



March 6, 2018

Office of Regulations and Interpretations, Room N-5655  
Employee Benefits Security Administration  
Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

**Submitted electronically via regulations.gov**

**Attention: Definition of Employer – Small Business Health Plans RIN 1210-AB85**

Dear Secretary Acosta and Director Turner:

On behalf of the Residential Eating Disorders Consortium (REDC), please accept the written comments below in response to the proposed rule “Definition of ‘Employer’ under Section 3(5) of ERISA— Association Health Plans RIN 1210-AB85”. The REDC is a national trade association of eating disorder treatment centers, representing approximately 80 percent of the intermediate levels of care for eating disorders provided in the United States including residential, partial hospitalization, day program and intensive outpatient treatment. Our members agree to treatment and operational standards including accreditation by the independent accrediting bodies of the Joint Commission and/or Commission on Accreditation of Rehabilitation Facilities (CARF), conduct collaborative research, and work together to address treatment access issues facing individuals with eating disorders and their families. Our mission is to collaboratively address issues impacting treatment programs to increase access to treatment for individuals struggling with eating disorders.

REDC members are in the business of treating people affected by the serious mental illness of eating disorders and co-occurring conditions associated with the disorder. Eating disorders are complex, biologically-based serious mental illnesses, having the highest mortality rate of any psychiatric illness— with one person losing their life every 62 minutes as a direct result of an eating disorder.<sup>1</sup> Over 30 million Americans experience a clinically significant eating disorder during their lifetime<sup>2</sup>, affecting individuals of all ages, races, genders, ethnicities, socioeconomic backgrounds, body sizes, and sexual orientations.<sup>3</sup> Under the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders: DSM-5, eating disorders include the specific disorders of anorexia nervosa, bulimia nervosa, binge eating

---

<sup>1</sup> Swanson, S., Crow, S., Le Grange, D., Swendsen, J., Merikangas, K. Prevalence and Correlates of Eating Disorders in Adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *Arch Gen Psychiatry* 2011; 68:714-23.

<sup>2</sup> Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, 61(3), 348-358.

<sup>3</sup> Le Grange, D., Swanson, S. A., Crow, S. J., & Merikangas, K. R. (2012). Eating disorder not otherwise specified presentation in the US population. *International Journal of Eating Disorders*, 45(5), 711-718.



disorder, avoidant/restrictive food intake disorder, and other specified feeding or eating disorders.<sup>4</sup> These disorders are unique in that they co-occur and can lead to a number of mental health and medical complications. For example, half of people with eating disorders have co-occurring substance use disorders.<sup>5</sup> Additionally, eating disorders are associated with a range of medical complications including cardiac disability, starvation, hepatitis, refeeding syndrome, cognitive dysfunction, kidney failure, esophageal cancer, osteoporosis, fractures (hip, back, etc.), hypoglycemic seizures, amenorrhea, infertility, high and low blood pressure, Type II diabetes mellitus, edema (swelling), high cholesterol levels, gall bladder disease, decalcification of teeth, severe dehydration, chronically inflamed sore throat, and inflammation and possible rupture of the esophagus.<sup>6,7</sup>

When our patient population does not have affordable and comprehensive insurance coverage that includes mental health and substance use disorder (MH/SUD) treatment at all levels of care, they are not able to be admitted into our facilities for lifesaving treatment without finding out-of-pocket means to cover their care. Consequentially, our businesses, the U.S. economy, and American families affected by eating disorders are negatively impacted when people with eating disorders cannot afford or receive comprehensive treatment. Studies show that when a person with a severe eating disorder like anorexia does not receive full comprehensive treatment, 41 percent of patients will relapse and are two times more likely to end up in the emergency room than someone without an eating disorder.<sup>8</sup>

In turn, any action that would positively or negatively affect people with serious mental illness' access to treatment coverage directly impacts the core of our business and ability to provide service to those in need. Overall, we support efforts made by the federal government to provide access to quality and comprehensive health insurance coverage and to lower premium costs to make coverage affordable for all Americans. The following provides both our support for and concerns within the proposed rulemaking. We look forward to working with you in the future to continue to improve access to comprehensive care for all and welcome follow-up conversations to discuss further.

