

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

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

Dear Secretary Acosta and Assistant Secretary Rutledge:

As organizations with a vision of achieving oral health for all, we appreciate the opportunity to comment on the Department of Labor (DOL) Proposed Rule: Definition of “Employer” under Section 3(5) of ERISA – Association Health Plan. We welcome DOL’s ongoing attention to affordability, flexibility, and innovation in its efforts to regulate employer-based health coverage options. We believe that private coverage, whether through a large employer, a qualified health plan, or an association health plan (AHP), must ensure access to timely, affordable, and high-quality care, including oral health care, that meets an individual’s unique needs.

We are concerned that the Proposed Rule could leave beneficiaries with less comprehensive coverage, higher out-of-pocket costs, and limited access to appropriate providers and could have troubling impacts for wider insurance markets. Therefore, we respectfully urge DOL to consider the implications of the rule before finalizing the proposed regulatory changes.

We look forward to working with you to find solutions that strike a balance between affordability and comprehensiveness of coverage.

**Definition of Employer (§2510.3-5)**

We urge that this expansion of ERISA to increase the availability of AHPs not come at the expense of a strong foundation of consumer protections for beneficiaries. The proposed change in the definition of “employer” under ERISA will weaken the safeguards for consumers that have been delineated in DOL guidance. Furthermore, the proposed definitional changes would also diminish the role of state regulators in oversight of AHPs even though, historically, states have played key roles in protecting consumers, providers and the stability of the market.

As the National Association of Insurance Commissioners (NAIC) has noted, “Just as consumers will act in their own financial self-interest, insurers will as well. When permitted by law, insurers will use a variety of tools to lessen their susceptibility to high-risk individuals.”<sup>1</sup> There are financial incentives for AHPs to not cover vulnerable populations or to limit that coverage through narrow benefit packages, provider networks and other means. This is of particular concern for oral health care.

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<sup>1</sup> NAIC. [Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act](#), 2011.

Timely access to dental care providers is of vital importance. Untreated dental disease can cause pain, missed school or work days, serious complications, and unnecessary emergency room expenditures. Access to dental care has historically been complicated by a variety of issues including cost and geography, with vulnerable populations like rural communities and low-income communities facing particular challenges.<sup>2</sup> Furthermore, treatment of more complex dental issues can require multiple visits and access to specialists. Inadequate provider networks or coverage can exacerbate these pre-existing health inequities. A clearly articulated framework for benefit design, cost-sharing, other key consumer protections and network standards can provide financial protection for plans, as well as individuals and families.

Current DOL guidance delineates vital protections for most types of AHPs and clarifies the role of states in oversight of plan compliance with requirements such as essential health benefits (EHBs), caps on out-of-pocket expenses, actuarial value (AV) requirements, prohibition of annual and lifetime limits and basic network adequacy requirements. As a result, beneficiaries know they have affordable access to needed providers and to regular preventive and primary care for their families. They also know that that they will not be subject to financially devastating cost-sharing if they experience a serious illness.

We urge DOL to consider the following concerns to ensure that families enrolled in an AHP have access to affordable and comprehensive oral health coverage and services, as well as continued basic protections and peace of mind regarding benefits, out-of-pocket expenses, and provider networks.

### **Benefits.**

It is critical that DOL maintain its vital oversight, in coordination with state regulators, of AHP benefit packages, given the weakening of health benefit design standards that could result from the proposed ERISA expansion.

Of particular concern is the maintenance of pediatric dental coverage. Oral health is critical to overall health, and impacts school performance, employability, and military readiness. Access to affordable coverage is one of the first steps toward ensuring that children get the care necessary to prevent and manage the disease that causes cavities. It is for this reason that Congress included pediatric oral services as part of the essential health benefits (EHB). As part of this effort to establish a comprehensive children's benefit package, Congress also sought to provide appropriate consumer protections and limit out-of-pocket costs, and eliminate unnecessary barriers to accessing oral health care. But experience has shown us that pediatric dental coverage is an easy target. In fact, a 2017 cost estimate report by the Congressional Budget Office for H.R. 1628 American Health Care Act of 2017, noted that without EHB delineation, pediatric dental benefits would be one of the top targets for cuts<sup>3</sup>

But our concerns are not solely based in hypothetical examples, they are also rooted in precedents from states whose EHB benchmark is less comprehensive than what is provided through a benchmark like the Children's Health Insurance Program (CHIP) or the Federal Employees Dental and Vision Insurance Program (FEDVIP). For example, Utah's EHB benchmark, a state employee health plan, only covers routine exams, cleanings, x-rays, and dental sealants but does not cover minor or major restorative

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<sup>2</sup> MacDougall H. [Dental Disparities among Low-Income American Adults: A Social Work Perspective](#). Health and Social Work. 2016;41(3):208-210. doi:10.1093/hsw/hlw026. Rural Health Information Hub. "[Oral Health in Rural Communities](#)." February 2017

<sup>3</sup> Congressional Budget Office, [Cost Estimate for H.R. 1628 American Health Care Act of 2017](#). 2017

treatments like fillings, crowns, and root canals that may be necessary to treat and manage tooth decay.<sup>4</sup> In addition to Utah, some states such as Colorado, Michigan, and Arkansas do not cover medically necessary orthodontics in their EHB benchmarks. Products following these guidelines could omit coverage despite the importance of comprehensive oral health care for children.

