



March 6, 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

**RE: Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans  
(RIN 1210-AB85)**

Dear Secretary Acosta and Assistant Secretary Rutledge,

The National Women’s Law Center (“the Center”) is writing to comment on the proposed rule, Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans.<sup>i</sup>

Since 1972, the National Women’s Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including income security, employment, education, and health and reproductive rights, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination. To that end, the Center has conducted extensive research regarding women’s specific health needs, and works to ensure all people have equal access to a full range of health care, regardless of age, race, sex, sexual orientation, gender identity, ethnicity, geographic location, or type of insurance coverage.

The Affordable Care Act (ACA) made dramatic improvements for women’s health coverage and women’s health care by ending discriminatory health insurance practices, making health coverage more affordable and easier to obtain, and improving coverage for essential health services women need. However, the proposed rule could result in the reversal of that progress by opening the door for Association Health Plans (AHPs) to take away coverage of essential health benefits women need, engage in gender rating and other discriminatory practices, and leave women to shoulder high health care costs, which threatens their health and economic security.

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While these comments focus on the particular harm the proposed rule poses to women, the proposed rule is deeply flawed beyond the specific proposals addressed in these comments. The Department must review and carefully consider comments submitted by other health care, patient, and civil rights groups that address those issues as well.

## **I. The Proposed Rule Would Result in Individuals – Especially Women – Losing Important Consumer Protections.**

The proposed rule would change the way AHP products are regulated, to the detriment of consumers, especially women. Currently, AHP products sold to individuals are considered to be individual market insurance and AHP products sold to small employers are considered to be small group market insurance.<sup>ii</sup> The insurance products are then subject to the same requirements and consumer protections that exist in those markets under the ACA, such as covering the essential health benefits and prohibiting gender rating and other forms of discrimination.

The proposed rule seeks to reverse this; as a result, an AHP would be treated as a single plan providing large employer coverage, and therefore exempted from the individual and small group market protections. This would invite insurance plans to once again put into place a host of practices that discriminate against women and deny them the coverage and health care they need.

### *A. The Proposed Rule Could Result in Women Losing Coverage of Essential Health Benefits*

The ACA requires issuers in the individual and small group markets to cover essential health benefits (EHBs), including maternity and newborn care, preventive and wellness services, mental health services, and prescription drugs. This requirement corrects notable benefit gaps that existed prior to the ACA and significantly advances women's access to critical health services. Allowing AHPs to circumvent these requirements, as the proposed rule would do, would be extremely detrimental to women. As the Center's pre-ACA research documents, when plans have discretion to set benefit categories, coverage that is vital for women, like maternity care, is often what is eliminated.<sup>iii</sup> The proposed rule, therefore, could send women back to the days before the ACA, when plans frequently failed to meet their important health needs.

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For example,

- Women could once again be denied maternity coverage. Before the EHB requirement of the ACA, the vast majority of plans in the individual market did not cover maternity care at all. The Center's research showed that only 12 percent of the most popular plans in the individual market covered maternity care.<sup>iv</sup> This left women paying costs ranging from \$30,000 for uncomplicated births to over \$50,000 for more complicated births.<sup>v</sup> And even among plans that covered maternity services, the coverage was not always comprehensive or affordable. The Center's research found that several plans charged a separate maternity deductible that was as high as \$10,000, and some plans had waiting periods of up to a year before maternity care would be covered.<sup>vi</sup>
- Women could also once again lack prescription drug coverage. Before the ACA made prescription drug coverage an essential benefit, one in five people enrolled in the individual market lacked coverage for prescription drugs.<sup>vii</sup> Prescription drug coverage is vital for women, who are more likely to be prescribed medications than men.<sup>viii</sup> Rolling back coverage of prescription drugs means women would not be able to access the medicine they need to prevent or manage ongoing health conditions.
- Women could also lose vital mental health coverage. Women are twice as likely as men to be diagnosed with depression their lifetime.<sup>ix</sup> Yet, before the ACA's essential health benefits requirement, mental health coverage was often excluded from plans, or was very limited.<sup>x</sup> According to an estimate from the Department, over 32 million people gained access to coverage for mental health services, substance use disorder treatment or both benefits because of the essential health benefits requirement and other ACA protections.<sup>xi</sup> The proposed rule threatens that coverage.

*B. The Proposed Rule Could Result in Businesses with a Predominantly Female Workforce Paying More for Coverage*

Under the ACA, individual and small group health plans are precluded from using gender to determine premiums.<sup>xii</sup> While the proposed rule would protect *individuals* from being charged more because of their gender, it appears that employers with higher rates of female employees could be charged higher premiums. The Center's research shows that gender rating occurred in the small group market before the ACA's prohibition on gender-rating,<sup>xiii</sup> leaving small businesses with predominantly female workforces, such as home health and child care businesses, paying more for coverage. The proposed rule, therefore, threatens to allow insurers to again practice discriminatory gender rating in the small group market.