Sincerely,

Dr. Jillian Lampert, PhD, RD, LD, MPH, FAED, President, Residential Eating Disorders Consortium

---

<sup>4</sup> American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

<sup>5</sup> National Center on Addiction and Substance Abuse at Columbia University. (2003). *Food for thought: substance abuse and eating disorders* <http://www.centeronaddiction.org/addiction-research/reports/food-thought-substance-abuse-and-eating-disorders>

<sup>6</sup> Westmoreland, P., Krantz, M. J., & Mehler, P. S. (2016). Medical complications of anorexia nervosa and bulimia. *Am J Med*, 129(1), 30–37.

<sup>7</sup> Thornton, L. M., Watson, H. J., Jangmo, A., Welch, E., Wiklund, C., von Hausswolff-Juhlin, Y., . . . Bulik, C. M. (2017). Binge-eating disorder in the Swedish national registers: somatic comorbidity. *Int J Eat Disord*, 50(1), 58-65.

<sup>8</sup> Tackling Relapse Among Anorexia Nervosa Patients. (2013). *Eating Disorders Review*, 24, 9-11.; Yafu Zhao, M., & Encinosa, W., Ph.D. (2011, September). An Update on Hospitalizations for Eating Disorders, 1999 to 2009. Retrieved from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb120.jsp>



## **I. REDC Initial Analysis of Proposed Rule**

---

The release of the proposed rule on January 4, 2018 in response to Executive Order (EO) 13813 entitled, “Promoting Healthcare Choice and Competition Across the United States”, directed the agency to increase flexibility around regulations to allow more employers to form Association Health Plans (AHPs).

Under current federal law and regulations, health insurance coverage offered or provided through an AHP to individuals and small employers is regulated under the same federal standards that apply to insurance coverage under the individual and small group marketplace through the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Oftentimes the AHP is not the sponsor of a multiple employer plan; instead, each employer that receives health coverage through an association is considered to have a separate, single-employer health plan and the association is the mechanism by which each individual employer obtains benefits and administrative services for its own separate plan. This current regulatory structure makes for a complex and costly compliance environment for AHPs, as they may be subject to both large group as well as small group and individual marketplace regulation concurrently, which is a disincentive to join or form an AHP.

The proposed regulation would permit increased flexibility and redefine “group or association of employers” more broadly under the Employee Retirement Income Security Act (ERISA), permitting AHPs to be categorized as large group plans for the principle goal of expanding access to high quality, affordable health coverage for employers and employees.

The REDC has weighed the pros and cons of this proposed rule and will address several components including:

- *Protection Against Discrimination Based on Health Status (Section 4d, p.34).* We highly support the Administration’s proposal to protect Americans by preventing AHPs from discriminating premium prices and services based on health-status.
- *Increased Flexibility/Possibly Lower Premiums for Consumers (Section 1.6, p. 55).* We support the possibility of increasing competition and lowering premium costs for consumers in the health insurance industry if AHPs provide quality and comprehensive mental health and substance use disorder coverage to their consumers.
- *AHPs Operating Across State Lines (Section 4a, p. 22).* We are concerned with ambiguities in legal jurisdiction when AHPs operate across state lines and/or metropolitan areas that cross state lines. The REDC requests additional clarification on which state law would govern the AHP when operating in multiple states.
- *Risk of Adverse Selection (Section 1.7, p. 62).* We are concerned that AHPs have historically been known to select younger, healthier risk groups. If AHP consumers are removed from the small group/individual marketplace, the move potentially could leave the ACA marketplace with an aggregation of high-risk individuals and shift costs to those Americans.



