DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

August 29, 2022

Scott White
Insurance Commissioner
Virginia Bureau of Insurance
PO Box 1157
Richmond, VA 23218

Dear Commissioner White:

I write on behalf of the Department of Health and Human Services (the Department) regarding HB 768/SB 335 (2022)[1] (generally referred to as the state law or the Virginia law in this letter). This legislation, recently enacted by the Virginia General Assembly and signed by the Governor, allows an association of real estate salespersons to purchase health insurance coverage in the large group market in Virginia, effective July 1, 2022.

Having reviewed HB 768/SB 335 and following discussions with the Virginia Bureau of Insurance on May 4, 2022, the Department is concerned that these amendments to state law are inconsistent with the individual and small group market requirements under title XXVII of the Public Health Service Act (PHS Act) and title I of the Patient Protection and Affordable Care Act (ACA) (collectively, the federal market reforms). Those requirements include the ACA's rating reforms as well as the medical loss ratio, rate review, and risk adjustment programs. This letter explains how the federal market reforms apply to health insurance coverage sold to or through an association described in the Virginia law, discusses the Department's concerns in more detail, and seeks information to help the Department assess whether the Commonwealth of Virginia should retain primary enforcement authority of those provisions with respect to issuers offering health insurance coverage in connection with such an association in Virginia.[2]

Description of State Law

HB 768/SB 335 amends and reenacts § 38.2-3521.1 of the Code of Virginia, relating to health insurance; association health plan for real estate salespersons. The state law allows a health insurance issuer to issue a large group policy of accident and sickness insurance to an association of real estate salespersons[3] under certain conditions, including that the association must have at

[1] *See* https://lis.virginia.gov/cgi-bin/legp604.exe?221+ful+CHAP0349+pdf and https://lis.virginia.gov/cgi-bin/legp604.exe?221+ful+CHAP0350+pdf.

[2] This letter does not constitute notice pursuant to 45 CFR 150.211 and 150.213 that the Department has begun the investigatory process described in 45 CFR 150.209 through 150.219 to determine whether the state is substantially enforcing the federal market reforms. However, information collected as a result of this letter may be used as part of such an investigation.

[3] "Real estate salesperson" means any individual, or business entity, who for compensation or valuable consideration is employed either directly or indirectly by, or affiliated as an independent contractor with, a real estate broker, to sell or offer to sell, or to buy or offer to buy, or to negotiate the purchase, sale or exchange of real estate, or to lease,

the outset a minimum of 25,000 members and meet certain other criteria. Under the state law, members of the association include employers with at least one employee that is domiciled in the Commonwealth of Virginia or certain self-employed individuals.[4]

The state law provides that health insurance coverage issued to such an association, which is deemed the policyholder, will be considered a large group market policy subject to the large group market and group health plan coverage requirements under the PHS Act and the ACA. The state law also requires the policy to comply with the requirement to provide essential health benefits and cost-sharing requirements as set forth in § 38.2-3451 and to provide an actuarial value of at least 60 percent. Further, the state law provides that the issuer of the coverage must rate the group as a single risk pool and set premiums on the basis of the collective group experience. Under the state law, premiums for the association coverage cannot vary based on gender or health status of an individual employee or self-employed individual, but may vary by age within a 4:1 ratio.

How the Federal Market Reforms Apply to Coverage Sold to or Through an Association described in the Virginia law

The Department has issued regulations and guidance explaining how the federal market reforms apply to health insurance coverage sold to or through associations.[5] In short, the test for determining whether health insurance coverage offered through an association is group market coverage, or individual market coverage, for purposes of the federal market reforms, is the same test as that applied to health insurance offered directly to employers or individuals. If the health insurance is offered in connection with a group health plan as defined in section 2791(a)(1) of the PHS Act and 45 CFR 144.103, it is considered group market coverage for purposes of the federal market reforms. If the health insurance offered to an association member is offered other than in connection with a group health plan, the coverage is generally considered individual market coverage for purposes of the federal market reforms.[6]

For the purpose of determining whether any particular insurance coverage is group rather than individual coverage within the meaning of title XXVII of the PHS Act, it is irrelevant whether

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rent or offer for rent any real estate, or to negotiate leases thereof, or of the improvements thereon. § 54.1-2101 of the Code of Virginia.

