Via Electronic Submission: *Regulations.gov*

March 6, 2018

U.S. 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)

The Center for Medicare Advocacy (Center) is pleased to provide comments in response to the proposed rule, Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans. The Center, founded in 1986, is a national, non-partisan law organization that works to ensure fair access to Medicare and quality health care. At the Center, we provide education and advocacy on behalf of older people and people with disabilities to help secure fair access to necessary health care. We draw upon our direct experience with thousands of individuals to help educate policy makers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that people receive the health care benefits for which they are eligible, and the quality health care they need.

We write with strong objection to the proposed rule on Association Health Plans (AHPs). We have deep concerns that the proposed rule will weaken the individual and small group markets that are critical sources of coverage for people with pre-existing health conditions. The effect of the rule will be lower costs and more choices for some small employers, but, conversely, increased cost and limited choice for others. Moreover, the history of AHPs is one of fraud and insolvency – leaving consumers with unpaid medical bills and no health coverage.

If the Department of Labor ("the Department") moves forward with finalizing this rule, we strongly urge you to maintain the nondiscrimination provisions. We also strongly oppose any effort to limit states' full authority to regulate AHPs. Both are critical to stem the damage that the proposed rule will cause for insurance markets and consumers themselves.

General Comments

Method of Solicitation of Feedback

We encourage the Department to hold a public hearing on the proposed AHP regulations. While public hearings are not mandatory, we understand that the Department has the authority to hold

them and has done so in the past. A public hearing would be another opportunity to get much needed broad-based public input. We continue to strongly urge all federal agencies to be transparent regarding opportunities for public comment and active in promoting such opportunities, in order to gather broad feedback from stakeholders and the general public.

Implement the Affordable Care Act (ACA)

A stated goal of the proposed rule is to "expand access to affordable health coverage…" This objective, with which we agree, will not be accomplished unless the Affordable Care Act (ACA) is fully implemented. The ACA is the law of the land, and the Administration is legally obligated to implement the law as we have stated in various comments submitted to the U.S. Department of Health and Human Services (HHS).

Throughout 2017 we called on the Administration to stop undermining the ACA and protect the care of millions of consumers in need of quality coverage. We highlighted the Administration's actions, including: cutting the ACA enrollment period in half; slashing funding for enrollment assistance; refusing to participate in enrollment events; shutting down www.healthcare.gov during critical times; refusing to pay cost-sharing reductions; and issuing an Executive Order allowing the sale of inadequate insurance plans (such as AHPs).

We have serious concerns about the proposed expansion of AHPs. These plans could weaken the ACA's guaranteed consumer protections, raise costs and destabilize the market. Under the proposed rule, AHPs could be treated like large employer plans, which don't have to play by the same ACA coverage rules as the individual or small group markets.

The American people deserve access to affordable, quality health coverage. We have expressed concerns that the undermining of the ACA has taken a toll. Even though 2017 ACA enrollment exceeded many expectations, the actual number of uninsured people in America has grown steadily in the last year. Nearly 3.5 million Americans have become uninsured since the end of 2016, according to a recent Gallup report, with coverage loss greatest among Latinos, African Americans and young people. This is unacceptable.

We oppose any endeavor to weaken ACA essential health benefits (EHBs) requirements. The ACA requires insurers to cover essential health benefits such as ambulatory services, emergency services, hospitalization, maternity care, mental health and substance abuse, prescription drugs, rehabilitative services, laboratory services, preventive and wellness services, and pediatric services. These benefits are critical for the health and well-being of millions of consumers, including people who are older or have disabilities.

Enhance and Protect the Well-Being of *All* Americans

We encourage DOL and other federal agencies involved in our nation's health care to undertake activities to identify and address health inequities with the ultimate goal of eliminating them. Programs must be unbiased, based on research, evidence, and medical and health-related facts, and must be responsive to individual patient and consumer needs and wishes. Services should be offered to all in accordance with their personal beliefs and convictions.

I. AHPs will weaken the individual and small group markets.

The 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. The only way, however, 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.

As part of the implementation of the ACA, 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.[1] 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.

The proposed regulation would create an uneven playing field between AHPs and the individual and small-group markets. Because the rule would subject AHPs to substantially weaker standards than ACA-compliant plans, the plans could be structured and marketed to attract younger and healthier people, thus pulling them out of the ACA-compliant small-group market and leaving older, sicker, and costlier risk pools 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 pre-existing conditions, and consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

II. AHPs should not be allowed to sell junk insurance and charge higher premiums to businesses based on employees' age, gender or industry.

Currently, as noted above, AHPs are regulated by the "look-through" doctrine set forth in 2011 guidance from CMS.[2] This guidance has the effect of looking through the association to understand who is purchasing coverage through an AHP, and then to determine regulation of the insurance products. Currently, AHP products sold to individuals are considered to be individual market insurance and AHP products sold to small employers are considered to be small group market insurance. The insurance products are then subject to the same requirements and consumer protections that exist in those markets under the ACA.