- *Risk of Fraud/Insolvency (Section 6, p. 41)*. We are concerned that self-funded or partially self-funded AHPs would not be regulated by state law. Given the history of AHP fraud and insolvency, our businesses would take a significant risk in accepting patients under these plans.

## II. REDC Commentary on Proposed Rule

---

### i. *Protection Against Discrimination Based on Health Status*

Prior to the Affordable Care Act (ACA), individual insurance plans and current short-term duration health insurance plans have historically denied insurance coverage or charged higher rates for coverage based on the health status of individuals affected by an eating disorder. Given this history of discrimination based on health status, we strongly support the Department of Labor’s proposal limiting discrimination by stating the rule, “addresses the risk of adverse effects on the individual and small group markets by including nondiscrimination provisions under which AHPs could not condition eligibility for membership or benefits or vary members’ premiums based on their health status.”<sup>9</sup>

Eating disorders are a common, complex, severe and biologically-based mental illness, and if left untreated can lead to death. The average onset of an eating disorder is 12 to 13-years-old<sup>10</sup> and can last the entire lifetime of an individual. It is not uncommon for our treatment centers to serve people up to the age of 75-years-old. Moreover, it is common for individuals with eating disorders to experience both mental and physical co-occurring conditions. Research suggests that nearly 50 percent of individuals with eating disorders have a substance use disorder—a rate five times greater than the general population.<sup>11</sup> In turn, our population is often faced with lifetime recovery due to their health status.

Historically before the enactment of the ACA, insurers denied individuals coverage or charged them higher premiums based on their eating disorder and similar health status. An estimated 30 percent (29.4 million) nonelderly women and 24 percent (22.8 million) men have declinable pre-existing conditions<sup>12</sup>, which highlights the importance of barring insurers from prohibiting access solely on their health status. Fortunately, protecting individuals with pre-existing conditions has the support from Republicans and Democrats alike. The 2017 ACA reform efforts within the American Health Care Act (H.R. 1628) passed in the House and attempted in the Senate, included the protection against discrimination based on health status. Given the past practices and bipartisan backing, we support this inclusion in the proposed rule.

**Recommendation:** In addition to the protection based on health status, we recommend adding in similar anti-discrimination protections to these provisions for AHP consumers to prevent similar discriminatory practices. Additional protections to incorporate into the final rule should include prohibiting AHP eligibility

---

<sup>9</sup> Department of Labor. (2018). *Definition of “Employer” under Section 3(5) of ERISA -- Association Health Plans*. Retrieved from <https://federalregister.gov/d/2017-28103>.

<sup>10</sup> Swanson, S., Crow, S., Le Grange, D., Swendsen, J., Merikangas, K. (2011). Prevalence and Correlates of Eating Disorders in Adolescents. *Archives of General Psychiatry*, E1-E10. Retrieved from: <https://www.nationaleatingdisorders.org/prevalence-and-correlates-eating-disorders-adolescents>.

<sup>11</sup> Dennis, Amy and Helfman, Bethany. (2016). What Parents and Families Need to Know. Retrieved from <https://www.nationaleatingdisorders.org/substance-abuse-and-eating-disorders>

<sup>12</sup> Claxton, Gary; Cox, Cynthia; Damico, Anthony; Levitt, Larry; & Pollitz, Karen. (2016, Dec 12). *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*. Retrieved from <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>



for membership, benefits, and premiums based on age, geographical location, and gender. In addition to charging higher rates based on health status, insurers have historically charged higher rates than the 3:1 ratio under the ACA. Women are affected by eating disorders at twice the rate of men,<sup>13</sup> making us particularly concerned that our female patients may face higher premiums under AHPs.