[4] A self-employed individual is defined as an individual who: (a) has an ownership right in a "trade or business," regardless of whether the trade or business is incorporated or unincorporated, (b) earns wages or self-employment income from the trade or business, and (c) works at least 20 hours a week or 80 hours a month providing personal services to the trade or business or earns income from the trade or business that at least equals the self-employed individual's cost of the health coverage. § 38.2–3521.1(G)(1) of the Code of Virginia.

[5] *See* 45 CFR 144.102(c). *See also* CMS Insurance Standards Bulletin Transmittal No. 02-02, 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 (Aug. 2002), available at https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/HIPAA-02-02.pdf; and CMS Insurance Standards Bulletin, 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 (Sept. 1, 2011), available at https://www.cms.gov/cciio/resources/files/downloads/association_coverage_9_1_2011.pdf.

[6] *See* 45 CFR 144.103 for the definitions of group market and individual market. *See also* section 1304(a)(2) of the ACA.

there is an association involved, and it is also irrelevant whether state law classifies association coverage as "group" coverage for purposes of state insurance laws.

Under section 2791(a)(1) of the PHS Act, the term "group health plan" is defined by reference to the term "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974 (ERISA). The definition of "group health plan" in title I of the ACA cross references section 2791(a)(1) of the PHS Act.[7]

An employee welfare benefit plan is defined in section 3(1) of ERISA to include, among other arrangements, "any plan, fund, or program…established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants, or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . ." (Emphasis added). The term "employee organization" is defined in section 3(4) of ERISA, as explained in more detail below. The term "employer" is defined in section 3(5) of ERISA as ". . . any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." The ERISA definition of "employer" includes the "direct" (or common law) employer of the covered employees or "any person acting… indirectly in the interest of" the common law employer.[8]

The Department of Labor has taken the view that, in the absence of the involvement of an employee organization, a single "multiple employer" plan may exist as a group health plan when a cognizable group or association of employers acting as an employer establishes a benefit program for the employees of member employers and exercises control over the amendment process, plan termination, and other similar functions on behalf of these employer members with respect to the plan and any trust established under the program.[9] These entities are generally referred to as "bona fide" employer groups or associations under the Department of Labor's guidance.[10]

Thus, in order to be an employee welfare benefit plan, a plan must, among other criteria, be established or maintained by an employee organization, by an employer, or by both. It appears, however, that the association described in the Virginia law could not establish or maintain a plan

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[7] *See* section 1301(b)(3) of the ACA. *See also* section 1304 of the ACA for definitions relating to markets and employers in title I of the ACA.

[8] ERISA section 3(5). *See also Nationwide Mutual Insurance Co. et al. v. Darden*, 503 U.S., 318, 112 S. Ct. 1344(1992).

[9] Advisory Opinion 2008–07A. Although not implicated with respect to the association described in the Virginia law, the Department of Labor has recognized certain other ways in which groups of employers can participate in a single ERISA plan, for example, because they share substantial common ownership (e.g., a controlled group of corporations).

[10] *See*, e.g., Advisory Opinions 2008–07A, 2003–17A and 2001–04A. *See also* Advisory Opinion 96–25A (stating that, if an employer adopts for its employees a program of benefits sponsored by an employer group or association that does not itself constitute an "employer," such an adopting employer may have established a separate, single-employer benefit plan covered by Title I of ERISA).

under either ERISA definition, including as a bona fide employer group or association under the Department of Labor's guidance.

Definition of Employee Organization under ERISA Section 3(4)

Section 3(4) of ERISA, in relevant part, defines the term "employee organization" to mean "any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan." The association described in the Virginia law does not appear to be one in which "employees participate" or that exists "for the purpose, in whole or in part, of dealing with employers . . ." Furthermore, in several opinion letters, the Department of Labor has identified several necessary criteria for purposes of determining what constitutes an "employees' beneficiary association" as that term is used in section 3(4) of ERISA. One of those criteria is that membership in such an association must be conditioned on employment status -- for example, where membership is limited to employees of a certain employer or members of one union.[11] However, membership in the association described in the Virginia law is not conditioned upon one's employment status but rather is open to both employers and self-employed individuals.

