



March 6, 2018

**VIA ELECTRONIC SUBMISSION**

The Honorable R. Alexander Acosta  
Secretary, U.S. Department of Labor  
200 Constitution Ave NW  
Washington, DC 20210

**RE: Public Comments on Association Health Plans and the Definition of “Employer” under Section 3(5) of ERISA (RIN 1210-AB85)**

Dear Secretary Acosta:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) would like to comment on the Department of Labor (DOL) proposed rule entitled *Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans*<sup>1</sup> (the Proposed Rule). This rule has the potential to significantly alter the dynamics of the existing individual and small group markets and, as such, CPR must express our very significant concerns with the expected effect this rule will have on access to essential health benefits, particularly rehabilitation services and devices.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function.

We share the Department’s goal of increasing access to affordable health care, but we believe the proposed rule would leave adults and children, particularly those with disabilities and chronic health conditions, with less comprehensive coverage and higher out-of-pocket costs. We believe that insurance coverage, whether through an employer, a plan purchased on the exchange, or an association health plan (AHP), must ensure access to timely, affordable, high-quality health care that meets the needs of individuals with disabilities.

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<sup>1</sup> Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 614 (Jan. 5, 2018). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2017-28103.pdf>.

The proposed rule may reduce the short-term cost of coverage through AHPs, but we expect the rule to primarily attract relatively younger and healthier consumers and leave relatively older and less healthy people out of the individual and small group markets and into the AHP market. According to the proposed rule, AHP consumer protections are not nearly as strong and benefit packages are not nearly as comprehensive as plans in the current marketplaces. AHPs will lead to adverse selection that will place even more pressure on the marketplaces to keep costs as low as possible. AHPs will have the net effect of driving insurance costs higher for current marketplace plans as the insurance pool is skewed, while AHP enrollees will be exposed to noncovered services and increased out-of-pocket costs when the bare bone benefit packages they purchase will be more likely to fail to meet their needs when needed most.

For these reasons, we urge DOL to seriously reconsider the proposed rule and, if it moves forward with AHPs, ensure that the final regulations require these plans to comply with the same consumer protections and cover the same minimum essential health benefits as exchange-based health plans, especially the category of benefits known as rehabilitation and habilitation services and devices.

#### **I. Access to Essential Health Benefits**

Under the Proposed Rule, AHPs would be regulated as group health plans under ERISA. As a result, AHPs would not be subject to the ACA's requirement to cover all ten categories of essential health benefits (EHBs). This would have a significant impact on individuals who have an illness, injury, disability and chronic condition and require rehabilitation services and devices to improve their health and functional ability. These same individuals also have a need for other essential health benefits such as prescription drugs, behavioral and mental health services, chronic disease management, and other benefits.

We are especially concerned that AHPs could decide not to cover rehabilitative and habilitative services and devices or significantly limit the scope of these benefits. The inclusion in the ACA of the category of rehabilitative and habilitative services and devices was a major milestone for the rehabilitation and disability community in that Congress recognized the importance of these benefits to improve the health and functioning of the American people. The passage of the ACA and its implementation represented significant gains for consumers of rehabilitation and habilitation services and devices.

This benefit category was clarified through federal regulations, perhaps more so than any other essential health benefit. In the February 2015 Notice of Benefit and Payment Parameters Final Rule, the Centers for Medicare and Medicaid Services (CMS) defined "rehabilitation services and devices" as follows:

Rehabilitation services and devices—Rehabilitative services, including devices, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

For the first time, this definition established a uniform, understandable federal definition of rehabilitation services and devices that became a standard for national insurance coverage. This definition has become a floor for both individual and small group health plans. It was also adopted by States that chose to expand their Medicaid programs. Importantly, the definition includes both services *and* devices. The adoption of a federal definition of rehabilitation and habilitation services and devices minimized the variability in benefits across States and the uncertainty in coverage for children and adults in need of these services.

