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[redacted]

February 20, 2024

U.S. Department of Labor
Employee Benefits Security Administration
Office of Regulations and Interpretations
Washington

Submitted Electronically

Re: RIN No. 1210-AC16
Public Comment to Notice of Proposed Rulemaking at 88 Fed. Reg. 87968 – 87981 (December 20, 2023)

Thank you for the opportunity to comment on the above-referenced NPRM. The return to narrow criteria for a so-called Association Health Plan ("AHP") to be "bona fide,"[1] removing the 2018 attempt to expand them, is very welcome. However, it leaves in place the supposition that small employers become "large employers" when a "bona fide" AHP is involved, depriving plan beneficiaries of valuable rights added by the Affordable Care Act ("ACA").

The underlying claim proceeds by treating individuals who are not employed by the "association" entity (to abbreviate the §3(5) "group or association") as if they are. They are employed by the members of the association. Nevertheless, employee-counts of those members are aggregated, and the sum is said to be the employee-count of the "association" entity. This fictitious count is said to be valid even for the governing provisions dividing "small" and "large" as to employers and group markets, for purposes of the new consumer rights added by the ACA.[2]

This comment will address, and oppose, this claim, herein called the "Aggregation Theory." It is contrary to law and unauthorized. This commenter will repeat much of his

[1] That term is Labor's coinage, as discussed below, fns. 17 - 19, evidently referring to an AHP that satisfies the conditions upon the "group or association of employers" described in ERISA, §3(5), 29 U.S.C. § 1002(5), where the nature of its employer-members, its structure, the health coverage arrangements, or other elements, are sufficient — whatever the effective conditions may be — to trigger the creation of fictive "employer" status for such "group or association" by the §3(5) language pertaining to groupings. That language will be called herein "the Association Clause." Its text begins with "includes," but its end is a reference back, in the phrase "acting for an employer in such capacity," to what precedes "includes." It might be re-written as: " … includes a group or association of employers acting indirectly in the interest of an employer, in relation to an employee benefit plan."

[2] Technical details of such definitions will be discussed below, but for now, the small/large dividing provisions are sub-sections (b)(1) and (2) (as amended by Pub. L. 114-60, §§2(b)(1) and (2)), then sub-section (a)(3), of ACA, §1304, 42 U.S.C. § 18024.

comment for the 2018 rulemaking, RIN No. 1210-AB85. It will add consideration of two developments since 2018:

1) The *New York v. U.S. Dept. of Labor* litigation,[3] where plaintiff States succeeded in the District Court with a March 28, 2019 judgment vacating the major pieces, if not all, of the 2018 criteria-expanding rule — specifically 29 C.F.R. §§ 2510.3-5(b)–(c) and (e).

2) A FOIA request, which this commenter made, to CMS, to examine the justification that that agency might have for the Aggregation Theory, and actual practice, if any, by CMS of implementing that theory, to alter results under (mainly) Title XXVII of the Public Health Service Act: shifting small-group-market scenarios into large-group-market treatment. As detailed below, the request was made in October, 2018. CMS has not provided the records requested or made any other substantive response. It is over five years in non-compliance with FOIA.

This year's comment will also explore the history of the Association Clause, further back than 1974 and bills of the 1960's, to its first appearance: in 1958 and some proposals made before then, in the Welfare and Pension Plans Disclosure Act, Pub. L. 85-836, ERISA's precursor.

Abbreviations

Legislation:

ERISA: Employee Retirement Income Security Act of 1974, Pub. L. 93-406. Titles I, III and IV are principally codified in 29 U.S.C. §§1001 to 1461, and Title II to various sections of Title 26, U.S.C.

WPPDA: Welfare and Pension Plans Disclosure Act, Pub. L. 85-836 (1958). Though it had far less scope than ERISA, it established the definitional structure, including of "employer" with the Association Clause, which was carried forward into ERISA. It also addressed preemption, in quite the reverse way that ERISA does. Its final vehicle was S. 2888, 85th Congress; see entry below for "1958 Hearings." Nine of its original sections were codified as 29 U.S.C. §§301 – 309; then six were added in 1962 by Pub. L. 87–420 as §§308a – 308f; then ERISA, §111(a)(1) repealed it.

HIPAA: Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191.

PHSA: Public Health Service Act; Act, July 1, 1944, 78th Cong., 2nd Sess. ch. 373. Since the portion of the PHSA of interest here is mostly its Title XXVII, which was initially added by

[3] 363 F. Supp. 3d 109 (D.D.C. 2019), *appeal in abeyance*, No. 19-5125 (D.C. Cir.).

HIPAA, §§102(a) and 111(a) — currently codified at 42 U.S.C. §§300gg – 300gg-139 —that title might be referred to as "Title XXVII" without "PHSA."

ACA: Patient Protection and Affordable Care Act, Pub. L. 111-148 which is conventionally treated as including health-related provisions in Pub. L. 111-152 (both 2010).

IRC: Internal Revenue Code of 1986, codified as Title 26, U.S.C., preserving section numbers. Citations herein will refer to "IRC" rather than 26 U.S.C.

APA: "Administrative Procedure Act," nowadays a popular name, likely the common understanding of which is 5 U.S.C. §§551 – 559 and 701 – 706. Of most interest herein is the rulemaking section, §553.[4]

FOIA: "Freedom of Information Act," a popular name for 5 U.S.C. §552.

References herein to these enactments may include their many amendments, except when preceded by "Original" to specify the act as first enacted. The term "ERISA Congress," for example, means the Congress that enacted Original ERISA.

Other materials:

· 2011 Bulletin: A bulletin authored by CMS, dated September 1, 2011 and headed "Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations."

https://www.cms.gov/cciio/resources/files/downloads/association_coverage_9_1_2011.pdf

This piece of material may well be at the heart of the issue over the Aggregation Theory, and it is helpful to recite the critical language here, particularly the "In the rare instances …" paragraph (emphasis added):

> CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules.
>
> **In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the "employer," the**

[4] The original APA (an enacted title) was Act, June 11, 1946, 79th Cong. 2nd sess. ch. 324. In 1966 Pub. L. 89-554 enacted Title 5, U.S.C. as positive law. Its §8(a) repealed the 1946 APA, but the latter's provisions were carried into Title 5, with some re-arrangement and re-formatting. Most of those became 5 U.S.C. §§551 – 559 and 701 – 706.

> **association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.**

· Trans. 02-02: A program memorandum, designated as Transmittal No. 02-02, authored by CMS, dated August, 2002 and headed "Application of Group and Individual Market Requirements Under Title XXVII of the Public Health Service (PHS) Act When Insurance Coverage is Sold To, or Through, Associations."

https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_02_02_508.pdf

· Trans. 02-03: Similar to Trans. 02-02, also dated August, 2002 and headed "The Obligations Health Insurance Issuers Have to Association Members and Associations Under Title XXVII of the PHS Act With Respect to Guaranteed Renewability of Coverage."[5]

https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_02_03_508.pdf

· MEWA Guide: A publication by Labor, entitled "MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation." For this year's rulemaking, reference herein will be to the revisions and April, 2022 rather than that of dated August, 2013.

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

For the following nine materials from 1955 to 1958, this commenter is unaware of an open-source online link for them. Digital/scanned copies are on file with him, but are so voluminous as to indicate against making them appendices. The scope of what this commenter has found of relevance to the Aggregation Theory dispute, will be discussed at various places below.

· 1955 Hearings: Welfare and Pension Plans Investigation: Hearings Before a Subcommittee of the Committee on Labor and Public Welfare, United States Senate, Eighty-Fourth Congress First Session, printed in three parts, of hearings from March to December, 1955.[6]

[5] Its main relevance herein is that the "instances" called "rare" in the 2011 Bulletin, to which the Aggregation Theory is asserted to apply, are called "exceedingly rare."

[6] The prints are consecutively paginated across the parts, totaling over 1600 pages.

· 1958 Reports: Three reports that led directly to the enactment of the WPPDA, by committees of the Senate, House, and Conference. Respective full citations are in the margin.[7] Citations herein will be followed by, e.g., "(Senate)" to specify them.

Additionally, three reports by the same subcommittee that held the 1955 Hearings were prepared: two interim in 1955 and one final in 1956. Citations herein will be "1955 First Interim Report," "1955 Second Interim Report," and "1956 Final Report." Respective full citations are in the margin.[8]

Other terms:

CMS, HHS: Centers for Medicare and Medicaid Services and the U.S Dept. of Health and Human Services, the former being a component agency of the latter.

EWBP: Employee welfare benefit plan, per the definition at ERISA, §3(1).

EHB: Essential health benefits, or the essential health benefits package, or the consumer's entitlement to receive them in her health coverage. ACA, §1302(a) describes the package, is incorporated into the ACA-added PHSA, §2707[9], which package comprises the service categories of ACA, §1302(b)(1), the cost-sharing limits of §1302(c) and the actuarial value requirements of §1302(d).

NPRM: Notice of proposed rulemaking, per the APA.

Conundrums About the Aggregation Theory Issue and the Role of Labor and its Rulemakings

A vexing issue faced by all who oppose the Aggregation Theory is this: Is Labor the author of the theory? Or is it CMS? Can the theory be overcome by a challenge addressed to Labor, either in the APA rulemaking process — such as in 2018 or the instant one — or by litigation, e.g., *New York*?

[7] S. Rep. No. 1440 (April 21, 1958)(to accompany S. 2888); H.R. Rep. No. 2283 (July 28, 1958)(to accompany H.R. 13507); H.R. Conf. Rep. No. 2656 (August 15, 1958)(to accompany S. 2888). They are reprinted at 1958 U.S.C.C.A.N. 4137 – 4210.

[8] Welfare and Pension Plans Investigation: Interim Report: Panel Discussion: Review of Selected Plans: Two Plans Evidencing Corrupt Operation: Submitted to the Comm. on Labor and Public Welfare by its Subcomm. on Welfare and Pension Funds, United States Senate, Eighty-Fourth Congress 1st Session (July 20, 1955); Welfare and Pension Plans Investigation: Interim Report Submitted by the Subcomm. on Welfare and Pension Funds to the Comm. on Labor and Public Welfare, United States Senate, Eighty-Fourth Congress 1st Session (January 10, 1955); and Welfare and Pension Plans Investigation: Final Report of the Comm. on Labor and Public Welfare Submitted by the Subcomm. on Welfare and Pension Funds , United States Senate, Eighty-Fourth Congress 2d Session, Rep. No. 1734 (April 16, 1956).

[9] ACA, §1302 and PHSA, §2707 are codified respectively as 42 U.S.C. §§18022 and 300gg-6.

This commenter's 2018 comment suggested the prospect of "hopping from foot to foot" by the greater Government (embracing both Labor and CMS), with one agency, or both, contending "that in all strictness the aggregation claim was not in the scope of [the 2018] NPRM." The comment continued that "the vagaries of [a two-agency] leapfrog strategy, to end up in weakening ACA protections [beginning with a low-prevalence aggregation effect, first uttered by the Obama Administration, so far as the public knows, amplified by then-President Trump's hostility to the ACA protections, realized in broader criteria for 'AHPs'], cannot be ruled out."

Those prospects and confusions were indeed played out, in the finalization preamble of June 21, 2018, 83 Fed. Reg. 28912, in the instant preamble, and in the *New York* litigation. The latter will be discussed below. In the former preamble, see —

● "By participating in AHPs, employees of small employers and working owners are able to obtain coverage that is not subject to the regulatory complexity and burden that currently characterizes the market for individual and small group health coverage and, therefore, can enjoy flexibility with respect to benefit package design comparable to that enjoyed by large employers." 83 Fed. Reg. at 28912, col. 3. The Aggregation Theory is not spelled out; but unmistakably it underlies the distinction between small and large employers: "burden" for the former, "flexibility" in benefit design for the latter.

● "[Referring solely to the 2011 Bulletin as authority,] because an AHP would constitute a single group health plan, whether the AHP would be buying insurance in the large or small group market would be determined by reference to the total number of employees of all the member employers participating in the AHP." 83 Fed. Reg. at 28915, col. 2.

● "[Opposing commenters specifically mentioned] the essential health benefits ('EHB') requirements [and urged the unlawfulness of small employers] band[ing] together to obtain health insurance that does not comply with all the ACA insurance rules applicable to small group market insurance. The Department disagrees that the Proposed Rule is unlawful under the ACA. … Thus, employer groups already can group together to collectively sponsor ERISA plans, and those plans have to comply with applicable group market rules." 83 Fed. Reg. at 28917, cols. 1 - 2. The Aggregation Theory is again the implicit underpinning of how such "banding together" avoids small group market rules, said to be lawful.

● "[To opposing commenters who assumed that] AHPs will generally be insured in the large group market or be self-insured, [thus] would not be subject to the requirement to provide EHBs, which only applies to non-grandfathered individual market and small group market insurance coverage [and urged the bad effects of such "minimal benefits" and that Labor make an EHB requirement as part of the new rule, Labor rejected such a requirement:] Such a mandate would run contrary to the goal of leveling the playing field between small employers in AHPs, on the one hand, and large employers, on the other, who generally are not subject to the EHB

requirements." 83 Fed. Reg. 28933, cols. 1 – 2. Again, the Aggregation Theory, making small employers treated as if they were large, is necessarily the means of such "leveling."

In the present rulemaking, the preamble might present a confusing picture, as to the embrace of the Aggregation Theory. A crucial page is 88 Fed. Reg. 87970, all in col. 2. There is a typical recital of the Aggregation Theory:

> In instances where the group or association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the "employer," the association coverage is considered a single group health plan. In that case, because the PHS Act definitions of large employer and small employer are based on the average number of employees employed on business days during the preceding calendar year, the number of employees employed by all the employers participating in the association determines whether the coverage is subject to the small group market or large group market rules.[10]

But the next paragraph raises much difficulty. Indeed it is copied almost *verbatim* from the 2011 Bulletin, and the comments here apply to its appearance in that CMS document as well. It appears flatly inconsistent with the Aggregation Theory, in the emphasized portions:

> In a "mixed" association where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member's circumstances, ***each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.*** For example, ***it is not permissible*** under the PHS Act for mixed association coverage ***to comply only with the large group market rules, with respect to its individual and small employer members***.

The last statement of impermissibility happens to be a correct statement of the law, since the Aggregation Theory is contrary to law. The same is true of the preceding statement about each association member's "status as [small or large] employer" determining whether health coverage is subject to any small/large distinctions in Title XXVII.

