinion that these are the "real" facts, which it uses to reach a predetermined conclusion completely at odds with the actual facts proffered.

4. PROPER LEGAL ANALYSIS DEMONSTRATES THAT DMP'S PARTNERS ARE WORKING OWNERS ENTITLED TO PARTICIPATE IN THE PLAN

While DOL has not issued further guidance distinguishing working owners "actively engaged in providing services" from passive ownership as set forth in 99-04A, the Code contains a long history of regulating the difference between these types of owners of a trade or business. 26 U.S.C. § 469 and subsequent regulations address the directly related issue of income and loss recognition (i.e., is it passive or not), including the recognition of income and losses by limited partners, by analyzing whether the partners themselves are active or passive owners within their respective business.

Generally, to determine how income and losses are recognized, 26 U.S.C. § 469 sets forth a standard based on "material participation" in the conduct of a trade or business.[11] In turn, material participation is generally defined as an activity[12] (on behalf of a trade or business) that is regular, continuous, and substantial with respect to limited partners, meets one of three threshold standards.[13] The relevant standard here is five hundred (500) or more hours of service in a year. Therefore, under 26 U.S.C. § 469, a limited partner is not considered to be a passive owner when the limited partner is providing more than five hundred (500) hours of participation to the limited partnership. See 26 CFR § 1.469-5T(a)(1). Therefore, it must be that a limited partner who is not a passive owner is materially participating and "actively engaged in providing services" to the

[11] 26 U.S.C. § 469(c)(1) (For this purpose, "participation" is defined as work performed by an individual (not managed), irrespective of the individual's capacity when performing the work, in connection with an "activity" (See FN 12, *infra*, for definition) in which the individual owns an interest at the time the work is done. 26 CFR § 1.469-5(f)(1). Importantly, work is not defined so a type or minimum amount is not required.

[12] An activity is one that is generally related to income production in the conduct of a trade or business. *Id.* at § 1.469-4T(c)(2)(iv). Note that no minimum amount of income is required to be a qualifying activity.

[13] *Id.* at § 1.469-5T(a)(1).

limited partnership. In the case of DMP, that is a limited partner contributing at least 500 hours of electronic data – the very thing that DMP requires and uses for income production.

The AO Request makes this point concerning working owners citing to *Yates* and 99-04A. While DOL had the AO Request under advisement, it filed an appellate brief citing *Yates* with approval for the proposition that working owners "can be both an employer and an employee for purposes of establishing and participating in an ERISA-covered benefit plan." Brief for Appellants at 3, State of New York, et al. v. U.S. Department of Labor, et al., No. 19-5125, (D.C. Cir. *appeal docketed* Aug. 8, 2019).[14] DOL further expounded on this position at pp. 40 – 43 of the brief, providing additional explicit judicial admissions that the AO Response's position as to "working owners" directly contradicts DOL's legal positions on the same issue.[15]

C. THREAT OF IRREPARABLE HARM

For a court to issue a temporary restraining order, there must be a substantial threat that irreparable harm will result if the emergency motion is not granted. *Clark v. Prichard* 812 F.2d 991, 993 (5th Cir. 1987). Every day, Plaintiffs are harmed by the uncertainty surrounding their novel partnership and health plan structure. Plaintiffs are continuously deprived of substantial revenue because potential partners sit on the sidelines while awaiting direction from the government as to the ERISA status of the Plan. Moreover, DMP's (and the other LPMS-managed partnerships') primary business purpose hinges on its ability to attract and maintain a broad assortment of partners in order to collect and market their generated data to third parties. Each day

[14] A true and correct copy of this brief is attached hereto as Exhibit D.

[15] Notably, DOL did not lose the underlying case concerning the "working owners" issue raised by Plaintiffs here. The New York v. DOL matter involves newly minted regulations whereby DOL sought to implement modifications to association health plan regulations. The successful challenge by the Plaintiffs in that matter concerns APA compliance entirely unrelated to DOL's position on "working owners." Consequently, the underlying reasoning and judicial admission of DOL is pertinent here, since this case involves DOL not applying the same underlying reasoning to a different kind of plan sponsor unaffected by the new regulations challenged there.

that Plaintiffs operate within diminished partnership ranks as a result of DOL's erroneous AO Response is a day of business that Plaintiffs cannot get back. If this Court declines to issue a TRO, Plaintiffs will be immediately and permanently harmed.