## II. Rehabilitation Services and Devices

Rehabilitation services and devices include a wide scope of care across a continuum of providers and provider settings. Rehabilitation services include but are not limited to rehabilitation medicine, inpatient rehabilitation hospital care, physical and occupational therapy, speech language pathology services, behavioral health services, recreational therapy, developmental pediatrics, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings. Rehabilitation devices include prosthetic limbs, orthotic braces, power and manual wheelchairs, specialized wheelchairs known as complex rehabilitation technology (CRT), speech generating devices, hearing aids, cochlear implants, vision devices, oxygen equipment and services, diabetic test strips, and many other types of durable medical equipment and assistive technologies.

The following vignettes demonstrate just a few examples of real-life instances where access to rehabilitation services and devices has maximized the health, function, and independence of those who have been able to access these services:

- *Rehabilitation Following a Traumatic Brain Injury.* Jason is a 43-year-old computer systems administrator. Following a bicycle accident in April 2014, Jason was diagnosed with a traumatic brain injury. Through an intensive team-based rehabilitation process, he was able to transition from total loss of motor skills, speech, and memory, resuming full function in his previous roles. He is now able to care for his three children, drive, and return to work.
- *Rehabilitation Following a Spinal Cord Injury.* Cayden is a 15-year-old high school student. Following a car accident in January 2016, he was diagnosed with a spinal cord injury causing paralysis in his arms and legs. With intensive rehabilitation from a multidisciplinary team of medical professionals, including physical and occupational therapists, he was able to regain balance and arm/hand function. He is now able to walk unassisted and drive, and has returned to school.
- *Rehabilitation Following a Stroke.* Ed is a 50-year-old high school volleyball and basketball coach. In September 2013, two strokes left him with a paralyzed left arm and leg. With intensive rehabilitation, he no longer uses on a wheelchair and has improved

his balance, leg, and arm function. He is now able to walk unassisted and dance, and has returned to coaching.

Individuals and families have come to rely on rehabilitation services and devices as a federal standard for coverage and to roll this back now by expanding access to AHPs that can choose not to offer these necessary benefits would negatively impact patient access to comprehensive care. It is of utmost importance that AHPs do not provide a false sense of health insurance coverage by offering minimal benefit coverage in exchange for lower premiums.

Discriminatory insurance practices are often driven by a desire to reduce short-term costs. However, limiting access to health care for people with disabilities or chronic conditions is not cost-effective in the long term as it often results in further complications and avoidable hospital admissions and readmissions. In addition, it should be noted that reducing coverage is not likely to significantly reduce the cost of coverage in the first place. This is particularly true for coverage of rehabilitative and habilitative care which accounts for just 2% of total premium dollars. Reducing coverage of these services would not significantly decrease the cost of insurance packages overall, but would lead to very high increases in out-of-pocket costs for children, families, and adults who need these services.

Both habilitation and rehabilitation services and devices are highly cost-effective and decrease downstream costs to the health care system and society at large for unnecessary disability and dependency. For these reasons, it is essential that any regulatory change to the individual or small group market, including AHPs, maintain access to the full continuum of rehabilitation care. We therefore urge the Department of Labor to rewrite this AHP rule to ensure access to and coverage of essential health benefits.

### **III. Nondiscrimination Protections**

The nondiscrimination protections in the Proposed Rule are similar, although not identical, to those applicable to group health plans under the Health Insurance Portability and Accountability Act (HIPAA), as amended by the ACA. We support that, under the Proposed Rule, AHPs are prohibited from conditioning membership based on a health factor, including disability. While this is an important provision of the proposed regulation and must be retained in the final rule, it does not go far enough to prevent potentially discriminatory benefit design or premium rating that approximates health status rating. In short, the rule should apply the same non-discrimination protections to consumers of AHPs that apply to those in the individual and small group markets.

#### **a. Benefit Plan Design**

Under the Proposed Rule, AHPs may design their plans in such a way as to make them unattractive to individuals with greater health needs or pre-existing conditions in order to keep overall premiums low. Benefit packages currently reflect the typical employer plan; to not require this is detrimental to individuals and families who have come to rely on the availability

of benefits that meet the health care needs of a wide range of individuals with disabilities and their families.

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. Specifically, discriminatory benefit design often occurs in the area of rehabilitative and habilitative services and devices. 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. 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.