Definition of Employer under ERISA Section 3(5)

Additionally, it appears that the association, as described by the Virginia law, cannot establish or maintain a plan as an "employer" within the meaning of ERISA section 3(5). The association is not the direct or common law employer of the association members.

Nor can the association as described by the Virginia law establish or maintain the plan on the theory that it is a bona fide group or association of employers acting in the interest of its employer-members to provide benefits for their employees.[12] The Department of Labor's guidance states that when membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employers (such as members who are not common-law employers) or where control of the group or association is not, directly or indirectly, vested solely in employer members, in form and in substance, the group or association is not a bona fide group or association of employers for purposes of ERISA section 3(5) and cannot act as an "employer" sponsor of a group health plan covering individuals who are not employees of employer members of the group or association.[13] The association described in the Virginia law is open to real estate professionals regardless of their status as employers (such as

[11] *See, e.g.*, ERISA Advisory Opinion 91-42A (Nov. 12, 1991).

[12] *See*, e.g., Advisory Opinion 2008–07A; U.S. Department of Labor, Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation (2022), available at 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.

[13] *See* Advisory Opinion 2003-13A.

self-employed real-estate professionals without common law employees) and therefore the association cannot act as the employer sponsor of a group health plan.[14]

Discussion of Federal Market Reforms

For the reasons discussed above, each member of an association described in the Virginia law must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer. Under the federal market reforms, the group market is divided into the small group market and the large group market, depending on the number of employees employed by the employer.[15] Coverage issued through an association described in the Virginia law to a small employer-member (generally meaning an employer with 50 or fewer employees) would be subject to the federal market reform requirements applicable to the small group market, while coverage issued through an association described in the Virginia law to a self-employed individual, without any common law employees, would be subject to the federal market reform requirements applicable to the individual market. This is true regardless of whether the association is deemed the policyholder for purposes of state law.

The requirements applicable to individual and small group (or merged) market coverage include, among others, the community rating rules under section 2701 of the PHS Act (restricting premium variation to certain specified factors), rate review under section 2794 of the PHS Act (establishing a process to determine whether rate increases are unreasonable), and the single risk pool provision under section 1312(c) of the ACA (establishing a specified rating methodology for individual and small group (or merged) market coverage). Moreover, the experience of enrollees in health insurance policies issued to individuals and small employers must be categorized in the individual or small group (or merged) market, respectively, for purposes of section 2718 of the PHS Act (relating to the medical loss ratio) and section 1343 of the ACA (relating to risk adjustment).

Federal Preemption Standard

Section 2724(a) of the PHS Act and section 1321(d) of the ACA, respectively, specify that state law will generally be preempted only to the extent it prevents the application of a provision of title XXVII of the PHS Act or title I of the ACA. The Department's guidance explains state law "prevents the application" of a PHS Act provision if the state law makes it impossible for an issuer to comply with federal law. If a state law simply permits, but does not require, an action that is prohibited under federal law, the state law would not be applicable. The issuer simply could not take advantage of the state law provision.[16]

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[14] The Department of Labor previously issued a final regulation creating a different pathway for associations to achieve association health plan status. That regulation has since been vacated by a district court. *See State of New York, et al. v. United States Department of Labor*, et al., 363 F.Supp.3d 109 (D.D.C. 2019). The Department of Labor's appeal of the decision in the Court of Appeals for the District of Columbia Circuit remains pending. Thus, the rule cannot supply a basis for the association to achieve association health plan status.

[15] *See* section 2791(e)(2) – (5) of the PHS Act and section 1304(a) and (b) of the ACA. *See also* 45 CFR 144.103.

