



March 6, 2018

Office of Regulations 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

To Whom It May Concern:

We are writing on behalf of the HIV Health Care Access Working Group (HHCAGW) – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and Hepatitis C-related health care and support services. We appreciate the opportunity to provide comments to the proposed Department of Labor rule, *Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans*.

Standards and protections governing individual and small group private insurance markets must ensure access to comprehensive and affordable coverage for people living with HIV, HCV, and other chronic conditions. We are concerned that the proposal to weaken consumer protections for Association Health Plans (AHPs) will harm vulnerable populations, and we urge HHS to consider the recommendations and comments detailed below.

Prior to the ACA, states defined multiple employer welfare arrangements (MEWAs)—which encompasses the AHPs that would proliferate if the proposed rule were finalized—as large group plans even though they were marketed to self-employed individuals and small businesses. The ACA required policies sold through Association Health Plans (AHPs) to individuals and small groups to be regulated under individual and small group market standards. This is important because it means that, under current law, AHPs must comply with ACA protections. Additionally, AHPs have a long history of fraud and financial insolvency that left consumers and providers with millions in unpaid claims, and the proposed rule would pave the way for federal preemption of state attempts to protect consumers from these risks. The proposed rules would lower the bar for AHP formation by allowing AHPs to form without a common interest beyond shared industry or geographic location, solely for the purpose of offering health insurance. We are concerned that the proposed AHP framework would lead to a proliferation of AHPs across the country, and that the lack of fiscal oversight and clear regulatory authority over AHPs would pose a significant financial risk to consumers and providers.

The Rule Would Weaken Important Consumer Protection and Benefits Standards

The proposal to change current rules by exempting AHPs from many of the federal standards and protections that apply to individual and small group plans, and to instead allow AHPs to offer coverage as large employer plans, would jeopardize important consumer protections. This proposal would allow AHPs to bypass important ACA protections for small group and individual insurance, such as Essential Health Benefits (EHBs) and rating restrictions, that will hurt consumers with pre-existing conditions. The proposed rule would allow AHPs to be regulated as large group plans even if they market to small businesses and self-employed individuals. This would harm people living with HIV, HCV, and people with other chronic conditions that have gained access to affordable coverage because of the ACA's important reforms.

The proposed rule prohibits AHPs from restricting membership in the association based on health factors or charging higher premiums to an employer based on the health of its employees. While this is a critical provision and should be retained in the final rule, it is far from sufficient to protect consumers. The proposed rule leaves ample room for AHPs to use permissible "bona fide employment-based classifications" (e.g., full or part-time status or geographic location) as a pretext for discriminating against groups of individuals on the basis of health factors. For example, under the proposed rule as currently drafted, AHPs could reject or charge higher premiums to groups of enrollees who work in professions or live in neighborhoods that are deemed high-risk. Additionally, although the proposed rule would prohibit AHPs from discriminating against employer members, AHPs that are treated as large group plans could still vary premiums based on health status, gender, and age of their overall enrollee pool.

In addition to using permissible "employment-based" criteria as a proxy for health status, AHPs could further discriminate against individuals with pre-existing conditions by structuring eligibility rules, benefit designs, and marketing practices in ways that encourage enrollment by healthier individuals and groups while discouraging less healthy individuals and groups. For example, an AHP could avoid covering certain benefits, such as specialty drugs or mental health care. Additionally, AHPs would not be subject to the ACA's rating restrictions. People who enroll in an AHP could therefore find they don't have coverage of benefits they need, or that they must pay large amounts out of pocket for their medical care.

DOL requests comment from stakeholders on its proposal to prohibit AHPs from treating different employer-members as different groups based on health factors of individual employees. Specifically, DOL requests comment on whether this structure would "create involuntary cross-subsidization across firms," and cites arguments in favor of health plan pricing where premiums match risk. We oppose any proposal that allows individuals or groups of individuals to buy insurance that matches their risk. This is functionally the same as allowing seemingly permissible "employment-based" criteria to serve as a pretext for discrimination on the basis of health factors. Health status is not static; individuals who are healthy today could be diagnosed with HIV, HCV, or another chronic illness at any time. Individuals with chronic illness could still be employed in low-risk professions, but their offer of coverage through the AHP may not be adequate for their needs if the AHP were allowed to bypass ACA protections such as EHBs and rating restrictions. Additionally, if the offer of coverage through the AHP meets minimum value and affordability requirements, individuals with high health needs would become ineligible for premium tax credits and therefore would not have the option of purchasing affordable coverage through the marketplace that meets their needs.

The Rule Would Weaken State Regulation and Oversight

Due to the widespread fraud and insolvency associated with AHPs, Congress amended ERISA in 1983 to clarify that states have authority to regulate such arrangements. The proposed rule suggests that states would continue to have regulatory authority over health insurance issuers and the insurance policies they sell to AHPs; however, we are concerned that the proposed rule does not establish a clear regulatory authority over AHPs, and we fear that state attempts to protect consumers from the risks historically associated with AHPs would be preempted if they are found to be inconsistent with the federal approach.