The suggestion that these correct effects are limited to "mixed" associations would be erroneous, however. Suppose an association has, say, 10 employer-members with employee-counts of 40 each. That would be a non-"mixed" association, this paragraph seems to say, and standard Aggregation Theory would still be in effect, counting 400 employees, so that all these small employers magically become "large." But suppose one new employer joins the

[10] Such "instances" are counterpoised to the "situations" described in the preceding sentence. There, Labor tracks the CMS terminology, found in Trans. 02-03, Trans. 02-03 and the 2011 Bulletin, of a plan "existing at a level," which terminology is cryptic — not clear whether it tracks Labor's non-BFGAE/BFGAE vocabulary. In such "situations," aggregation does not occur: "In situations involving employment-based association coverage where the group health plan exists at the individual employer level, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or large group market rules."

association, having 55 employees. Or, one of the 10 grows its payroll to 55. The association will have become "mixed"; and per this paragraph all the sub-51 employers become "small" in law, and their employees enjoy EHB, etc.

That is bewildering. But then in the next paragraph, the preamble returns to standard Aggregation Theory, unexcepted for "mixed" associations, describing "small employers … band[ing] together to purchase coverage in the large group market," and the resulting deprivation of consumer rights, EHB and others.[11]

As for the reality behind Labor's measures regarding AHP criteria, resulting in the 2018 rule, then-President Trump's well-known hostility to the ACA project triggered the sequence that led to it. E.O. 13,765 in the first days of his term called for the entire repeal of the ACA and for all agency moves "pending repeal" that could undermine it. Then E.O. 13,813 expressly named greater prevalence of AHPs in the health system as key to the anti-ACA agenda.[12] To wit: "Expanding access to AHPs will also allow more small businesses to avoid many of the PPACA's costly requirements." That avoidance necessarily depends on the Aggregation Theory. The AHP NPRM followed just months later. 83 Fed. Reg. 614 (January 5, 2018). President Biden's E.O. 14,009 confirmed the link between the two Trump Orders, revoking both in the same sentence.[13]

In sum, the acceptance by the greater Government of the defeat of consumer rights, of EHB perhaps most notably, through making small employers large, however narrow or broad the AHP criteria might be, was undeniably the background of Mr. Trump's 2018 move, but in continuity with the prior and succeeding Administrations, Obama and Biden. That defeat, of course, rests on the Aggregation Theory. Thus it is far from clear that Labor will not continue to graft that theory onto §3(5) criteria, or that CMS's position — standing in the wings of what is ostensibly Labor's stage set — has turned against the theory.

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[11] The paragraph is describing the would-be "expan[sion of] access to AHPs" by the 2018 rule, i.e., broader criteria, But there is no indication that the destruction of rights due to aggregation, where AHP criteria are met, depends on whether the criteria are broad or narrow. It reads: "As explained below, by expanding access to AHPs, the 2018 AHP Rule sought to allow small employers and working owners to band together to purchase coverage in the large group market, thereby avoiding the application of certain legal provisions governing individual and small group markets, such as modified community rating, single risk pool, and [EHB]."

[12] The two Trump Orders are respectively at 82 Fed. Reg. 8351 (January 24, 2017) and 82 Fed. Reg. 48385 (October 17, 2017). See also the Request for Information at 82 Fed. Reg. 26885 (June 12, 2017) entitled "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients," expressly based on E.O. 13,765.

[13] 86 Fed. Reg. 7793 (February 2, 2021).

The rejectionist attitude of then-President Trump to the ACA continued to the end. See E.O. 13,951, 85 Fed. Reg. 62179 (October 1, 2020). Though the 2018 AHP rule had been put out of effect a year-and-a-half earlier in the *New York* litigation, the then-President touted it. He also expressed his undying hope for the total annihilation of the ACA, this time by judges, apparently alluding to the meritless attempt finally put to rest by *California v. Texas*, 593 U.S. 659 (2021). What that Order actually directed, after historic descriptions such as those two, is relatively innocuous; and President Biden has not revoked it.

In *New York*, these unclarities were very prominent in the November 14, 2019 oral argument before the D.C. Circuit.[14] The fact that the plaintiff States did not sue CMS, only Labor, seemed to brood over the colloquies with Judges Tatel and Katsas, akin to the rulemakings of 2018 and this year being nominally only by Labor, although CMS's sub-regulatory position is their background. To begin, see 2019 Tr. 13, Judge Tatel both questioned whether upholding Labor's new rule would accomplish the escape from ACA-added rights that motivated the new rule, and briefed the simple argument (emphasized) that is much like the central one of this comment:

> [E]ven if you're totally right that the final rule survives under Chevron II under ERISA, does it accomplish its goal because of the Affordable Healthcare Act's definition of large employer? In other words, these ***associations*** can't be, ***can't qualify because they don't employ anyone, they don't employ employees***, that's [Plaintiff States'] argument.
>
> The reply of Labor's counsel, Mr. Shih, was notable (emphasis added):
>
> I think the fundamental response is that ***nothing in the Department of Labor's rule affects how association health plans*** whether created under the old guidance or the new rule ***are treated***. So, the provision that you're referring to ***is implemented by CMS***, and CMS –

In short, one hop from the Labor foot to the CMS foot. It may be regrettable that Judge Tatel interrupted, and the nature of Labor's position was not then firmed up.

Mr. Shih and the judge proceeded to talk in terms of the whole controversy having two "steps" or "parts," and the counsel disagreed "that that the Government needs to prove two to prevail," 2019 Tr. 14, line 22, where "two" evidently meant "step two" — the question of CMS's Aggregation Theory. There followed, at 14 – 15:

> JUDGE TATEL: No, no, no, not here. Maybe I asked the question wrong. Your position is that in order to prevail here you just need to defend, we just need to accept your Chevron II argument about the definition [presumably, that it prevail by deference], about the ERISA definition of employer, right?
> MR. SHIH: That's right.
> JUDGE TATEL: And then what happens under the Affordable Care Act is for another day, correct?
> MR. SHIH: Yes.

[14] A copy of the transcript is Appendix 1 to this comment, and will be referred to as "2019 Tr."

Those answers by counsel seem consistent with the position, at 13, of no effect on the "treatment" of AHPs, and pointing to CMS. So things were relatively clear for a moment. The buck had been passed; Plaintiffs and like parties would have to somehow pursue CMS for relief.

But the waters were promptly muddied, Judge Tatel suggesting that "it's [not] quite that simple," and continuing (still at 15):

> JUDGE TATEL: … the reason the Department gave for changing these standards, the criteria was to make it possible for small employers, right? Small employers to be able to join together in associations and function in the major [presumably meaning "large group"] market, right?
> MR. SHIH: Yes.
> JUDGE TATEL: That's the purpose of it?
> MR. SHIH: Yes.

The Aggregation Theory was back in play, in the new rule, and the litigation. These latter positions by counsel were consistent with both 2018 preambles, and in turn with then-President Trump's determination to nullify the ACA's new consumer rights, expressed in executive orders and elsewhere, outlined above. They are not consistent with Counsel's earlier suggestions that the Aggregation Theory was not in issue.

Another feature of Labor's presentation was Judge Tatel revisiting the point, 2019 Tr. at 15 – 16, made by the Plaintiffs in their brief and underlying this comment, that associations do not employ employees (not the relevant ones), and the key word to focus on is "employ," not "employer." Where the transcriber wrote "healthcare (indiscernible)," it follows from context that the judge was meaning the large/small employer definitions re-enacted by the ACA, i.e., in §1304(b). He said:

> Suppose I think that the word employ in the healthcare (indiscernible) is just plain old unambiguous, I mean, it seems like it is, it says employ employees, and associations don't employ employees.

For Mr. Shih's part, for Labor, he tended to confirm that the only basis held out by Labor, or CMS of the Aggregation Theory is the 2011 Bulletin. It is hard to discern what each of his references to CMS "explanations" and "interpretations" is pointing to, at 17 – 19.

At 17, line 16, however, he tried to portray CMS "repeatedly explaining" something. There followed mention of 1997. That is obscure, but may allude to a passage in Labor's Reply Brief to the Circuit,[15] at 20. It said that a CMS rule of that year "explained" that, for PHSA Title XXVII, the term "employer" has the meaning given the term under ERISA. Congress said so, in 1996, of course: PHSA, §2791(d)(6). CMS putting it in a rule has no significance. Then came mention of 2002. That could only mean Trans. 02-02; and the brief so specified. But what

[15] July 25, 2019. A copy is Appendix 2 to this comment, and will be referred to as "Labor Brief."

Trans. 02-02 actually says — not the Aggregation Theory — will be reviewed below in some detail. Finally, with Judge Tatel at 2019 Tr. 17 – 18, Labor's Counsel identified the 2011 Bulletin. So ended the repeated explaining.[16]

The plaintiff States, by Mr. Grieco, offered a thoughtful argument that the Aggregation Theory was in issue in the case, where it was quite clearly (despite the somewhat elusive position statements by Labor, above) a basis of, and reason for, the challenged rule. At 2019 Tr. 26 – 27:

> JUDGE TATEL: [D]oes this Court have to go beyond deciding the straightforward ERISA question? … Do we have to say anything about the Affordable Care Act in this case?

The judge then asks Counsel to suppose hypothetically that the Court decides for Labor, apparently on the AHP criteria expansion by itself, then asks:

> JUDGE TATEL: … Then the question of what effect this has on the Affordable Care Act, and the ability of small employers … to qualify in the major market, that's a different question for another case, you have to wait and see what, how HHS interprets the statute, right? [The last supposition, that HHS/CMS has not interpreted the statute, is puzzling in light of the sub-regulatory 2011 Bulletin.] … Tell me why [you disagree]?
> MR. GRIECO: So, as this Court has recognized in a number of cases, when there is an interpretation, even if it's in the preamble to the rule, if there is one interpretation that is central to the rule, the rule cannot evade …[or] … cannot escape review of that interpretative principle based on the fact that …it doesn't happen to mention that in the portion that's actually going into the C.F.R.

Finally, the NPRM commendably says: "The Department seeks comments from interested parties on *all aspects* of this proposal to rescind the 2018 AHP Rule in its entirety." 88 Fed. Reg. 87978 (emphasis added). The Aggregation-Theory link to undercutting the gains of the ACA are surely an aspect, and should be opposed in this rulemaking.

Terminological Conventions

This comment will use the term "bona fide group or association of employers" (hereinafter, "BFGAE") as Labor has coined it. [17] There is some misfortune there, in that it

[16] In the brief, but not at oral argument, Labor mentioned another 2011 item, by Federal Register page. It turns out to be a preamble for a CMS rule about PHSA 2794 (42 U.S.C. § 300gg-94), which mandates a Federal-State process of oversight of unreasonable premium increases. It applies to all "markets," individual and small and large group. In its rule, CMS would frankly omit large-group-market issuers from its scope of the process, beginning at 42 C.F.R. §154.101(b). There is no apparent authority in §2794 for that omission. At any rate, the only conceivable point on the preamble page that Labor Brief cites (76 Fed. Reg. 54,971 (Sept. 6, 2011)) is a quote from Trans. 02-02, not about the small/large split in the markets at all, but the individual/group split.

[17] *See, e.g.*, MEWA Guide at 8: "In order for a group or association to constitute an 'employer' within the meaning of Section 3(5), there must be a bona fide group or association of employers acting in the interest of its employer-

resembles the term "bona fide association" that is used in the PHSA.[18] The term is understood to denote what the Association Clause calls a "group or association," whose characteristics — in the whole context, which may include characteristics of the putative "plan" in question — are "sufficient" or "qualifying" (perhaps terms preferable to "bona fide") to effect the work of the clause, which is to include such entity in the term "employer" (with respect to the health coverage provided to individuals it does not actually employ).

"AHP" stands for "association health plan." The question of just what it means is addressed in the margin.[19]

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members to provide benefits for their employees." Labor used it in the three preambles as well, especially many times in the 2018 finalization to discuss such Association-Clause-qualifying groups or associations, and formally adopted it for the text of the ostensible new rule, e.g., 29 C.F.R. §2510.3-5(b).

[18] The PHSA significance of "bona fide association" ("BFA") is different from that of the Association Clause. Now it affects issues about insurers' duties of guaranteed renewal, PHSA, §§2703(b)(6) and 2742(b)(5) (42 U.S.C. § 300gg-2(b)(6) and 300gg-42(b)(5)), also in the effectively obsolete §2741(second e)(1) (§300gg-41(second e)(1)) on guaranteed issue. In the Original Title XXVII and before the ACA, BFA also figured in the guaranteed issue section, §2711 (prior 42 U.S.C. § 300gg-11) at (f); and the section the ACA moved to §2703 was at §2712 (§300gg-12).

Also, the BFA definition at PHSA, §2791(d)(3) (42 U.S.C. § 300gg-91(d)(3)) has some resemblance to various criteria for a BFGAE (both in Labor's pre-rule sub-regulatory policy and the expanded 2018 criteria). An especially critical element in the former, §2791(d)(3)(B), that the latter lacks is that the entity's formative purpose is "other than obtaining [health] insurance [coverage]." That missing requirement that the health plan is only incidental, of course, sparked major concern that the 2018 expansion would enable pretextual uses of the Association Clause. Compare, MEWA Guide, at 8, where formative purpose is a "factor."

[19] "AHP" seems to be a term broadly and fuzzily covering a range of real-world scenarios where multiple employers — actual, "direct," or "common-law" employers rather than ones so labelled by the Association Clause — join in arranging for some health coverage for employees, in some way. "AHP" does not appear in any statutes relevant here, and so of course has no legal definition.

Labor has used the term often throughout preambles (but not in rule text). Its usage does not seem to be consistent about whether it is concomitant to the term "BFGAE." That is, are "AHPs" exactly those plans established or maintained by BFGAEs?

Or, is it the case that some but not all AHP scenarios successfully meet the criteria for the "group or association" to be a BFGAE? For example in the 2018 NPRM, 83 Fed. Reg. at 615, col. 3, Labor decried the situation without the criteria expansion thus: "AHPs currently face a complex and costly compliance environment that may simultaneously subject the AHP to large group, small group, and individual market regulation, which undermines one of the core purposes and advantages of forming or joining an AHP. Accordingly, the Department is proposing to amend the definition of employer in section 3(5) of ERISA to change this state of affairs." But when the employer group is a BFGAE, supposedly the Aggregation Theory applies, and surely in virtually all cases puts the employee count over 50, so no member would be under small-group rules (and the desired "change [of] this state of affairs" seems to be universal). Thus, since at least some AHPs are subject to small-group, their plans must not be that of a BFGAE, as "AHP" is used in that passage.

On the other hand, concomitance seems to be intended in many appearances of "AHP," as in several references to the 2018 expansion of BFGAE criteria as "expanding access to AHPs." E.g., 88 Fed. Reg. 37970, col. 2. This commenter submits that the Aggregation Theory can be scrutinized without having to decide precisely what "AHP" means.

