AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and
CEO

March 6, 2018

The Honorable Alexander Acosta
Secretary
U.S. Department of Labor
200 Independence Avenue, NW
Washington, DC 20210

Re: RIN 1210-AB85; Definition of "Employer" Under Section 3(5) of ERISA–Association Health Plans

Dear Secretary Acosta:

The American Lung Association appreciates the opportunity to submit comments on the proposed rule Association Health Plans (AHPs).

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD. And as such, the Lung Association is committed to ensure all patients have access to quality and affordable healthcare and are treated with guidelines-based care.

In March of 2017 the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, the proposed rule on AHPs would jeopardize access to healthcare that is affordable, accessible and adequate for lung disease patients. AHPs have a history of providing inadequate care to patients. If the Department of Labor (DOL) wishes to change the rules governing AHPs, additional patient protections, including coverage of the Essential Health Benefits, should be required. However, the proposed rule as currently written does not protect patients, and the American Lung Association requests that the Department rescind the proposed rule.

The Lung Association along with 14 patients organizations have outlined major concerns with the proposed rule in the attached comments (see Appendix B), however the Lung Association is a unique position to comment in more detail the issues described below.

Preventive Services

The Lung Association appreciates that AHPs would be required to cover preventive services with no cost-sharing. Current law requires most private health plans to cover preventive services without cost-sharing, including co-pay, co-insurance and deductible. The defined preventive services are any treatment receiving an "A" or "B" from the United States Preventive Services Task Force (USPSTF) and any immunization having a recommendation from the Advisory Committee on Immunization Practices.

These preventive services save both money and lives and are particularly important for lung disease patients. Current preventive services include lung cancer screenings for people at high-risk for lung cancer, which allow lung cancer to be discovered earlier, at a more treatable stage. Lung cancer is currently the leading cancer killer for both men and women in the United States, and the expansion of access to this important screening can save lives. Additionally, up to 50,000 adults die each year from vaccine-preventable diseases.[1] Coverage of preventive services removes the barrier of cost-sharing to getting the influenza, pneumococcal and other vaccines, saving both lives and money. However, while coverage of preventive services at no cost-sharing is critical for lung disease patients, these alone are not adequate coverage, and we again urge DOL to include coverage of all 10 essential health benefits in this rule to ensure that patients have access to all of the services, medications and treatment that they need.

Tobacco Surcharges

The American Lung Association opposed section 2701 of the Affordable Care Act, which allows insurance plans in the individual and small group markets to charge tobacco users up to 50 percent more in premiums than non-tobacco users. This policy will herein be referred to as the "tobacco surcharge."

A health insurance surcharge for tobacco use and what is for many, a chronic disease of tobacco addiction, is likely to produce adverse consequences. There is little evidence that financial incentives or disincentives through insurance premiums change individual behavior. In fact, recent studies from Health Affairs[2] and the Center for Health and Economics Policy at the Institute for Public Health at Washington University[3] have suggested that tobacco surcharges do not increase tobacco cessation. The studies also have data suggesting tobacco users eligible for Marketplace or exchange health plans forgo health insurance rather than paying the surcharge. Tobacco users often have expensive comorbidities. Charging a tobacco surcharge could cause those enrollees to go without coverage and access to preventive care (including tobacco cessation treatments), allowing comorbid health conditions to worsen. This could result in more expensive healthcare being required later on.

Tobacco surcharges are an unproven theory to improve public health – in contrast to several thoroughly tested, evidence-based interventions and policies that are proven to reduce smoking consumption and prevalence. These tools include offering a well-promoted comprehensive tobacco cessation benefit without barriers.

While the Lung Association recognizes tobacco surcharges are legally allowed, currently states are also able to limit or prohibit the surcharge in their state. The AHP rule, if enacted, will take enrollees out of marketplace coverage – coverage that is regulated by the state – and put them in ERISA regulated plans. This will take away the important role of state in regulating health insurance.

The Lung Association also requests DOL hold public hearings on this rule prior to any promulgation of a final rule. This proposed rule on AHPs, if implemented, would impact patients and the public at large with regards to the range of health benefits offered. It is important DOL has ample opportunity to hear from patient voices on access to quality and affordable healthcare. A public hearing, while not required, would provide an additional avenue to hear from patients on how they could be impacted by the proposed rule.

The American Lung Association appreciates the opportunity to submit comments on this important rule and urges the Department of Labor to rescind this proposed rule. As outlined in the attached coalition comments, if proposed, the rule would undermine marketplace stability, jeopardizing access to quality, affordable healthcare for lung disease patients.

