

# KENTUCKY EQUAL JUSTICE CENTER

March 6, 2018

*via regulations.gov*

Public Comments on:

The Employee Benefits Security Administration (EBSA) Proposed Rule:

**RE: [Definition of Employer Under Section 3\(5\) of ERISA-Association Health Plans](#)**

To Whom It May Concern:

I write on behalf of Kentucky Equal Justice Center (KEJC), a civil legal services program that works closely with the four legal aid organizations and community partners across Kentucky, focusing on low income or otherwise vulnerable Kentuckians. Our advocates assist individuals and families learn about, enroll, and troubleshoot their healthcare from all sources, with a particular focus on Medicaid. We appreciate this opportunity to provide feedback on the definition of employer under Section 3(5) of the ERISA-Association Health Plans.

The health law fellowship at KEJC exists in part to monitor changes to laws that impact the health and quality of life of low income or otherwise vulnerable Kentuckians. This proposed federal rule would allow insurance companies to skirt Affordable Care Act provisions that prevent insurance companies from selling so-called short-term plans lacking comprehensive coverage. This proposed federal rule, if finalized, carves a pathway for insurance companies to offer subpar insurance coverage, known as short-term plans, as an alternative to comprehensive coverage sold on the ACA's marketplaces. Promoting this type of coverage would create an uneven playing field in which younger, healthier consumers flock to the less expensive, yet bare-bones plans, that don't cover many essential services, forcing older and less healthy patients to pay higher premiums for the comprehensive coverage they need.

**Plans as long as 364 days, "less than 12 months", are still health plans that should be regulated but the PPACA, aka the Affordable Care Act.**

The ACA always exempted "short-term" plans from the insurance guardrails that apply to regular nongroup coverage: These plans were intended to cover travelers or other people who need 1 to 3 months of coverage to fill gaps in between more permanent insurance arrangements. Last week the Trump administration proposed

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to greatly broaden the definition of “short-term” to be up to 364 days and then renewable indefinitely, allowing the creation of a parallel system of nongroup coverage that does not comply with core insurance protections around premiums, benefits and preexisting conditions.

State legislatures and insurance regulators could:

- Assess insurers that offer short-term coverage and reinvest these funds in a reinsurance program for the individual market. States could require insurers to price short-term plans in a way that more closely resembles their true costs through a “free rider” assessment. This assessment could apply to insurers that offer short-term coverage and be reinvested in the individual market for reinsurance. The assessment would likely result in higher premiums, which could cause lower enrollment in short-term plans, higher enrollment in ACA plans, and a healthier overall risk pool. This change would help prevent free-riding on the ACA-compliant market by requiring short-term plans to contribute towards the health of the individual market.

- Require short-term policies to meet a minimum medical loss ratio. States could require short-term coverage to meet the same medical loss ratio that applies in the individual market. Current federal rules require individual market insurers to spend at least 80 percent of premiums on health care services. The average loss ratio for short-term coverage in 2016 was 67 percent, suggesting this line of business is more profitable than the individual market where loss ratios have been much higher since 2014. Imposing a higher medical loss ratio for short-term coverage would help level the playing field and increase the value of these policies for consumers.

- Require completion of an ACA marketplace eligibility determination before allowing enrollment in short-term coverage. States could prohibit insurers from selling a short-term policy to a consumer unless that consumer shows that they’ve already received a marketplace eligibility determination. This might mean that a consumer attests that they received a marketplace eligibility determination and do not qualify for subsidies or a special enrollment period through the marketplace. This requirement could help ensure that consumers better understand their coverage options and the availability of subsidies for ACA-compliant coverage.

All in all, this is an attempt to circumvent the legislative process and deregulate the health insurance industry in ways required by the Patient Protection and the Affordable Care Act.

If you have any questions regarding these comments, please contact me at the information included below.



Please also send a copy of any response prepared to these comments to the same contact information:

Sincerely,

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