The success of the DMP's business model (as well as the other LPMS-managed limited partnerships) depends on its ability to attract enough partners in order to generate statistically meaningful user data. DMP created its group health plan as a recruitment method to achieve this essential goal. Access to group health plans is an attraction and retention tool utilized by an overwhelming majority of US employers, and many companies (particularly in transient sectors, such as temporary staffing) publicly advertise access to their group health plans in order to attract new employees. DMP's benefit plan model is therefore nothing new; only its ownership structure is in any way novel. And contrary to the underlying assumptions of the AO Response, "novel" is not a synonym for illegitimate, or unlawful. DMP fully conforms to the Business Organizations Code of Texas, its state of domicile, and its group health plan fully conforms with ERISA, including its treatment of limited partners as employees for the purposes of establishing group health plan eligibility.

DOL states "We have consulted with the Departments of Health and Human Services and the Treasury. They have advised … that … the limited partnership programs … would not be a group health plan … and thus, the limited partnership programs would generally be subject to regulations applicable to the individual market, not the small or large group markets." Apparently three key agencies of the federal government believe that prospective partners who may be attracted to join DMP and the other LPMS-managed partnerships partly to gain access to its group health plan should instead seek coverage from the only source the government believes to be

"lawful" - the failed Obamacare market. In order to consider the harm being done to Plaintiffs and their partners by the AO Response, it is therefore necessary to consider the alternative.

The individual market as it currently exists was created by passage in 2010 of the Patient Protection and Affordable Care Act, commonly known as "ACA" or "Obamacare." ACA has had highly uneven impacts on various segments of the US population. Approximately 9,000,000 people are enrolled in ACA exchange plans, and 8,000,000 of these enrollees – nearly 90 percent – receive "free insurance" thanks to premium subsidies from the federal government. Meanwhile, approximately 24,000,000 US citizens – more than two and a half as many as those enrolled in ACA exchange plans – have no coverage whatsoever. The reason most frequently cited by those who lack health coverage is inability to afford individual market premiums.[16] As a rule, the uninsured are neither impoverished (because those who are receive ACA subsidies) or wealthy (because wealthy people are able to pay whatever it costs to get coverage, and generally do). The uninsured population is thus made up overwhelmingly of the self-employed middle-class, which is the fastest-growing segment of the US population.[17]

DOL (and, according to its AO Response, two other key federal agencies) apparently believe that the status quo is not only acceptable but desirable, and must be defended against Plaintiffs' model and any other alternatives to ACA. In that belief, they are joined by America's Health Insurance Plans (AHIP), a lobbying association dominated by the largest insurance carriers in the US.[18] The status quo has certainly been beneficial to these carriers. In the decade since passage of ACA, while the overall stock market has achieved historic gains, the five largest health insurance carriers have risen in value three times more than the market as a whole. (The S&P 500

[16] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
[17] https://dataspace.princeton.edu/jspui/bitstream/88435/dsp01zs25xb933/3/603.pdf
[18] UnitedHealth, Cigna, Humana, Anthem, Aetna.

index has increased by an average of 19% annually since 2010, while the five largest health insurance carriers have increased 60% annually, or 584% in total.) AHIP recently filed an *amicus curiae* brief in *Texas v. Azar*, and released a statement declaring that "The district court's original decision to invalidate the entire ACA was misguided and wrong."[19]

Plaintiffs, on the other hand, believe that giant corporations which reap billions in profits from the US Treasury, and spend more than $40 million annually on lobbying efforts to protect their "right" to do so, as well as bureaucrats who intentionally misinterpret laws, regulations, and legal precedent in such a way as to harm more than twice as many people as they allegedly help, are misguided and wrong.

Currently, over 50,000 Americans maintain access to health coverage and affordable health care through plans similar to the Plan. The eligibility for inclusion in the Plan (and similar group health plans) rests upon the "working owner" construct implicit in the participant's active contribution of electronic data to the business purposes of the partnership. Should the AO Response stand despite its numerous flaws noted above, all of those hard-working Americans would suddenly lose their health coverage. This would occur because the Plan (and similar group health plans) are ERISA compliant single-employer group health plans, but are not Obamacare individual insurance products. To allow the AO Response to stand without restraint pending the Court's final adjudication of the issues raised in Count 1 of the FAC would mandate that DMP and LPMS dissolve all of these plans providing an affordable, ERISA compliant alternative to ACA individual plans.

