

March 5, 2018

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

Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
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)**

Dear Secretary Acosta and Assistant Secretary Rutledge:

HealthyWomen appreciates the opportunity to comment in response to the proposed rule, Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans.

HealthyWomen is the nation's leading independent, nonprofit health information source for women. For nearly 30 years, millions of women have turned to HealthyWomen for answers to their most personal health care questions. HealthyWomen provides objective, research-based health information, and advocates on behalf of women to ensure that women's health is a primary focus by policy makers and others. Our mission is to educate and empower women to make informed health choices for themselves and their families about access to care, and the safety of health care products and services.

HealthyWomen is writing today to strongly object 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, and harm women and families, and by extension their communities.

We understand that the proposed rule may lower costs and offer more choices for some individuals and small employers, but in doing so it would increase costs and limit choices for all other employers, and for individuals in less-than-perfect health, i.e. those with pre-existing conditions. Moreover, historically AHPs have experienced significant fraud and insolvency that has left patients with unpaid medical bills and no health insurance coverage. We are also very concerned about how the proposed rule would reshape the individual and small group insurance markets, and believe there are ways that if finalized, this rule can offer some protections for

women, families, and their communities – particularly transparency about benefits, protections against gender and other discriminations, and the ability of states fully to regulate and oversee AHPs as discussed below.

There must be transparency about covered benefits and value:

We appreciate the Department requesting information about required notices by AHPs. We strongly believe that AHPs should be required to provide clear and transparent information to potential and enrolled employers and beneficiaries about what services and benefits are covered, and the individual's financial responsibilities. Specifically, those notices and information should compare the AHPs plan to the Essential Health Benefits (EHB) required under the Affordable Care Act (ACA), as well as the actuarial value and expected medical loss ratio for the plan. One of the dramatic improvements the ACA made for individuals shopping for health insurance was the requirement for clear and concise explanations of what an insurance plan covered and the enrollees expected costs.

Providing such information will enable employer groups and employees to know what the plans actually cover, and such information is crucial for competitive purchasing and an economically responsible market for health insurance. Further, employers should be required to inform employees that if the AHP does not meet minimum value, they have the 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 and all EHBs not covered by their plans. The bottom-line is that individuals and small businesses must be notified if AHPs are not meeting minimum value or are not providing all the EHBs required under the ACA.

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. Given the history of AHPs problems with fraud and solvency, such transparency requirements are crucial.

AHPs should not be able to discriminate based upon gender, age, or industry:

Currently, AHP insurance plans 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.

AHPs are regulated by the “look-through” doctrine set forth in 2011 guidance from CMS.¹ 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. 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 EHBs. 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 women and families.

We are particularly concerned that a rule without a requirement for health insurance to cover maternity care will both discriminate against women and families, and unduly burden communities. Specifically, if insurance can be sold without maternity benefits, those that do include such coverage will be more expensive for young women and families. This could lead some women and families to forego maternity coverage, and it has been widely shown that lack of coverage for maternity services leads to less prenatal care and worse clinical outcomes.ⁱⁱ Such worse outcomes (with the United States already lagging behind its peer countriesⁱⁱⁱ), are more than just public health statistics, but place real burdens on communities' schools and social services – which can then require increased taxes. In addition, as was pointed out by the Black Women's Health Imperative at a briefing HealthyWomen organized in October 2018, black women in the United States are three to four times more likely to die from pregnancy complications.^{iv} And from a community and economic development perspective, poor childbirth outcomes impede women from being productive and consistent workers, further constraining local economic growth.

Overall, with the rule as proposed, AHPs could substantially scale back their benefits, dropping benefits entirely or dramatically limiting them. Selling insurance plans with limited benefits was a predatory practice that existed before the ACA designed to discourage anyone with a pre-existing health condition or high expected health care utilization – such as the expectation of pregnancy – from enrolling in coverage. This was one of the long-standing problems in the individual and small group insurance markets that the ACA sought to improve or constrain. Specifically, before the ACA, only 12 percent of plans in the individual market covered maternity care benefit.^v Even among plans that covered maternity services, the coverage was not always comprehensive or affordable. One study found that several plans charged a separate maternity deductible that was as high as \$10,000, and some plans had waiting periods of up to a year before maternity care would be covered.^{vi}

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.

Again, the ACA attempted to improve or limit such problems in the individual insurance market. For example, before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating, costing women approximately \$1 billion a year.^{vii} While the

proposed rule would protect individuals from being charged more because of their gender, employers with higher rates of female employees could be charged higher premiums, which would ultimately be passed down to their employees.