*ii. Increased Flexibility/Potential for Lower Premiums for Consumers*

Currently, health insurance premium costs are rising across the nation at an unsustainable rate. Consumers saw a 37 percent increase for an average benchmark health plan from FY17-FY18.<sup>14</sup> Additionally, as it relates to covering mental health and substance use disorder under the ACA individual and small group marketplaces, high deductibles offer a barrier for treatment—especially with ACA Silver plans. Constituting AHPs as large group plans that are subject to less regulation than the small group/individual marketplace plans could yield lower premiums for consumers—increasing access and competition in the health insurance market. Depending on the generosity of AHP coverage offered, premiums in the new AHPs are projected to be \$1,900 to \$4,100 lower than the annual premiums in the small group market and \$8,700 to \$10,800 lower than the annual premiums in the individual market by 2022.<sup>15</sup> The proposed rule contends that AHPs can help reduce the cost of health coverage because of increased bargaining power, economies of scale, administrative efficiencies and transfer of plan maintenance responsibilities from participating employers to the AHP sponsor.<sup>16</sup>

Overall, if there is a regulatory capability to decrease premium costs while ensuring AHP consumers have access to quality and comprehensive mental health and substance use disorder treatment, we are supportive of this plan. However, we do have concerns that without establishing guardrails in regulations, AHPs may decide to opt-out of providing comprehensive MH/SUD coverage as one way to curtail premium costs. Under the constructs of a large group plan as proposed, AHPs would not need to provide the 10 essential health benefits (EHBs) as mandated under the ACA for the small group/individual markets, which includes mental health and substance use disorder benefits. The Congressional Budget Office (CBO) estimated that in the financial determination by States on which benefits to cover if given the option, dropping coverage for services with high costs would likely include mental health and substance use disorder treatment, rehabilitative and habilitative treatment and specific drugs.<sup>17</sup> This practice was common in large employer health plans prior to the ACA when 32 percent of covered workers had coverage which restricted benefits for outpatient mental health and just 12 percent of insurers provided unlimited outpatient mental health visits.<sup>18</sup>

---

<sup>13</sup> Wade, T. D., Keski-Rahkonen A., & Hudson, J. (2011). “Epidemiology of eating disorders.” Retrieved from <https://www.nationaleatingdisorders.org/research-males-and-eating-disorders>

<sup>14</sup> Jost, Timothy. (2017). Insurer Participation Down, Premiums Up In Uncertainty-Plagued Marketplaces. *Health Affairs*. doi: [10.1377/HBLOG20171030.733625](https://doi.org/10.1377/HBLOG20171030.733625)

<sup>15</sup> Avalere Health. (2018). “Association Health Plans: Projecting the Impact of the Proposed Rule.” Retrieved from <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf>

<sup>16</sup> Department of Labor. (2018). *Definition of “Employer” under Section 3(5) of ERISA -- Association Health Plans*. Retrieved from <https://federalregister.gov/d/2017-28103>.

<sup>17</sup> Congressional Budget Office. (2017, June 26.) H.R. 1628 Better Care Reconciliation Act of 2017. Retrieved from <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf>

<sup>18</sup> The Kaiser Family Foundation and Health Research and Education Trust. (2002). *Employer Health Benefits 2002 Annual*



**Recommendation:** We recommend including regulations that would ensure there are options for comprehensive MH/SUD coverage in AHPs to guarantee that individuals have access to this care. As an incentive to keep costs low, an AHP can offer an opt-out option for MH/SUD benefits even though the price difference is negligible. Research suggests that adequate eating disorder treatment is reasonably cost-effective given its ability to reduce overall co-occurring medical/surgical costs and dramatically reduce mortality.<sup>19</sup> Further, coverage for these services has a negligible effect on premium amounts. One study states that requiring insurers to provide access to the full range of eating disorder treatment would increase monthly premium amounts by only \$0.37 in 2012.<sup>20</sup>

*iii. AHP Plans Across State Lines*

The proposed rule would allow employers to band together for the express purpose of offering health coverage if they are: (1) in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same State or the same metropolitan area.<sup>21</sup> We see the value in providing plans within metropolitan areas, as the consumer search for providers is often not based on state lines. However, our concern is that without a defined state jurisdiction for AHPs as exists under the current legal constructs, treatment of people with severe mental illness, like eating disorders and/or a substance use disorder, may be negatively affected by the varying state laws governing this coverage. Research posits that two-thirds of states apply different regulations to AHP plans than they do to plans sold in the same market without an AHP.<sup>22</sup> Further, the same research cites that half of the states entirely or partially exempt national AHPs from state regulation.