Sincerely,

Harold P. Wimmer
National President and CEO

CC: Ms. Jeanne Klinefelter Wilson
Deputy Assistant Secretary for Policy
Employee Benefits Security Administration

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[1] Weinberger B, Herndler-Brandstetter D, Schwanninger A, et al. Biology of immune responses to vaccines in elderly persons. Clin Infect Dis. 2008;46:1078-1084.
[2] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract
[3]Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

Appendix A

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance

must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

Appendix B

March 6, 2018

The Honorable Alexander Acosta
Secretary
U.S. Department of Labor
200 Independence Avenue, NW
Washington, DC 20210

Ms. Jeanne Klinefelter Wilson
Deputy Assistant Secretary for Policy
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: **RIN 1210-AB85; Definition of "Employer" Under Section 3(5) of ERISA– Association Health Plans**

Dear Secretary Acosta and Deputy Assistant Secretary Wilson:

Thank you for the opportunity to submit comments on the Department of Labor's (the Department) proposed rule on Association Health Plans (AHPs). The 15 undersigned organizations urge the Department not to finalize this proposed rule and instead focus its efforts on protecting patients and consumers in order to ensure they will continue to have access to affordable, adequate, and understandable health care coverage.

Our organizations represent millions of patients and consumers facing serious, acute, and chronic health conditions across the country. We have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge

the Department to make the best use of the collective insight and experience our patients and organizations offer in response to this proposed rule.

In March 2017, our organizations agreed upon three overarching principles to guide any work to reform and improve the nation's healthcare system.[1] These principles state that: (1) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need including all the services in the essential health benefit package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. Enrollment should be easy to understand, and benefits should be clearly defined.

Our organizations are deeply concerned about the impact the Department's proposed rule on AHPs will have on the individuals and families we represent. While AHPs can offer cheaper coverage, they frequently do not adhere to important standards, including financial protections and coverage for essential health benefits. AHPs also have a long history of fraud and insolvency and have historically affected small employers and individuals. Many of these plans collected premiums for health insurance coverage that did not exist and did not pay medical claims --leaving businesses, individuals, and providers with millions of dollars in unpaid bills. For consumers and patients, the results were disastrous. Our organizations are extremely concerned that the proposed rule will once again leave consumers in the lurch with insufficient coverage, unpaid medical bills, and lifelong health implications – just as many of these plans did before the Affordable Care Act (ACA) was passed.

In the proposed rule, the Department recommends eliminating and/or altering several standards and regulatory structures that have served to protect patients and consumers, including those related to benefit structure, cost, and oversight. We are deeply concerned about these proposed policies and the potential negative impact on the communities we represent. Therefore, we strongly encourage the Department not to finalize this proposed rule until the needs of our communities have been met. Should you decide to proceed, then any modifications should, at a minimum:

- Require AHPs to comply with the Essential Health Benefits (EHBs) coverage requirements to ensure coverage adequacy, as well as protections from lifetime and annual caps, and annual out-of-pocket maximums;
- Allow the employees of businesses that choose to enroll AHPs to remain eligible for premium tax credits to encourage market choice;
- Require AHPs to provide clear consumer information, including details about coverage, costs, and plan policies, prior to enrollment; and
- Clarify and bolster state regulation of AHPs.

Adequacy

Healthcare coverage for the populations we serve must be adequate, covering the services and treatments patients need, including patients with unique and complex health needs. It is paramount that protections including EHB packages, the ban on annual and lifetime caps, and restrictions on premium rating all be preserved. We are deeply concerned that the AHPs created by this proposed rule

[1] Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

could offer entirely inadequate, even discriminatory, coverage to the communities we represent. Additionally, we are also concerned that some of the proposals included in the proposed rule would make it difficult for consumers to understand their options and make informed choices about the coverage they select. Our organizations emphatically urge the Department to not to finalize the rule or, if unwilling to do so, modify the proposed rule to fully protect consumers and patients against harm.

Essential Health Benefits (EHBs)

One of the most troubling aspects of Association Health Plans is that they are not required to comply with EHB coverage requirements created under the ACA. This proposed rule would regulate AHPs as if they were *Employee Retirement Income Security Act* (ERISA)-governed large-group health plans (sometimes referred to as single multi-employer plans) that do not have to comply with many of the ACA's coverage and adequacy requirements.

This is deeply concerning to our organizations because the individuals we represent rely on the current law's coverage requirements for access to medically necessary care. Prior to the passage of the ACA and creation of the ten EHB categories, patients and consumers often found themselves enrolled in plans that failed to provide coverage for medically necessary care. Patients with serious illnesses would discover they were not covered for new and innovative treatments, some could not get coverage for emergency room services, and patients with chronic illnesses were often denied coverage for life-improving, sometimes even life-saving, medication.

