Before the
Department of Labor
Washington, DC 20210
March 6, 2018

In the Matter of
Definition of Employer Under Section 3(5) of ERISA-Association Health Plans
Docket ID No. EBSA-2018-0001-0001
Comments of FreedomWorks Foundation

FreedomWorks Foundation is a 501(c)(3) nonprofit and educational foundation dedicated to building, educating, and mobilizing the largest network of activists advocating the principles of smaller government, lower taxes, free markets, personal liberty, and rule of law. In doing so, FreedomWorks Foundation acts as a "service center" for the millions of citizen-leaders who make a difference in the fight for lower taxes, less government, and more freedom.

FreedomWorks Foundation appreciates the opportunity to provide comments to the Department of Labor (DOL) in response to this proposed rulemaking under the Employee Retirement Income Security Act (ERISA). FreedomWorks Foundation ultimately supports this proposed regulatory change.

This proposed regulation would relax standards of qualification to be considered a single sponsor of an association health insurance plan (AHPs), allowing more employer groups and self-employed individuals to band together to qualify and purchase large group plans or self-insure. Relaxing these standards allows association members to offer more affordable and tailored health insurance plans for their employees as these plans are exempt from a multitude of constricting regulations placed on individual, small group, as well as large employer plans under the Patient Protection and Affordable Care Act (ACA).

One of the core projects of FreedomWorks Foundation is the Regulatory Action Center. The Regulatory Action Center is dedicated to educating Americans about the impact of government regulation on economic prosperity and individual liberty.

FreedomWorks Foundation is committed to lowering the barrier between millions of FreedomWorks citizen activists and the rule-making process of government bureaus to which they are entitled to contribute. In line with this project, FreedomWorks Foundation would like to offer the following broad comments about healthcare policy, ACA, and why we are ultimately supportive of this particular rulemaking.

Background

On July 12, 2017, FreedomWorks Foundation submitted comments to Health and Human Services (HHS) responding to a request for comments regarding Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients, Docket ID No. CMS-9928-NC.[1] In those comments, we first made clear that seeking to expand health insurance coverage is no panacea for America's healthcare crisis.

The problem with America's healthcare system is a problem ACA ultimately exacerbated: third-party payers, be they government programs or insurance companies, blunt competitive market forces. If a consumer faces a fixed cost (or no cost) for the service or product they receive, then they have no incentive to compare prices and thus providers have no incentive to compete on this criterion. Fixed costs

[1] Document ID: CMS-2017-0078-2338

also induce overconsumption as patients receive essentially infinite benefit relative to cost for every marginal procedure or product while providers enjoy information asymmetry over patients, insurance companies, and government. Both of these factors put upward pressure on prices for care.

While third parties serve a purpose in a sustainable healthcare market place, the only way to sustainably slow and ultimately reverse the cycle of healthcare price inflation is to reevaluate third parties' role as the primary payers. Insurance and government safety nets should serve to cover unpredictable and catastrophic injuries and conditions, but not regular check-ups or non-life threatening or non-debilitating ailments. In the latter cases, markets directly between patients and providers should be facilitated, allowing for competitive pressure to drive prices down. In short, health insurance should work more like automobile and home insurance.

Modern healthcare policy lacks this critical bifurcation between health insurance and actual healthcare products and services. As a result, a complex web of increasingly expensive subsidies and programs is constantly playing catch-up with runaway healthcare price inflation while simultaneously accelerating it. Should healthcare policy continue to focus only on expanding insurance or government coverage versus facilitating actual affordable care between patients and providers, no amount of taxes or borrowing will sustain the healthcare system in the long-term.