This comment will use the term "Employee-Count Test" to mean a rule where some effect depends on the number of employees ***of an employer*** being greater than, or not, a given number. An example is the central one for this NPRM, of ACA, §1304(b)(1) and (2).[20]

The term "Employee-Count Aggregator" will mean a legal rule that, given a set of actual employers, takes the sum of their employee-counts, and makes it, in legal contemplation and for purposes of some Employee-Count Test, the "employee"-count of some new "employer," the latter being a legal fiction that the rule has also effectively created. An example that is clear, and explicitly tied by the ACA Congress to the last-mentioned Employee-Count Test, is ACA, §1304(b)(4)(A),[21] reading:

> *(4) Rules for determining employer size*
>
> For purposes of this subsection—
>
> (A) Application of aggregation rule for employers
> All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of title 26 [IRC, §414] shall be treated as 1 employer.

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[20] 42 U.S.C. § 18024(b)(1) and (2)(defining "large" and "small" employer to be those with employee counts over, or not over, 50). That distinction of course then informs the definition at subsec. (a)(3) of the same section, where employees' health coverage, per a "group health plan," is legally classified in the large group or small group market.

The ACA Congress renewed those definitions, that are also found in the PHSA, §2791(e)(2) – (5) (42 U.S.C. § 300gg-91(e)(2) – (5). It did so also with the definition of "group health plan," at ACA, §1301(b)(3) (42 U.S.C. § 18021(b)(3)) which continues to refer back, intermediated by PHSA, §2791(a)(1), to the definition of EWBP at ERISA, §3(1) (29 U.S.C. §1002(1)). Further, that Congress, through §1551 (42 U.S.C. § 18111), generally adopted all the PHSA, §2791 definitions. Those have included, in the 1996 original at subsecs. (d)(5) and (6), definitions of "employer" and "employee" *simpliciter*, that incorporate those of ERISA, §3.

[21] 42 U.S.C. § 18024(b)(4)(A). The clarity that ACA, §1304(a)(4)(A) is an Employee-Count Aggregator comes first from its context. It is expressly "[f]or purposes of [the] subsection" in which it sits, i.e., (b). The only legal rules for which employee count matters in subsec. (b) are the large/small employer definitions in paras. (1) and (2), which are Employee-Count Tests.

Secondly, the headings of par. (4) and subpar. (A) expressly tell us that they are "for determining employer size" and that (A) is an "aggregation rule." While this is not an occasion where doubt is left, after context review, "the heading of a section [is a] tool[] available for the resolution of a doubt about the meaning of a statute." *E.g., Yates v. U.S.*, 135 S. Ct. 1074, 1083 (2014)(citations omitted).

ACA, §1304(a)(4)(A) renewed and re-affirmed the enactment by the HIPAA Congress of the same rule, and tie to the "large group market" issue, at PHSA, §2791(e)(6)(A) (42 U.S.C. § 300gg-91(e)(6)(A)). Had there been any difference in the definition of "large," or of the connected Employee-Count Aggregators, at least for purposes of any Title XXVII provision newly added by ACA, Title I, like §2707 mandating EHB, it seems that ACA, §1304(a) would prevail, as it expressly applies to all "[I]n this title [Title I]." 124 Stat. 171. ACA, §1551 (42 U.S.C. § 18111) need not have played a role. But the definitions of "large group market," "large employer," and the Employee-Count Aggregators, are substantively identical between the pre-ACA and ACA ones, making it unnecessary to decide which route made ACA, §1304(b)(4)(A) an Employee-Count Aggregator applicable here, and the sole one clearly laid down by Congress.

The Aggregation Theory amounts to the claim that the Association Clause is an Employee-Count Aggregator.

Also, the term "Entity-Unifier" will mean a rule that, given a set of actual legal entities, causes them to become one, in legal contemplation and for purposes of some other rule where it matters whether they are treated as a unity, or separately. This is a legal fiction, in the effective creation of the new, single entity, and in the annihilation of the separate existence of the "members." Entity-Unifiers are found often in the statutes in this field, and often use a phrase like "treated as," "considered to be," or "deemed to be," before "one (or a single) employer." An example is ACA, §1304(b)(4)(A), above. All Employee-Count Aggregators are also Entity-Unifiers (as the terms are intended for this comment). But there are Entity-Unifiers that are not Employee-Count Aggregators, i.e. the other rule for which unification matters is not an Employee-Count Test.[22]

Language like ACA, §1304(b)(4)(A) achieves such annihilation of the separate existence of the members, by acting first upon them, and not only upon the resulting uniting entity. The former are the "all persons" that are the subject of the sentence. They have "treatment" (or "consideration" or "deeming") meted out to them, namely of merging into the one entity, losing what is otherwise their separate existence. This is what this comment means by the unification of the entities.

With this understanding already, one sees the crucial contrast with the Association Clause. It acts upon the additional fictive entity,[23] but nothing in it acts upon the involved members of the set of actual employers. The latter are not "treated as" anything. Thus the Association Clause is not an Entity-Unifier at all, and accordingly cannot be an Employee-Count Aggregator. This point will be expanded shortly.

The Merits of the Employee-Count Aggregator Claim: Review of Support and Introduction to the Statutory Text

Before studying the history of ERISA, its precursor WPPDA, HIPAA, ACA etc., one should begin with the relevant statutes as they read today, or perhaps other matter that purports

[22] For one example now, see ERISA, §3(40)(B)(i) (29 U.S.C. §1002(40)(B)(i), where the purpose is to determine whether one or multiple "employers" exist in the scenario, the latter being needed to meet the definition of MEWA. Actual multiple employers with the stated "control" characteristic are fictively made one (thus precluding existence of a MEWA). Indeed that particular point has significance for this NPRM and comment, seen below, accompanying fn. 31.

[23] The clause might not even create a new legal entity, the "association," e.g. something having substantial existence otherwise — with a name, a charter, a budget, an office, its own actual employees, etc. Those elements are determined by the real-world actors; even a loose association could probably be a §3(5) "group or association," or at least a "group." What the clause does create is satisfaction of the word "employer" — in a way additional to that of having its own actual employees — for purposes of satisfying the need for involvement of an "employer" to make a health plan an EWBP.

to be law. What law is there in support of the claim that the Association Clause is an Employee-Count Aggregator?[24] No preamble by Labor provides any analysis of statutory text, with such aides as statutory or legislative history, or perhaps caselaw. Its entire reliance has been on the 2011 Bulletin (by CMS). The claim made in 2011 Bulletin, and so in turn by Labor, has been mere assertion without argument. In contrast to this absence of support for the Employee-Count Aggregator claim, the defects of that claim begin with text.[25]

With a first textual pass, staying within the four corners of §3(5), the claim that the Association Clause is an Employee-Count Aggregator is simply false. In a situation of a BFGAE — no matter the effective criteria for that status — the Association Clause makes that entity a fictive "employer" (such that it would not be an "employer" in the absence of the Association Clause). That status as "employer" might be significant for all sorts of purposes in ERISA. But it does not at all go to make employees of the constituent employers of the BFGAE into fictive "employees" of that entity; and such individuals are certainly not *actual* employees of that entity either.[26] The Association Clause says nothing about the legal attributes of such individuals at all. Those making the Employee-Count Aggregator claim would need an additional provision — within the Association Clause, §3(5), or somewhere — to effect that fictional transformation. It is simply not there; and their claim is unsupported.

Not only is there an absence of the needed extra provision, to fictively make members' employees into "employees" of someone who does not actually employ them, Congress followed §3(5) with the definition of "employee" that simply affirms its ordinary English meaning, in contrast to the special, and fictional, manipulations it made to "employer": "The term 'employee' means any individual employed by an employer." ERISA, §3(6).[27]

For the purposes in ERISA where coming under the term "employer" matters, one need only look to §3(1), and the question whether there is an EWBP. This is the fundamental issue of ERISA's scope, and a core basic element is that the "plan, fund, or program" is "established or maintained by an employer or employee organization." "Employee organization" means a labor union in the common sense, and the §3(4) definition expands to some other possible scenarios.

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[24] Where this comment refers to just "the Employee-Count Aggregator claim," it is meant to be such claim being made about the Association Clause.

[25] *E.g., New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)("[W]e begin … in any exercise of statutory construction with the text of the provision in question …"), *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015)("If the statutory language is plain, we must enforce it according to its terms.")

[26] This is not to be confused with the "association" often being an organization with substantial activities, and staff in its own right. That entity would be an actual "employer," of course, as to such staff. But those are not employees of the member employers, which the NPRM seeks to use in manufacturing a "large employer" out of those members' smaller workforces.

[27] 29 U.S.C. §1002(6).

But the present context presupposes that the "employee organization" prong is not involved, and the question comes down to whether the establisher/maintainer is an "employer."

Thus if there is a plan that serves employees of a set of employers, but no one of those employers is the "establisher/maintainer," and rather such employers' "association" is the "establisher/maintainer," then absent the Association Clause fictively applying the word "employer" to that association, there is no EWBP.[28] That effect of the clause, regulating the fundamental issue whether scenarios are subject to ERISA, is plenty of "work to do."[29]

Labor's Correct Reading of §3(5) as to the "Members" and the "Employees": Negating the Aggregation Theory

Remarkably, Labor agrees with all the premises about the Association Clause, essentially that it does not destroy the existence of the "members" as "employers," that underlie the foregoing. MEWA Guide, beginning at 22, examines the question whether a scenario contains only a "single employer," which would thus fall outside the definition of "MEWA." Turning to scenarios that might meet criteria for existence of a BFGAE (per the Association Clause, that is), the guide at 20 first confirms that the significance — the ample "work to do" — of meeting BFGAE criteria is to make it the establisher/maintainer of a plan within the meaning of ERISA, §3(1):

> As discussed earlier, the Department has taken the position that a bona fide group or association of employers would constitute an "employer" within the meaning of ERISA Section 3(5) for purposes of having established or maintained an employee benefit plan.

The analysis then turns to the question for the MEWA definition of how many "employers" are there, where a BFGAE exists? It necessarily must address the fate of the member employers: do they lose their existence, as "employers"? The answer is "no," in that, in the first sentence that follows, there is not a "single employer" to defeat the MEWA definition: the sentence is saying there is a multiplicity. The guide next confirms that a "member" is not some sort of Potemkin "employer" that has lost its employees, rather that such individuals

[28] The same result occurs, with the clause in place, where the scenario does not meet criteria to make the "group or association" a BFGAE. *See*, MEWA Guide at 8 – 9, where Labor continues with the view that there still could multiple ERISA-subject plans: "Where no bona fide group or association of employers exists, the benefit program sponsored by the group or association would not itself constitute an ERISA-covered welfare plan; however, the Department would view each of the employer-members that utilizes the group or association benefit program to provide welfare benefits to its employees as having established separate, single-employer welfare benefit plans subject to ERISA. In effect, the arrangement sponsored by the group or association would, under such circumstances, be viewed merely as a vehicle for funding the provision of benefits (like an insurance company) to a number of individual ERISA-covered plans."

[29] That is, it well heads off any concern that if the Association Clause is not made into an Employee-Count Aggregator it would be surplusage. *See, United States v. Home Concrete & Supply, LLC*, 566 U.S. 478, 485 (2012), *citing, TRW Inc. v. Andrews*, 534 U. S. 19, 31 (2001).

remain employees of *the member*, *not of the BFGAE*, per the sentences emphasized in the following:

> However, unlike the specified treatment of a control group of employers as a single employer, there is no indication in Section 3(40), or the legislative history accompanying the MEWA provisions, that Congress intended that such groups or associations be treated as "single employers" for purposes of determining the status of such arrangements as a MEWA. *Moreover, while a bona fide group or association of employers may constitute an "employer" within the meaning of ERISA Section 3(5), the individuals typically covered by the group or association-sponsored plan are not "employed" by the group or association and, therefore, are not "employees" of the group or association.*[30] *Rather, the covered individuals are "employees" of the employer-members of the group or association.* Accordingly, to the extent that a plan sponsored by a group or association of employers provides benefits to the employees of two or more employer-members (and such employer-members are not part of a control group of employers), the plan would constitute a MEWA within the meaning of Section 3(40).

In sum, the Association Clause is not even an Entity-Unifier (in that the members do not vanish as "employers"), and certainly not an Employee-Count Aggregator in that employees necessarily cannot be "treated as" (which would be a fiction) the workforce of the BFGAE.

Additionally, the above Labor analysis correctly contrasts the effect of the "control group" provision within the MEWA definition, ERISA, §3(40)(B)(i)[31] with that of §3(5), in the above first sentence and in the parenthetical in the final sentence. The former does effectively destroy the existence of the members, leaving a single employer, while the latter does not. Again, the former is an Entity-Unifier, and clearly so, by acting upon the members of the "group" just as ACA, §1304(a)(4)(A) does. ERISA, §3(40)(B)(i), unlike ACA, §1304(a)(4)(A), is not also an Employee-Count Aggregator: there is no question of "how many employees" for §3(40), only of "how many employers"?[32]

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[30] This is consistent with the guide's discussion of "who is an 'employee,'" at 24, where it acknowledges that an employer-employee relationship does not necessarily exist with an entity, specifically including a "group or association," that has been made an "employer" by the definition: i.e., a BFGAE. It notes the unadorned definition at §3(6) of "employee" to reinforce that such person must be in an employer-employee relationship with the putative "employer," which relationship does not exist where the latter is merely a BFGAE.

[31] 29 U.S.C. §1002(40)(B)(i). It reads: "[For purposes of this paragraph—] 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."

[32] Labor is committed to these readings of §3(5) because it holds that all AHPs are MEWAs. *E.g.*, 83 Fed. Reg. 28912, 28919, fn. 18, 28953, and 28959 (June 21, 2018)(saying that AHPs are a type of MEWA); 88 Fed. Reg. 87979 (December 20, 2023): "AHPs have been in existence for some time and are a subset of MEWAs." Whatever "AHP" means to Labor, see fn. 19 above, surely BFGAE-maintained plans are a subset of the set of AHPs. Thus, all BFGAE-maintained plans are MEWAs.

CMS Also Has Agreed with the Negation of the Aggregation Theory: What the 2011 Bulletin and Trans. 02-02 Do Not Say, and What They Do Say

Labor has claimed that CMS material dictates the Aggregation Theory. At the top line, this has been the 2011 Bulletin. In the 2018 AHP preambles: 83 Fed. Reg. 618, col. 3 (reciting the "In the rare instances …" paragraph) and 83 Fed. Reg. 28915, col. 2 (excerpted above, p. 6[33]).

The 2011 Bulletin, in turn, cites Trans. 02-02 *one time*. 2011 Bulletin, at 2, with note 3. It is only for the largely uncontroversial individual/group split of markets. "The analysis set forth in [Trans. 02-02], summarized below, remains authoritative for determining when association coverage is considered individual or group coverage under Title XXVII …" The divide, formed first by the employer definitions of ACA, §1304(b)(1) and (2), of small from large group markets is, of course, an entirely different split. The 2011 Bulletin does not cite Trans. 02-02 at all, regarding that split. That bulletin cites nothing for its crucial paragraph at 3: "In the rare instances …" etc.