Discriminatory Plan Design

Under the proposed rule, the Department would maintain one of most important patient protections for individuals with pre-existing conditions: guaranteed issue. AHPs would not be allowed to turn away individuals seeking to purchase their plan. They would also be required to treat all enrollees within their plan the same way, and could not deny certain coverage or benefits to one enrollee while offering it to another. These are the same standards under which ERISA-covered employer plans must operate. Our organizations strongly support guaranteed issue and thank the Department for including it in the proposed rule.

However, while this proposed rule would not allow AHPs to offer varying benefit designs to enrollees based upon health factors, it would allow AHPs to offer differing coverage to groups of enrollees based upon non-health related factors. These factors could include gender, age, employee classifications, locations, or any other non-health criteria that could stratify the plan beneficiary population. Therefore, AHPs could structure their coverage and benefit designs using "non-health related factors" to effectively exclude entirely classes of beneficiaries with higher rates of illness and disease.

Furthermore, even if AHPs chose to offer uniform coverage to all beneficiaries regardless of any non-health related factor, they are still allowed to freely structure their benefit design in any way they see fit. This allowance would once again allow discriminatory plan design that excludes benefits for patients with certain health and preexisting conditions.

Consequently, under this proposal, AHPs could design a plan that excludes coverage for medically-necessary prescription drugs, certain specialists who treat particularly expensive conditions, or other medically necessary care for individuals with chronic conditions. According to the Kaiser Family Foundation, approximately 27 percent of American adults currently have a condition that would result in

being denied health coverage.[2] Of Crohn's & colitis patients surveyed before the implementation of the ACA, 42.5 percent of those who sought insurance coverage had specific health conditions excluded from their coverage.[3] Our patients could once again face these same coverage denials within AHPs under this proposed rule, resulting in entirely inadequate coverage.

This allowance for discriminatory benefit design completely undermines the guaranteed issue requirement by enabling AHPs to de facto deny coverage to individuals with pre-existing conditions by creating "non-health" classifications with substantially weaker coverage, or by refusing to offer coverage for the specific care they need.

Network Adequacy

AHPs would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant Qualified Health Plans (QHPs) must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, oncology, maternity and newborn care, mental health, and emergency services, AHPs are not required to comply with these standards.

This is particularly concerning for our organizations as we represent the individuals who are most in need of access to emergency services, outpatient care, and specialty physicians. These physicians and health services are also often the most expensive. Without regulation and oversight of network adequacy within AHPs, as this proposal would allow, the physicians and services patients rely on could be excluded from AHP provider networks altogether. For example, AHPs may choose to exclude all cardiologists, oncologists, or specialty clinics from their provider networks. They may also include facilities or specialists in the network that are far too distant from beneficiaries to be accessible.

ACA Section 1557 Nondiscrimination Protections

Under our interpretation of the proposed rule, AHPs would only be required to comply with ACA section 1557 nondiscrimination requirements if the entity offering the plan receives Federal financial assistance.[4] Understanding that AHPs may be operated by a variety of entities, we envision many AHPs would be exempt from ACA section 1557 requirements, potentially subjecting our patients to harmful discriminatory policies.

Consumer Education and Transparency

As advocates for health care consumers, many of whom live with serious, acute, and chronic health conditions, our organizations are concerned that employers and prospective enrollees of AHPs will not be sufficiently informed about these products prior to enrollment. Our experience prior to passage of the ACA suggests that many patients were confused about what a policy did and did not cover due to a lack of required transparency, resulting in cases of medical debt and bankruptcy[5]. Patients were also forced in some cases to delay or forgo treatment. We are concerned that we will see a dramatic

[2]Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, and Karen Pollitz, "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Found. Issue Brief, Dec. 12, 2016, available at https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

[3] Rubin DT, Feld LD, et. al. Crohn's & Colitis Foundation of American Survey of Inflammatory Bowel Disease Patient Health Care Access. *23*(2), 224-232.

[4] Department of Health and Human Services, "Section 1557: Frequently Asked Questions", available at https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html#_ftnt32.

increase in these outcomes if AHPs are made easily available to consumers without clear transparency about what they do, and do not cover.