[19] https://www.ahip.org/ahip-issues-statement-upon-filing-an-amicus-brief-with-the-supreme-court-requesting-certiorari-in-tx-v-us/

D. PUBLIC INTEREST SERVED WITH ISSUANCE OF TRO

The final element Plaintiffs must establish to obtain a temporary restraining order is demonstrating that such an order will not disserve the public interest. Given the numerous fatal flaws in the AO Response, restraining enforcement or application of the AO Response will serve the public interest well because all parties to this case and the general public at large will have clarity on this health care arrangement. Furthermore, issuance of the requested order would serve the public interest by preserving the current health coverage of tens of thousands of Americans at least until a final hearing on the merits of Plaintiffs' claims. To allow such access to affordable health care would in no way harm Defendants or the public interest. First, Defendants claim a lack of authority to regulate the Plan in their AO Response. Enjoining them from claiming a lack of authority is not a harm to Defendants. Furthermore, any claims by Defendants and/or other parties that the Obamacare "risk pool" may be harmed by temporary or permanent approval of the Plan are disingenuous in the extreme. 90% of current ACA individual market participants receive premium subsidies from the federal government, and are highly unlikely to abandon their coverage in favor of coverage such as the DMP Plan, which is completely unsubsidized by tax dollars. The "risk" of some portion of the remaining 10% – which represents less than one million individuals – abandoning Obamacare in favor of DMP or similar Plans must be balanced against the current plight of the more than twenty-four million individuals who have no coverage at all and the fact that Obamacare plans have been steadily losing approximately one million individuals on annual basis for multiple years anyway.

IV. CONCLUSION

In light of the foregoing, the Court should grant DMP's Motion for TRO and Preliminary Injunction.

Respectfully submitted,

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CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that service of the foregoing *Plaintiff's Brief in Support of Motion for Temporary Restraining Order and Preliminary Injunction* was made, this 3rd day of February, 2020, by the Court's Case Management/Electronic Files system upon the attorneys for the parties.

Respectfully submitted this 3rd day of February, 2020.

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

DATA MARKETING PARTNERSHIP, LP and LP MANAGEMENT SERVICES, LLC, Plaintiffs, UNITED STATES DEPARTMENT OF LABOR, EUGENE SCALIA, *in his official capacity as Secretary of the United States Department of Labor*, and UNITED STATES OF AMERICA, Defendants.	)	Civil Action File No. 4:19-cv-00800-O

DECLARATION OF ALEXANDER RENFRO

1.

My name is Alexander Renfro and I acted as counsel for LP Management Services, LLC in preparing and presenting the Advisory Opinion request attached to the First Amended Complaint as Exhibit A.

2.

Unless otherwise stated, the facts stated herein are within my personal knowledge. I am over the age of twenty-one and competent to testify to the matters set forth in this Declaration. I understand that this Declaration is given for use in the above-styled action, and that it may be used for any purpose permitted by law.

3.

In October, 2018 (the "October Meeting"), I, along with other representatives of LPMS, including Christopher Condelucci, met with the United States Department of Labor ("DOL") in an effort to be transparent with the relevant regulatory agencies that would interact with the health

insurance plan that was being created for employees and limited partners of Data Marketing Partnership, LP.

4.

In attendance at the October Meeting and representing the interests of DOL, among others, was Preston Rutledge, Assistant Secretary of the DOL and head of the Employee Benefits Security Administration ("EBSA") division of the DOL.

5.

EBSA has direct oversight of ERISA within the DOL.

6.

By all accounts, the October Meeting was constructive. LPMS representatives explained the plan structure to DOL representatives and we provided high level detail of the goals of the Plan and the business structure of DMP and potential similarly situated partnerships.

7.

At the October Meeting, Mr. Rutledge explained to me and other LPMS representatives from that an Advisory Opinion Request was the best route to ensure approval of the Plan by DOL.

8.

In response to this advice from Mr. Rutledge on behalf of DOL, I promptly submitted an AO Request on November 8, 2018.

9.

We parted ways with DOL with the explicit commitment to continue discussions so that DOL could be comfortable approving the Plan as an ERISA-subject single-employer group health plan.