Our primary concern is the inability to guarantee mental health parity within AHPs that cross state lines. In 2008, President George W. Bush signed into law the bipartisan Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (mental health parity) (PL 110-460). Mental health parity is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. Mental health parity originally applied to large group plans, and while it does not apply directly to small group health plans, its requirements are applied indirectly in connection with the ACA's EHB requirements. These mental health parity protections prohibit plans from imposing higher annual or lifetime limits, financial limitations, and treatment limitations on mental health benefits than is applicable to medical/surgical benefits.<sup>23</sup> Mental health parity law states that the law does not mandate coverage for mental health treatment, but only applies to plans that offer mental health benefits.

---

Survey. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/04/3251.pdf>.

<sup>19</sup> Scott J. Crow & J.A. Nyman. The cost-effectiveness of anorexia nervosa treatment. *Int'l J. Eating Dis.* March 2004; 35(2):15-60.

<sup>20</sup> Compass Health Analytics, Inc., Actuarial Assessment of Massachusetts House Bill No. 3024 Defining Eating Disorders as Biologically-Based Illnesses prepared for Division of Health Care Finance and Policy, Commonwealth of Massachusetts, available at: <http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/mandates/eating-disorder-compass.pdf>.

<sup>21</sup> Department of Labor. (2018). *Definition of "Employer" under Section 3(5) of ERISA -- Association Health Plans*. Retrieved from <https://federalregister.gov/d/2017-28103>.

<sup>22</sup> Kofman, Mila; Lucia, Kevin; Bangit, Eliza, & Pollitz, Karen. (2006). Association Health Plans: What's All the Fuss About? *Health Affairs*, 25, 6. doi: 10.1377/hlthaff.25.6.1591.

<sup>23</sup> (2014). Mental Health Parity. Health Affairs Health Policy Brief. doi: 10.1377/hpb20140403.871424.



Particularly of note, after the passage of mental health parity, several states took proactive steps to provide even greater mental health parity requirements for plans within their state, and other states offer disease-specific coverage requirements, including eating disorders. Our overarching concern is that with states holding different laws for mental health parity and coverage requirements, without AHPs being regulated under one state jurisdiction and consumers crossing state lines, there would be confusion and gray areas regarding how plans, providers, and consumers should comply with state law. For example, operating an AHP in the Kansas City Metropolitan Area could negatively impact equal access to MH/SUD care. In 2015, the Missouri State Legislature passed SB 145 “Requires health benefit plans cover diagnosis and treatment of eating disorders “which provided clear guidelines for insurance companies to utilize when determining approval or denial of coverage for an eating disorder. The legislation states that medical necessity for eating disorder treatment should not be based upon an individual’s weight but should also consider their overall physical and medical needs.<sup>24</sup> Conversely, Kansas’ mental health parity law specifically cites treatment limitations at the discretion of the insurer including limits on treatment frequency, number of visits and days of treatment, which insurers have historically used to curtail coverage.<sup>25</sup>

Another example of similar metropolitan area state law differences is in Illinois as it relates to Public Act 99-480 which extends coverage beyond Federal law. The new law includes important provisions to extend and clarify coverage, educate consumers about their rights, require minimum treatment benefits, and improve enforcement of parity laws.<sup>26</sup> Particularly for the Chicago metropolitan area, these Illinois state law benefits contrast in some ways to what is offered in Wisconsin where insurers are not required to provide a minimum set of treatment benefits.<sup>27</sup> These disparate laws have the potential to segregate our consumers into different levels of treatment and care.

