

March 6, 2018

Office of Regulation and Interpretations  
Employee Benefits Security Administration, Room N-5655  
U.S. Department of Labor  
200 Constitution Avenue NW  
Washington, DC 20210

**Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85**

As organizations dedicated to promoting the health of our nation’s children and pregnant women, we appreciate the opportunity to comment on the Department of Labor (DOL) Proposed Rule: Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans. We believe that commercial coverage for children and pregnant women, whether through a large employer, a qualified health plan or an Association Health Plan (AHP), must ensure access to timely, affordable, high-quality, and age-appropriate health care (including dental, vision and hearing services) that meets their unique needs. Plans must also promote the health of women before, during, and between pregnancies.

We share the Department’s goal of increasing access to affordable health care coverage in the commercial market, but are very concerned that the Proposed Rule could leave children, particularly children with serious, chronic, or complex medical needs, with less comprehensive coverage, higher out-of-pocket costs, the possibility of unpaid health care bills, and limited access to appropriate providers. Therefore, we respectfully urge DOL to consider the implications of the rule for the health and wellbeing of our nation’s children and pregnant women before finalizing the proposed regulatory changes.

We look forward to working with you to find better solutions that strike the correct balance between affordability and comprehensiveness of coverage for children and pregnant women. Our specific comments are below.

**Definition of Employer (§2510.3-5)**

We believe that any expansion of ERISA to increase the availability of AHPs must be combined with the continuation of a basic framework of consumer protections for children, pregnant women, and families. As proposed, however, the change in the definition of “employer” under ERISA will weaken the safeguards for children, pregnant women, and families that have been delineated in DOL guidance. Furthermore, the proposed definitional changes create ambiguity about the role of state regulators in oversight of AHPs, even though states have a track record in protecting consumers, providers, and the stability of the market.

Unfortunately, we know that there are inherent financial incentives for plans to not cover seriously ill children, women who are or could become pregnant, and other vulnerable populations or to limit that coverage through narrow benefit packages, provider networks, and other means. As the National Association of Insurance Commissioners (NAIC) has noted<sup>1</sup>, “Just as consumers will act in their own financial self-interest, insurers will as well. When permitted by law, insurers will use a variety of tools to lessen their susceptibility to high-risk individuals.” A clearly articulated framework for benefit design, cost-sharing, other key consumer protections, and network standards can provide financial protection for plans,

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<sup>1</sup> See NAIC. [Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act](#), 2011.

as well as families, and help children with special health care needs or a serious or chronic illness fulfill their lifelong potential.

Current DOL guidance delineates such a framework of vital protections for most types of AHPs and clarifies the role of states in oversight of plan compliance with requirements such as essential health benefits (EHBs), caps on out-of-pocket expenses, actuarial value (AV) requirements, prohibition of annual and lifetime limits, and basic network adequacy requirements. As a result, families know they have affordable access to needed providers and to regular preventive and primary care for their healthy children, as well as coverage for pregnancy, childbirth, and postnatal care for both new mothers and their babies. They also know that they will not be subject to financially devastating cost-sharing if their child experiences a serious illness.

We urge DOL to consider the following recommendations and concerns to help ensure that families enrolled in an AHP have those same basic protections and peace of mind regarding plan benefits, out-of-pocket expenses, and provider networks.

**Benefits.** It is critical that DOL conduct strong oversight, in collaboration with state regulators, of AHP benefit packages, given the weakening of health benefit design standards that will result from the proposed ERISA expansion. Children are not little adults; they require services and care specific to their unique developmental and medical needs. However, under the proposed rule, both children and pregnant women enrolled in an AHP may not be assured that their plan will cover important benefits like maternity care, vaccines, prescription drugs, mental health services, dental and vision services, and habilitative services. Gaps in these core benefits can result in life-long health consequences that are both avoidable and costly for families and society.

**Cost-sharing protections.** We share your concerns regarding the affordability of coverage, but remind you of the importance of protecting families from bankrupting out-of-pocket costs. Enrollment in an AHP not subject to cost-sharing limits, specific AV standards, or the prohibition of annual and lifetime limits on the cost of benefits could financially overwhelm a family with a child who requires extensive health care services or medications, or a woman who has a complicated pregnancy and delivery. Furthermore, research has found that families faced with additional financial burden may delay needed care, which can increase inappropriate utilization of emergency rooms and affect a child's long-term health outcomes and future productivity. For example, a 2014 study<sup>2</sup> examined how children with asthma obtained care under different levels of cost-sharing and the financial stress their families experienced because of their child's illness. The researchers found that families with higher levels of cost-sharing were significantly more likely to delay or avoid going to the doctor or emergency room for their child's asthma, to borrow or cut back on necessities to afford care, and to avoid care.

**Adequacy of provider networks.** We urge the Department to work with state regulators to ensure that states have both the tools and the authority to conduct stringent oversight of AHP network design. Provider network design and oversight is critically important for children in need of pediatric specialty and subspecialty services, because adult providers are not equipped to care for their unique health and developmental needs. Inadequate and limited networks that do not include a range of appropriately trained pediatric specialists and subspecialists may result in care delays with poor medical outcomes that ultimately cost insurers and consumers more.

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<sup>2</sup> See [Financial Barriers to Care Among Low-Income Children With Asthma](#), JAMA Pediatrics, July 2014.

In addition, it is not uncommon for children to travel across state lines to get needed care from a pediatric provider with the requisite training and expertise due to the regional nature of pediatric specialty care. However, as proposed, AHPs could be formed by employers within a common city, county, or metropolitan area, which could result in provider networks with varying geographic boundaries. Absent specific standards that ensure a full range of in-network pediatric providers, families may not have access to an appropriately trained in-network specialist due to those geographic limits.

