Comment: Definition of Employer – Association Health Plans, EBSA-2023-0020)

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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 ninth edition and for many years 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. 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 write these comments in support of the Department of Labor's proposal to rescind it 2018 association health plan rule, which was not only ill-advised from a policy perspective, but also violated the Affordable Care Act (ACA) insofar as it allowed owners of businesses who have no employees to be covered through the group rather than the individual market. Indeed, the preamble to the 2018 rule suggested that an AHP could be formed composed solely of, "working owners" who have no employees.

I also urge the Department to go further and not only rescind the 2018 rule but to adopt a new clear rule on definition of employer that would not allow association health plans to include "working owners" that do not have common law employees other than the employers. **But please do not delay rescinding the 2018 rule while you proceed with drafting a new rule.**

Under the 2018 rule an AHP could be comprised of participants who are common law employees, common law employees and working owners, or comprised of only working owners. In all cases, the working owner could be treated as an employee and the business as the individual's employer for purposes of being an employer member of the association and an employee participant in the AHP. This violates the ACA.

The ACA applies a number of consumer protection and insurance stabilization provisions to the individual market 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 (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 group markets separate, providing special protections to the individual market where the worst problems were being experienced in the pre-ACA market and fewer constraints on the group market which was better functioning.

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 on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year."

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. 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" again 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, however, that employers with fewer than two employees may be regulated by states as small group coverage. This begs the question, however, as to whether business owners can be considered to be their own employees, and, if so, they may 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) ("The term "employee" means any individual employed by an employer"); 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 is in conflict with the ACA, that is, the ACA governs.

Under the ACA, an employer without at least one employee cannot be a group. The question to be resolved becomes, therefore, whether a "working owner," with no employees other than the owner can be a group health plan and whether a working owner with no other employees can be the sole employee of him or herself?

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.*
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> *(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 could not be treated as employees and thus as plan participants unless other, non-owner, employees also worked for the firm.

In justifying covering “working owners” without employees through group association health plans, the 2018 rule preamble cited the Supreme Court’s opinion in Yates v. Hendon, 541 US 1 (2004), Yates concluded that a working owner could be an employee and thus a plan participant protected by ERSA, resolving a long-standing dispute on this issue.

It is important to observe, however, footnote 6 in the Yates case, which 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 Yates court also acknowledged that this was the position adopted by the Solicitor General’s brief submitted as Amicus Curiae (p. 18, n.9), which acknowledged that owners without any employees might qualify for ERISA plan participation for Title II, but not for Title 1 (or Title IV).

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.

Yates cites several cases in footnote 6 for the proposition that “if a benefit plan covers only working owners, it is not covered by Title I.” Schwartz v. Gordon, 761 F.2d 864 (CA 2, 1985), develops most fully the rationale for this position:

Title I of ERISA, 29 U.S.C. Secs. 1001-1461, which was enacted in 1974, applies only to an "employee benefit plan," 29 U.S.C. Sec. 1003(a). It establishes federal "standards of conduct, responsibility, and obligation," 29 U.S.C. Sec. 1001(b); see 29 U.S.C. Secs. 1101-1114, that must be observed by the fiduciaries of such plans and violations of which are remediable in "Federal courts" and form the predicate of the present action. The statute authorizes the Secretary of

Labor to "prescribe such regulations as he finds necessary or appropriate to carry out the provisions" of the Act, 29 U.S.C. Sec. 1135.

The Act defines an "employee benefit plan" as "any plan ... established or maintained by an employer ... that ... (i) provides retirement income to employees, or (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond," 29 U.S.C. Sec. 1002(2)(A) (emphasis supplied). The term "employee" is defined by the statute as "any individual employed by an employer," 29 U.S.C. Sec. 1002(6).

Dr. Schwartz argues that in the absence of an express exclusion of plans established by self-employed individuals like himself (and Title I does exclude certain types of retirement plans) such persons must be deemed "employees" and their retirement plans "employee retirement plans" covered by Title I. We disagree. In the first place, in 1975, one year after Title I was enacted, the Secretary of Labor promulgated regulations pursuant to Congress' express delegation of rule-making authority to him. 40 Fed.Reg. 34526 (Aug. 15, 1975). These regulations clarify the statutory definition of "employee benefit plan" in various respects and provide in pertinent part:

"(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. For example, a so-called 'Keogh' or 'H.R. 10' plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under Title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals are participants covered under the plan, will be covered under Title I." (Emphasis supplied). 29 C.F.R. Sec. 2510.3-3(b).