**Recommendation:** We recommend the Department provide additional clarity on the following (1) which state would hold jurisdiction over AHPs when operating in a metropolitan area that crosses state lines; and (2) which state would hold jurisdiction over consumers when crossing state lines including (a) if consumers in a state with stronger protections would be permitted the same rights under the AHP plan if it fell outside of the state, and (b) if consumers in a state with weaker protections would be permitted the rights of an AHP plan based in a state with stronger protections. As the examples detailed above, individuals in need of eating disorder treatment would receive comprehensive care coverage in Missouri and Illinois, while individuals seeking treatment in Kansas and Wisconsin could be faced with limited care or denial of coverage.

When recovery is cut short by insufficient treatment or denial of coverage, individuals are discharged before they acquire the skills necessary to sustain treatment gains, resulting in costly and potentially life-

---

<sup>24</sup> Teicher, Rachel. (2015). Missouri Bill Changes Insurers to Comply with Parity and Cover Eating Disorder Treatment. Retrieved from <http://www.kantorlaw.net/Blog/2015/May/Missouri-Bill-Challenges-Insurers-to-Comply-with.aspx>

<sup>25</sup> Kansas Office of Revisor of Statutes. (n.d.). 40-2,105a. Kansas mental health parity act; insurance coverage for services rendered in the treatment of mental illnesses, alcoholism, drug abuse or substance use disorders; limitations. Retrieved from [http://www.ksrevisor.org/statutes/chapters/ch40/040\\_002\\_0105a.html](http://www.ksrevisor.org/statutes/chapters/ch40/040_002_0105a.html)

<sup>26</sup> The Kennedy Forum. (n.d.). Mental Health and Addiction Parity in Illinois. Retrieved from <http://thekennedyforumillinois.org/wp-content/uploads/2015/12/Summary-of-HB-1-Parity-Provisions.pdf>

<sup>27</sup> Office of the Commissioner of Insurance. (2017). State of Wisconsin: Fact Sheet on Mandated Benefits for the Treatment of Nervous and Mental Disorders or Substance Use Disorders. Retrieved from: <https://oci.wi.gov/Documents/Consumers/PI-008.pdf>



threatening cycle of inpatient admissions and inadequate outpatient care. We would recommend that preferential treatment for states that have stronger consumer protections, to allow individuals within those metropolitan areas to be governed under those robust laws.

*iv. Risk of Adverse Selection*

An estimated 10 percent of our patient population holds insurance plans within the ACA individual and small group marketplace. We are concerned that the potential change in how AHPs form, may disrupt the risk-balance within the underlying ACA requirements, creating a government-funded high-risk pool. Without being subject to the ACA regulatory requirements, AHPs may be able to offer lower cost plans that appeal to younger, lower-risk groups. This appeal can lead to an aggregation of high-risk pools in the small group/individual markets, effectively raising costs and premiums for those groups. According to the National Association of Insurance Commissioners (NAIC), allowing employers with a younger, healthier workforce to withdraw from the small group market would leave small businesses with older, sicker employees.<sup>28</sup> While rates may decrease for those businesses belonging to AHPs, premiums in the remaining ACA pool are expected to rise by 2.7-4.0 percent in the individual market and 0.1-1.9 percent in the small group market.<sup>29</sup> Similarly, the American Academy of Actuaries suggests AHPs fragment the insurance market as lower-cost groups and individuals move to establish an AHP, and high-cost groups and individuals remain in the traditional market.<sup>30</sup> This would ultimately result in higher-cost individuals and small groups finding it more difficult to obtain affordable coverage.

According to the Kaiser Family Foundation (KFF), state high-risk pools cover a fraction of the number of people with pre-existing health conditions who lack insurance. To afford a state risk pool, states typically exclude coverage of services associated with health status for a selected period of time and charge higher premiums. Even with these exclusions, the federal government has had to cover the losses to these states, which has seen payouts exceed over \$1 billion dollars.<sup>31</sup>

**Recommendation:** Given that a portion of our patient population receives coverage from the ACA marketplace, increasing premiums beyond the 2018 rates will dramatically affect our patient's ability to afford and receive care. We encourage the Department to consider the adverse effect these legal changes for AHPs would have on state costs, the remaining ACA insurance markets, and the populations those markets serve.