[16] *See* Section IV, HCFA Program Memorandum, The Relationship of Certain Types of State Laws to the Application of the Guaranteed Availability Requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in the Small Group Market, Program Memorandum/Insurance Commissioners/Insurance Issuers,

The Virginia law requires issuers to rate coverage offered to an association of real estate salespersons based on a separate, experience-rated risk pool. This provision, if applied to coverage that is individual or small group (including merged) market coverage under federal law, would make it impossible for an issuer to comply with the ACA's single risk pool requirement, and accordingly, would be preempted. Furthermore, the Virginia law classifies coverage offered to an association of real estate salespersons as being in the large group market for state law purposes and permits premiums to vary up to a 4:1 ratio based on age. This ratio, however, exceeds the 3:1 ratio permitted by federal law. Therefore, issuers offering non-grandfathered small group or individual health insurance coverage through an association described in the Virginia law are not permitted to take advantage of this state law provision to vary premiums.

Issuers also must use the relevant market classifications under the federal market reform framework for purposes of determining which federal requirements apply, including the risk adjustment, rate review, single risk pool, and medical loss ratio requirements.[17] The Virginia law will be preempted or will not apply to the extent it prevents the application of these or other federal market reforms.

Enforcement of Federal Market Reforms

Pursuant to section 2723 of the PHS Act and section 1321(c)(2) of the ACA, states have the opportunity to be the primary enforcers of the federal market reforms applicable to health insurance issuers that issue, sell, renew, or offer health insurance coverage in the individual or group market in the state.[18] In the event the Centers for Medicare & Medicaid Services (CMS) determines that a state is not substantially enforcing one or more of the federal market reform requirements with respect to health insurance issuers, CMS is responsible for enforcement of those provisions in the state.[19] Any issuer subject to CMS' enforcement authority that fails to comply with an applicable provision of title XXVII of the PHS Act or title I of the ACA may be subject to a civil money penalty.[20]

If CMS assumes enforcement authority of one or more federal market reforms in Virginia, CMS may take enforcement action against any issuer that fails to comply with applicable federal requirements, including in situations where the issuer otherwise received approval from the state to offer such coverage. In addition, CMS would review policy forms and rate filings of issuers and perform market conduct examinations or conduct investigations, as necessary, to ensure compliance with the requirements that CMS is responsible for enforcing. If any issuer subject to CMS enforcement authority does not comply with applicable federal market reforms that CMS is responsible for enforcing, CMS may impose a civil money penalty of up to $100 each day, as

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Transmittal No. 00-03 (June 2000), available at https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/HIPAA-00-03.pdf.

[17] *See, e.g.*, 45 CFR 153.20, 45 CFR Part 153, Subparts D, G, and H (risk adjustment); 45 CFR 154.102 and 154.103 and 76 FR 54969 (Sept. 6, 2011) (rate review); 45 CFR 156.80 (single risk pool); 45 CFR 158.103 and 158.120 and MLR Annual Reporting Form Filing Instructions for the 2021 MLR Reporting Year, pp 6-7, available at https://www.cms.gov/files/document/2021-mlr-form-instructions.pdf (medical loss ratio).

[18] *See* section 2723(a)(2) of the PHS Act and section 1321(c)(2) of the ACA.

[19] Ibid. *See also* 45 CFR 150.101, et. seq.

[20] *See* section 2723(b)(2) of the PHS Act and section 1321(c)(2) of the ACA.

adjusted under 45 CFR Part 102, for each responsible entity, for each individual affected by the violation.[21]

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I ask for your assistance in ensuring that consumers in Virginia receive all the protections they are entitled to under the PHS Act and the ACA. Please respond within 30 days of the date of this letter to indicate whether the Virginia Bureau of Insurance will enforce applicable federal market reform requirements, consistent with the information outlined above regarding the Department's regulations and guidance, with respect to coverage sold through an association of real estate salespersons described in the Virginia law.

For further information, please contact Jacob Ackerman, Senior Advisor, Center for Consumer Information & Insurance Oversight, by email at jacob.ackerman1@cms.hhs.gov or phone at 202-641-8967.

Sincerely,

Chiquita Brooks-LaSure

[21] *See* sections 2718(b)(3) and 2723(b)(2) of the PHS Act and section 1321(c)(2) of the ACA. *See also*, e.g., 45 CFR 150.315, 153.740, 156.805, and 158.606.