The proposed regulation would not apply the "look-through" doctrine to AHPs that fit the new definitions of associations in the rule. As a result, an AHP would be treated as a single plan providing large employer coverage, and therefore exempted from the individual and small group market protections.

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 the essential health benefits. Individuals and small employers would not necessarily have coverage that includes benefits such as maternity care, prescription drugs, and mental health and substance use services. We are extremely concerned that this will take consumers and patients back to the days before the Affordable Care Act, when plans frequently failed to meet the needs of individuals and families.

As a result of this proposed rule, AHPs could substantially scale back their benefits, dropping benefits entirely or dramatically limiting them. Limiting plan benefits was a predatory practice that existed before the ACA as a way to discourage anyone with a pre-existing health condition or high expected health care utilization from enrolling in coverage.

The proposed rule puts the economic stability and health of consumers at risk by allowing employers to offer limited coverage that fails to meet the needs of individuals and families. A small employer, for example, with a relatively healthy workforce might offer an AHP with low premiums but that also provides limited benefits. If an employee later develops a health condition such as cancer or HIV, or requires hospitalization – they could suddenly find that necessary care or treatment is not covered.[3]

While the proposed rule prevents health status rating of separate employers, the rule appears to allow groups or associations to base premium rates on any other factor, including gender, age, industry and other factors actuaries create to estimate health care utilization. Plans would be exempt from the rating protections that apply to individual and small group markets. Small businesses with a workforce that is older, disproportionately women, or in industries that are believed to attract high health care utilizers would suffer the most.

The age and industry of employers could lead to higher premiums for employers with older employees or in certain industries because these factors can be used as a proxy for higher health care utilization and/or employees with less-than-perfect health.

We strongly recommend that the Department 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 the ACA.

III. Individuals and small businesses must be notified if AHPs are not meeting minimum value or providing all the essential health benefits.

We appreciate the Department's request for information about required notices. 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 Department 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.

IV. Individuals and small businesses must be protected from discrimination.

We are pleased that the proposed rule applies the HIPAA 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 employer members or employers' 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. This proposal 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 final rule. We support this provision applying to all AHPs, regardless of when in time they were established. AHPs currently in operation should be required to fully comply with nondiscrimination requirements, without exception and without delay.

While this is an important provision of the proposed regulation, it does not go far enough because an AHP can engage in other practices that result in discrimination against people with medical needs. The proposal exempts AHPs from ACA consumer protections designed to protect people with preexisting conditions. An AHP would be exempt from EHB provisions, rate reforms, guaranteed issue and single-risk pool requirements. Consequently, an AHP can simply 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 maternity, mental health benefits, and expensive prescriptions. People who need such coverage would not enroll in AHP coverage. 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. Rating practices would likely result in healthier groups being covered through an AHP.

Furthermore, an AHP could engage in marketing practices targeted at attracting healthier people. An AHP could avoid a geographic area where there is a high incident of cancer rates, heart disease, and diabetes and thereby avoid covering sicker populations. Its geographic location can also be used to engage in redlining practices. An AHP could limit membership to a specific industry that has lower claims than other industries. All of these, and other discriminatory practices, would be allowed because AHPs would be exempt from EHB, rate reforms, and guaranteed issue requirements.

In order to more meaningfully prevent discrimination, the Department should also strengthen the protections in this provision by preventing groups or associations from varying premium rates to different employer members based on gender, age, zip code or other geographic identifier, industry, or other factor that may be used to vary rates based on expected health care utilization. The final rule should also apply EHB, guaranteed issue and single-risk pool requirements. The single-risk pool requirement is an important way to ensure that AHPs, where they exist, do not result in a segmented market.

Failure to extend these protections, in addition to protections against discrimination based on health status, to AHPs will expose employers and their employees to discriminatory practices, including discriminatory rating and marketing practices. Failure to extend these protections will also place the regulated health insurance markets in jeopardy, as AHPs would be free to cherry pick healthy consumers out of the regulated markets, leaving those markets to fail as the risk pool worsens and premiums spiral out of control.

Conclusion

We appreciate the opportunity to submit these comments. For additional information, please contact David Lipschutz, Senior Policy Attorney (licensed in CA and CT), at dlipschutz@medicareadvocacy.org, or 202-293-5760.

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1 The Center for Medicare and Medicaid Services. (2011, September1.) "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 8 February 2018, from https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf.

2 The Center for Medicare and Medicaid Services. (2011, September1.) "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 8 February 2018, from https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/association_coverage_9_1_2011.pdf.

3 Lueck, S. (2018, January 8.) *Trump Rule on Association Health Plans Could Devastate Small-Group Markets*. Retrieved 8 February 2018, from https://www.cbpp.org/blog/trump-rule-on-association-health-plans-could-devastate-small-group-markets.