An especially regrettable passage from the 2018 rulemaking tended to confound the two splits, and suggest that CMS's basis for both was the same. It began in col. 2 at 83 Fed. Reg. 618 with: "Guidance issued by the [CMS] in 2011 … clarifies that the test for determining whether association coverage is individual, small group, or large group market coverage for purposes of Title XXVII of the PHS Act is the same test as that applied to health insurance offered directly to individuals or employers." That resembles a sentence from the 2011 Bulletin, at 2; but the latter spoke only to "individual or group market coverage," not to the small/large split. And Labor's footnote cited the 2011 Bulletin, but also a "see also" to Trans. 02-02, which, again, CMS did not

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If the MEWA Guide readings were not true, and the members of a BFGAE did have their separate existence destroyed, there would be but one "employer," not the many needed for the MEWA definition — just as the quoted analysis says. So it would be false that all AHPs are MEWAs.

[33] That passage may require an unproductive tangent about an expression that has crept into some Aggregation Theory writing: "the [insurance] look-through doctrine." The provenance of this notion and expression is unknown, and, to this commenter, it is baffling and unilluminating. Apparently it denotes the negative of aggregation. Congress has never uttered "look-through doctrine." And though the cited Labor preamble passage describes "the insurance look-through doctrine as set forth in [the 2011 Bulletin]," the 2011 Bulletin did not utter "look-through doctrine" either. "Doctrine" suggests a proposition of law that, perhaps borne of judicial caselaw, is not set out in any statute or APA rule, and tends to the esoteric.

The correct rule for this issue is one that Congress has uttered, in ACA, §§1304(b)(1) and (2), and is not esoteric but very simple: To count the employees of Employer A, one counts the individuals employed by Employer A. One does not count persons employed by Employers B, C, D or the like, notwithstanding that A, B, C, D, etc. might be part of a "group or association" for purposes of other law. That disregarding of the individuals employed by B, C, D etc. might be — one can only guess — the "looking through" referred to. But it is not per a "doctrine"; it is what Congress enacted.

cite as to the small/large split. Labor's narrative continued on with what "[t]he CMS 2011 guidance further state[d]" and recites the first two aggregation-related paragraphs from that bulletin, as if to create the impression that they also dated back to 2002.

It was reviewed above, text accompanying fn. 15, how also in Labor Brief (in *New York*, to the Circuit) a sense of ancient vintage for CMS's aggregation view was suggested, by citing Trans. 02-02.

Returning to the 2011 Bulletin, after the fraught "In the rare instances …" paragraph, CMS followed with the "'Mixed' Associations" section, that Labor has now included in the present preamble. As outlined above, p. 7, it contradicts the Aggregation Theory — which the bulletin had just set forth — leaving the small employers in the "mixed" association small. There is no discussion of how to reconcile the passages. Further, it is unexplained how it should matter that the association is "mixed."

Trans. 02-02, through most of 2, is concerned only with the group/individual split, not small/large. Near the bottom, the two bullets and the sentence that leads into them, speak of an apparently different kind of "mixed" association, which is difficult to understand: an association, presumably of employers, is providing health coverage to its "members" — whether that means the employers are getting health coverage, or perhaps "members" means the individual employees, is unclear — but no group health plan is in the scenario. Anyway, in the final paragraph at 2, CMS asserts:

> Also, to the extent an association has any members that are small employers (which are defined generally as employers with two to 50 employees), ***the issuer is subject to the requirements that apply to small group coverage***, such as those related to disclosure, with respect to any small employer in the association.

On its face, that is a frank contradiction of the Aggregation Theory, even clearer than the "'mixed' association paragraph in the 2011 Bulletin, applicable to all associations, all small employers. This commenter knows of no attempt by CMS to explain this, in light of expressions in 2011 of the Aggregation Theory.

CMS Has Not Put Forth Its Rationale, If Any, for the Aggregation Theory, As Called for by the 2018 FOIA Request

Appendix 3 to this comment is a copy of the October 10, 2018 request. It was addressed to HHS and all sub-agencies, while naming CMS in particular, since it was mostly about the 2011 Bulletin. This comment will not belabor the details of agency acknowledgement communications, of 5 U.S.C. §553 and the possibilities of time extension, a June, 2019 requester follow-up letter, etc. But receipt was dated by HHS and CMS as either October 18 or 22, 2018. Working through the possible §553 timelines, the maximum response time an agency can effect

is about 40 working days. So non-compliance began about with the New Year, 2019. The records are over five years overdue.

That follow-up letter raised several points about why CMS's response should not be difficult or so time-consuming. Excerpts are: "It is incongruous that HHS would take so long to find and produce the records. The activities by HHS/CMS, and perhaps in connection with Labor … are not old, but mostly were prompted by ACA … Nor are the issues obscure …One would think that HHS/CMS would have ready to hand the materials supporting the statements in its September 1, 2011 Bulletin … [I]f the record turns out to stand as it is, with no response, it would reflect that HHS/CMS has no written materials at all to support the key assertion in that Bulletin … One would think that the file on this issue would be well-known within the agency, ready to justify that assertion, as the Administration's present initiative depends on it."

Yet when the requester checked for status on CMS's online facility for doing so, last on February 19, 2024, 4.5 more years *after* that follow-up letter, the report was: "Responsive records returned to the FOIA office for review and disclosure analysis." On its face then, responsive records do exist, but are not being provided.

The request quoted the "most occasions"/"rare instances" paragraphs from the 2011 Bulletin. Record category 1.C homed in on the critical legal assertion there, the Aggregation Theory. It read:

> [P]lease refer especially to the assertion made by your final sentence from the aforesaid passage, reading: "In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules." All records that you had used, relied upon or considered in arriving at that assertion, or in supporting that assertion, or that discussed the question whether that assertion is true, including any that tended to the contrary of that assertion.

The most prominent feature of that assertion is that, so far as any public available material is known, at least to this commenter, it was newly born on September 1, 2011, citing nothing. The responsive records — such as do exist, and evidently there are some — would reveal whether there any precedents to the 2011 Bulletin, or, if none were made public, what CMS did have to support the Aggregation Theory. Obviously, this would be of great value for examining whether the Government has been on the wrong legal track.

Category 2 noted two pre-ACA provisions in Title XXVII, termed "Original HIPAA small employer rights" For short, guaranteed issue and disclosure, they are specified in the margin, taken from the FOIA.[34] Their present versions, after amendment and redesignation by

[34] "Original HIPAA small employer rights" means the right described in such former PHSA, §2711(a)(1)(A) that certain "health insurance issuer[s]" "must accept every small employer (as defined in section 2791(e)(4))," etc., and/or the right described in such former PHSA, §2713(a), namely: "In connection with the offering of any health

the ACA, are PHSA, §§2702 and second 2709 (42 U.S.C. § 300gg-1 and 300gg-9). They had the more common nature of making it "good to be small," giving small employers rights as against issuers, redounding to the good of the employees as well. Categories 2.A and 2.B went to the HIPAA-ACA time period, to see if CMS took the position that a small employer lost those rights, if its actual or potential health plan were maintained by a §3(5) group or association of employers. No. 2.B went to records of any CMS experience in deciding, in any particular cases, of that status and loss of rights.[35]

Labor should prevail upon CMS to provide these long overdue responses, and put them in the record of this rulemaking.

Statutory and Legislative History

If there were any doubt or ambiguity left after the textual review so far, statutory and legislative history reinforces the falsity of the Aggregation Theory. One begins with the texts of the Original WPPDA and the Original ERISA, to see what those Congresses might have thought about the Association Clause and employee aggregation.[36]

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insurance coverage to a small employer, a health insurance issuer— (1) shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b), and (2) upon request of such a small employer, provide such information."

[35] If there were none, it would indicate that CMS's adherence to the Aggregation Theory was not longstanding, although §3(5) and the Title XXVII definitions were the same during the HIPAA-ACA and post-ACA periods. It would shed light on the possibility that the theory was newly hatched, for some reason, for the ACA.

Actually, there might have been a third small employer right cited, as to mental health parity under PHSA, §2726 (42 U.S.C. § 300gg-26), §2705 before the ACA. Some 2018 commenters noted the exemption in sub-sec. (c)(1): another "good-to-be-small" employee-count provision, which Labor discussed at 83 Fed. Reg. 28934 – 28935. Labor reported there that CMS would adhere to the effect of §3(5), with the supposed Aggregation Theory, for that case as well, perhaps reluctantly during the Trump Administration: small employers would be ousted of the exemption, which would go to the good of consumers. Sec. §2705 (now §2726) is almost as old as the rest of Title XXVII, added by Pub. L. 104-204, §703 (1996). During the HIPAA-ACA period, did CMS actually implement that in real cases?

[36] The language of the definition of "employer" was identical in the two acts, except that the ERISA version added the first comma, and shortened "employee welfare or pension benefit plan" to "employee benefit plan." The WPPDA version of §3 did not define the abbreviating and combining term "employee benefit plan." ERISA, §3 did so, at para. (3), which pushed the paragraph number for "employer" from (4) — in WPPDA — to (5).

WPPDA and ERISA are, respectively, 72 Stat. 997 – 1003, available at https://www.congress.gov/85/statute/STATUTE-72/STATUTE-72-Pg997.pdf, and 88 Stat. 829 – 1035, available at https://www.congress.gov/93/statute/STATUTE-88/STATUTE-88-Pg829.pdf

1958: Congress Was Not Interested in Counting Employees of Employers, and Enacted No Aggregators

One sees that the WPPDA Congress *could not have enacted* an Employee-Count Aggregator at all, by the Association Clause or anything else, because Original ERISA contained no Employee-Count Test — not when clearly understood to involve a count of individuals *as employed by employers*. One must carefully distinguish such a count-test from one that counts individuals *as beneficiaries of a plan* even, though the word "employee" might be used for them. The distinction is all-important here, as ACA, §1304(b)(1) and (2) are of the former kind, while any counting provisions in WPPDA and ERISA have included, at most, those of the latter kind.

The available Congressional materials of 1955 to 1958 contain much investigation of various alleged bad acts in the handling of the funds of welfare and pension plans, ranging from no or minimal accounting, to diversions, to, in some instances and accounts, blatant thievery. The 1955 Hearings were largely investigatory, hence the lead title of the prints was "Welfare and Pension Plans Investigation." Three reports produced by that same subcommittee in 1955 – 1956 were similar. But these materials of those years began some discussion of the substance of remedial legislation, at the level of concepts if not of draft text. The concepts included recurring concern with what came to be called the issue of "coverage," i.e. what entities or scenarios should be subject to an act's requirements. That term became the heading of §4 of the WPPDA, and would be used also for §4 of ERISA.[37]

E.g., 1955 Hearings, Part 1, 40: "*Coverage of proposed regulations* [:] When it is granted that certain Government safeguards are desirable to protect the interests of welfare fund beneficiaries, it then becomes necessary clearly to define just what kinds of "welfare" programs the controls should cover." (From a paper filed by a business-side organization, the Commerce and Industry Association of New York, Inc., which begins at 34.) That is, should the universe of all welfare/pension arrangements be divided by some criteria or others, and only some "covered."

For many participants, the idea of such a division grew out of the accumulated material about bad acts. Continuing in the paper last quoted, still at 40: "A line must be drawn somewhere between (1) those programs as to which the recent investigations have demonstrated abuses requiring correction and as to which regulation is needed and is feasible and workable, and (2) those as to which there has been no finding or evidence of malfeasance or abuse and as to which regulation would be but a nuisance and would serve no purpose." A possible basis from separating out "abuse"-prone programs was whether they were jointly administered (by employer-side and union-side representatives) or not ("unilateral" plans). The quoted paper viewed such a split with some favor, but acknowledged that a "workable way to delimit the regulatory scheme to *precisely* [maladministration] types of situations" might not exist, but

[37] 29 U.S.C. §1003. ERISA, of course, is a much larger act with more than one major topic in its four titles. Its §4(a) applies to Title I alone; and it has refined provisions on applicability or "coverage" for the other three.

"*approximately* the desired coverage can be achieved" by some criteria involving joint administration split. *Id.* at 41 (emphasis added).

Another possible limit might exclude from "coverage" all plans where the employee-beneficiaries were not unionized at all. Indeed the particular plans the subcommittee looked into may have been all from unionized workplaces.

Nevertheless, no union-basis exclusion was enacted. None appeared in the "plan" definitions of WPPDA, §§3(a)(1) and (2) — featuring the "or by both" language, like the essentially identical language of ERISA, §3 — or the "coverage" inclusions and exclusions of §§4(a) and (b) — the same going for the ERISA correspondent.

"Coverage" also received a fair amount of attention in 1956 Final Report. At 72, one sees an early expression of the view that the act would only cover plans from the realm of employment, broadly speaking, including union membership: "Under the formula proposed above, many otherwise vexing problems are eliminated. Voluntary associations of individuals such as lodges, etc., would not be require to report. The subcommittee can see no necessity for their reporting."[38] This limit, of course, succeeded in the enacted WPPDA, carried forward to ERISA and HIPAA, and to the attributive noun "group" having the unnatural meaning that continues today, for the term "group health plan" and then the "group market"/"individual market" split in PHSA Title XXVII.[39]

1956: The First Appearance of an Association Clause, and of Individual-Count Tests

As the 84th Congress headed toward the WPPDA, S. 3051 was introduced on January 26, 1956. It was the first appearance in any writing of a version of the Association Clause, so far as this commenter knows. It is printed at 102 Cong. Rec. 1328 – 1330,[40] along with an explanatory statement. It was a bill by the Eisenhower Administration, Dept. of Labor, introduced at its request by Sens. Ives (R-NY) and Allott (R-CO).

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[38] At that time, April, 1956, it was still undecided which agency should have cognizance of the potential statute. *See id.* at 74 – 75, discussing pros and cons of several. Excluding plans without a basis in employment (broad sense) would tend to point towards Labor as the agency. Nonetheless, the subcommittee came to "no strong views" about "the choice of … agency[, which] is secondary to the necessity of obtaining adequate legislation" while inclining toward the Securities and Exchange Commission. *Id.* at 75.

[39] That meaning now results from the incorporation of the ERISA, §3(1) definition into PHSA, §2791(a)(1), and the "market" definitions in the latter section. See, e.g., a CMS preamble, 75 Fed. Reg. 74864, 74871 (col. 2) (December 1, 2010), where it noted that health coverage of certain collections of individuals might be "group" not just in ordinary English but "under the conventions of statutory accounting," and yet must be classified as "individual" for Title XXVII purposes.