Supplementing this interpretation, the regulations exclude from the definition of "employee," "[a]n individual and his or her spouse" employed by a trade or business when one or both of them wholly owns the company. 29 C.F.R. Sec. 2510.3-3(c)(1).

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Dr. Schwartz' contention that the Secretary of Labor's regulation is "at odds with the statute, the legislative history and case law" must be rejected. On the contrary, the legislative history of Title I of ERISA, which appellant confuses with that of Title II, is plainly consistent with the regulation. Congress enacted the Self-Employed Individuals Tax Retirement Act of 1962 for the purpose of encouraging self-employed persons to establish their own individual "Keogh" or "H.R. 10" pension plans by offering them favorable tax benefits. Toward that purpose it shortly thereafter changed the definition of "employee" in the Internal Revenue Code to include a self-employed person. See 26 U.S.C. Sec. 401(c). Title I, on the other hand, was adopted by Congress in 1974 for entirely different purposes, one of which was to remedy the abuses that existed in the handling and management of welfare and pension plan assets that constitute part of the fringe and retirement benefits held in trust for workers in traditional employer-employee relationships. See S.Rep. No. 127, 93d Cong., 1st Sess. 3-5, reprinted in 1974 U.S. Code Cong. & Ad. News 4639, 4838, 4839-42. Workers in such traditional employer-employee relationships are more vulnerable than self-employed individuals to abuses because the workers usually lack the control and understanding required to manage pension funds created for their benefit and to establish

adequate vesting, funding and participation standards. As a result, many employees who had been led by collective bargaining agreements to rely on future pension benefits as a form of deferred wages, see id., suffered serious hardships when the promised funds largely evaporated as a result of mismanagement. See, e.g., 119 Cong.Rec. 30003 (1973) (remarks of Sen. Williams); 120 Cong.Rec. 4279 (1974) (remarks of Congr. Brademas).

A self-employed individual who voluntarily decides to set aside a portion of his income for his own retirement, unlike a worker employed by another, has complete control over the amount, investment and form of the fund created by him for his retirement. The remedial scheme established by Title I for workers employed by others was therefore not necessary for the protection of self-employed persons, and Congress accordingly has not changed the definition of "employee" in that Title to include self-employed persons. The change of the definition in Title II, on the other hand, was necessary to make more equitable the tax treatment of plans set up by self-employed individuals compared to that of other plans. S.Rep. No. 383, 93d Cong., 1st Sess. 9, reprinted in 1974 U.S. Code Cong. & Ad. News 4890, 4897.

Thus the legislative history supports the distinction drawn by the Secretary of Labor between the definition of "employee benefit plan" as used in Title I for protection of workers employed by others and the definition of the term as used in Title II to insure tax benefits on an equal basis to self-employed individuals and others with respect to their retirement funds. Indeed, although the definition in Title I has been in effect and applied since 1975 and Congress has twice amended ERISA's definition sections, it has left the Title I definitions of employee and employee benefit plans standing, thus adding weight to the Secretary's explicit construction of the terms. Board of Governors v. First Lincolnwood Corp., 439 U.S. 234, 248, 99 S.Ct. 505, 513, 58 L.Ed.2d 484 (1978).

By excluding from the definition of an employee benefit plan only those plans with no employees, the Secretary's regulation implicitly leaves within the scope of Title I any plans that include both the retirement assets of the self-employed and the assets of their employees. Under some circumstances, the reasoning behind this approach is clear: when the assets of employees and a self-employed employer are commingled, for example, the only way to assure the needed protection for the former is to protect the latter as well. Under other circumstances, however, protection for the self-employed employer may seem unnecessary to guard the interests of employees, as when the assets of each are kept in wholly segregated accounts within a plan.

We cannot say, however, that the Department of Labor was unreasonable in its apparent decision to afford employers in the latter situation the protection of ERISA Title I. The line drawn by the Department of Labor regulation simply excludes from Title I coverage those plans, such as Schwartz', in which there are no employees and for which the fiduciary protections afforded by the Act are accordingly least important. That there may be another category of plans that should arguably be excluded does not weigh in favor of expanding the scope of the Act to take in the Schwartz plan.

