March 6, 2018

VIA ELECTRONIC SUBMISSION

Secretary R. Alexander Acosta
United States Department of Labor
200 Constitution Avenue, NW
Washington, DC 20120

Re: RIN 1210-AB85

Dear Secretary Acosta:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the Department of Labor's (DOL's) proposed rule entitled "Definition of 'Employer' under Section 3(5) of ERISA—Association Health Plans" which would expand the availability of association health plans (AHPs). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

Introduction

We write today with serious concerns about the proposed rule's **Impact on Older Workers** and its potential to escalate **Fraud and Abuse**.

The passage of the Affordable Care Act (ACA) guaranteed individual and small-group market consumers a basic set of benefits and protections. These protections included a prohibition on discrimination in coverage based on preexisting conditions, limitations on pricing based on age, and access to essential health benefits (EHBs). We are concerned the proposed AHP rule would be a step backwards, undoing these valued protections for some consumers, and leading to rising costs and inadequate health insurance coverage for even more.

The proposed changes may lower costs and create more choices for some small employers, but they would also increase costs and limit choice for all others, and for individuals in less-than-perfect health.

Moreover, the history of AHPs is one of fraud and insolvency—these plans often leave consumers with unpaid medical bills and no health coverage.[1]

Impact on Older Workers

As an organization with a primary focus on older adults, Medicare Rights is especially concerned that this proposal would disproportionately burden people aged 50-64 in the existing small group market. Specifically, the proposed rule would once again allow punitive pricing based on age. Plans would be free to charge small businesses significantly higher rates to cover older workers than younger workers. This would effectively render coverage inaccessible for small businesses with older workers. By contrast, under current law, while older workers have higher rates, they are limited to 3 times more than younger workers.

While an older worker may not be denied coverage outright based on their age or pre-existing condition, the proposed rule would allow AHPs to be formed and designed in such a way that would once again allow discrimination based on a pre-existing condition and higher costs for small employers that employ older workers. Accordingly, AHPs would attract and meet the needs only for a healthier pool, making this coverage option unaffordable for employers with an older workforce or with workers who have pre-existing conditions.

The proposed rule itself provides examples that illustrate the complexity of the proposal.[2] It also shows how discrimination based on a pre-existing condition could be built into an AHP, despite Employee Retirement Income Security Act of 1974 (ERISA) rules. The nondiscrimination standards that DOL relies upon are inadequate to guarantee meaningful consumer protections for older adults and people with pre-existing conditions.

While the proposed rule asserts that AHPs may provide a useful service by helping small employers find insurers or pool administrative services and some risks, this proposal fundamentally undermines the quality, affordability, and availability of health insurance, especially for older workers and people with pre-existing conditions. By permitting an employer to contract for limited benefits, this rule will put families at risk of discovering a major illness is not covered by their plans. A worker may be diagnosed with cancer and, just as they are dealing with the stress of that diagnosis, learn they have inadequate coverage, or no coverage at all. Current law avoids this devastating outcome by requiring employers to provide coverage that includes the EHBs. By reversing these rules, we are taking a step back in time, exposing more working American families to unaffordable costs and inadequate health insurance coverage.

Fraud and Abuse

AHPs have long been used as vehicles for selling fraudulent insurance coverage. In an effort to address this problem, in 1982 Congress amended ERISA to clarify states' authority to regulate association health plans. Many states then moved to limit the potential risks associated with the AHP market, including

[1] Mila Kofman, "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," Georgetown University Health Policy Institute (Summer 2005), https://georgetown.box.com/shared/static/nih75z89vjsawwk0zfwb.pdf.
[2] Definition of "Employer" under Section 3(5) of ERISA—Association Health Plans, pp. 80-82.

fraud, insolvency, and market segmentation. But even with increased oversight, fraudulent insurance sold through associations remained a problem. Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over $252 million in medical bills. For consumers and patients, the results were disastrous: some victims were forced into bankruptcy; others have lifelong physical conditions as a result of delayed or foregone medical care.[3]

The ACA sought to further reduce these risks. As part of the health law's implementation, the Centers for Medicare & Medicaid Services (CMS) provided guidance to bring AHPs in line with the standards and consumer protections in the ACA. 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.[4] Because of this guidance, known as the "look through" doctrine, the coverage was required to comply with the ACA's protections for people with preexisting conditions and other standards such as the essential health benefits.

