AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

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Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans (RIN 1210-AB85)

Dear Deputy Assistant Secretary Wilson:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the proposed rule, Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA maintains that the proposed rule will weaken the individual and small group markets that are critical sources of coverage for people with preexisting conditions who require habilitative and rehabilitative services and devices. While the effects of the rule may lower costs and offer more choice for some small employers, it would also increase costs and limit choice for all other employers and individuals in less-than-perfect health. Additionally, the history of association health plans (AHPs) is one of fraud and insolvency that leaves consumers with unpaid medical bills and no health coverage.[1]

Currently, state insurance commissioners have broad oversight and regulatory authority of AHPs. However, the proposed rule could impede states' rights and create a mechanism to supersede or override state mandates, which might limit state authority in the future.[2] Specifically, ASHA questions if states under the proposed rule would be allowed to require coverage of essential health benefits (EHBs).

This letter includes ASHA's comments on the following provisions outlined in the proposed rule:

- Individual and Small Group Markets
- Essential Health Benefits
- Request for Information about Required Notices
- Health Nondiscrimination Protections

Individual and Small Group Markets

The Department of Labor (Department) states that the proposed rule will provide additional opportunities for employer groups or associations to offer coverage alternatives to small businesses that are more affordable than insurance currently available on the individual and small group market.

However, the only way that the coverage will be more "affordable" is if it has fewer protections against fraud and insolvency, covers fewer benefits, or syphons healthier individuals and small groups from other markets.

While implementing current federal law, the Centers for Medicare & Medicaid Services (CMS) provided guidance to bring AHPs in line with the standards and consumer protections mandated in federal statute. CMS required that health insurance policies sold through an association to individuals and small employers must be regulated under the same standards that apply to the individual market or the small-group market.[3] Because of this guidance, known as the "look through" doctrine, the coverage was required to comply with the established protections for people with preexisting conditions and other standards such as EHBs. By exempting an AHP from the "look-through" doctrine, plans offered to working owners and small employers would be exempt from the requirement to provide EHBs including rehabilitative and habilitative services and devices. ASHA is concerned that this will take consumers and patients back to before the mandate for comprehensive insurance coverage to address unexpected injuries and illness, when plans frequently failed to meet the needs of individuals and families.

In addition, the proposed regulation would create an uneven playing field between AHPs and the individual and small-group markets. AHP plans could be structured and marketed to attract younger and healthier individuals because the rule would subject AHPs to substantially weaker standards than those plans that are currently subject to federal requirements in the individual and small group markets. This would pull young and healthier individuals out of the ACA-compliant small group market and potentially leave older, sicker, and costlier risk pools of individuals behind. If healthier individuals and small groups are syphoned from the individual and small group markets, costs will increase, and plan choices will decrease for employers and individuals remaining in those markets. Consumers who need comprehensive coverage, including those with preexisting conditions, and consumers with incomes too high to qualify for subsidies would face rising premiums and potentially fewer plan choices.

ASHA encourages the Department to continue to apply the "look-through" doctrine rather than treat AHPs as large group plans. If an AHP is offering coverage to individuals, including working owners, or small employers, the plans should be required to meet standards and protections set forth in established federal law.

Essential Health Benefits

As a result of the proposed rule, AHPs could substantially scale back their benefits by dropping benefit categories entirely or dramatically limiting them. Consumers with specific health needs would be impacted based on the generosity of the benefits offered. For example, an individual with Parkinson's disease who has difficulty with speech and swallowing requires rehabilitative speech-language pathology services to treat the deficits. Another example is a 3-year-old child with severe congenital hearing loss who requires the fitting of hearing aids and habilitative treatment to develop auditory and speech-language skills provided by both an audiologist and speech-language pathologist.

Rehabilitative services and devices are essential in helping Americans retain, improve, or regain skills and functions that may have been lost or diminished due to an injury, illness, or disability. Rehabilitation is provided to individuals with neurological and medical conditions such as acquired brain injury or disease, stroke, and head and neck cancers. Americans who need habilitative services and devices rely on their health care coverage to: (a) acquire skills and functions that were never

learned due to a disability, and; (b) retain skills so they can live as independently as possible. Habilitation is typically appropriate for individuals with neurological and developmental conditions that—in the absence of such services—prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood. Often skills acquired through rehabilitative and habilitative services and devices lead to breakthroughs in functional ability that would not have been possible without access to timely and appropriate rehabilitation and habilitation benefits. This reduces long-term disability and dependency costs to society.