Therefore, 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.

Existing protections against discrimination under HIPAA should be maintained:

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. We applaud this proposal, as it 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 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. As noted above, 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 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, diabetes, or low birthweight infants, 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 covering EHBs, 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 market micro-segmentation.

Failure to extend those 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 those 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.

States must retain authority to regulate Association Health Plans:

The proposed rule raises questions about preemption of state law. We oppose preemption of state authority in this area, and any attempt to preempt states through this rulemaking would be seen as usurping Congress' authority. States have long taken the lead in addressing AHP insolvencies and fraud, and maintaining competitive markets, and any attempt to preempt state authority would harm consumers. The Department's inability to serve as the sole regulator has been well documented. The Department neither has the resources nor the expertise to serve as the sole regulator, both of which weigh strongly against the Department taking action to prevent states from regulating in this area. Any attempts to issue class or individual exemptions for AHPs would be an attack on the states and would only serve to enable and promote fraud and insolvency.

Given the history of AHPs financial and marketing problems, the ability of states to regulate AHPs is particularly important. For example, AHPs would set up headquarters in a state with limited regulatory oversight and then market policies to businesses and consumers in other states with more robust regulation, thereby bypassing those states' more protective rating and benefit standards.^{viii} While such ability to "sell across state lines" sounds good, history reveals a very darker picture: Prior to the ACA, AHPs were frequently used as a vehicle for selling fraudulent insurance coverage. Scams initially flourished after Congress exempted AHP arrangements from state oversight in 1974 through Employee Retirement Income Security Act (ERISA).^{ix} The operators of those fraudulent AHPs targeted small businesses and self-employed people, and then collected premiums for non-existent health insurance, did not pay medical claims, and left businesses and individuals with millions of dollars in unpaid bills and patients without health insurance coverage.^x Even with increased oversight in recent years, fraudulent insurance sold

through associations has remained a problem: Between 2000 and 2002, 144 operations left over 200,000 policyholders with over \$252 million in medical bills.^{xi}

Thus, we are extremely concerned that the proposed regulation will once again leave consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, and lifelong health impairments – just as AHPs did before the ACA provided more oversight and protection. Therefore, the ability for states to have real and extensive oversight of AHPs is a crucial consumer protection and public health imperative.

We recognize that the Department states that the proposed rules do not alter existing ERISA statutory provisions governing multiple employer welfare arrangements (MEWAs), we are concerned that the proposed rules will have the result of preempting existing and future efforts by states to regulate MEWAs. The proposed rules' new framework allowing many more AHPs to be treated as large, single employer plans invites new insurance scams by creating confusion about states' enforcement authority over AHPs. 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 fraudulent operations.^{xii}

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. This will maintain states' ability to protect consumers from the potential ramifications of fraudulent or insolvent AHPs, and to manage their insurance markets.

Thank you for this opportunity to comment in response to the proposed rule, Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans. If you have any questions or concerns about our comments or recommendations, please contact me at 732-530-3425 or beth@healthywomen.org.

Sincerely,

A handwritten signature in black ink that reads "Beth Battaglinio". The signature is written in a cursive, slightly slanted style.

Elizabeth Battaglinio, RN
Chief Executive Officer
HealthyWomen

- i 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
- ii Chang J, Elam-Evans LD, Berg CJ, Herndon J, Flowers L, Seed KA, et al. Pregnancy-related mortality surveillance – United States, 1991–1999. *MMWR Surveill Summ*. 2003 Feb 21;52(2):1–8. pmid:
- iii Central Intelligence Agency World Fact Book – Infant Mortality (<https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html>), and Bulletin of the World Health Organization 2015;93:135, "Maternal mortality and morbidity in the United States of America" (<http://dx.doi.org/10.2471/BLT.14.148627>)
- iv CDC PUBLIC HEALTH GRAND ROUNDS "Meeting the Challenges of Measuring and Preventing Maternal Mortality in the United States," November 17, 2017 (<https://www.cdc.gov/cdcgrandrounds/archives/2017/november2017.html>)
- v National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf
- vi National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf
- vii National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf
- viii 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>
- ix Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from <https://hpi.georgetown.edu/ahp.html>
- x Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from <https://hpi.georgetown.edu/ahp.html>
- xi Kofman, M. (2005). *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*. Georgetown University Health Policy Institute. Retrieved 8 February 2017, from <https://hpi.georgetown.edu/ahp.html>
- xii 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>