10.

In the weeks and months that followed, informal conversations took place between representatives of LPMS and DOL in anticipation that a more formal meeting would soon follow.

11.

In a reversal of his previous position, Mr. Rutledge eventually expressed to Mr. Condeluci that he did not see why DOL needed to issue an Advisory Opinion at all because ERISA already allows partners to be treated as employees for purposes of plan eligibility.

12.

During this conversation, Mr. Rutledge told Mr. Condeluci that LPMS should "just do it," meaning implement the Plan, rather than wait for a formal DOL Advisory Opinion that might be a long time coming.

13.

As a result of informal verbal questions and observations from DOL, the AO Request was slightly revised and resubmitted to DOL in early 2019, culminating in the final version of the AO Request submitted on February 27, 2019.

14.

During a meeting I attended on March 6, 2019, then DOL Chief of Staff Nicholas Geale told me, a group of representatives from LPMS, and interested states, including Mr. Condeluci, and Louisiana Attorney General Jeff Landry (the lead signatory to the State AG Letter) that although the LPMS structure was "ingenious" and that he "wished he'd thought of it," DOL could not respond to the AO Request due to perceived conflict with litigation around DOL's new Association Health Plan (AHP) rule.

15.

At one point during the meeting, representatives from DOL became animated said that if the LPMS group disagreed about DOL's priorities, they should "take it up with the White House."

16.

In a subsequent meeting that Mr. Condeluci had with Mr. Geale at DOL, Mr. Geale proposed that if LPMS would withdraw its AO request (and/or cease pressing for an answer to it), Mr. Geale would "look [LPMS representatives] in the eye" and promise that DOL would not investigate or otherwise interfere with any LPMS-managed partnership plans.

17.

LPMS' representatives attempted to explain to Mr. Geale that even assuming DOL refrained from investigating or hampering LPMS-managed partnership plans such as DMP's Plan, the fifty-six separate state and territorial insurance commissioners could pose significant and indefinite regulatory burdens on LPMS-managed partnership plans through investigations and rulings of their own. It simply was not practical or advisable to rely on handshake promises with the threat of politically motivated investigations by individual states or territories in the absence of an ERISA ruling.

18.

Presumably because LPMS was not willing to simply "take their word for it" and since that time, DOL rapidly changed course in its dealings with LPMS regarding the propriety of the LPMS-managed partnership plans as well.

19.

Following months of silence from DOL, a response to the AO Request was finally issued on January 24, 2020 (the "Response").

20.

This response called upon information that neither I nor any representative of LPMS or DMP communicated to DOL, whether informally at our meetings or formally in the actual AO Request.

21.

DOL never followed up with me nor any other representative of LPMS or DMP in an effort to ascertain a true and accurate factual landscape regarding the structure proposed in the AO Request.

22.

I give this Declaration freely and without coercion.

23.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 3rd day of February.

Alexander Renfro

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

DATA MARKETING PARTNERSHIP, LP, and LP MANAGEMENT SERVICES, LLC Plaintiffs, UNITED STATES DEPARTMENT OF LABOR, EUGENE SCALIA, *in his official capacity as Secretary of the United States Department of Labor*, and UNITED STATES OF AMERICA, Defendants.	)	Civil Action File No. 4:19 – cv – 00800 – O

DECLARATION OF RANDALL W. JOHNSON

1.

My name is Randall W. Johnson. I am the Manager of Limited Partner Management Services, LLC ("LPMS"), the general partner of Data Marketing Partnership, LP ("DMP"), a Plaintiff in the above-styled action.

2.

Unless otherwise stated, the facts stated herein are within my personal knowledge. I am over the age of twenty-one and competent to testify to the matters set forth in this Declaration. I understand that this Declaration is given for use in the above-styled action, and that it may be used for any purpose permitted by law.

3.

LPMS is a limited liability company that is duly formed under the laws of the State of Georgia and registered to do business in the State of Texas.

4.

Among other things, the primary business purpose of LPMS is to serve as General Partner of various limited partnerships and manage the day-to-day affairs of these partnerships, including DMP.

5.

Each of those limited partnerships, including DMP, has sponsored an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act ("ERISA"). 29 U.S.C. § 1002 (1).

6.