[40] Available via https://www.congress.gov/bound-congressional-record/1956/01/26/senate-section

Definitions were contained in §3. The first one defined the plans that would be governed by the act, in terms largely like those later enacted in §§3(1) and (2) of both the WPPDA and ERISA. The brief definition of "employee" was identical to those in the WPPDA and ERISA.[41] And that of "employer" — §3(c) — set the pattern followed in those enactments, of packing a possibly existing "group or association of employers" into the compass of that word, giving it an unnatural, term-of-art meaning. In turn, that word is used in the core "plan" definition, in lieu of writing in group or association of employers" there, to allow for its being the plan's "establisher."

The bill's "employer" definition was quite similar to §3(5) of the WPPDA and ERISA.[42] The language was:

> The term "employer" includes any person acting directly or indirectly in the interest of an employer in relation to an employee, or a group or association of employers, but shall not include [certain governmental employers[43]].

The next year, shortly into the first session of the 85th Congress, the bill was introduced again, as S. 1145, printed at 102 Cong. Rec. 1814 – 1816 (February 11, 1957).[44] It was virtually identical with S. 3051 of 1956 — the "employer" provision *verbatim* — and done by the same senators at Labor's request. Sen. Ives again read an "explanation," largely the same as that for S. 3051.[45]

That these bills put an Association Clause into the picture, *before* and *after* the 1956 Final Report (April, 1956), should be kept in mind when reviewing that report.

When 1956 Final Report 72 referred to "the formula proposed above," it was to a series of tests of size of plans, based on counting individuals, beginning at 71. The concern was for the burden on the administering agency, e.g., not to "swamp [it] with an impossible task." There was concern running through these early materials, perhaps implied, for the burdens on whatever parties administered the various plans. In either case, the effect of the test would run in the more intuitive direction found in many such laws: favoring the "small" enterprise, as less able to bear the burdens. That direction is reversed for some of the ACA reforms, like EHB, making it good to be "large," supposedly amplified by the Aggregation Theory.

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[41] *Viz.*, "The term 'employee' means any individual employed by an employer."

[42] A discussion of the differences is below, p. 28 *et seq.*

[43] That is, this version of the gloss on "employer" would effect the exclusion of plans of public employers by carving them out of the domain of that word, rather than in the "coverage" provision: §4(b)(1) in both the WPPDA and ERISA.

[44] Available via https://www.congress.gov/bound-congressional-record/1957/02/11/senate-section

[45] Changes made in the bill text were slight and stylistic, except that in the "Enforcement" section, §9, sub-sec. (b) creating a false-statement offense was omitted. Instead, the explanation said that the general false-statement offense, 18 U.S.C. §1001, would apply.

The concern for agency burden is remarkable to read now, in comparison with the much more ambitious tasks ERISA put to Labor, and Treasury. For the programme of WPPDA was to combat the perceived plan problems with, in short, paperwork. Written statements were to be made and filed with an agency, and made available to the beneficiaries: "transparency," the term often used lately, would curb the undesirable conduct. There would be an initial statement, which the enacted WPPDA, §6 would call the "description of the plan," followed by annual reports, governed by §7 of the enactment. The agency's core task was just to receive and manage such papers.

The size-based coverage proposals of 1956 Final Report 71 – 72 first addressed the initial "registration" document with one, fairly expansive test. Then, annual reporting coverage was to be subject to a refined test of four parts. Only one of the five tests would count the individuals ***employed by an employer***.[46] The others count the individuals that ***the plan "cover[ed]" or "include[d],"*** though only such individuals as were employees (presumably of some employer connected with the plan), referring to them with the word "employees." Thus, beneficiaries who were not such employees were not in the count.

Thus only that one test that looked to the employee roster of an employer, not a plan, is of the same nature as ACA, §1304(b)(1) and (2). But the key point, looking ahead to 1958, is that the WPPDA Congress did not enact any such test.

In the initially introduced version of the vehicle that became the WPPDA, S. 2888, there was a test with a threshold of 100 "employees," but it, too, looked to employees so far as covered by the plan, thus it was of the nature of the four other tests described in 1956 Final Report 71 – 72. According to 1958 Reports (Senate) 30, the sub-100 exemption, which would only be partial, would not be in a definition, or a part of §4 on "coverage," but placed in a section making exemptions from substantive duties, proposed §8: "Section 8(a) provides that a report will not be required of plans covering fewer than 100 employees until the expiration of 2 years following the date of enactment of the act."[47]

In the corresponding House bill, H.R. 13507, there were no size-based exemptions. 1958 Reports (House) 11 – 18. Ultimately, in Pub. L. 85-836 as enacted, there was an exemption with

[46] That was number (1) of the annual reporting criteria. The subcommittee stated estimates that if all employers with eight or more employees, and involved with a plan, there would be about 554,000 annual reports, if the threshold were 20, 211,000, and "such a volume would be too burdensome an operation." The subcommittee came to a proposed threshold of 100, resulting in about 30,000 reports.

[47] As there described, proposed §8(b) would give the administering agency discretion to extend such exemption of "such small plans" for "any period of time." On the other hand, proposed §8(c) gave affected employees the right to obtain certain information "from the management of the plans, upon request."

a threshold of 26 "employees," but as "cover[ed]" by the plan. It was placed in the "Coverage" section, §4, adding para. (4) to the set of exceptions made by sub-sec. (b).[48]

That exception was not in the initial S. 2888, and of course not in H.R. 13507. In both, the sub-sec. (b) exceptions stopped with para. (3). 1958 Reports (Senate) 26 - 27; 1958 Reports (House) 13. Paragraph (4) was added in the conference. 1958 Reports (Conf.) 3. Thus, it replaced the 100-threshold provision in the initial S. 2888: with features both more and less favorable to the whole of plan administrators, as to their duties. It was permanent and did not need an agency extension, and took the "small" plans out of act coverage altogether, not just from the annual report duty. On the other hand, the threshold was much smaller. 1958 Reports (Conf.) at 9 briefly described the Senate, House, and final positions on size-based exemptions, without venturing an estimate of the number of act-subject plans.

By counting only the relevant "employees" benefiting from a plan, the threshold of all benefiting individuals could be substantially higher than 26, for plans that did include non-employee "participants" and/or "beneficiaries."[49] The 1962 Amendments, Pub. L. 87-420, §6 changed "employees" to "participants." 76 Stat. 36. Thus the exemption shrank, over the run of plans, though not as much as if the new word were "beneficiaries."

With either the original or amended version, though, the critical feature of §4(b)(4) was that it counted individuals covered by the plan, not those employed by a given employer. The major difference, of course, is realized for a plan with multiple employer-side "establish[ers]." Regardless of the structure of the relations among the establishers, of whether the members of the multiplicity are only employers in the ordinary sense, of whether there are "groups" or "associations" of ordinary-sense employers, or of whether any "groups" or "associations" are, or purport to be, separate legal entities rather than mere multiplicities, the single plan is what §4(b)(4) looked to. The count was of individuals benefiting from the plan, regardless of which employer (ordinary sense) each one might be employed by (or, after the 1962 amendment, whether they were employed at all).

One can restrict attention to the Original WPPDA, though, to answer the question: did the WPPDA Congress enact an Employee-Count Aggregator, chiefly looking to the Association Clause? The answer is "no." The first and decisive reason is that nothing in the act counted employees of an employer. The summing effected for the §4(b)(4) test was fully accomplished by that provision's own terms. It had no need of the Association Clause, or of §3(a)(4) as a whole, or by any implication drawn out of that clause or paragraph.

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[48] *Viz.*: "such plan covers not more than twenty-five employees." For consistency with other size-based proposals, this is here termed a threshold of 26 for *being subject* to the act.

[49] The former word adds in former employees and union members who might not be employees. The latter takes in whole universe of benefiting individuals, those "who [are] or may become entitled to a benefit [under the plan]," which, typically, could add in certain relatives. See the definitions at WPPDA, §§3(6) and (7), with which ERISA, §§3(7) and (8) are identical, but for a clarifying phrase added for "participant."

Looking to the 100-threshold test in the initial S. 2888, with the idea of showing that counting individuals was once in the minds of participants in the discussions, would produce the same result as for enacted §4(b)(4). It was also a count taken of the plan, of its own force. It is no help to the Aggregation Theory.

The discussion in 1956, in 1956 Final Report 71 – 72, of one Employee-Count-Test among five size-based tests, is also not sufficient, for teasing an aggregation rule out of what was "in minds." One recalls that an Association Clause, at least a near copy of what was eventually enacted, was noted at 1956 Final Report 77 – 78, and had been available to the subcommittee since January. (See above review of S. 3051.) The crucial problem for a proponent of the Aggregation Theory trying to find support in 1956 Final Report is that there is no mention at all of a possible provision anything like an Association Clause, specifically, one making the meaning of the word "employer" unnatural, packing into it an entity that does not employ the people of interest as to the plan.

As was the case in 1955 Hearings, specific, named employers' associations are often discussed in 1956 Final Report. The corresponding plans are, presumably, those termed "multiemployer," as it canvassed the kinds of extant plans. Given the frequency of such arrangements, as described in those materials, it is somewhat surprising to then see the "rough[] estimate[]," 1956 Final Report at 14, of the percentage of "Multiemployer-jointly (employer-union) administered fund[s]": among welfare plans just 7%, versus 92% for single employer administered plans.[50]

The assumed 7% prevalence was large enough that it is *not* surprising that, when it came time for hard drafting of bill text, those involved would provide for the scenario of a "group or association of employers" rather than a single employer, being on the employer side of the "establishers" of a plan. This is consistent with the inclusion of an Association Clause in the definition of "employer," in S. 3051, then S. 1145, then in the enacted WPPDA. But when the subcommittee was still at the point of conceptual discussion, one sees no reference to the extant Association Clause in S. 3051, say on the following page, 1956 Final Report 15, describing multiemployer plans. And at 77 – 78, where S. 3051 was noted, there is no mention whatever of its Association Clause, and how it might have a role in bringing multiemployer plans under the purview of an act.[51]

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[50] For pension plans, 13% versus 86%, respectively. There is no entry for "multiemployer" plans that are not "jointly" administered.

The report noted a recent survey, not identified, for New York State and City welfare plans. Multiemployer plans were said to be 29% for the State. But for the City, 40%. The writers judged that the City might be less "characteristic of the country as a whole." It makes sense that the City's 40% would have pushed the State figure up to 29%. And the writers seemed to see no reason to doubt a country-wide 7%.

[51] One next recalls that the Eisenhower-Labor bill was re-introduced with no significant change *after* 1956 Final Report, S. 1145: thus having an Association Clause but not taking any account of individual-counting tests discussed in that report.

In sum, there is no evidence of anyone thinking that an Association Clause in a definition of "employer," had any connection to possible — not even enacted — counts of persons employed by an employer.

The Most Important Word for Understanding the Role of the "Employer" and "Employee" Provisions in Section 3 of the Early Bills, the WPPDA, and ERISA, in Defining the Measure's "Coverage," is the Verb "To Employ" in the "Employee" Definition.

Before moving on from the 1950's, a review of the version of the "employer" provision in S. 3051 and S. 1145 — for brevity, the "Eisenhower" version or bill — will be helpful. Its different structure, from that in the enacted §3(4) (WPPDA) and §3(5) (ERISA) — the "enacted" version — makes it easier to see its role in the ultimate task of determining "coverage."

A first feature to note about the enacted version is its technical flaw of circularity, of being self-referring. That is, "employer," the word being defined, is used in the definiens. The Eisenhower version avoids that flaw, chiefly by not being a true *definition*, but an "including" gloss on the word. It does not say "'employer' means …" Instead it takes the reader's understanding of what an "employer" is, at it finds it, and adds to the domain of the word, for the special legal purpose of its use in §3(a) (defining the "plan" of interest, just as enacted §§3(1) and 3(2) in both the WPPDA and ERISA). The resulting domain is unnatural, i.e., larger than that of reader's ordinary-English understanding of an employer. Specifically, it adds "any person acting … in the interest of an employer." This commenter understands that to mean some kind of *agent*, who is not identical with the employer in question.

The enacted version also describes this agent-like person, though splitting the "directly or indirectly" of the Eisenhower version, to suggest that such agents "act" only "indirectly," *before* the mention of "association[s]." The Eisenhower version does get to describing "association[s]," another unnatural addition, later in the text. Indeed, in that version, "or a group or association of employers," read literally, seems free-standing, not conditioned by "acting … in the interest of an employer in relation to" — something.[52] That might be charged as a technical flaw of the Eisenhower version, but it is doubtful that its drafters meant to sever the group or association from the "acting in the interest" condition.

One can see, then, that the goal of the drafters was to expand the "coverage" plans to include those "established by" any one of three types of entity, or quasi-entity:

(1) an ordinary-English employer,

[52] In the move to the enacted version, that something changed from "an employee" to "an employee benefit plan." The latter is arguably more restrictive, but in the context of getting the meaning of "employer" over to the "plan" definition, it is hard to imagine a real difference.

(2) an agent of an employer in such sense, and
(3) such an agent that is a group or association of employers.

It was a fateful decision, apparently by the Eisenhower drafters, to pack all three into the word "employer," before taking that unnaturally expanded term into the "plan" definition. The alternative might have been to write the "plan" definition so as to take in all three as possible "establishers."[53] Then, §3 (in all three versions) was immediately followed by §4 on "coverage."[54] The latter took the "plan" definition, out of §3(a), or the enacted §§3(1) and (2), and determined the core of "coverage."

The Eisenhower drafters' decision to pack the other two alternatives (besides the ordinary-English employer) not into the "plan" definition but the "employer" gloss may have been regrettable, as it persisted into the WPPDA, then ERISA, to this day, and gave rise to the confusions like the Aggregation Theory. But on a review such as the foregoing, it should have been innocuous. The enacted version of the "employer" gloss may have improved on the Eisenhower, such as clarifier the tie of a "group or association" to action in the interests of an employer. But anyone proposing that the meaning was substantively changed should bear the burden of producing evidence.

This review then looks forward to the well-known 1992 settlement of what the forms of "to employ" mean in §3, the verb itself and the two nouns: *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318. The Court, finding no statutory help on the meaning of an ERISA, §3(6) "employee," held that the tests of the common law employment relationship would apply.[55]

The Court remarked of the language of §3(6) that it is a "nominal" definition, "completely circular" and "explain[ing] nothing." 503 U.S. at 323. In short, per the Court, "employee" was a term not defined by Congress for ERISA purposes; to fill the void the Court discussed various sources, and decided on the "common law" tests. The plaintiff lost.

The Court's criticism of §3(6) might be excessively harsh. The definiens uses the verb "to employ." In turn, that verb is not defined by ERISA, but essentially the Court's solution was to give it the meaning, in line with what this comment has been calling the "ordinary-English" one of "employer," of common law. Accordingly, a §3(5) "group or association" does not employ, in the common-law sense, the employees of its member-employers.[56]

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[53] In the Eisenhower bill and the WPPDA, "established" was the only verb. "Maintained" was added for the ERISA version.