Before comprehensive coverage of medically necessary services was mandated, few Americans understood what habilitation is or the benefits it brings to those who rely on these services and devices. In fact, only three states adopted coverage requirements for habilitative services in the individual market. Since the enactment of the EHBs, the value of rehabilitative and habilitative services has been widely acknowledged and access to these services has expanded.[4, 5]

One of the criticisms of the EHB requirement is that it significantly increases premiums; however, evidence suggests that other factors may have a greater impact an on premiums. For example, Milliman provides an estimate of the total cost of providing selected hearing services, speech-language therapy, hearing supplies, devices, and related professional services in a commercial employer group population, noting a utilization rate of approximately one per thousand, with PMPM (per member per month) claim costs of approximately $1.48 for 2014. These estimates are based on current levels of coverage, eligibility, and benefit design.[6]

A recent analysis indicates EHBs, if removed, would not notably trim the cost of monthly premiums.[7] Instead, costs borne by consumers would increase considerably. The analysis also finds that rehabilitative and habilitative care represent only 2% of the premium. ASHA remains steadfast in its support for the continued coverage of rehabilitative and habilitative services and devices within the individual and small group insurance markets.

Request for Information about Required Notices

ASHA appreciates the Department's request for information about required notices. If this rule is finalized and AHPs do not meet standards for minimum value, AHPs should be required to provide notice to employer groups and potential beneficiaries. This will ensure that employer groups and employees are aware that the plans are less comprehensive than health plans available in the individual or small group markets. Further, if the AHP does not meet minimum value, the employees and their dependents should be made aware of their right to receive coverage through the health insurance marketplaces, potentially with premium tax credits based on their income. Similarly, AHPs should be required to notify employer groups and potential beneficiaries of any EHBs not covered by their plans.

The Department should clarify that all notice requirements applying to group health plans also apply to plans under this regulation, including notice of appeal rights, summary of benefits and coverage, and summary plan descriptions.

Health Nondiscrimination Protections

ASHA is pleased that the proposed rule applies the Health Insurance Portability and Accountability Act nondiscrimination provisions in § 2590.702(a) and § 2590.702(b) to AHPs. The nondiscrimination provisions prevent AHPs from discriminating based on health status related factors against employers, their employees, or dependents. As proposed, this would prevent AHPs from using health factors to determine eligibility for benefits or in setting premiums. Health factors

include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. ASHA applauds this proposal, as it is essential to help protect both employers and their employees from discrimination based on health status. We strongly encourage the Department to retain this requirement in the final rule and support this provision applying to all AHPs, regardless of when they were established. AHPs currently in operation should also be required to fully comply with nondiscrimination requirements.

While the nondiscrimination protections are an important provision of the proposed regulation, an AHP can engage in other practices that result in discrimination against people with medical needs. The proposal exempts AHPs from federally established consumer protections (e.g., EHBs, guaranteed issue) designed to protect people with preexisting conditions. Consequently, an AHP can avoid covering people and businesses with medical needs. Using benefit design, an AHP can attract healthier groups. For example, individuals and small employers would not necessarily have access to coverage that includes rehabilitative and habilitative services and devices. People who need such coverage would not enroll in an AHP. Also, an AHP could discriminate in rates, charging women higher rates than men, charging smaller businesses higher rates than larger businesses, charging businesses in certain industries higher rates, and charging older people higher rates without limit. These rating practices would result in healthier groups being covered through an AHP.

Failure to extend established federal protections (e.g., EHBs, rate reforms, guaranteed issue) and nondiscrimination protections based on health status to AHPs, could result in increased discrimination.

Thank you for the opportunity to provide comments on the Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans proposed rule. If you or your staff have any questions, please contact Daneen G. Sekoni, MHSA, ASHA's director of health care policy, health care reform, at dsekoni@asha.org.

Sincerely,

Elise Davis-McFarland

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2018 ASHA President

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[1] Keith, Katie. (2018, Jan 5). "The Association Health Plan Proposed Rule: What It Says and What It Would Do." *Health Affairs* [Blog Post]. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20180104.347494/full/.

[2] Lucia, Kevin and Corlette, Sabrina. (2018, Jan 25). "Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency and Market Instability." *The Commonwealth Fund*. Retrieved from http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority.

[3] The Center for Medicare and Medicaid Services. (2011, September 1.) *"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."* Retrieved from https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf.

[4] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/

[5] https://www.healthcare.gov/sbc-glossary/#medically-necessary

[6] Milliman is an actuarial consulting firm with offices worldwide.

[7] Blumberg, Linda and Holahan J. (2017). Urban Institute and The Robert Wood Johnson Foundation. *The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums under the ACA*. Retrieved from https://www.rwjf.org/en/library/research/2017/07/the-implications-of-cutting-essential-health-benefits.html?cid=xem_other_unpd_ini:qs7_dte:20170710.