Survey data, focus group testing and academic research on Americans' understanding of health insurance reveals serious deficiencies in comprehension of the common language and concepts of health plans. Research has highlighted evidence of Americans' health and health insurance literacy including: nearly nine out of ten adults had difficulty using health information to make informed decisions about their health[6]; 51 percent of respondents did not understand the basic health insurance terms premium, deductible and copay; and only 16 percent could calculate the cost of an out-of-network lab test.[7] Consumers Union has cautioned that it is not enough to know the difference between premiums, deductibles, and copays, one must also understand how these costs must be sequenced to understand how health insurance must be viewed in the context of real world health care needs.[8]

We note that the ACA sought to address many of these concerns by implementing new and evolving measures to help inform and educate consumers about health insurance, including the online Marketplaces, the Summary of Benefits & Coverage, Glossary of Health Care Terms and Actuarial Value, and for some, access to new professional insurance counselors with no vested interest in consumers' choice of health plan. These resources are helping consumers make more informed choices by presenting and explaining details about coverage, costs, and plan policies. Yet because most of these helpful tools would not be required resources of AHPs, prospective enrollees of AHPs would not benefit from them, improvements in health care and health insurance literacy could be reversed, and more Americans would be at risk of being under-insured once more. This lack of transparency is particularly concerning as it relates to AHPs because of the history of fraud and insolvency. Consumers have grown accustomed to being able to purchase a high-quality plan on the marketplace and may not even realize these plans to not meet those same standards.

Affordability

Our organizations recognize that illness impacts individuals across the economic spectrum. We believe that everyone – regardless of their economic situation – should be able to obtain the treatment they require. Having access to treatments also means that treatments should be affordable to the individual, including reasonable premiums and cost-sharing, as well as protecting individuals with pre-existing conditions from being charged more for their coverage. We are concerned that the proposed policy fails to achieve this aim.

<u>Solvency protections from AHPs</u>

Unfortunately, in the past there have been numerous examples of AHPs that have become insolvent either because the AHP was formed with fraudulent intent or failed to be adequately capitalized. In such instances, consumers – many of whom had serious and chronic diseases – experienced great harm when they were left with significant medical bills after their AHP folded and were unable to pay their claims.[9]

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[9] *ibid.*

These consumers would have received little to no advance notice that their plan would fail to provide adequate coverage until it was too late.

We are pleased that the proposed rule allows states to impose requirements such as reserve standards and other financial requirements on AHPs. However, this proposal assumes that the states are adequately resourced to enforce these requirements. In addition, some states may be hesitant to regulate these plans given that questions remain about the extent to which states have the authority to do so.[10]

AHPs are substandard coverage

as discussed in detail above, we are concerned that the proposed rule would allow an AHP to offer non-comprehensive coverage. This coverage could fall far short of the needs of individuals – particularly those with serious and chronic conditions. We are concerned that some employers may offer AHPs to their employees, despite the fact that the overall benefit package may not provide adequate coverage, but would meet the actuarial value for minimum essential coverage (MEC) requirements.[11] Under current law, if an employer offers MEC-compliant coverage, the individual is permitted to enroll in a plan on the marketplace, but would be precluded from eligibility for advance premium tax credits (APTCs). As a result, individuals – such as those with serious or chronic illnesses – who are offered an AHP through their employer and need comprehensive coverage would be unable to obtain adequate coverage through the marketplace with the help of APTCs. To correct this, we urge the Department to amend current regulations to permit an individual who declines an employer-sponsored AHP to be deemed eligible for APTCs based on income.

Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only apply to EHB-covered services. In this proposal, the Department would facilitate the proliferation of health insurance options that do not have to comply with EHB coverage requirements. Therefore, this proposal would once again subject patients to significant financial insecurity due to medical needs. In 2007 alone, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.[12] Patients who faced heart transplants, used specialty medications, had complicated pregnancies, a cancer diagnosis, or other rare and complex conditions could easily meet or exceed lifetime and annual caps. For example, prior to the ACA, many children with hemophilia would hit the lifetime limit on coverage under both parents' insurance plans before turning 18, leaving them without coverage options. For these reasons, we strongly urge the Department to consider the financial implications to our patients of removing this critical protection.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for QHPs to include an annual out-of-pocket maximum set each year by the Department of Health and Human Services (HHS). For 2017, the annual out-of-pocket limit for an individual is $7,350, and for a family plan is $14,700.[13] Similar to the ban on annual and

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[10] See, K. Lucia and S. Corlette, "Association Health Plans: Maintaining State Authority is Critical to Avoid Frau, Insolvency, and Market Instability." *To the Point*, The Commonwealth Fund, Jan. 24, 2018, available at http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority.

[11] 45 C.F.R. § 156.604.

[12] Himmelstein DU, Throne D, Warren E, Woolhander S, Medical bankruptcy in the United States, 2007: results of a national study. Am J Med 2009 Aug; 122(8): 741-6. Doi.