[54] With the gigantic §3 of today's ERISA, that close proximity, in the 1950's language, might be obscured.

[55] The case did not involve §3(5) "association" issues, but whether the plaintiff was a §3(6) "employee" able to bring suit under ERISA, versus a contractor or some other kind of non-employee.

[56] This of course echoes the cogent analysis by Labor in MEWA Guide, noted above, pp. 16 - 17: "[T]he individuals typically covered by the group or association-sponsored plan are not 'employed' by the group or association and, therefore, are not "employees" of the group or association."

Before looking at ERISA's treatment of aggregation, the evolution of policy about preemption should be sketched. It was a remarkable reversal, from the 1950's measures to ERISA. The latter's §514 (29 U.S.C. §1144) grants strong relief to parties in charge of EWBPs against State regulation, albeit with sprawling complexities take would take a book chapter to analyze. Section 10 of the Eisenhower bill and of the WPPDA were forthright negaters of preemption. The former was totally so, and said nothing more. The WPPDA's had a sub-sec. (b) that carried the Eisenhower section forward and into enactment, but added a sub-sec. (a) that gave only mild relief, for plans with multi-state operations, against some duplication of filing papers with State regulators.

The difference is substantial, for the motivations of parties in charge of plans of putative groups or associations of employers. For them, ERISA preemption creates cross-cutting incentives about the desirability of recognition as (in present terminology) a BFGAE, making the plan a EWBP: the disadvantage of being subject to the Federal act, versus the advantage of relief from State regulation. When parties request advisory opinions from Labor about BFGAE status, the opinions, which comprise Labor's "pre-rule guidance," generally give little indication of which of those two effects motivated the request. But one can sense that the advantages of preemption predominates.

Under the 1950's provisions, though, the incentive was all one way, just the opposite of wanting to be deemed a BFGAE: to avoid the, not insignificant, paperwork requirements, with no offsetting benefit of preemption. This informs two concerns of many participants in considerations leading to the WPPDA — throughout the materials mentioned above: (1) with making the "coverage" of the measure fulsome (but for a few specified exceptions), under language effective to take in all possibilities of how benefit plans were structured, in light of the extant real-world practices before them; (2) with extant State regulatory efforts not to be displaced, but to continue side-by-side with the new Federal "transparency" effort being added, thus the anti-preemption provisions.

The first of these rounds out the discussion above, of the prominence of the issue of coverage, to the 1950's Congress. It had much evidence before it of the extant practice by employers to establish plans run not one employer at a time, but through associations they had formed. That was the environment in which the Association Clause was first drafted, and enacted. It was toward the goal of such effective language, to preclude association-related plans from being missed. Thus the definition of "employer," together with that of "employee" and the "plan" definition(s), and the operative statement of "coverage" in §4 (Eisenhower and WPPDA) were all of a piece in the task of defining "coverage." So they should be read all of a piece, so as to understand the role of the Association Clause for the coverage task, and its having nothing to do with aggregation for Employee-Count Tests, that would not appear until 1996.

1974: Congress Was Not Interested in Counting Employees, and Enacted No Aggregators

For the activity leading up to ERISA, and in its text, one sees again that the ERISA Congress could not have enacted an Employee-Count Aggregator at all, by the Association Clause or anything else, because Original ERISA contained no Employee-Count Test. As for §3(5), this commenter can finds no evidence that Congress did anything but copy it from WPPDA, §3(4), essentially *verbatim*. If someone moves to propose that the ERISA Congress had a new meaning in mind, for the existing language before it, it should fall to him/her to find evidence of it.

Nor is there any evidence, so far as this commenter can find, of contemplation of an Employee-Count Test. As with the enacted WPPDA, there was no provision for which any employee-counting rule would have significance.[57]

In the Original ERISA, there were three mentions of entities being "small" (and none of being "large"). One was in Title II affecting the IRC, in a new subsec. (j) of its §401, where "small" merely appeared in the phrase "small business corporation."[58] The appearance concerned "shareholder-employee[s]," and thus connected to the provisions of IRC "Subchapter S"[59] — in which figure both terms "small business corporation" and "shareholder-employee." The so-called "S corporation" is just a "small business corporation" that has made a certain election, and the latter term has its definition at IRC §1361(b)(1). That definition is autonomous from ERISA (at least its non-Title II titles) and among its indicia of smallness are the numbers of classes of stock and of shareholders, not employees.[60] Thus no employee-counting rule in ERISA (if there were one) could affect it.

The other two mentions of "small" were in "soft" provisions, in that, first, they used the word but mandated no particular number of individuals to define it.[61] One of those merely

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[57] Before confirming the absence of an Employee-Count Test, a possible cavil might be that "could not have enacted" is too strong. That would have to indulge that the ERISA Congress thought as follows: "We have no reason to count employees. But a future Congress might add a provision that counts employees, and might raise issues about how to do so. So we will insert one or more employee-counting rules now, that will be 'ready' to operate upon some hypothetical future amendment." This last supposition is entirely fanciful; surely here again the burden is on those relying on it to show clear evidence that the ERISA Congress *actually* intended it. The probability, just described in the text, that the ERISA Congress simply re-used the WPPDA language, and §3(5) was not a product of fresh thinking, makes such an idea even more fanciful.

[58] 88 Stat. 954.

[59] Of Ch. 1 of Subtitle A of the IRC, comprising §§1361 – 1379 (in 1974 and today).

[60] Indeed there is a form of entity-unification in the elaborations of that definition, at subsec. (b)(3)(A) and (B). Like the Entity-Unifiers mentioned elsewhere in the comment, Congress made the effect clear, destruction of separate status for a certain kind of subsidiary: It "shall not be treated as a separate corporation." Subpar. (A)(i). It is not clear, however, how that unification would affect the shareholder count in the basic definition, since it must be an "S corporation" that elects that treatment.

[61] Thus a possible counting rule, like an aggregator, had no target to aim at.

mandated, to Congress's own task force, a study of several topics, one being "small employers" and ERISA, Title IV — which concerns plan termination and the Pension Benefit Guaranty Corporation ("PBGC").[62] Thus, no hard legal consequences attached to being classified as small.

In its last appearance, "small" modified "plans" in 4042(a)[63], within Title IV. It concerned PBGC's termination procedures generally, and included that PBGC "*may* prescribe a simplified procedure" as to "small plans." (Emphasis added.) This is "soft" also in that Congress accepted that such an exceptional procedure might not exist at all. And having given PBGC that degree of discretion, it appears PBCG was free to make its own definition of "small," which might have measured indicia like dollars or participants, not necessarily employees. But moreover for this mention of "smallness," since it is said of the plan, an Employee-Count Aggregator could not have had any effect. That is, in a scenario indeed involving a BFGAE, a plan involving multiple actual employers necessarily exists, and that plan has already combined all the participants into one group: no need to decide about aggregating them as employees.

Then, Original ERISA did contain one test, and a "hard" legal one, that depended on counting individuals. It was in §4021, of which subsec. (a) states the basic scope of plans subject to Title IV and PBGC, i.e., termination insurance premiums, concomitant with eligibility to be so insured. Subsec. (b) listed exceptions, that of par. (13) being a plan "established and maintained by a professional service employer which [never after ERISA's enactment date has] more than 25 active *participants* in the plan." (Emphasis added.)[64]

But as in §4042, and years before in WPPDA, §4(b)(4), this size test is on the plan, not an "employer" (whether actual or made by statutory fiction). This search for at least *individual*-count tests is in the realm of plans involving multiple employers, but here again the participants are already combined for a size test.

Indeed, §4021(a)(13) does have attached to it an odd sort of aggregation rule, at subsec. (c)(3), reading: "In the case of a plan established and maintained by more than one professional service employer, the plan shall not be treated as a plan described in subsection (b)(13) if, at any time after [ERISA enactment] the plan has more than 25 active participants." Once again, subsec. (b)(13) would test in any event the roster of *the plan*, not of any one workforce (in case of several involved employers). Subsec. (c)(3) just re-states the maximum of 25 to gain excepted status, and if necessary at all it is only because Congress used the singular "a professional

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[62] ERISA, §3022(a)(3) (29 U.S.C. §1222(a)(3)). 88 Stat. 999.

[63] 29 U.S.C. §1342(a). 88 Stat. 1021.

[64] 29 U.S.C. §1321(b)(13). 88 Stat. 1016.

service employer" in (b)(13). Congress might have instead there written "one or more professional service employers," obviating (c)(3).[65]

Thus, the ERISA Congress could not have meant the Association Clause to be an Employee-Count Aggregator. The proposal that the clause might have had its meaning changed by later legislation, like HIPAA or ACA, is simply extravagant. Meaning might have changed if a later Congress had either —

(A) amended §3(5), of course, or

(B) at least had made reference to it, and its making an "employer" out of the BFGAE it describes, so as to say whether individuals, who do not actually work for such "employer," will be treated as employees of such "employer."

Congress has done neither.[66] Strictly though, even measures like (A) or (B) would not have changed the *1974 meaning* of §3(5). Even with (B), the later Congress would not be "amending" §3(5) but merely enlisting it as an incorporated test. The later provision, not the Association Clause, would be the Employee-Count Aggregator, presumably clearly stated as such. Otherwise, courts hold that (noting some possible exceptions such as (A) or (B)), "later-enacted laws … do not declare the meaning of earlier law."[67]

For further examination of what the Association Clause meant in 1974, one can look for any legislative history. As noted earlier, this commenter finds no evidence that drafters in the run-up to ERISA did anything but copy the ready-to-hand definitions in the WPPDA. The definition of "employer" had the same language as enacted, and today, in the first ERISA bills filed in both House and Senate, 93rd Congress: H.R. 2 (January 3, 1973), H.R. 462 (January 3, 1973), S. 4 (January 4, 1973).[68] Thus if there were any previous debate over a version of the definition, e.g., that had no or a different Association Clause, it is difficult to find.

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[65] Despite the inelegance, one sees again here that when Congress provides for, or clarifies, aggregation, it does so unmistakably, in supposed contrast to the Association Clause.

[66] The incorporation by the HIPAA Congress of ERISA, §3(5) as the definition of "employer" for Title XXVII, §2791(d)(5) (42 U.S.C. § 300gg-91(d)(5)) accomplishes neither (A) nor (B). It left the meaning of §3(5) untouched, and the question remained, "what is that meaning?" The modification made to the definition, requiring at least two employees, may well be significant for the "working owner" issue, at least where the definition of "employer" matters for Title XXVII, or ACA, Title I.

[67] *Almendarez-Torres v. U.S.*, 523 U.S. 224, 237 (1998).

[68] The language match was *verbatim* except that latter two spoke only of a "pension or profit-sharing-retirement plan" rather than an "employee benefit plan." Indeed these early versions reached only money benefits and plans, not health or other welfare benefits and plans. As in the discussions of the 1950's, one can see that the drafters were aware of situations in which several employers pooled resources to provide pensions, and decided to ensure that such arrangements would be plans subject to the act — conferring rights of employee-participants much more ambitious than the WPPDA — and its core concerns like vesting rights, adequate funding, and plan termination insurance. Having the WPPDA's Association Clause available, they evidently did so by simply copying the clause with its fictive, unnatural modification of the word "employer" so that the association would fit into the term "an

This commenter's search of legislative history from the ERISA Congress, that is readily available, show no discussion at all of the Association Clause.[69] And the Index to Subcommittee History has no entry for "association," in the section for definitions or otherwise.[70] In sum, the meaning or wisdom of the clause appears to have been almost unnoticed by the ERISA Congress, such as an effect on counting "employees" or any other, besides the most obvious one of expanding the word "employer" for the purpose of definitions of "plans" that the act would regulate.

Returning to the possibility — called "fanciful" above, fn. 57 — that the ERISA Congress inserted an Employee-Count Aggregator, namely the Association Clause, despite enacting no Employee-Count Test for it to act upon, but only to lie dormant for a future test, this absence of attention to the clause augments the implausibility of such a theory. Surely such an

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employer" in the basic language on what is subject to the act, an approach that survived to enactment. For example, in S. 4 that language was found in §104(a), not a §3 definition, but was very like that in §3(1) in H.R. 2 and the eventual Act.

See, Senate Subcomm. on Labor of the Comm. on Labor and Public Welfare, *Legislative History of the Employee Retirement Income Security Act* (Comm. Print 1976)(hereinafter, "Subcommittee History). That print is in three volumes, which as of this writing are available through https://catalog.hathitrust.org/Record/000732830. The three bills mentioned here begin, respectively, at 3, 67 and 93 (in Vol. I).

[69] Besides Subcommittee History, this goes also for —

● *Hearings on S. 4 [etc.] and S. 75 [etc.] Before the Senate Subcomm. on Labor of the Comm. on Labor and Public Welfare, 93rd Cong.* (Feb. 15 and 16, 1973);

● Senate Subcomm. on Labor of the Comm. on Labor and Public Welfare, Retirement Income Security for Employees Act of 1973, S. 4: Bill Text, Summary of Major Provisions, and Background Material (Comm. Print 1973); and

● [Same subcommittee], Employee Retirement Income Security Act, 1974: Public Law 93-406 (H.R. 2): Text of Public Law, Statement on the Part of the Managers, and Summary of the Legislation (Comm. Print 1974).

As of this writing, the first is available through https://catalog.hathitrust.org/Record/101818500 and the other two through https://catalog.hathitrust.org/Record/000732830.

Also, going back into 1972, search was made, with the same results, in —

● *Hearings on S. 3598 [etc.] Before the Senate Subcomm. on Labor of the Comm. on Labor and Public Welfare, 92nd Cong.* (June 20 and 21, 1972). That bill already contained the definition of "employer" just as it would (limited to money plans) in bills of 1973 to 1974, *Id.* at 7, and was dated May 11, 1972. A search reveals no discussion of the issue.

