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Senator Claire Ayer, Chair
Senate Committee on Health and Welfare
State House
Montpelier, VT 05602

Re: S. 53, An Act Relating to Universal Primary Care

Dear Senator Ayer:

As a result of communications with Deb Richter, MD, and others, I am of the understanding that testimony has been presented to your Committee to the effect that certain provisions of federal law prohibit the enactment of a primary care delivery system such as is contemplated in S. 53. I am also under the impression that you might be interested in hearing other perspectives on this question.

As a preliminary matter, I should note that I am a lawyer without a client in these circumstances. Neither am I a lobbyist paid to influence a legislative interest. I am simply expressing my personal views as a resident of this State with a long-standing interest in affordable, accessible health care for all Vermonters, and as a lawyer with some legal expertise in health care and health insurance law and regulation by virtue of my past service for the Vermont Legislature, for the Vermont Department of Financial Regulation (formerly BISHCA), and for the Rhode Island Office of the Health Insurance Commissioner.

I understand that it has been claimed that federal law relating to Health Savings Accounts ("HSA"), and the Employee Retirement Income Security Act of 1974 ("ERISA") preempt (i.e. "prohibit") the enactment and implementation of a separate delivery system for primary care in Vermont. I am not aware of any actual legal analysis, written or otherwise, supporting such claims. From my perspective, based on a preliminary analysis of the question, these federal laws do not conflict with the concept of a universal primary care system, for the following reasons:

<u>Health Savings Accounts</u>

- My understanding of the HSA claim asserted by others is that a Vermont resident would not be eligible to purchase a High Deductible Health Plan ("HDHP"), and make contributions to an HSA because the primary care delivery system contemplated by S.

53 would be considered health plan coverage which is not an HDHP under federal law.

- The federal law applicable to HSA's is found at 26 U.S.C. § 223 of the Internal Revenue Code. See also IRS Publication 969 https://www.irs.gov/publications/p969#en_US_2016_publink1000204041
- The Internal Revenue Code defines an "eligible individual" for HSA purposes as someone who is covered under an HDHP and is not covered under any health plan which is not a high deductible health plan. 26 U.S.C. § 223(c)(1)(A).
- There is no specific definition of "health plan" in the statute; however, the statute generally speaks to coverage provided under an insured or self-insured plan. See, for example, § 223(c)(2)(B) and (C). In contrast, the primary care system envisioned in S. 53 is designed as an alternative to health insurance coverage that is different in its fundamental concept to a health insurance plan.
- I am not aware of any IRS rule or guidance which would prohibit individuals from purchasing an HDHP and making contributions to an HSA if the individual was also eligible to receive health care at, for example, a Federally Qualified Health Center, or an Indian Health Services clinic, or any other health service delivery system similar to such as is being proposed in S. 53.

The Employee Retirement Security Act of 1974

- My understand of the ERISA claim is that because ERISA prohibits an employer from eliminating primary care coverage in its health plan, employers would be left in the position of having to pay twice for the same benefits (by insurance premium or employer contribution, and by any revenue source used to fund the universal primary care system). A related claim seems to be that the Affordable Care Act prohibits a qualified health plan to "carve out" preventive care as a covered benefit. See ""Cost Estimates for Universal Primary Care", submitted to the Legislature in December, 2015, page 17.
- I do not disagree that ERISA and the ACA prohibit a state from eliminating coverage for primary care or preventive care in certain circumstances. A basic principle of ERISA is that it preempts states from imposing benefit plan mandates on self-insured plans. Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985). The ACA is quite clear that both primary care and preventive services must be covered in a qualified health plan, and in certain group health plans. 45 C.F.R. § 147.130 (preventive care); 45 C.F.R. § 147.150 (essential health benefits). However, I do not see any language in S. 53 that would require health plans to eliminate preventive services or primary care coverage. I envision

that under a universal primary care delivery system, primary care and preventive care would continue to be covered under such health plans in accordance with the law, even if the incidence of claims might be infrequent; for example, a need for primary care when traveling out of state.

- As for "paying twice", I am confident that Vermont health insurance regulators would ensure that the premium cost of a qualified health plan under the ACA, or an insured health plan under ERISA would take into account the actual, lower insured expenses for these services. Likewise, employer contributions under a self-insured ERISA plan undoubtedly would reflect the actual, lower expenses for these services.

In summary, I urge the Committee to carefully consider the public policy issues raised by S. 53. I also urge that you not truncate starting that important public policy discussion because of what appears to me to be unfounded legal assertions concerning a universal primary care delivery system.

I am happy to answer any questions the Committee may have concerning these matters. I wish you well in your work this session.

Sincerely,

Herbert W. Olson

cc: Faith Brown, Committee Assistant
Maria Royle, Legislative Counsel