[13] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Final Rule, 81 Fed. Reg. 94058 (Dec. 22, 2016).

lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. If the Department moves forward with this proposed dramatic expansion of non-EHB compliant AHPs, it will also be subjecting patients with complex and chronic conditions to unaffordable cost-sharing for medically-necessary services on which they rely.

Accessibility

The third key principle agreed to by our organizations is that healthcare must be accessible. Everyone needs access to quality and affordable healthcare to manage chronic diseases and be able to access medical care during a health emergency. The connection between access to health insurance and health outcomes is clear and well documented.[14,15]

Market Segmentation

We are concerned about the impact of the proliferation of AHPs on the overall individual market. We expect that individuals with serious and chronic conditions will continue to enroll in coverage offered through state marketplaces. Conversely, younger and healthier individuals may be more likely to shop for coverage on the basis of premiums and thus may be more drawn to lower cost AHPs, despite the fact that these products will likely have less comprehensive coverage.

Over time, as younger and healthier individuals leave the marketplace, premiums will likely increase and fewer issuers may participate in a state's marketplace. This could lead to market segmentation that "could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage."[16]

Other Concerns

As detailed above, our organizations are very concerned about the impact of this specific regulation. However, when combined with other actions, regulations, and policies pursued by the Administration it is clear that their compounded impact will destabilize the individual insurance market and increase access to substandard insurance and its alternatives.

Shortening the open enrollment period by half, reducing funds for outreach and advertising, restricting eligibility for Medicaid through waiver approvals, and the repeal of the individual mandate are all affecting the coverage landscape. In addition, the policies in the short term limited-duration insurance proposed rule and policies within the Notice of Benefit and Payment Parameters proposed rule would allow states to diminish the value of some essential health benefit categories, change the annual out-of-pocket costs maximums and open the door to lifetime and annual caps, which will negatively impact individuals and families struggling with chronic, serious, or acute disease. We urge the Administration to work with Congress and organizations like ours to ensure that consumers everywhere have access to affordable *and* high-quality insurance plans while maintaining a strong marketplace.

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[14] Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

[15] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

[16] American Academy of Actuaries, "Issue Brief: Association Health Plans", Feb. 2017, available at http://www.actuary.org/content/association-health-plans-0.

Protect State Regulatory Authority

The proposed rule raises questions about preemption of state law and future regulatory authority. While the Department states that the proposed rule would not alter existing ERISA statutory provisions governing multiple employer welfare arrangements, we are concerned that the proposed rules will have the result of preempting existing and future efforts by states to regulate them. The proposed rule's new framework allowing AHPs to be treated as single multiple-employer plans creates confusion about states' enforcement authority. In the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut down scam operations.[17]

States must maintain the ability to protect patients and manage their insurance markets. We urge the Department to clarify that ERISA single employer AHPs, including those that cover more than one state, would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

Finally, we strongly oppose any proposal that would exempt AHPs from state regulation. States have long taken the lead in protecting patients by addressing AHP insolvencies and fraud and maintaining competitive markets. States have the history, resources, and local expertise to serve in this role and we urge the Department not to take action that would prevent that.

Conclusion

Our organizations represent millions of patients, individuals, caregivers, and families who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide our recommendations on the proposed rule. However, given the history of AHPs, we are deeply concerned that the rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law – and put those we represent at risk.

We urge the Department not to finalize the AHP proposed rule until the needs of our populations are met and instead to focus on lowering premiums for QHPs. Short of this, in order to protect vulnerable populations, the Department must modify the AHP proposed rule with the following:

- Require AHPs to comply with the Essential Health Benefits (EHBs) coverage requirements to ensure coverage adequacy, as well as protections from lifetime and annual caps, and annual out-of-pocket maximums;
- Allow the employees of businesses that choose to enroll AHPs to remain eligible for premium tax credits to encourage market choice;
- Require AHPs to provide clear consumer information, including details about coverage, costs, and plan policies, prior to enrollment; and
- Clarify and bolster state regulation of AHPs.

As leaders in the healthcare and research communities and staunch patient and consumer advocates, we look forward to working with Department of Labor leadership and staff on the direction of such important public policy. Thank you for the opportunity to submit comments on this rule. If you have any

[17] Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority.

questions or would like to discuss these comments further, please contact Katie Berge, American Heart Association Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Autism Speaks
COPD Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Futures without Violence
Leukemia & Lymphoma Society
Lutheran Services in America
Muscular Dystrophy Association
National Multiple Sclerosis Society
National Organization for Rare Disorders