[70] I Subcommittee History at xiv *et seq.* The definitions section entry for "employer" lists numerous references, not surprisingly. Many are simply where §3(5) or its equivalents show up in prints of bills or amendments. If a report or floor statement took note of the Association Clause within §3(5), for support, explanation, criticism, etc., the indexers likely would have noted it in an entry for "association."

extraordinary decision, to insert a provision with no present significance, would have attracted discussion.[71]

By contrast, the ERISA Congress did note the issue of employer unification (for purposes other than the non-existent one of counting employees). The House Ways and Means Committee said of "affiliated employers" (emphasis added):

> *Affiliated employers.* — The committee bill also provides that in applying the coverage test, as well as the antidiscrimination rules, the vesting requirements, and the limitations on and benefits [sic], employees of all corporations who are members of a "controlled group of corporations" (within the meaning of sec. 1563(a) [of the existing IRC]) are to be treated as if they were employees of the same corporation. Thus, if two or more corporations were members of a parent-subsidiary, brother-sister, or combined controlled group, all of the employees of all of the corporations would have to be taken into account in applying these tests. A comparable rule is provided in the case of partnerships and proprietorships which are under common control (as determined under regulations), and all employees of such organizations are to be treated for purposes of these rules as though they were employed by a single person. The committee, by this provision, intends to make it clear that *the coverage and antidiscrimination provisions cannot be avoided by operating through separate corporations instead of separate branches of one corporation.* For example, if managerial functions were performed through one corporation employing highly compensated personnel, which has a generous pension plan, and assembly-line functions were performed through one or more other corporations employing lower-paid employees, which have less generous plans or no plans at all, this would generally constitute an impermissible discrimination. By this provision the committee is clarifying this matter for the future. It intends that prior law on this point be determined as if this provision had not been enacted.[72]

This is, so far as readily available history material goes, the sole discussion of unifying employers, by an admitted fiction, to further ERISA's objectives. As in the emphasized passage, the intent of unification was to negate, *to the favor of* plan participants (thinking mainly of "pension" rather than "welfare" plans), evasions achieved by separation of entities. This is a far cry from the effort, of the NPRM, to find in Original ERISA a policy of *injuring* welfare plan

[71] Such a proposed effect for the Association Clause is unusual enough to invoke the observation that the "dog didn't bark," where it probably would have if the remarkable meaning were intended. *E.g., Church of Scientology of California v. Internal Revenue Service*, 484 U.S. 9, 17 – 18 (1987), calling the proposed meaning there "expansive" and "an alteration to the basic thrust of the draft bill." The Court noted the absence of "bark" — the allusion is to a twist in a Sherlock Holmes plot — in the floor statement of the sponsor of the relevant measure. *See also*, *Chisom v. Roemer*, 501 U. S. 380, 396, n. 23 (1991)("Congress' silence in this regard can be likened to the dog that did not bark. See A. Doyle, Silver Blaze …") *Church of Scientology* was more recently cited in *Koons Buick Pontiac GMC, Inc. v. Nigh*, 543 U.S. 50, 63 (2004).

[72] H.R. Rep. No. 93-807 (February 21, 1974) at 50, *reprinted at* 1974 U.S.C.C.A.N. 4670, 4716. Also available in II Subcommittee History at 3170: see fn. 68 for an online source.

participants, with the far-fetched theory that the ERISA Congress foresaw later Congresses writing employee-count rules (HIPAA), and making a high employee-count grounds to lessen rights to the quality of benefits (per the ACA, apparently).

Congress Knowing How to Make an Employee-Count Aggregator: Explicitly and Always Involving Common Organizational Control.

One can now review how Congress, including in the process of enacting ERISA, makes Entity-Unifiers (and in some cases, after 1974, Employee-Count Aggregators). Original ERISA contained several Entity-Unifiers. One of major significance was, and still is, at §210(c), reading:

> For purposes of sections 202, 203, and 204,[73] all employees of all corporations which are members of a controlled group of corporations (within the meaning of section 1563(a) of the [IRC], determined without regard to section 1563(a)(4) and (e)(3)(C) of [the IRC] shall be treated as employed by a single employer.

One looks into such §§202 – 204 to see how entity-unification mattered.[74] They concerned, respectively, eligibility to participate in an employee benefit plan, vesting and accrual. Sec. 202 created rights to participate that depended, in several ways, on the amount of service for an employer, including duration. That was the only issue in §202 for which it would matter whether several employers, or just one, were in the picture. That is, if an individual switched from one employer to another (being "first-instance" or actual separate employers), s/he would not compile the needed duration of service, unless the law treated the set of such employers as one, with an Entity-Unifier.

Sec. 203 created minimum rights to vesting of pension benefits — their becoming non-forfeitable — that were similarly measured by amount and duration of service for the employer.[75] This again was the only issue for which it would matter whether a set of an individuals were made one by the law, or left separate. Sec. 204 demanded of a pension plan several minima in the individual's accrual of benefit rights. It largely spoke of duration of participation in a plan, not directly of employment service. For that issue, the first unifying rule in §210, at its subsec. (a)(1) as to several employers maintaining one plan, might have accomplished the summing of participation durations if an individual moved among such

[73] ERISA sections 210, 202, 203 and 204 are, respectively, 29 U.S.C. §§1060, 1052, 1053 and 1054.

[74] The actions of these Original ERISA sections are described in in the past tense in the following review, to focus on how the same Congress that wrote the Association Clause also expressed entity unification when it meant to. Indeed, the essentials of these sections remain in today's ERISA.

[75] The condition on compiling a duration of service that it be for the same employer was clear enough from context, and in §§203 and 204 is often not expressed with words like "for the employer." The question answered by the §210 unifier is thus, "was it the *same* employer"?

employers. But one test, at subsec. (b)(1)(F), depended on years of service, and subsec. (b)(3)(A) ties the measure of participation back to that of service. In sum, the ERISA Congress did make Entity-Unifiers, and knew how to write them unmistakably.[76]

The unifying of entities was based on concepts of "common control" of organizations, by incorporating IRC §1563(a). That section was passed in 1964 along with §1561, in order to limit such a group to one use of a certain tax exemption.[77] It defines "controlled group" with the concept of interlocking control among corporations, dependent on stock ownership, with exacting specifications about stock. Its immediate concern was the taking advantage of the tax exemption(s) — as §1561 would list — more than once, by a decision-maker as to organizational structure, who used separate entities.[78] It does not use a phrase like "shall be treated as one," but the meaning is equivalent.[79] It is effectively an Entity-Unifier.

IRC, §1563(a) was thus available to the ERISA Congress as a test for entity unity. It was also used, for instance, in the sharp limitations on an employer's pension plan's holding of its own securities, in ERISA, §407.[80] The affected securities are also those of an affiliate, which was defined — per subsecs. (d)(1) and (7) — by reference to IRC, §1563(a). Also, importantly for the later legislation discussed herein, Original ERISA added IRC, §414. Its subsecs. (b) and in turn (c), referred to §1563(a), and shifted to "shall be treated as" language. The former read: "For purposes of sections 401, 410, 411, and 415, all employees of all corporations which are members of a controlled group of corporations (within the meaning of section 1563(a), determined without regard to section 1563(a) (4) and (e) (3) (C)) shall be treated as employed by a single employer."[81] Subsec. (c) covered non-corporation "trades or businesses," mandating Treasury regulations which must be on "principles similar" to those of subsec. (b).[82]

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[76] This review of §§202, 203 and 204 also confirms what was set out above, that the ERISA Congress did not enact anything that counted employees.

[77] Pub. L. 88-272, §235(a). The exemptions addressed in §1561 grew to four, until the recent tax amendments (Pub. L. 115-97) cut them back to one. But §1563 remains as it has since 2004.

[78] The policy behind §§1561 and 1563 regards the economic and governance reality to be that there is one decision-making "person," and thus that such multiple exemptions are unjustified. Congress's unification of entities can be described as fictive, as this comment does — as against their separate status as recognized by applicable State laws and chosen by the single decision-maker to seek other economic and legal advantages. But unification could also be called an anti-fiction. That is, a unification regards separateness as the fiction, as against the reality of unity, that the Entity-Unifier restores.

[79] Since the group members still have separate tax liabilities, and return duties, the question immediately arises of how to allocate among them the one amount of the exemption. The original and today's §1561 proceed directly to that, and saying first that they shall be treated as one is would have been unnecessary and cumbersome.

[80] 29 U.S.C. §1107.

[81] ERISA, §1015. 88 Stat. 925 – 926.

[82] The original IRC, §414 ended with subsec. (l). Subsecs. (m) and (o), which along with (b) and (c) figure in later Entity-Unifiers and Employee-Count Aggregators that are relevant here, were added after ERISA but before

IRC, §1563, and the Entity-Unifiers that used it, contrast with the Association Clause, according to the claims of the NPRM, in several ways which include —

(A) Clarity that they are Entity-Unifiers at all.[83]

(B) Clarity of content, in the detailed rules on what and how much stock to count, for the percentage tests in §1563. By contrast, the criteria for triggering the Association Clause, to confer what Labor would call BFGAE status, are vague and amorphous, so far as the terse ERISA, §3(5) text goes.

(C) Clarity of policy, to counteract advantages to businesses thought unjustified, because one person could decide to split entities to gain advantages. And the advantages come at the expense of parties such as employees, such as in denying duration of service to one who move around among members of a controlled group. The Entity-Unifier serves to help such other parties. By contrast, the Association Clause being used as an Entity-Unifier, and indeed Employee-Count Aggregator, involves assisting member employers, to the detriment of the rights of employees. The direction of these motivations accords with that in the one discussion of entity unification in the available legislative history, recited above at text accompanying fn. 72.

(D) The tight bonds among entities involved in a controlled group, with the hard, legal powers arising from interlocking ownership, which can be fairly called the "structure" of a single organization. It contrasts with the loose connections of a "group or association," no matter what the criteria for a BFGAE turn out to be. This looseness is apart from the vagueness of the Association Clause about the criteria, per item (B). Given a status quo of autonomous employers, is it at all likely that they would move from there, to surrender their autonomy, arrange for interlocking ownership, and merge into a §1563(a) group? But Congress demanded this in its clear Entity-Unifiers.

In sum, it is incongruous that the ERISA Congress intended a second means of entity unification, by the Association Clause. Courts often rely on the fact that, elsewhere in its statutes, Congress "knows how to" effect a result, strongly counter-indicates finding the result from creative readings of non-explicit language.[84]

HIPAA: Subsec. (m), in 1980, identically by Pub. L. 96-605, §201(a) and Pub. L. 96-613, §5(a). Subsec. (o), in 1984 by Pub. L. 98-369, §526(d)(1).

[83] It is supposed here, *arguendo*, that an Entity-Unifier reading of the Association Clause is at least unclear, rather than foreclosed by the purely textual consideration given earlier.

[84] *E.g., State Farm Fire & Cas. Co. v. U.S. ex rel. Rigsby*, 137 S.Ct. 436, 444 (2016). "[T]he [involved act's] structure shows that Congress knew how to draft the kind of statutory language that petitioner seeks to read into [a certain section.]" And specifically applicable here where the Entity-Unifiers are so explicit, "[there is a] general principle that Congress' use of 'explicit language' in one provision 'cautions against inferring' the same limitation in another provision." *Id.* at 442, *citing, Marx v. General Revenue Corp.*, 133 S.Ct. 1166, 1177 (2013).

After 1974: Additions of Employee-Count Tests to ERISA

As set out above, the Original ERISA had no Employee-Count Tests. But Congress later added these:

• §210(e)(2)(A)[85] — for purposes of special rules for "eligible combined plans." The test, defining "small employer," appears in IRC, §4980D(d)(2)(A), with a number (modified from 50 to 500 for §210(e)(2)(A)), and includes the often-used Employee-Count Aggregator using IRC, §414(b), (c), (m) and (o).[86]

• §712(c)(1)(B)[87] — for purposes of exemption from mental health and substance use disorder parity. The 50-employee test defines "small employer," and includes the Employee-Count Aggregator using IRC, §414(b), (c), (m) and (o).

• §4222(f)(3)(A)[88] — affecting withdrawal liability dispute procedures. The 500-employee test defines "small employer," and includes the Employee-Count Aggregator, in subpar. (B), based on "common control" per §4001(b)(1),[89] whose substance draws from IRC, §414(c).

Notably, all three provisions make largeness a detriment to the employer, plan, etc., in that having an employee count less than the stated number for "small" status gives relief from, or

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[85] 29 U.S.C. §1060(e)(2)(A). Such subsec. (e) was added in 2006 by Pub. L. 109–280, §903(b)(1).

[86] See above, fn. 82 on the additions of IRC, §§414(m) and (o).

They are exceptions to the trend that all Entity-Unifiers considered here trace to an express incorporation of IRC, §1563(a). But both subsections draw on similar concepts of organizational control, and/or connection. For subsec. (m), an "affiliated" group of "service organization" involves both "regular[]" or "significant" performance of services within the group, and ownership relations like shareholder, partnership, or holding of a percent of interests.

Subsec. (o) states an open-ended policy, that "shall" be effected by Treasury regulations, to "prevent the avoidance of [certain] employee benefit requirement[s] … through the use of … separate organizations [etc.]." This description presupposes that there is *some person* with the ability to "use separate organizations," which person is like the controlled group expressly mentioned in other Entity-Unifiers. Its attention to a decision to "use" separation suggests regarding that person's unity as the truer reality, as discussed above, fn. 78, and separation is disfavored. Moreover, the aim is to *help* employee/participants by unification, in complete contrast to the harmful effect of the Association Clause, if the Aggregation Theory were true.

[87] 29 U.S.C. §1185a(c)(1). Such §712 was added in 1996 by Pub. L. 104–204, title VII, §702(a).

[88] 29 U.S.C. §1401(f)(3)(A). Such subsec. (f) was added in 2004 by Pub. L. 108-218. Sec. §1301(b)(1) is 29 U.S.C. §4001(b)(1), whose language was in Original ERISA.

[89] 29 U.S.C. §1301(b)(1). It is an Entity-Unifier that, of its own force, applies to all of ERISA, Title IV. Its "common control" concept applies to all trades or businesses, under prescribed PBGC regulations that must be "consistent and coextensive" with Treasury regulations for IRC, §414(c). Therefore §4001(b)(1), too, substantively refers back, via IRC, §414(b), to IRC, §1563(a). See above, text accompanying fn. 81.

easing of, obligations. Again, the proposed use of the Association Clause as an Employee-Count Aggregator is just the opposite. Indeed, these three provisions share all the points of contrast with the Association Clause discussed above (points (A) – (D) near fn. 83) about explicitness,[90] and use only of a kind of unification — ownership and control — where it makes inherent sense to treat the scenario as one entity, and so in turn to count the workforces as one.

The HIPAA additions of Employee-Count Tests and Aggregators

The HIPAA Congress enacted its clear Employee-Count Aggregator, applicable to its interest in counting employees to distinguish large and small employers, for certain issues in the new Title XXVII:[91] §2791(e)(6)(A). It used the often-used standard, importing control and ownership concepts, of reference to IRC, §§414(b), (c), (m) and (o): "[A]ll persons treated as a single employer" under those provisions, "shall be treated as 1 employer." In much the same way as for the ACA version, the employee-count aggregation effect is indisputable: Employee-count is the only question in the involved subdivision for which treating employers as one, could matter. And the catchlines confirm.