The ACA is a bill designed to increase the usage of third-party payments in the healthcare sector, which has the effect of increasing healthcare costs, not lessening them, because consumers do not see the true costs of their care. ACA not only expanded Medicaid and mandated insurance coverage for those not qualifying for Medicaid, subsequent regulations have raised the minimum standard of what qualifies as health insurance and thereby further reduced the already-limited presence of direct markets between patients and providers in certain areas of care. For these very basic reasons, ACA will do nothing to ultimately solve America's healthcare problem. Emulating the problem it further institutionalized, ACA is nothing more than an extremely expensive bandage.

While firmly committed to the principles outlined above, FreedomWorks Foundation also recognizes that the role of executive branch agencies such as DOL is to enforce the law. While we fundamentally oppose ACA in its entirety, the scope of changes DOL or any other agency are empowered to make is limited by the Constitution. This is another principle by which FreedomWorks Foundation firmly stands. Thus, in regards to ACA, FreedomWorks Foundation is supportive of regulatory changes that work within the bounds of the law to—even incrementally—reduce the role of third parties in structuring the healthcare choices for American consumers.

In our July 2017 comments to HHS, FreedomWorks Foundation identified three areas of regulatory reform to drive the healthcare market closer to a functioning direct market between patients and providers to the extent that such is possible under the constraints of the ACA.

In regards to the particular proposed rulemaking these present comments address, DOL has noted they consulted with HHS and has subsequently proposed a regulatory change that would address, to some extent, all three areas outlined in our initial comments to HHS. These regulatory issues identified in our initial comments to HHS last year are the Essential Health Benefits standard, Actuarial Value standards, and the Medical Loss Ratio regulations.

Essential Health Benefits

The Essential Health Benefits (EHBs) standard under ACA not only was the primary driver behind mass insurance cancellations at the outset of the law taking effect, these standards are now increasing premiums across the country.

EHBs are the minimum broad categories of coverage required by each insurance plan. There are ten EHBs set in statute. These are:

1. Ambulatory services
2. Emergency services
3. Hospitalization
4. Laboratory services
5. Maternity and newborn care
6. Mental health and substance abuse services
7. Prescription drugs
8. Rehabilitative and habilitative services and devices
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

By the very nature of some of these EHBs, in addition to the ACA's mandated Actuarial Value standards, it is clear why they caused mass cancellations and why they are driving premiums higher today. There is simply no reason why many millions of Americans would ever seek out some of these forms of care, particularly those related to bearing and caring for children. As with most products and services, the number of features provided generally has a positive correlation with price. This correlation is stronger in a field such as insurance as premiums are largely a calculation of the risk a claim is made. With more services qualifying for claims, the risk is higher and therefore premiums are higher as a result.

Germane to the principles of sustainable healthcare reform outlined above, EHBs also inherently increase the price of care itself by expanding the role of third parties into more sub- sectors of the healthcare market. To whatever extent a direct market existed between patients and providers in these broad coverage areas before ACA, there is no longer an incentive for patients to shop and negotiate prices and payments for services for which they are technically already paying via their premiums. This eases pressure on providers to compete on prices as well. In fact, the incentives suggest the providers will compete to offer the most expensive, and perhaps superfluous, services as the patient is no longer responsive to price.

As DOL's proposed rulemaking notes, large group plans are not subject to EHBs. As a result of this regulatory change, Americans employed by firms within large group-qualifying associations will face reduced premiums and will not necessarily be forced to purchase coverage for care they may rarely or never need. Further, the prevalence of third-party insurance payments for various forms of care will be reduced, increasing pressure on healthcare providers to compete on cost.

Actuarial Value

Similar to EHBs, the Actuarial Value (AV) standards imposed by ACA increase the presence of insurance in the market, the cost of insurance, and ultimately the price of care itself. AV is defined as the average percentage of total covered healthcare costs an insurance plan will pay versus what patients enrolled in that plan will pay in combined deductibles, premiums, and any other out-of-pocket costs. ACA sets the minimum AV for qualifying plans at 60 percent, with higher AV tiers of 70, 80, and 90 percent in the individual and small group markets.