DMP, along with other entities managed by LPMS, are startups. As startups, neither DMP nor the other entities managed by LPMS have generated profits or substantial revenue yet.

7.

The primary business purpose of DMP is the capture, storage organization, and sale to third-parties of electronic data generated by its partners, as well as facilitating partners providing online marketing services.

8.

To succeed, this business model requires the aggregation of large quantities of data, which, in turn, requires large numbers of limited partners contributing data to the partnership.

9.

Without a large data pool and significant numbers of limited partners, DMP's data business suffers because it is unable to offer its clients and potential clients a sufficiently robust dataset for their marketing needs.

10.

LPMS, as the general partner of DMP, is responsible for day-to-day business management decisions including, but not limited to, the execution of rental/office lease agreements, employment contractors, data marketing and related agreements, and grantor decisions to form a group health plan.

11.

The limited partners of DMP are individuals who have obtained a limited partnership interest for free through the execution of a joinder agreement with DMP, which is approved by LPMS.

12.

Limited partners will participate in global management issues through periodic votes of all partners of DMP. Together, LPMS and the limited partners wholly control and operate DMP.

13.

DMP is a limited partnership that is duly formed under the laws of the State of Texas and qualified to do business in the State of Texas.

14.

In addition to certain other management rights, limited partners will have a say in how aggregated data will be sold or used by DMP.

15.

In order to qualify for the Plan and as stated in the eligibility section of the Plan, each limited partner agrees to contribute more than five hundred (500) hours of work per year through the generation, storage, transmitting, and sharing of their data.

16.

In order to generate the necessary electronic data, participating partners install proprietary software for computers and/or mobile applications for mobile devices. This software captures the electronic data generated by the partner's use of their computer and/or mobile device and transmits it to a secure, cloud-based "data bank" maintained by the partnership. The aggregated electronic data is then anonymized and organized for marketing to third-party purchasers.

17.

Partners control and manage the production, capture, segregation, aggregation, and sale of their own individual data, empowering partners in a manner not otherwise available to them.

18.

Profit generated by the sale of the limited partners' data can then be dispersed via payments by DMP to limited partners. This will be reported as guaranteed payments and subject to employment taxes.

19.

DMP employs at least one common law employee to assist the partnership with administrative and/or revenue generating services.

20.

To attract, retain, and motivate talent in support of DMP's primary business purpose, DMP established and markets a high quality single-employer self-insured health insurance plan (the "Plan"). The Plan is intended to be an "employee welfare benefit plan" as defined under § 3(1) of the Employee Retirement Income Security Act ("ERISA"). DMP intends for the Plan to comply with ERISA.

21.

The Plan automatically covers all common law employees of DMP. The Plan is available to provide coverage to limited partners if they choose to participate, but partners are not required to do so.

22.

Given the adverse impact of the Affordable Care Act a/k/a Obamacare ("ACA") on the cost of health benefits for small business owners and the self-employed, the Plan and similar group health plans for the other LPMS-managed partnerships provides DMP and the other partnerships a significant incentive for members of this demographic to join the partnership.

23.

In reliance on communications received from DOL representatives by legal counsel for LPMS, LPMS began accepting limited partners into limited partnerships it manages and formed the ERISA-subject health plans for them, including a plan for DMP. As of January 30, 2020, nearly 50,000 Americans have signed joinders making them limited partners of the limited partnerships managed by LPMS, and are participants in the plans offered by those partnerships.

24.

Those joinders and plan enrollments were offered in reliance on the assurances provided to LPMS' counsel by DOL officials, and the assumption that DOL would follow its own published rules regarding advisory opinion requests, including asking any questions necessary to consider the request, and giving it timely and fair consideration. As startups, neither DMP nor the other entities managed by LPMS have enrolled sufficient numbers of partners to reach the quantity of electronic data necessary to generate profitable offers to purchase the data.

25.

As a result of the AO Response (defined in and attached to the First Amended Complaint), DMP and the other LPMS-managed partnerships have ceased enrolling new partners into any health plans, which has drastically reduced their ability to attract new partners to their data marketing programs. Consequently, the partner data DMP endeavors to market and sell to third parties is less valuable directly because of the AO Response, resulting in a failure to grow DMP's revenue and the potential closure of the business.

26.

I give this Declaration freely and without coercion.