Unfortunately, we know that there are inherent financial incentives for plans to limit coverage of people with disabilities and pre-existing conditions through narrow benefit packages, narrow provider networks and through other means. A clearly articulated framework for AHP plan benefit design, cost-sharing, other key consumer protections and network standards can provide financial protection for plans, as well as families, and help individuals with disabilities fulfill their lifelong potential.

#### **IV. Annual and Lifetime Limits**

Based on the Proposed Rule, it is our understanding that the prohibition against annual and lifetime limits would still apply to AHPs. We share the Department's concerns regarding the affordability of coverage, but remind DOL of the importance of protecting families from potentially-bankrupting out-of-pocket costs. Enrollment in an AHP not subject to the prohibition of annual and lifetime limits on the cost of benefits could financially overwhelm an individual who requires extensive health care services or medications. In addition, annual and lifetime caps are currently tied to essential health benefits. We seek confirmation from DOL of the application of this important provision to AHPs and how these provisions would operate if the Department does not require coverage of essential health benefits under AHPs. In addition, we seek clarification as to how the maximum out-of-pocket limit would apply to AHPs since this limit is also tied to essential health benefits.

#### **V. Oversight of AHPs**

Under the Proposed Rule, there is a lack of clear oversight over AHPs, including confusion over whether it is the state or the federal government's responsibility to regulate AHPs. We strongly recommend further clarity on the role of states in the regulation of fully insured AHPs. Historically, some AHPs have demonstrated a pattern of insolvency and unpaid claims. In the past, ambiguity regarding distinctions between federal and state authorities governing AHPs left individuals and their families with unpaid benefits and large financial obligations. We are 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.

On its own, DOL lacks the resources to effectively regulate and oversee AHPs. Filing a federal lawsuit is the key enforcement protection under current ERISA law and this is out of reach for most individuals who need to challenge coverage denials. Therefore, it is critical that the final rule specifically affirm the state's role in regulating fully insured AHPs. As such, states should be allowed to apply the same standards to AHPs as they apply to other commercial group plans, including essential health benefits, network adequacy requirements, rate review and other consumer protections.

The proposed rule would specifically allow AHPs to cross state lines (either because employees are in the same industry, line of business or profession) or employees (*irrespective of whether they are in the same industry, line of business or profession*), are in a "geographically limited area" such as a metropolitan area, even if the area crosses state lines. This raises very significant jurisdictional issues about whether state regulators will be able to regulate AHPs that occupy multiple states. If the AHP must only satisfy the rules of one "home" state, there is a serious risk that the AHP may select the state with the weakest consumer protections. The final rule must clarify that states have the authority to require AHPs to meet their individual health insurance consumer protection rules.

Authority of state regulators to regulate and oversee AHP plans is essential, as there are few consumer remedies available under ERISA if a plan denies coverage. 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 this proposed ERISA expansion. In sum, we ask that you seriously reconsider this proposed rule and revise it to ensure it meets the needs of people with disabilities and chronic conditions.

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The CPR Coalition membership greatly appreciates your attention to our concerns involving this important proposed rule. Should you have further questions regarding this information, please contact [Peter.Thomas@powerslaw.com](mailto:Peter.Thomas@powerslaw.com) or call at 202-466-6550.

Sincerely,

**CPR Supporting Organizations**

Academy of Spinal Cord Injury Professionals

ACCSES

American Academy of Physical Medicine and Rehabilitation

American Association on Health and Disability

American Congress of Rehabilitation Medicine

American Medical Rehabilitation Providers Association

American Occupational Therapy Association

American Physical Therapy Association

American Spinal Injury Association

Amputee Coalition

Association of Academic Physiatrists

Association of Rehabilitation Nurses  
Brain Injury Association of America  
Christopher and Dana Reeve Foundation  
Clinician Task Force  
Disability Rights Education and Defense Fund  
Epilepsy Foundation  
Lakeshore Foundation  
National Association of State Head Injury Administrators  
The National Athletic Trainers' Association  
National Rehabilitation Association  
National Stroke Association