Ultimately, minimum AV standards limit the dollars spent by consumers in the healthcare market relative to insurance companies, fueling all the aforementioned problems caused by third-party payments in terms of cost inflation. Further, such standards limit the flexibility of insurance companies to offer purely

catastrophic coverage or other high deductible plans that better match the risk and budgets of certain consumers, as these plans weigh down the AV average.

DOL's proposed rulemaking to allow more small employers to band together and form large group-qualifying associations will all-but eliminate the harmful effects of AV standards while not subjecting insurance enrollees to standards any different than the pre-ACA market. Large group plans are subject to a form of AV called minimum value (MV) under ACA. Whereas AV standards force consumers in the individual and small group markets into plans that fit within narrow bands of coverage ranging plus or minus two percent from 60 percent, 70 percent, 80 percent, and 90 percent thresholds, large group plans are subject to a single 60 percent MV threshold. This would grant significantly greater flexibility for insurance companies to offer more affordable plans with higher deductibles to employer associations, while the higher deductibles will encourage more consumer pressure on healthcare providers to compete on prices. This would both expand the total number of individuals covered while marginally expanding direct price negotiation between patients and providers for non-emergency care.

While FreedomWorks Foundation opposes any minimum standard for AV or MV in principle, according to HHS, 98 percent of employer-sponsored plans prior to the implementation of MV already satisfied the 60 percent requirement.[2] In effect, more plans and thus more Americans will be essentially free of this distortionary form of insurance regulation.

Medical Loss Ratio

ACA requires insurance companies to spend a fixed percentage of premium dollars collected on actual medical benefits versus overhead and profits through what is known as a Medical Loss Ratio (MLR). This regulation is just as problematic as EHBs and AVs. Currently, ACA sets an MLR of 80 percent for individual and small group plans and 85 percent for large group plans.

The consequences of such a rule are numerous. First, it limits the incentive for insurance companies to enter the market as it distorts the risk-reward calculation any business makes before opening or expanding. The reward is capped while the risk remains unknown, as is the very nature of insurance. This limits consumer choice in insurance markets.

More problematic is that MLR standards, like EHBs and AV standards, also increase the share of third-party payments in the health care market. By setting the total amount of money an insurance company can keep as a percentage of the money it collects and spends, the company has every incentive imaginable to collect and spend as much as possible. This drives up premiums as well as the actual cost of care, as the insurance companies join patients in lacking a strong incentive to be conscious of the prices providers charge.

As noted, large group plans are subject to a more-stringent MLR. FreedomWorks Foundation finds this to be problematic for any new association formed and choosing to purchase third-party insurance as a result of DOL's proposed rulemaking. Many of the benefits of reduced EHBs and AV standards will be lost due to the higher MLR. However, self-insured plans, meaning those plans where the employer or the association covers the cost of employee care directly, are entirely exempt from MLR standards. This is, for now, a worthwhile trade-off as it will be important to study how associations respond to this incentive and if associations of non-insurance companies are more effective in negotiating prices with healthcare providers for the beneficiaries of their plans.

[2] Yong, Pierre L., John Bertko, and Richard Kronick, "Actuarial Value and Employer-Sponsored Insurance," Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, November 15, 2011.

Conclusion

FreedomWorks Foundation appreciates the opportunity to provide these broad suggestions to DOL regarding regulatory reform under ACA and support the proposed rulemaking at hand. ACA facilitated an expanded role for third-party payers in the healthcare market place, only enlarging the core problem of healthcare price inflation. To the extent possible, administrative agencies with ACA jurisdiction should seek to empower patients to apply market pressure on providers to begin the process of halting and reversing healthcare price inflation. Neither government nor insurance companies will ever be able to spend a patient's healthcare dollars as efficiently as the patient themselves. To the extent that DOL can implement the reforms suggested above and outlined in this proposed regulation, America's healthcare system will be that much more sustainable long-term.

Thank you.
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