A search through the two committee reports readily available for Pub. L. 104-191 show no discussion at all of complications about the definitions of "large" and "small," or of "employee" and "employer."[92] There are just bare-bones listings of those terms as among those being defined, and for the latter two that they are incorporated from ERISA. In the conference report, see Item IX at 232 – 233 (1996 U.S.C.C.A.N. 2045 – 2046). As to "employer" and ERISA, §3(5), there is no mention of doing anything remarkable, like making it into an Employee-Count Aggregator. Indeed the report does not even mention that the clear aggregator — eventual PHSA, §2791(e)(6)(A)— was attached to the large/small definitions. The committee said all it had to say about employee count, through the bill text for those definitions and their aggregator.[93]

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[90] Thus, for each of these three Employee-Count Tests, their own Employee-Count Aggregator refer expressly to it, and of course there is no reference to the Association Clause, i.e., to criteria for being a BFGAE. Moreover, combing all of today's ERISA, there appears to be not one explicit reference to the clause, which might be flagged by appearance of the phrase "association of employers," or even to §3(5). As discussed above, near fn. 30, and well recognized by MEWA Guide, the Association Clause does operate by implicit reference in §3(1) by being the definition of "employer," to play the important role in the definition of "EWBP."

[91] They concerned "guaranteed issue," and disclosure, in (pre-ACA) §§2711 and 2713.

[92] These are H.R. Rep. No. 104-496 (March 25, 1996) and H.R. Conf. Rep. No. 104-736 (July 31, 1996), *reprinted at* 1996 U.S.C.C.A.N. 1865 et seq., and also available through — https://www.congress.gov/bill/104th-congress/house-bill/3103/committees.

[93] By contrast, an Employee-Count Test was drafted as to availability of "medical savings accounts," and the committee gave substantial attention to a difficult employee-count issue there, of going above and below the line of 50 from year to year. H.R. Conf. Rep. No. 104-736 at 283 – 284.

Thus, in HIPAA's text and history, there is only confirmation of the trend of Congress "knowing how to" write a true Employee-Count Aggregator, and no help for the Employee-Count Aggregator claim about the Association Clause.

Effects on Other Provisions Where Employee Count Matters and §3(5) Applies

The legally "large" status that Labor desires to give to employers that are actually small has an apparent effect on other laws that count employees, which the 2018 NPRM does not discuss. This section of this comment had more impact in 2018, when the Trump Administration was moving to increase the prevalence of BFGAEs. This commenter pointed out the boomerang effects for "good-to-be-small" provisions.

Yet even with the criteria returning to their previous narrowness, these effects might still be realized. This commenter sees no reason why such "enlargement," by a legal fiction, would not extend to IRC, §4980H (popularly called "the employer mandate") and IRC, §45R (tax credit for smaller employers that provide health insurance).

For both, large status is a detriment to employers; it is "good to be small." But the Aggregation Theory, supposedly, makes small employers "large" and imposes that detriment. This effect may be so jarring to understandings of all about the ACA's scheme as to work a *reductio ad absurdum* of the underlying Aggregation Theory.

Other commenters in 2018 also raised, at least, the §4980H problem. Labor offered no analysis of it, at one point ducking the issue as one within Treasury's jurisdiction and "outside the scope of this rulemaking." 83 Fed. Reg. 28932, n. 51. But earlier, at 28915, col. 3, Labor seemed to reject outright that §3(5) and the Aggregation Theory would apply "for purposes of taxation."

Technically, the route from §4980H to ERISA, §3(5) does not run through definitions of "large employer" in ACA, §1304(b)(1) or PHSA, §2791(e)(2), because §4980 coins a new term, "applicable large employer" at subsec. (c)(2)(A). But the definiens there uses the word "employer" (omitting details, one is to see if the "employer … employed … at least 50 full-time employees"). Then sub-sec. (c)(6) provides: "Any term used in this section which is also used in the [ACA] shall have the same meaning as when used in such Act."

"Employer" is a term used in §4980H, and in the ACA, looking at matters it added to Title XXVII. One need look no farther than the enhanced guaranteed issue section, PHSA, §2702 (42 U.S.C. § 300gg-1). Its sub-sec. (a), newly written by ACA, §1204(4), and uses the word "employer" simpliciter (in case one quibbles over it appearing many times in Title XXVII as part of "large employer" or "small employer").[94]

[94] It might not even be necessary to look in Title XXVII for an ACA-added use of "employer," because of ACA, §1551 (42 U.S.C. § 18111), the default incorporation — for all of ACA, Title I, thus IRC §14980H — of all the PHSA, §2791 definitions. That also could suffice as the ACA, namely in §1551, "using" all the imported terms.

Thus, the Title XXVII definition at §2791(d)(6) applies, which imports ERISA, §3(5). Then, by the fiction of the Aggregation Theory, the employees of the members of the BFGAE are, in law, "employees" of the BFGAE. They are the individuals who count for the phrase "[a BFGAE] who employed …" The theory makes otherwise sub-50-employee employers into over-49-employee employers; and the definitional element for the subsection-(b) tax[95] will have been met.

The triggering clause for that tax is sub-sec. (b)(1)(B): "1 or more full-time employees of the applicable large employer has been certified to the employer under [ACA, 1411] as having enrolled for such month in a qualified health plan [with a premium tax credit under IRC, §36B] allowed or paid with respect to the employee." Again one can substitute "BFGAE" for "employer." Suppose what is likely, due to the Aggregation Theory, that a given BFGAE is an "applicable large employer" under §4980H(c)(2)(A). Again one substitutes "employees of the members of the BFGAE" for "employees" in sub-sec. (b)(1)(B). With those substitutions, and one such employee taking the §36B credit, the tax is imposed. [96]

It might seem at first that the applicability of §4980H is moot, because in every case where a BFGAE does exist for health coverage purposes, coverage is being offered that might make all employees ineligible for the IRC, §36B credit, per its subsec. (c)(2)(B). But not all coverage meets the minimum-value and affordability tests of §§36B(c)(2)(C)(i) and (ii), excepting from subsec. (c)(2)(B). While some coverage inherently exists if BFGAE status is attained, it is not legally required to meet those tests to attain that status. Surely the text of ERISA, §3(5) does not so suggest. Failure to meet them is exactly how IRC, §§4980H(b)(1)(A) and (B) can both be true: Coverage is offered, but it is of low quality. And the subsection-(b) tax is imposed.

Thus, the Aggregation Theory expands the reach of the "employer mandate." A BFGAE might either pay the tax,[97] or at least experience the strictures of the minimum-value and affordability rules.

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[95] That is, the tax within §4980H that is distinguished from that of subsec. (a) in that the employer did "offer[] [certain coverage] to its full-times employees," per subsec. (b)(1)(A).

[96] In New York, Labor Brief (Appendix 3) did not duck the issue, but attempted to resist that result, at 22 – 23. It cited a Treasury Q&A, which was conclusory, and then offered its own argument, which appeared to rest on a Supreme Court case suggesting that enacted definitions could sometimes be disregarded. But it would require contextual considerations, which Labor Brief did not make. The disregard as to §4980H would be best explained by the extra-statutory agenda of nullifying some ACA requirements while not increasing others, requiring that sauce for the goose *not* be sauce for the gander. The District Court had correctly seen the link to §3(5), beginning with §4980H(c)(2)(6), though not spelling out where in Title XXVII "employer" was used. 363 F. Supp. 3d at 121, n.6. It concluded that Labor's goose-not-gander "outcome appears to be foreclosed by statutory language …" But any hard consequences the court drew from this anomaly are not obvious.

[97] Under the concluding matter of subsec. (b)(1), the tax presumably falls on "the employer," that is on the BFGAE, recalling that the BFGAE substitutes for "the employer" here, and in every IRC section added or affected by ACA, Title I.

Similar results appear to hold for the §45R credit, omitting the walk-through of its language here. It may be that, from now, few additional small employers would use their two years of availability for the subsidy, and it was never generous in amount. Also, small employers seeking both to join a BFGAE and use §45R could apparently not have avoidance of EHB (ACA, §2707) as a goal, because the credit requires "qualified health plans" per ACA, §1301(a)(1), which must be EHB-complaint. Subpar. (B). Nevertheless, some small employers might see §45R as advantageous. But if they are in a BFGAE they might find, if Labor's Employee-Count Aggregator claim becomes effective, that they have been made not small.

Countervailing effects of that claim seem to spread elsewhere — anywhere ERISA, §3(5) is applicable, directly or by some path of incorporating references. So, there seems no reason it does not spread to the three provisions in today's ERISA with Employee-Count Tests, set out above at notes 85 - 89 and surrounding text. For the second of those — in ERISA, §712 — the direct applicability of §3(5) is clear, carrying with it — by supposition — employee-count aggregation over a BFGAE.[98]

Difficult issues of ERISA, §3(5) applicability, set out in the margin, also attend IRC, §4980D — the excise tax on any non-compliance with IRC, Ch. 100, which post-ACA takes in most of the ACA market reforms in PHSA, Title XXVII. Section 4980D includes, by an Employee-Count Test, substantial relief for small employers (50 employees and under) at subsec. (d)(2)(A). If such small employers form a BFGAE, and §3(5) does apply, carrying with it — by supposition — the employee-count aggregation effect, those employers cease to be small and lose that relief.[99]

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[98] There may be reasons to dispute such applicability for the first and third of those, not explored here.

[99] To explore the issues of §3(5) applicability: IRC, §4980D was not originally a part of ACA, Title I, but added by HIPAA: §402(a). And the PHSA, §2791 definitions impliedly apply to all of Title XXVII, but not elsewhere, without more.

A path from §4980D(c)(2)(A) to ERISA, §3(5) can still be made out, as follows. The ACA dramatically expanded the scope of IRC, §4980D(a) of "the requirements of chapter 100 [IRC, §§9801 et seq.] (relating to group health plan requirements)." The ACA added to such chapter 100, §9815, providing in subsec. (a)(1) that all requirements — with two exceptions made by §9815(b) — of PHSA, Title XXVII, Part A "shall apply to group health plans," etc., making them requirements of Ch. 100, and in turn encompassed by IRC, §4980D(a).

Such §9815 was part of ACA, Title I (added by subsec. (f) of its second §1563, like as subsec. (e) of that §1563 folded PHSA, Title XXVII into ERISA, at §715).

The question then is, what is the definition of "group health plan" in IRC, §9815(a)(1)? ACA, §1551 applies at first blush to this Title I language, making PHSA, §2791(a)(1) superior. It mainly adopts the EWBP definition at ERISA, §3(1).

But IRC, §4980D(f)(1) had adopted a "group health plan" definition in a pre-ACA provision in IRC, Ch. 100, §9832(a). In turn, that adopts the "group health plan" definition given by IRC, §5000(b)(1). The latter has similarities to ERISA, §3(1) in requiring involvement of an "employer" or "employee organization." But it is not

As outlined above, Labor has attempted to resist these consequences, by assertion, a bit more in *New York*. This commenter submits, though, that the statutes that lead to them do not provide any "opt-out" to Labor, or to employers. BFGAE members would not be able to pick and choose the effects of their manufactured "large" status that they like. When Congress creates an option, it knows how to do so clearly, generally using the word "elect," and has often done so in the IRC. An example is in the tax version of the mental health and substance use disorder parity requirement, IRC, §9812, where subsec. (c)(2) provides an exemption arising from compliance-cost increases, that a plan may "elect[] to implement," par. (2)(E)(i), or not, par. (2)(A).

Labor or Treasury also would have no statutory authority to ignore these hypothetical effects. Once BFGAE status exists, and were the law to have it entail aggregation of the employee count, the obligations and possible taxes would also exist. The problem causing these incongruities is in the Aggregation Theory, not in the paths to ERISA, §3(5) that Congress has enacted.

Conclusion

Along with rightly abandoning the 2018 criteria expansion, Labor should abandon the Aggregation Theory. Perhaps it should collaborate with CMS for this, e.g., where CMS promulgates a rule clearly negativing the theory.

The conundrums reviewed at the outset continue to plague the issue. But it should be kept in mind that no CMS expression of the theory, including its foundational one in the 2011 Bulletin, is a C.F.R. rule promulgated under the rulemaking requirements of the APA. Thus that

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necessarily bound by ERISA's definition of "employer," §3(5), with its Association Clause and — by supposition — the Employee-Count Aggregator claim.

Deciding this question may depend on the "unless specifically provided for otherwise" clause of ACA, §1551. Does the chain of pre-ACA definitions, IRC, §§4980D(f)(1) to 9832(a) to 5000(b)(1) count as one "specifically provided for otherwise"? Alternatively, is "provided for" understood to mean "provided for by ACA, Title I itself"? To follow on the latter alternative, a place to "specifically provide[] for" a non-PHSA, §2791 definition might have been in IRC, §9815 itself — being within ACA, Title I. It might have stated that it is the IRC, §5000(b)(1) definition attached to "group health plan" as it appears in §9815. That might have shed the Aggregation Theory attached by way of ERISA, §§3(1) and (5), to the PHSA, §2791(a)(1) definition of "group health plan." But no such thing appears in IRC, §9815.

Supposing that the IRC, §9815(a)(1) sense of "group health plan" equates to that of the ERISA, §3(1) EWBP, does the effect of the Employee-Count Aggregator claim — here supposed *arguendo* to attach to the word "employer" in §3(1) — then carry eventually over the reference in IRC, §4980D(a) to the requirements of Ch. 100? That is, does that meaning of "employer" — for which "BFGAE" is to be substituted — include the employee count of the BFGAE?

If yes, then small employers become large employers, and lose the relief given by §4980D(d)(2)(A).

bulletin does not have the force and effect of law. *Chrysler Corp. v. Brown*, 441 U.S. 281, 313 (1979).

Labor's citing to that bulletin in preambles has added nothing to its legal status. As opposed to rule text, rulemaking preamble matter, though it can have relevance for interpreting rule text, and be necessary to satisfying APA requirements, like the 5 U.S.C. §553(c) condition upon that the agency "consider[] the relevant matter presented, [and] incorporate in the rules adopted a concise general statement of their basis and purpose," is not part of the 5 U.S.C. §551(4) "rule" that goes through the 5 U.S.C. §553 process to attain first-instance force and effect of law.[100] With the Aggregation Theory now affecting actors in the field only through sub-regulatory matter, a first fairly effective step, as a practical matter, would be to negative it in preamble, or other "guidance."

In sum, the Aggregation Theory is an unauthorized modification of ACA, §§1304(b)(1) and (2), the general Employee-Count Test that determines the correct group market.

Respectfully submitted,

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[100] *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290, 297 (D.C. Cir. 2018), citing *Wyeth v. Levine*, 555 U.S. 555, 575–577 (2009), *Nat. Res. Def. Council v. EPA*, 559 F.3d 561, 565 (D.C. Cir. 2009). Also, while the regime of "*Chevron*" deference may be presently under review, the Supreme Court has held, *Christensen v. Harris County*, 529 U.S. 576, 587 (2000), that such deference does not apply to non-APA-promulgated material, "which lack the force of law."