But this rule would not just impact children, under the proposed rule, consumers enrolled in an AHP may not be assured that their plan will cover important benefits. Gaps in these core benefits could result in life-long consequences that reach beyond children's oral health, despite being both avoidable and costly for families and society.

### **Cost-sharing protections.**

We share the DOL's concerns regarding the affordability of coverage, but we also urge consideration for the importance of protecting families from bankrupting out-of-pocket costs. Enrollment in an AHP not subject to cost sharing limits, specific AV standards, or a prohibition of annual and lifetime limits on the cost of benefits, could financially overwhelm a consumer who requires extensive health care services or medications. Furthermore, research has found that families faced with additional financial burden may delay needed care, especially for dental care, which can increase inappropriate utilization of emergency rooms and affect a child's long-term health outcomes and future productivity.<sup>5</sup>

### **Adequacy of provider networks.**

We urge the department to work with state regulators to ensure that states have both the tools and the authority to conduct stringent oversight of AHP network design. We are concerned that the proposed rule would allow for approval and sale AHPs that have made minimal efforts to ensure reasonable access for beneficiaries. This is of particular concern with regard to children's dental care, especially in rural areas where dental providers may already be few and far between, and where families must travel long distances in order to access care.<sup>6</sup>

In addition, as proposed, AHPs could be formed by employers within a common city, county, or metropolitan area, which could result in provider networks with varying geographic boundaries. Absent specific standards that ensure a full range of in-network providers, families may not have access to necessary in-network specialists due to those geographic limits. This variation in geographic scope among AHPs calls for a review and oversight system that allows for at least the same level of scrutiny as states currently apply to the individual and small group market. At a minimum, we ask that DOL work with states to implement a set of minimum quantitative and other standards for AHP networks comparable to those articulated in the NAIC Model Act<sup>7</sup> No. 74. The Model Act is designed to give states options that fit the needs of their particular state. It also includes a minimum framework for a degree of network adequacy standards and reporting that addresses access to care for vulnerable children and adults.

### **Nondiscrimination (§ 2510.3-5(d))**

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<sup>4</sup> [Utah Basic Plus Benefits Summary](#).

<sup>5</sup> See [Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services](#). Health Affairs 2016 35:12, 2176-2182

<sup>6</sup> Rural Health Information Hub. "Oral Health in Rural Communities." February 2017. Available at: <https://www.ruralhealthinfo.org/topics/oral-health>.

<sup>7</sup> See National Association of Insurance Commissioners [Health Benefit Plan Network Access and Adequacy Model Act](#). 2015

While we support the Department's attempt to protect against discrimination based on health status, we believe the nondiscrimination provisions in the rule are insufficient and must be strengthened to ensure that consumers are protected against adverse risk selection and cherry-picking.

Under the current language AHPs would be exempt from many of the ACA's consumer protections and free to, for instance, rate on factors like age, gender, group size, and the type of industry in which an employer works. Furthermore, we believe that the proposed rule leaves allowances for troubling health plan benefit and provider network design that can serve as disincentives for individuals with significant health conditions to enroll in those health plans. In the case of discriminatory network design, the issuer can avoid risk and lower premium costs because it does not cover necessary providers and/or care, and as such, avoids enrolling individuals with those specific health care needs.

We also are concerned about the impact of AHPs with limited benefit packages and networks on individuals and families that seek coverage through ACA-compliant plans inside or outside of the Marketplaces. As the department notes in the rule's regulatory impact analysis, the expansion of AHPs that offer lower-cost, less-comprehensive coverage would be especially attractive to healthier individuals, thereby drawing them out of the traditional market. This market segmentation will result in increased premiums for the more comprehensive non-AHP, ACA-compliant plans that more appropriately cover necessary services and providers, including oral health services and providers. Unfortunately, the nondiscrimination provisions of the proposed rule would not protect children and families from these discriminatory practices.

### **State and Federal Oversight of AHPs**

We are concerned that the proposed AHP expansion under ERISA does not address gaps created by the lack of clarity on federal preemption of state laws and oversight of AHP's. We request further clarity on the role of states in the regulation of fully insured AHPs.