This variation in geographic scope among AHPs calls for network adequacy review and oversight that provides a system that allows for at least the same level of scrutiny that states currently apply to the individual and small group markets. We ask that DOL work with states to implement a set of minimum quantitative and other standards for AHP networks comparable to those articulated in the NAIC Model Act<sup>3</sup> No. 74. The Model Act is designed to allow states to tailor their standards to the needs of their particular state. It also includes a minimum framework for a degree of network adequacy standards and reporting requirements that addresses access to care for vulnerable children and adults.

### **Nondiscrimination (§ 2510.3-5(d))**

While we support the Department's attempt to protect against discrimination based on health status, we believe the nondiscrimination provisions in the rule must be strengthened to ensure that children, pregnant women, and their families are protected against adverse risk selection and cherry-picking. In particular, we believe it is necessary to prohibit AHPs from discrimination that can occur due to limited benefit designs, limited drug formularies, and narrow provider networks. We believe that the proposed rule opens the door to health plan benefit and provider network design that can serve as disincentives for individuals with significant health conditions to enroll in those health plans. For example, issuers could exclude certain pediatric specialty providers from their networks and, in so doing, steer parents of a child with special health care needs away from their plan. As a result of this discriminatory network design, the issuer can avoid risk and lower premium costs because it does not enroll individuals with significant health care needs.

We are also concerned about the impact of AHPs with limited benefit packages and networks on children, pregnant women, and families who seek coverage through ACA-compliant plans inside or outside of the Marketplaces. As the Department notes in the rule's regulatory impact analysis, the expansion of AHPs that offer lower-cost, less-comprehensive coverage would be most attractive to healthier individuals, thereby drawing them out of the traditional market. The segmented market will result in increased premiums for the more comprehensive non-AHP, ACA-compliant plans that more appropriately cover the services and include the providers that children and pregnant women need. Unfortunately, the nondiscrimination provisions of the proposed rule would not protect children, pregnant women, and families from these discriminatory practices.

### **State and Federal Oversight of AHPs**

In the event that DOL moves forward with the proposed AHP expansion, we strongly urge you to maintain states' regulatory authority over AHPs. Furthermore, this authority must be clearly articulated in the final rule. In the past, ambiguity regarding distinctions between federal and state authorities governing AHPs resulted in rampant fraud and insolvency, and left children and their families with unpaid benefits and large

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<sup>3</sup> See NAIC, [Health Benefit Plan Network Access and Adequacy Model Act](#), 2015.

financial obligations.<sup>4</sup> We are very concerned that the proposed rule will result in a return to that complex patchwork of AHP requirements and state and federal oversight responsibilities, which will undermine coverage and access to care.

Therefore, it is critical that the final rule specifically affirm the state's role in regulating AHPs. For example, states should continue to be allowed to require AHPs to comply with state mandated benefits, network adequacy requirements, rate review standards, and other consumer protections. In addition, we support the continuation of state regulatory authority over the solvency of self-funded AHPs, as well as other state regulatory responsibilities to prevent inconsistencies between fully and self-insured plans regarding these important core protections.

In addition, we urge DOL to work with states and the NAIC on the collection of data that will enable regulators, as well as stakeholders, to assess whether and how children, pregnant women, and families are being served by AHPs. To help ensure that AHPs are providing children, pregnant women, and families with access to high-quality and timely care promised to them in their plan contract, it is critical that DOL collect and use plan data to document, identify, and analyze patterns in consumer behavior and in coverage. The data transparency requirements under Section 2715A of the Affordable Care Act should serve as a model for data transparency requirements for AHPs.

In particular, we believe the Department, in collaboration with the NAIC and states, should collect disaggregated, plan-level enrollment/disenrollment data that includes information on enrollee income, geographic location, and demographic information. In addition, we recommend the collection of claims data (paid and unpaid) by age and income to help assess the impact of cost-sharing requirements, service denials, coverage limits, and out-of-network care. For example, the availability of such data could help determine if children with serious, chronic, or complex health conditions, such as children with a congenital heart defect or cystic fibrosis, are disproportionately enrolled (or not enrolled) in particular plans, indicating uneven risk selection. Claims data also could identify a pattern of coverage denials for certain types of high-cost services furnished by specialty providers that may indicate discriminatory benefit or plan design.

In conclusion, we reiterate that we share the Department's concerns regarding the need to address health care affordability. However, we are very concerned that the proposed expansion of AHPs without basic protections and strong oversight fails to achieve a reasonable balance between affordability and access to quality care, and does children and pregnant women— and ultimately the nation — a serious disservice. We respectfully encourage the agency to work collaboratively with us to identify delivery system reforms and other health care quality improvement initiatives that will reduce health care costs, drive down premiums, and improve care. We look forward to working with you to ensure that all health benefit plans address the unique health care needs of children, pregnant women, and their families.

If we may provide further information or otherwise be of assistance, please contact Jan Kaplan at the Children's Hospital Association, at 202-753-5384 or [jan.kaplan@childrenshospitals.org](mailto:jan.kaplan@childrenshospitals.org).

American Academy of Pediatrics  
Children's Defense Fund  
Children's Dental Health Project

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<sup>4</sup> See Kofman, M. [Association Health Plan: Loss of State Oversight means Regulatory Vacuum and More Fraud](#). Georgetown University Health Policy Institute, 2015.

Children's Hospital Association  
Family Voices  
First Focus  
Georgetown Center for Children and Families  
National Association of Pediatric Nurse Practitioners