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*C. The Proposed Rule Could Result in Discrimination Against Women with Pre-existing Conditions*

The Health Insurance Portability and Accountability Act of 1996's (HIPAA) non-discrimination provisions – which the proposed rule applies to AHPs – prevent discrimination based on health status related factors against employer members or employers' employees or dependents. In theory, as the proposed rule purports, this would prevent AHPs from using "health status" to determine eligibility for benefits or in setting premiums. Health factors include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. These non-discrimination protections are important but are not enough to protect against discriminatory practices that undermine women's access to the health coverage that they need. Specifically, the proposed rule exempts AHPs from ACA consumer protections – like rate reforms, guaranteed issue, and single-risk pool requirements – designed to protect people, including the 65 million women nationwide, with pre-existing conditions.<sup>xiv</sup>

Under the proposed rule, an AHP could try to simply avoid covering people and businesses with medical needs. Using discriminatory benefit design or marketing practices, for example, an AHP can attract healthier groups, leaving those with pre-existing conditions without the coverage they need. This would be especially detrimental to women. Before the ACA, women were routinely denied coverage or dropped from existing coverage because of conditions unique to women, like having had a Cesarean delivery, a prior pregnancy, or breast or cervical cancer.<sup>xv</sup>

*D. The Department Must Clarify the Application of Non-Discrimination Provisions to Protect Against Such Discrimination*

While the proposed rule opens the door for insurance companies to attempt to revive the discriminatory practices outlined above, such practices would be in violation of other key non-discrimination standards. Foremost among them is Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in any health program or activity *any part of which* receives federal financial assistance. Therefore, any AHP whose issuer receives federal financial assistance, including participating in the health insurance marketplaces, must comply with Section 1557. Section 1557 prohibits any covered health insurance plan from discriminating on the basis of sex, including but not limited to, using sex or gender to determine the cost of coverage, excluding maternity care from coverage, or creating pre-existing condition exclusions that target women. If the Department chooses to go forward with the rule as proposed, it must make

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absolutely clear that such practices are not allowed, and remind insurers of their obligations to comply with Section 1557 and any other relevant non-discrimination protections.

## **II. The Proposed Rule Will Harm Women in AHPs and Those Who Remain in the ACA Marketplaces.**

While the Department claims that the proposed rule increases more affordable coverage options for consumers, the truth is that any such option would come at the expense of consumers. That is because the proposed rule would create an uneven playing field between AHPs and the individual and small-group markets. Because the rule would subject AHPs to substantially weaker standards than ACA-compliant plans, the plans could be structured and marketed to attract younger and healthier people, thus pulling them out of the ACA-compliant small-group market and leaving older, sicker, and costlier risk pools behind. If healthier individuals and small groups are syphoned from the individual and small group markets, costs will increase and plan choices will decrease for employers and individuals remaining in those markets. Consumers who need comprehensive coverage, including those with pre-existing conditions, and consumers with incomes too high to qualify for subsidies would face rising premiums and potentially fewer plan choices.

And even the healthier individuals who are attracted to AHPs could find themselves in dire situations. That is because AHPs have a history of fraud and insolvency. Indeed, for the thirty years prior to the ACA, AHPs were frequently used as a vehicle for selling fraudulent insurance coverage. Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over \$252 million in medical bills.<sup>xvi</sup> Four of the largest operations left 85,000 people with over \$100 million in medical bills.<sup>xvii</sup> For consumers and patients, the results were disastrous: some victims were forced into bankruptcy; others have lifelong physical conditions as a result of delayed or foregone medical care.<sup>xviii</sup> The proposed regulation could once again leave consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, and lifelong health implications – just as AHPs did before the ACA provided more oversight and protection.

For women either in AHPs or left in the individual and small groups markets, these result would be devastating, especially for women struggling to make ends meet. Specifically, high health costs compound for women who are already more likely than men to live in poverty, earn less than men, and are more likely to work in low-wage jobs with less ability to absorb extra costs.<sup>xix</sup> And for women of color who are more likely to live in poverty than whites, high health care and coverage costs are particularly prohibitive. Medical debt can cause serious consequences for women's finances, particularly for lower income women, by using up

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savings, facing difficulty paying for basic necessities, and being forced to borrow money to pay their bills.<sup>xx</sup> And high health costs not only jeopardize women's economic security, they also jeopardize their ability to get the care that they need, particularly since women are more likely than men to forego health care because of cost. Research shows that, in the years before the ACA helped to make individual and small group coverage more affordable, women of color were more likely to go without health care because of cost at higher rates than men or white women,<sup>xxi</sup> leaving them vulnerable to a lifetime of illness.

