TESTIMONY OF TIMOTHY STOLTZFUS JOST ON MEWA AND ASSOCIATION HEALTH PLAN BILLS

My name is Timothy Stoltzfus Jost. I am an emeritus professor at the Washington and Lee University School of Law. I taught ERISA in health law courses for many years and am the author of the ERISA sections of West Publishing Company's Health Law teaching book, now in its eighth edition, which for many years has been the most widely used book for teaching health law in American law schools. I have followed the implementation of the Affordable Care Act since its inception until the end of 2017 at the Health Affairs blog and continue to follow ACA regulations and court decisions. I was from 2011 until 2017 an appointed consumer representative to the National Association of Insurance Commissioners. I am an elected member of the National Academy of Medicine.

I am writing to express my concern about multiemployer welfare arrangement (MEWA) and Association Health Plan (AHP) bills pending before the General Assembly this term. Although the numerous MEWA and AHP proposals differ in their particulars, they are all intended to allow small businesses and self-employed individuals to risk select out of the common risk pools created by the Affordable Care Act. This will inevitably have the effect of increasing the cost of health coverage for older individuals or small groups and for people with pre-existing conditions. See https://www.cbpp.org/research/health/association-health-plan-expansion-likely-to-hurt-consumers-state-insurance-markets

Some of these bills offer some protections against risk selection, such as prohibiting preexisting condition exclusions and gender rating, but others permit 4 to 1 ration for age rating (compared to 3 to 1 under federal law) and all would generally allow selection of some groups or individuals to the exclusion of others. Some also allow underwriting individual small groups based on their claims experience. To the extent associations and MEWAs actually lower health coverage costs, it will undoubtedly be because of risk selection and thus at the expense of others in the health insurance market.

If the concern motivating these bills is really lowering health care costs for individuals and small groups, the General Assembly and Bureau of Insurance would be better advised to review insurer rate proposals more carefully and discourage excessive profiteering by insurers. Federal law requires individual and small group insurers to spend at least 80 percent of their premium revenues on enrollee claims costs (that is, to have at least an 80 percent medical loss ratio or mlr) or rebate the difference to consumers. For 2020, Virginia insurers rebated $234 million to their consumers. Virginia had for 2020 the highest mlr rebates of any state, the highest in the small group market, and the second highest in the individual market (behind Texas). https://www.cms.gov/files/document/2020-rebates-state.pdf We don't need association health plans to lower premiums, we just need to ride closer herd on insurance company profiteering.

Each of these Bills Conflicts with Federal Law

Although MEWAs and AHPs are not identical, each of these bills would allow the establishment of entities that would be regulated as employee plans under the federal Employee Retirement Income Security Act (ERISA) rather than under state insurance laws. As currently written, they would be illegal under ERISA because they would allow self-employed persons with no employees to be covered as

employees under an ERISA plan and would allow small groups and individuals to be covered as large groups where associations or MEWAs covered in aggregate more than 50 enrollees.

These are important issues, because under federal law individual and small group plans are treated very differently from large group plans. Federal law, as amended by the Affordable Care Act (ACA), applies a number of consumer protection and insurance stabilization provisions to the individual and small group markets that are not applied to the large group market. These include, for example, the essential health benefits and metal level actuarial value requirements (42 U.S.C. 300gg-6, 18022), strict limitations on underwriting criteria, including rules that do not permit premiums to vary more than 3 to 1 based on age (42 U.S.C. 300gg), the single risk pool requirement (42 U.S.C. 18032), and participation in the risk adjustment program. (42 USC 18063). It was the clear intent of the drafters to keep the individual and small group and large group markets separate, providing special protections to the individual and small group markets where the worst problems were being experienced in the pre-ACA market and fewer constraints on the large group market which was better functioning.

Although association health plans can legally cover small groups or individuals, they can only do so if they cover small groups under small group market rules and individuals under individual market rules. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr The AHP and MEWA bills currently before the General Assembly would violate this requirement by attempting to aggregate small groups and individual self-employed individuals into large groups.

Market Definitions Under Federal Law

42 U.S.C. 18024(a)(2) defines the individual market to mean "the market for health insurance coverage offered to individuals other than in connection with a group health plan." Section 18024(a)(1) defines group market to mean a plan "maintained by an employer," while section 18024(b) defines a "small employer" as employing an average of at least 1 employee but no more than 50 employees.

In other words, if an individual and his or her family is insured independent of group coverage, the individual has individual coverage. If the individual is covered as an employee of an employer that has at least one employee, the coverage is group coverage. If an employer has 50 or fewer employees, it is a small employer. But what if an individual owns a business and claims to employ him or herself, and to be his or her only employee? Individual or small group coverage?