27.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 3rd day of February.

Randall W. Johnson

SIDE-BY-SIDE COMPARISON OF REPRESENTED FACTS IN DOL ADVISORY RESPONSE AND REQUEST FOR ADVISORY OPINION

AO RESPONSE	AO REQUEST
Revenue expected to be zero (p.3)	Guaranteed payments will be made and will be subject to employment taxes (p.3)
No facts on how partners are meaningfully employed by the partnership. (p.2)	Several pages of facts, under heading "Statement of Facts." Partners execute a joinder agreement and provide time and service by generating and contributing their data which is used to generate revenue to the partnership, which in turn is then distributed to the partners. (p.2)
Sole service of limited partners is to install software on personal devices to capture data as they browse the internet or use their devices. (p.2)	Services provided by partners other than installation of software: Partners contribute time and service to the partnership generating data for the specific purpose of adding to the revenue generating activities of the partnership. (pp. 2 and 3)
Partners do not perform any work for the partnership apart from permitting partnership to track the use of their devices. (p.2)	Partners are the partnership's decision makers on the use of the data. (p.3)
Allowing tracking of data is no different from what they are already doing while using their device. (p.2)	Partners retain control over and manage their own data in the following ways: 1. Partners decide what device(s) the software is installed on and what device(s) is used to log data collection by the partnership. 2. Partners decide what data is collected and how time and service is spent. Partners also decide what data is not collected by using a different device, signing out of the software, using a private mode on their device, deciding to delete any data collected, or voting to not share data collected with one or more clients of the partnership.

SIDE-BY-SIDE COMPARISON OF REPRESENTED FACTS IN DOL ADVISORY RESPONSE AND REQUEST FOR ADVISORY OPINION	
AO RESPONSE	**AO REQUEST**
	3. Each partner has a vote on how their data is used and to what companies data is sold (p.3)
Partner's work "does not differ in any meaningful way from the personal activities limited partners would otherwise engage in" when using their devices. (p.2)	This claim is speculative and unfounded. This claim is not based on any representation in the AO Request. Once a person is compensated for activity they used to perform for free, one may naturally anticipate that their habits will change. Increased output would be one simple expected change, along with deliberate decisions to generate data on specific devices which can credit the partner with income as opposed to others. Partner's work differs in these ways, among others: 1. How the partnership aggregates their data; 2. How the partnership will use their data; 3. How their data will be sold by the partnership; and 4. What companies the partnership sells their data to. (p.3)
No information provided on partner's participation in global management issues through periodic voting. (p.2)	See above.
Software captures the data tracking ***of other companies*** as partner uses their device. (p.2)	Software captures data generated by user directly, not from other collection sources. (p. 3).
No information on meaningful equity interest of each partner or any appreciable financial benefit to each partner except health coverage. (p.2)	Limited partners collectively own partnership through valid equity interest and receive income from their time and service to partnership. (p.3)
The activity of the partners is the same as partners generating economic value when visiting websites of companies that track consumer traffic. (p.2)	Consumers using commercial websites generate value for said sites. Partners in DMP generate revenue for partnership, which they collectively own. (p.3)

SIDE-BY-SIDE COMPARISON OF REPRESENTED FACTS IN DOL ADVISORY RESPONSE AND REQUEST FOR ADVISORY OPINION

AO RESPONSE	AO REQUEST
Partners do not have any assigned work location. (p.2)	Partners can work remotely while their data is collected for use by the partnership. (p.3)
Partners do not notify partnership of commencement of work. (p.2)	When the partner's data is collected, the partnership's timestamped receipt of the data will indicate the time spent in furtherance of the partnership's requirement that each partner provide data to the partnership. (p.3)
Partners do not depend on partnership as a source of business income. (p.3)	Partners will receive guaranteed payments from the income generated by the sale of data to third parties in accord with the amount of work product they contribute to said sales. (p.3)
Primary reason for partners to participate is to acquire health coverage. (p.3)	Health coverage is provided as an incentive for participation, along with control over their data and a share in the revenue from the sale of the data. (p.3)

[NOT YET SCHEDULED FOR ORAL ARGUMENT]

No. 19-5125

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

STATE OF NEW YORK, *et al.*,

Plaintiffs-Appellees,

v.

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

Defendants-Appellants.

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

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

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.