In the preamble to the 2018 proposed rule, DOL claimed that Yates' holding that self-employed working owners can be plan participants supported its position that working owners can get small group coverage (or participate in large group coverage through an association) even if they have no other employees. Yates in fact addressed a different question—assuming that an owner has other employees in a plan, can it also be a participant? This is the question the Yates Court answered, but is not the

question addressed, incorrectly, by the DOL 2018 AHP rule. The question of whether a working owner without employees can qualify as a group plan participant was answered by the Schwarz case and similar cases, and the answer is no.

The Department of Labor has also consistently recognized that if individuals do not qualify as employers for purposes of establishing group health plans, they cannot participate in MEWAs as employers. As reiterated in a 2017 Advisory Opinion, "where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employer, and where control of the group or association is not vested solely in employer members, the group or association is not a bona fide group or association of employers for purposes of ERISA section 3(5). See, e.g., Advisory Opinion 94-07A."

The Department of Health and Human Services has also long recognized that the large group, small group, and individual markets are distinct, and that individuals who are not employees of employers cannot be covered by group health plans. Congress established the structure for three markets under HIPAA in 1996. Federal interpretation of the three distinct markets and the "look through" treatment for AHPs is well documented in CMS Guidance issued in 2002 [Program Memorandum Insurance Commissioners and Insurance Issuers, Centers for Medicare and Medicaid Services, Transmittal No. 02-02 (August 2002); 02-03 (August 2002); 02-04 (September 2002); and 02-05 (September 2002).]. Individuals have individual, not group coverage.

In 2010, three and a half decades after ERISA was adopted and over a decade after HIPAA, Congress enacted the ACA. When "Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute." Lorillard v. Pons, 434 U.S. 575, 581 (1978)

In adopting the ACA, which clearly distinguishes between individual and group insurance markets and provides special protections for the individual market, which it regarded as peculiarly vulnerable, Congress was aware of the way in which "working owners" were treated in ERISA regulations and case law and of HHS insurance market definitions and adopted these definitions. The ACA market definitions do not allow DOL to treat "working owners" without employees as group rather than individual market participants. "Working owners" without employees should be left in the individual market where Congress left them.

There is also a practical reason to rescind the 2018 rule's coverage of working owners without common law employees through group AHPs. The preamble of the 2018 proposed rule discussed the possibility of abuses if AHPs are simply allowed to market coverage to individuals without an employment relationship and claimed that it does not authorize this. If individuals can claim to be "working owners" simply by attestation, these abuses will obviously occur, contrary to the stated intention of the DOL in 2018. This will not only mean that individuals are receiving coverage through fraudulent misrepresentations, but that such individuals will be vulnerable to post-claims underwriting and rescissions if they incur significant medical costs. The fact that the DOL 2018 rule contained no meaningful procedures for determining whether people who claim to be working owners in fact are, makes it all the more urgent that "working owners" only be allowed to participate in AHPs if they are in fact employers of employees other than themselves. This is what the ACA and sound public policy require. The 2018 rule violated the law and should be rescinded. Even better, a new rule should be promulgated clearly providing that AHPs cannot include working owners without employees.

While it is important that the Department rescind the 2018 rules' language permitting an association health plan to cover "working owners," it is important to continue to recognize the 2018 rule's position that "working owners" must in fact be working. Yates recognized that a working owner of a trade or business who employed at least one employee other than the employer and the employer's spouse could also be considered an employee and participate in an ERISA plan. This assumed, however, that the employer was actually also an employee, working for the trade or business.

Even though a shareholder in a corporation may be an owner, unless the shareholder is actively involved in the work of the corporation, the shareholder cannot be a working owner participant in the corporation's ERISA plan. Similarly, although a bona fide partner can be a participant in an ERISA plan covering the trade or business for which the partner works, a partnership formed solely to market health insurance to the partners cannot offer an ERISA plan to the "partners", because it does not exist in the context of an employer-employee relationship.

Under the 2018 rule, a "working owner" of a trade or business must work an average of 20 hours a week or 80 hours per month for the trade or business, or at least earn enough in wages to cover the cost of the working owner's cost of coverage. Although this rule may not offer a full definition of what it means for a working owner to "work," it at least offers a minimum. In rescinding the 2018 rule, the Department should make it clear that an association health plan that markets health coverage to individuals cannot be an ERISA plan unless those covered by it are actually employees, including working owners who actually work.

Although I do believe that it would be best if DOL established a clear rule on definition of employer, **it is essential that DOL proceed expeditiously to rescind the 2018 rule, and then propose a permanent rule with a definition.**