42 U.S.C. 18111, the definitions section of the ACA, incorporates into the ACA the definitions found in 42 U.S.C. 300gg-91, the definitional section of the Public Health Services Act (PHSA). 42 U.S.C. 300gg-91 defines "individual market" to mean: 'the market for health insurance coverage offered to individuals other than in connection with a group health plan." The section proceeds: "In general subject to clause (ii), [The individual market] includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year." The provision does go on to say that employers with fewer than two employees may be regulated by states as small group coverage. This begs the question, however, of whether business owners can be considered to be their own employees, and if so, can they be treated as small groups even though they have no actual, common law, employees.

The PHSA (42 USC 300gg-91) defines group health plan by reference to ERISA section 3(1); employee by reference to ERISA 3(6); and employer as follows: "The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002 (5)], except that such term shall include only employers of two or more employees." That is to say, employer-owners without any employees do not qualify under the ACA as employees.

The reforms and amendments of the ACA apply to ERISA plan. 29 U.S.C. 1185D, added by the ACA, provides: "the provisions of part A of title XXVII of the Public Health Service Act [The ACA's insurance reforms] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart." This section further provides that "to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply." If a provision or interpretation of ERISA conflicts with the ACA, that is, the ACA governs.

Self-employed Individuals Without Employees Must be Insured as Individuals, not as Groups

ERISA regulation 29 CFR 2510.3-3, adopted in 1975 and in force at the time the ACA was adopted, provides:

> (a) General. This section clarifies the definition in section 3(3) of the term "employee benefit plan" for purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit plans within the meaning of section 3(3) of the Act. Under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I.
> (b) Plans without employees. For purposes of title I of the Act and this chapter, the term "employee benefit plan" shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. . ..
> (c) Employees. For purposes of this section:(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

In other words, for purposes of Title I of ERISA—the title where its primary health plan obligations are found--a working owner with no employees cannot be treated as employees and thus as plan participants unless other, non-owner, employees also worked for the firm.

The proposed bills are no doubt based on an association health plan rule promulgated by the Trump Administration Labor Department. This rule, defining "employer" for purposes of ERISA, was adopted at 83 Fed. Reg. 28,912 (June 21, 2018), and codified at 29 C.F.R. pt. 2510. It would have allowed "working owners," that is sole proprietors without any employees, to qualify as both employers and employees for purposes of ERISA.

This rule was set aside and invalidated by an order of Judge John D. Bates of the federal court of the District of Columbia on March 28, 2019. His order was appealed to the District of Columbia Court of Appeals, but that Court has not yet decided the appeal. In fact, the D.C. Circuit has continued the case, presumably indefinitely, until the Biden administration promulgates a new association health plan rule. The district court order is still in effect, therefore, and the rule remains invalid. The earlier understanding of ERISA, under which self-employed persons with no employees could not be participants in an ERISA plan, remains in place

In justifying covering "working owners" without employees through group association health plans, the Trump administration cited the Supreme Court's opinion in Yates v. Hendon, 541 US 1 (2004), Yates concluded that a working owner with at least one employee could be an employer and thus a plan participant protected by ERSA, resolving a long-standing dispute on this issue. Footnote 6 in the Yates case, however, stated:

> Courts agree that if a benefit plan covers only working owners, it is not covered by Title I. See, e.g., Slamen v. Paul Revere Life Ins. Co., 166 F.3d 1102, 1105 (CA11 1999) (sole shareholder is not a participant where disability plan covered only him); In re Watson, 161 F.3d 593, 597 (CA9 1998) (sole shareholder is not a participant where retirement plan covered only him); SEC v. Johnston, 143 F.3d 260, 262—263 (CA6 1998) (owner is not a participant where pension plan covered only owner and "perhaps" his wife); Schwartz v. Gordon, 761 F.2d 864, 867 (CA2 1985) (self-employed individual is not a participant where he is the only contributor to a Keogh plan).

The cases cited by Yates recognize the long-standing position of the federal agencies that an ERSIA plan must have at least one employee participant other than the owner to be a group health plan. For example, 42 USC 300gg-21(d), which allowed partners in partnerships to be participants in group health plans, recognizes that self-employed individuals can only become plan participants if one or more employees are eligible to be participants in the plan as well as the partner.

Insofar as the proposed bills would allow self-employed persons with no employees to be covered by an ERSIA MEWA or AHP plan, they violate federal law and should not be adopted.