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March 6, 2018

Submitted electronically via <http://www.regulations.gov>

Amy Turner
Director, Office of Health Plan Standards
Employee Benefits Security Administration
Department of Labor
Attention: Definition of Employer- Small Business Plans RIN 1210-AB85
200 Constitution Avenue NW
Washington, DC 20210

RE: Comments on Definition of Employer – Small Business Plans RIN 1210-AB85

Dear Director Turner,

Bi-State Primary Care Association appreciates the opportunity to comment on the Department of Labor's proposed rule regarding Association Health Plans and the proposed changes to the definition of employer.¹

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization that promotes access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in New Hampshire and Vermont. Bi-State's combined NH and VT membership includes 29 Community Health Centers (CHCs), delivering primary care at 120 locations for over 302,000 patients, the majority of whom live at or below 200% of the federal poverty level and face multiple social and economic factors impacting their need for health care and their ability to access care appropriately.² CHCs historically have, and will continue to care for all patients in their community, extending their expertise in caring for our most vulnerable: the uninsured and underinsured.

The Department of Labor's notice of proposed rulemaking (NPRM) intends to adopt a new definition of "employer" for purposes of determining when employers can join together to offer or enroll in an Association Health Plan (AHP) that is treated as a group health plan under ERISA. Depending on the type of AHP, which state it operates in, and the number of individuals covered, the benefits covered and the costs incurred may be different than those currently required by federal law for the small group and individual market. By design, the NPRM allows for flexibility around benefits covered by AHPs, and the benefits impacted include: limitations on pre-existing conditions, essential benefits, and out-of-pocket maximums. Under current law, these benefits are standardized for the small business and individual health insurance markets.

For CHCs, it is important that their patients have access to the best coverage available to them; whether that be through AHPs, the Marketplace, Medicare or Medicaid, or some other form of insurance, as coverage is an important element in providing good health care. Coverage does not just mean holding an insurance card, but rather the ability to access preventive services and care coordination, in addition to primary care needs. This also includes access to specialty care – including care beyond the walls of the

¹ 83 Fed. Reg. 614 (January 5, 2018).

² For a family of 3, 200% of the federal poverty level is approximately \$40,840 per year. See FPL Guidelines: <https://aspe.hhs.gov/poverty-guidelines>.

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CHC. Too often we see patients that have an insurance card, but their options for care are limited, meaning that they must travel many miles to find a covered provider, or the plan includes a prohibitively high deductible, making the coverage essentially useless to its holder. This under-insurance puts a strain not just on the patient, but on the CHCs too because they are required to provide care, regardless of the patient's ability to pay. It is important that any proposal to create a new form of coverage offer affordable and robust coverage, allowing patients to access the care that they need, primary and preventive as well as acute, in their communities and without barriers to care.

From a financial perspective, when our patients have good coverage, that in turn eases the financial burden on our federal grant dollars that go toward covering the costs of delivering care effectively to our medically underserved patients and communities. Comprehensive coverage allows patients to access the care they need and frees up those much-needed grant dollars for those with no insurance at all.

Accordingly, the following are our concerns with the proposed changes in the NPRM:

- **Consumer protections:** CHCs exist to serve our patients who are our consumers. As designed, AHPs would be a disservice to our consumers. In the past, DOL noted that AHPs have left a legacy of insolvency and fraud with millions of unpaid claims effecting patients and providers. Additionally, there are no federal financial standards or fiscal oversight to guarantee AHPs remain financially stable. Even if states set financial standards, reserve contributions, and solvency requirements, there still remain issues around enforcement and regulations, and the states' reporting requirements from the AHPs.
- **States authority to regulate:** States want the authority to regulate AHP actions as states would be mostly powerless to protect residents without that authority, and in the past AHPs have left consumers uninsured. Regulation at Department of Insurance within each state grants regulatory standards for solvency requirements. If the arrangements that are created are not financially stable, and without regulators observing the practices of an AHP, it could leave consumers exposed and uninsured.
- **Market instability and fragmentation:** AHPs by nature segment the insurance markets as they are intended to pull off a segment of the population. If the segment population is healthy this would cause adverse selection as populations that are left in the market place would be older and sicker which will lead to an increase in premiums. AHPs would expand alternative parallel markets for health coverage, which would lead to higher premiums for consumers, especially those with pre-existing conditions. The balance between health and unhealthy can shift so much that the general insurance market goes into a what is known as a 'death spiral' where the coverage becomes increasingly more expensive and potentially unattainable. Additionally, the lower cost of premiums may be an attraction for someone to join an AHP, but the coverage will be limited and in turn the patient's health care options will be limited.
- **Lack of adequate coverage:** AHPs do not have to provide Essential Health Benefits (EHB). The principle objective of the NPRM is to expand employer and employee access to affordable high quality coverage. The principle of affordable is only possible with a shallow benefit package which would not cover all the EHBs. The current health insurance market guarantees access to comprehensive health coverage such as EHB regardless of health status which an AHP would not need to meet. AHPs do not have to cover EHB and may deny or charge more to people who have pre-existing medical conditions, or exclude such conditions, and limit the amount of benefits.
- **No limits on premium variation based on age, geography-rural areas, or gender:** The NPRM leaves open the possibility that AHPs can exclude coverage or limit services for more costly populations which would allow for age and gender discrimination. Additionally, AHPs could incentivize employers to not offer certain benefits or charge employers more for covering maternity care, or paying for insulin, or expensive Hepatitis C or HIV drugs.

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- **Network adequacy:** Provider networks for a multi-state plan need a robust network in each state and we are wondering how the states could assure such a robust provider network as this is not addressed in the NPRM. A robust primary care network is the core foundation for group health plan coverage.
- **Issues of churn:** With the individual mandate not enforced in 2018 and ending in 2019, there are no protections for the patients and for the plans. Individuals could purchase coverage before a surgical event, have coverage for a short duration, and then stop paying the premiums which then the plan would have to pay out the claims without the benefit of the continued premiums. This would hold the insurer hostage to paying the claim without the premiums over time.

In closing, Bi-State appreciates the opportunity to submit comments on this important issue, and both our staff and member CHCs would be happy to provide further information that would be helpful. Please do not hesitate to contact me at (603) 228-2830 extension 112 or via email at tkuenning@bistatepca.org if you would like additional information or require clarification on the comments presented above.

Sincerely,

A handwritten signature in cursive script that reads "Tess Kuenning".

Tess Stack Kuenning, CNS, MS, RN
President and Chief Executive Officer
Bi-State Primary Care Association