*v. Risk of Fraud or Insolvency*

Historically, Congress and states have taken steps to mitigate fraud and abuse within AHPs. The proposed rule also includes risk mitigation techniques such as requiring that the group or AHP have a formal

---

<sup>28</sup> NAIC. "Consumer Alert: Association Health Plans are Bad for Consumers. Retrieved from [http://www.naic.org/documents/consumer\\_alert\\_ahps.pdf](http://www.naic.org/documents/consumer_alert_ahps.pdf)

<sup>29</sup> Avalere Health. (2018). "Association Health Plans: Projecting the Impact of the Proposed Rule." Retrieved from <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf>

<sup>30</sup> Hanna, Craig & Uccello, Cori. (2017). Issue Brief: Association Health Plans. Retrieved from <https://www.actuary.org/content/association-health-plans-0>

<sup>31</sup> Pollitz, Karen (2017). Issue Brief: High-Risk Pools for Uninsurable Individuals. Retrieved from <https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/>



organizational structure with a governing body and have by-laws to ensure organizations are genuine with the organizational structure necessary to act “in the interest” of participating employers.<sup>32</sup> However, the partially- and self-funded AHPs are concerning, as states will not have clear regulatory authority to oversee these plans. A Government Accountability Organization (GAO) report<sup>33</sup> previously identified 144 unique entities not authorized to sell insurance benefits coverage over a two-year period. The Department of Labor and the states reported that 144 unique entities:

- Sold coverage to at least 15,000 employers, including many small employers;
- Covered more than 200,000 policyholders; and
- Left at least \$252 million in unpaid medical claims, only about 21 percent of which had been recovered at the time of GAO’s 2003 study.

Fraudulent entities—such as those cited in the GAO report—leave Americans unable to pay their medical bills and health care professionals, like our Members, forced to contend with ways to finance uncompensated care. As business owners, a long history of unpaid medical claims puts our businesses at an increased risk in contracting with future AHPs.

**Recommendation:** To further protect against fraud and insolvency, we recommend including language within the rule to require all AHPs contract with an insurance underwriter to help develop their business plan.<sup>34</sup> For AHPs that are self-funded, we recommend that each self-funded plan include risk-based capital to ensure the association understands the capital needed to support their overall business operations and keep those monies in reserves.

### **III. Conclusion**

---

Access to quality and comprehensive care that includes MH/SUD treatment, is of critical importance to the work of the REDC and a key pillar for successful health outcomes for our patients. The REDC is in support of lowering health care costs for Americans and increasing competition within the health insurance industry; however, not at the expense of losing access to mental health services and supports many individuals rely on today. Overall, we are very supportive of the protection against discrimination based on health status and the possibility of lowering premium costs. We highly encourage the Department to provide more regulatory guidance to address issues like AHPs not providing mental health and substance use disorder coverage, the jurisdiction for AHPs operating across state lines, protections against other discriminatory practices based on age, gender and geographical location, and ensuring AHP solvency to encourage providers contract with these plans.

---

<sup>32</sup> Department of Labor. (2018). *Definition of “Employer” under Section 3(5) of ERISA -- Association Health Plans*. Retrieved from <https://federalregister.gov/d/2017-28103>.

<sup>33</sup> Government Accountability Organization. (2004). *Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*. Retrieved from: <https://www.gao.gov/assets/250/241561.pdf>

<sup>34</sup> *Roundtable on Small Business Health Plans: Senate Health, Employment, Labor and Pensions Committee*, Senate, 115<sup>th</sup> Cong. (2018) (Testimony of Mike Sturm).



Residential Eating  
Disorders Consortium

We thank the Department of Labor for the opportunity to provide feedback on this important issue. We look forward to reviewing the finalized rule and continuing to work together to improve access and quality healthcare to all Americans.