### **III. At the Very Least, Individuals and Small Businesses Must be Properly Notified if AHPs are Not Meeting Minimum Value or Providing All the Essential Health Benefits.**

If the Department goes forward with the proposed rule, at the very least, AHPs should be required to provide proper notice to employer groups and potential beneficiaries. Notice must be provided if plans do not meet standards for minimum value. This will ensure that employer groups and employees know that the plans are less comprehensive than health plans available in the individual or small group markets. Further, if the AHP does not meet minimum value, the employees and their dependents must be made aware of their right to receive coverage through the health insurance marketplaces, potentially with premium tax credits based on their income. Similarly, AHPs should be required to notify employer groups and potential beneficiaries of any essential health benefits not covered by their plans. And the Department should also clarify that all notice requirements that apply to group health plans apply to plans under this regulation, including notice of appeal rights, summary of benefits and coverage, and summary plan descriptions. Proper notification is particularly important for women, who make the majority of their families' health care and coverage decisions.

### **IV. The Proposed Rule Must Confirm States' Authority to Regulate AHPs.**

The proposed rule creates confusion about states' enforcement authority over AHPs. For example, it is unclear whether states' attempts to regulate AHPs by requiring them to provide essential health benefits or comply with small group rating rules would be pre-empted as inconsistent with federal law. In the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut them down.<sup>xxii</sup>

If the Department goes forward with the proposed rule, it should clarify that ERISA single employer AHPs, including those that cover more than one state, would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and

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regulation. This will maintain states' ability to protect consumers from the potential ramifications of fraudulent or insolvent AHPs, and to manage their insurance markets.

And the Department should clarify that AHPs are not exempt from state regulation. States have long taken the lead in addressing AHP insolvencies and fraud and maintaining competitive markets, and any attempt to preempt state authority would harm consumers.

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As demonstrated by the attempts in Congress to repeal the Affordable Care Act, the public refuses to return to a time of discriminatory insurance practices that harmed consumers and kept them from obtaining quality, affordable health care. This is especially true for women, who often bore the brunt of pre-ACA discriminatory insurance practices. The Department must reconsider its proposed rule with these concerns in mind, taking care to ensure that insurance plans do not turn back the clock on the ACA's consumer protections that have been critical for women's access to coverage and economic security.

Sincerely,



Fatima Goss-Graves  
President & CEO  
The National Women's Law Center

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i 83 Fed. Reg. 614, *Definition of "Employer Under Section 3(5) of ERISA Association Health Plans* (January 5, 2018).

ii The Centers for Medicare and Medicaid Services, *Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act When Insurance Coverage Is Sold to, or through, Association*

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<http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers>.

viii Mayo Clinic, *Nearly 7 in 10 Americans Take Prescription Drugs*, Mayo Clinic, *Olmsted Medical Center Find* (June 19, 2013), <https://newsnetwork.mayoclinic.org/discussion/nearly-7-in-10-americans-take-prescription-drugs-mayo-clinic-olmsted-medical-center-find/>.

ix *See* Mayo Clinic, *Depression in Women: Understanding the Gender Gap* (January 2016),

<https://www.mayoclinic.org/diseases-conditions/depression/in-depth/depression/art-20047725>.

x *See* Palanker, *supra* note 7.

xi U.S. Department of Health and Human Services, *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans* (February 2013),

[https://aspe.hhs.gov/sites/default/files/pdf/76591/rb\\_mental.pdf](https://aspe.hhs.gov/sites/default/files/pdf/76591/rb_mental.pdf).

xii The ACA prohibits plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Fair Health Insurance Premiums, 45 C.F.R. § 147.102 (2014).

xiii *See* NAT'L WOMEN'S LAW CTR., *supra* note 3, at 9.

xiv U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform* (November 2011), <https://aspe.hhs.gov/basic-report/risk-pre-existing-conditions-could-affect-1-2-americans>.

xv *See* NAT'L WOMEN'S LAW CTR., *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition*, at 10 (October 2009), <https://nwlc.org/wp-content/uploads/2015/08/stillnowheretoturn.pdf>; NAT'L WOMEN'S LAW CTR., *supra* note 3, at 4-5.

xvi Kofman, M., *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Georgetown University Health Policy Institute, (2005), <https://hpi.georgetown.edu/ahp.html>.

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xix *See* Brief for NAT'L WOMEN'S LAW CTR., et al. as Amici Curiae Supporting Respondents at 7-11, *King v. Burwell*, 576 U.S. \_\_\_, 135 S. Ct. 2480 (2015).

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