The proposed rule does not clarify whether and to what extent states can continue to apply the state small group and individual market standards to AHPs. This lack of regulatory clarity would allow AHPs to bypass state laws or the ACA's protections, or both, depending on how they are structured. AHPs that self-insure would be treated as self-insured employer health plans under ERISA, even if they market to self-employed individuals in addition to small groups. This would allow self-insured AHPs to bypass state regulations and ACA protections that apply to the individual and small group markets. AHPs that do not self-insure, and which would therefore be subject to state regulations, could choose to establish themselves in states with weaker regulations but still offer coverage in multiple states or nationwide due to the proposed changes to the Department's "commonality" requirements. This would create a race to the bottom and threaten the viability of the individual market in states with stricter rules. This was a common practice of AHPs prior to the 1983 ERISA amendments, and many states therefore require AHPs to obtain a license from the insurance department before marketing in their state. Additionally, AHPs with enough members could be treated as large group plans even though they will be marketed to small groups and individuals, allowing them to bypass laws and protections applicable to small group and individual plans.

The Department points to its authority to exempt AHPs from state insurance regulation, and seeks comment on whether the Department should use this authority to exempt AHPs from state oversight and insurance standards. We oppose this exercise of authority and urge the Department not to take any actions that weaken state regulation and oversight of AHPs or that otherwise preempt state law intended to preserve important consumer protections.

The Rule Would Make Comprehensive ACA-Compliant Coverage More Expensive

If the proposed rule were finalized in its current form, AHPs could bypass important ACA protections and structure eligibility rules, benefit designs, and marketing practices in ways that encourage enrollment by healthier individuals and groups while discouraging less healthy individuals and groups. AHPs would be competing in the same market as individual and small-group plans, but would be subject to different rules. Although the rule prohibits AHPs from setting premiums based on an individual employer's claims history, the AHP would still be allowed to base premiums on its overall enrollee risk pool. An AHP that structures its eligibility rules and benefit designs to attract a healthier risk pool would therefore be able to charge lower-than-average premiums. This would create an uneven playing field and lead to adverse selection because AHPs could siphon health individuals from the ACA-compliant plans in the individual and small group markets.

The impact of this exodus by healthy self-employed individuals from the individual market would be substantial; the U.S. Department of the Treasury found that, in 2014, one in five Marketplace consumers

was a small business owner or self-employed.¹ People and small businesses that want comprehensive coverage in the individual and small-group insurance markets could find their options dwindling or that the premiums are unaffordable. This is especially harmful to people living with HIV, HCV, and other chronic conditions who may not be able to find individual or small group coverage that is adequate to meet their high health needs.

The ACA's single risk pool requirement requires issuers to determine rates based on the combined experience of all members within each market, and the risk adjustment program transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees. Together, these requirements create statewide rating pools for the individual and small group markets. AHPs would not be subject to these requirements, and the ability of AHPs to siphon healthier individuals from the ACA-compliant plans would therefore bifurcate the individual and small group markets and create a rate spiral.² This would make it difficult or impossible for individuals living with HIV, HCV, and other chronic conditions to purchase affordable individual or small group coverage that meets their needs.

Thank you for the opportunity to comment this proposed rule. We urge HHS to continue its commitment to ensure that people living with HIV, HCV, and other chronic and complex conditions have access to quality, affordable healthcare coverage. Please contact Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, Andrea Weddle at aweddle@hivma.org with the HIV Medicine Association, or Robert Greenwald at rgreenwa@law.harvard.edu with the Center for Health Law and Policy Innovation if we can be of assistance.

Respectfully submitted by:

ADAP Educational Initiative | AIDS Alabama | AIDS Action Baltimore | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | AIDS United | American Academy of HIV Medicine | APLA Health | AIDS Resource Center of Wisconsin | Communities Advocating Emergency AIDS Relief (CAEAR) | Community Access National Network (CANN) | Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association | Housing Works | Human Rights Campaign | Legal Council for Health Justice | Michigan Positive Action Coalition | Minnesota AIDS Project | National Alliance of State and Territorial AIDS Directors | National Latino AIDS Action Network | NMAC | Positive Women's Network - USA | Project Inform | Rocky Mountain CARES | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | Southern HIV/AIDS Strategy Initiative | The AIDS Institute | Treatment Access Expansion Project

¹ Treasury Note: One in Five 2014 Marketplace Consumers was a Small Business Owner or Self-Employed, U.S. Dept. of the Treasury, Jan. 12, 2017, <https://www.treasury.gov/connect/blog/Pages/One-in-Five-2014-Marketplace-Consumers-was-a-Small-Business-Owner-or-Self-Employed.aspx>.

² Letter from American Academy of Actuaries to the Employee Benefits Security Administration Office of Regulations and Interpretations, Feb. 9, 2018, http://actuary.org/files/publications/AHP_modeling_considerations_02092018.pdf.