AHPs also have a long, troubling history of financial instability and insolvency when medical claims exceed the association's ability to pay. Despite the ACA's improvements to the oversight of these plans, there are no federal financial standards in place to guarantee that AHPs will remain financially stable. This accountability gap is especially troubling as the administration seeks to allow AHPs to cover millions more individuals and small employers.

We are extremely concerned that the proposed rule would roll back existing, albeit insufficient, oversight requirements and the ACA's consumer protections. Such changes would once again leave consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, and lifelong health implications—just as AHPs did before the ACA provided more oversight and protection.

In addition, we fear the DOL would not be able to muster the necessary resources to provide legitimate oversight of these new plans. The DOL acknowledges that AHPs have had a long history of fraud and abuse, but it does not identify significant additional resources that will police such plans and ensure that fraud will be minimized. This puts all AHP consumers at risk of discovering they have no coverage when they need it most. Consumers must be able to rely on the health insurance coverage they purchase. Insurance that vanishes in a time of need is not really insurance.

Recommendations

For the reasons outlined above, we do not believe this proposed rule is in the best interest of consumers or the public and private health insurance markets. Accordingly, we respectfully urge the DOL to abandon this line of rulemaking. If the Department does move forward, we ask it to do so in a way that recognizes the unique circumstances facing older workers and people of all ages with preexisting conditions, in part by considering and incorporating the following recommendations:

Any final version of the rule must maintain the ACA's nondiscrimination provisions.

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[3] Mila Kofman, "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," Georgetown University Health Policy Institute (Summer 2005), https://georgetown.box.com/shared/static/nih75z89vjsawwk0zfwb.pdf.
[4] The Center for Medicare and Medicaid Services, "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" (September 1, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf.

The DOL has also requested comments on the types of consumer protections and disclosures that would be needed as part of any final AHP regulation. At a minimum, AHPs should be required to provide notice to employer groups and potential beneficiaries if plans do not meet standards for minimum value. This will ensure that employer groups and employees know 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 must 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 essential health benefits not covered by their plans.

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

The DOL must not move forward without a clear understanding of how the proposed changes would impact health care markets. The proposed rule's own impact analysis acknowledges that there is massive uncertainty in the effect of the AHP rule on consumers: "While the impacts of this proposed rule, and of AHPs themselves, are intended to be positive on net, the incidence, nature and magnitude of both positive and negative effects are uncertain."[5] Rules that risk upending whole market segments must be carefully considered, with robust information gathering and modeling done before the rules are finalized.

To further mitigate this intense uncertainty, we urge the DOL to hold at least one meaningful public hearing on the proposed AHP regulations before finalizing any rules that have the risk of leading to widespread coverage losses, fraud, and abuse. This would allow consumers, experts, and stakeholders to explore what this rule would mean for the health care system as a whole, and for the individual and small group markets in particular.

The final rule must maintain and make clear the states' authority to regulate AHPs.

Conclusion

Thank you for the opportunity to provide comment.

As stated, we have grave concerns that the proposed expansion of AHPs could put consumers at risk of fraud and abuse, preempt state consumer protections and oversight of these insurance products, and greatly increase the likelihood that working Americans, especially those age 50-64, would face higher insurance premiums and loss of access to critical health insurance coverage.

If the DOL insists on finalizing this rule, we strongly urge the Department to keep the ACA's nondiscrimination provisions intact. We also strongly oppose any effort to limit states' authority to regulate AHPs. These protections are critical to stem the damage the rule would cause for insurance markets and consumers themselves.

[5] Definition of "Employer" under Section 3(5) of ERISA—Association Health Plans, pp. 47-48.

For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.