In the past, ambiguity between federal and state authorities governing AHPs resulted in widespread fraud and insolvency, and left consumers with unpaid benefits and large financial obligations.<sup>8</sup> In fact it is because of these concerns that other national organizations, like the National Governors Association,<sup>9</sup> the National Association of Insurance Commissioners,<sup>10</sup> and the National Conference of Insurance Legislators<sup>11</sup> have historically expressed opposition for legislation with similar implications for removing opportunities for state oversight.

We are very concerned that the proposed rule will result in a return to a complex patchwork of AHP requirements and state and federal oversight responsibilities, which will undermine coverage and access to care. Therefore, it is critical that any rule clearly articulate and affirm the state's role in regulating fully insured AHPs. States should be allowed to apply the same standards to AHPs as they apply to other commercial large group plans, including mandated benefits, network adequacy requirements, rate review and other valuable consumer protections. Furthermore, we support continued state regulatory authority

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<sup>8</sup> Kofman, M. Association Health Plan: Loss of State Oversight means Regulatory Vacuum and More Fraud. Georgetown University Health Policy Institute. 2015. Available at: <https://hpi.georgetown.edu/ahp.html>

<sup>9</sup> See National Governors Association, "[Governors Oppose Association Health Plans](#)," May 2004

<sup>10</sup> See National Association of Insurance Commissioners, "[CONSUMER ALERT: ASSOCIATION HEALTH PLANS ARE BAD FOR CONSUMERS](#)," 2004

<sup>11</sup> See National Conference of Insurance Legislators, "[NCOIL URGES CONGRESS TO OPPOSE AHP LEGISLATION, CAUTIONS AGAINST HARM TO CONSUMERS](#)," 2005

over the solvency of self-funded AHPs, as well as other state regulatory responsibilities to prevent inconsistencies between fully and self-insured plans regarding these important core protections.

We also seek clarification that state requirements for AHPs, including laws and regulations that prohibit their establishment in the state, will not be superseded by federal regulations or guidance. Without transparency on issues of preemption or potential waivers, states' efforts to protect their citizens, health care networks, and insurers may be undermined.

In addition, we urge DOL to work with states and the NAIC on the collection of data that will enable regulators, as well as stakeholders, to assess whether and how consumers and their families are being served by AHPs. To help ensure that AHPs are providing beneficiaries with access to high-quality and timely care promised to them in their plan contract, it is critical that DOL collect and use plan data to document, identify and analyze patterns in consumer behavior and in coverage. The data transparency requirements under Section 2715A of the Affordable Care Act should serve as a model for data transparency requirements for AHPs.

In particular, we believe the department, in collaboration with the NAIC and states, should collect disaggregated, plan-level enrollment/disenrollment data that includes information on enrollee income, geographic location, and demographic information. In addition, we recommend the collection of claims data (paid and unpaid) by age and income to help assess the impact of cost-sharing requirements, service denials, coverage limits and out-of-network care.

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In conclusion, we reiterate that we share the department's concerns regarding the need to address health care affordability. However, we believe that the proposed expansion of AHPs, without basic protections and assurances of oversight, does not improve healthcare access but risks weakening existing insurance markets and increasing the availability of plans that do not meet the needs of children or families. Congress has repeatedly and unequivocally demonstrated the importance of oral health care as an essential component of coverage for children and adolescents. We respectfully urge DOL to recognize the need to maintain and strengthen the availability of coverage that is both affordable and inclusive of the benefits necessary to keep children healthy.

We encourage DOL and HHS to work collaboratively with us to identify delivery system reforms and other health care quality improvement initiatives that will reduce health care costs, drive down premiums, and improve care. We look forward to working with you to ensure that all health benefit plans address the medical and oral care needs of all Americans.

Thank you for your consideration and we look forward to working with you to continue to improve the country's oral health. If we may provide further information or otherwise be of assistance, please contact Deborah Vishnevsky at the Children's Dental Health Project, at 202-417-3596 or [dvishevsky@cdhp.org](mailto:dvishevsky@cdhp.org).

Thank you,

The Children's Dental Health Project

ACHIEVA/The Arc of Greater Pittsburgh

Advocates for Children of New Jersey

All About Children Pediatric Partners, PC

Arcora Foundation

Connecticut Oral Health Initiative

Justice in Aging

National Dental Association

National Interprofessional Initiative on Oral Health

Ohio Asian American Health Coalition

Oral Health Florida

PA Coalition for Oral Health

Rhode Island KIDS COUNT

The Los Angeles Trust for Children's Health

Virginia Coalition of Latino Organizations