



March 5, 2018

Jeanne Klinefelter Wilson, Deputy Assistant Secretary
Employee Benefits Security Administration
Office of Regulations and Interpretations
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

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

Dear Deputy Assistant Secretary Wilson:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the [proposed rule](#) titled, “Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans” as published by the Employee Benefits Security Administration (EBSA) in the January 5, 2018 *Federal Register*.

In this proposed rule, EBSA would broaden the criteria under the *Employee Retirement Income Security Act* (ERISA) to allow employers and self-employed individuals to purchase association health plans (AHPs) by allowing multiple “employers” to band together to be considered the sponsor of a single employee welfare benefit plan or group health plan. The rule would eliminate the requirement that associations have a purpose other than offering health insurance. It also enables AHPs to be treated as large employer plans for purposes of health coverage requirements, even if they provide coverage to small businesses or individuals. AHPs would not have to cover the *Affordable Care Act’s* (ACA) list of essential health benefits (EHBs). They would also be exempt from the ACA rule requiring insurers to spend at least 80 percent of premium revenue on medical care. The proposed rule does require associations to accept all applicants, including those with preexisting conditions, and sicker people could not be charged higher premiums than healthy people. However, premiums could vary by a host of factors prohibited or limited by the ACA, including gender, age and industry.

We recognize that AHPs could expand affordable access to health coverage for certain individuals. **However, the AAFP has significant concerns with these proposals since AHPs will not provide meaningful insurance coverage.** We are very concerned since allowing small employers to buy low-cost health insurance plans through AHPs is a step away from important and needed consumer protections under the ACA. The AAFP strongly supports the goal of providing robust access to affordable health care coverage for all Americans, but AHPs move us further away from that goal. The AAFP recognizes that EBSA is working to promote choice and competition, and reduce regulatory burden, in healthcare markets. While competition is important and serves as a tool to

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increase the availability and affordability of services, we do not think greater competition should come at the expense of meaningful insurance coverage

Importance of Essential Health Benefits

All commercial and private health insurance plans should adhere to ACA's EHBs requirements to prevent insurance discrimination against any individual based on their health status, age or gender. While we acknowledge that AHPs may extend limited access to coverage for currently uninsured individuals, coverage guaranteed under these plans would be neither adequate nor meaningful. Women and older, sicker Americans would likely face higher costs and fewer affordable insurance options. **The AAFP is also concerned that under the rule, insurers could reduce or eliminate certain EHBs to avoid vulnerable, expensive patients by excluding specific services.** For instance, if an insurer wanted to scale back prescription drug coverage, it could do so, as long as it ramped up coverage in another category at a comparable level. In doing so, insurers could potentially make plans more expensive for people with long-term chronic conditions.

While relaxing EHB requirements could decrease cost for healthy enrollees, and thus potentially attract younger and healthier consumers, it could also endanger coverage for a more vulnerable population. Inadequate benefits could leave this population with too little coverage to meet their health care needs. While ratcheting down EHBs may reduce upfront premium costs, it could have devastating financial implications for families with the sickest patients whose insurance coverage may not cover medically necessary services.

Need for a Standard Primary Care Benefit for High-Deductible Health Plans

In addition, the AAFP is increasingly concerned with the escalation in deductibles that has occurred in the employer-sponsored, small group, and individual insurance markets. Higher deductibles create a financial disconnect between individuals, their primary care physician, and the broader health care system. **Therefore, in an effort to maximize the proven benefits of health care coverage and a continuous relationship with a primary care physician, the AAFP [proposes](#) the establishment of a standard primary care benefit for individuals and families with high-deductible health plans (HDHP).** Under our proposal, individuals would be able to connect with the health care system through visits with their primary care physician or their primary care team. These visits would be exempt from cost-sharing requirements such as deductibles and co-payments. The establishment of a standard primary care benefit would guarantee connectivity to the health care system for individuals with HDHPs and serve as a guardrail against disease progression that leads to more costly care.

Individuals with a HDHP, as defined by the Internal Revenue Service, would have access to their primary care physician, or their primary care team, without the cost-sharing requirements (deductibles and co-pays) stipulated by their policy.

The company issuing the HDHP to the individual or family would be responsible for providing full coverage of primary care services for the plan year. Covered services would include primary care, prevention & wellness and care management services. Plans would pay primary care physicians for the following services at the contracted rate:

1. Evaluation & Management (E&M) codes for new and existing patients 99201-99215;
2. Prevention & wellness codes 99381-99397;
3. Chronic care management codes (CCM); and
4. Transition care management (TCM) codes.

Ensuring connectivity to the health care delivery system through continuous access to a primary care team is not only efficient health policy, it also is sound economic policy for individuals, families and employers. A [recent study](#) conducted by the University of Portland found that every \$1 invested in primary care resulted in \$13 in savings for other health care services, including specialty, emergency room, and inpatient care.

Support for Medical Loss Ratio Policy

Over several years, the AAFP has strongly supported applying the medical loss ratio (MLR) policies to all health insurance plans. The MLR is expressed as a percentage, generally representing the percentage of revenue used for patient care, rather than for other items such as administrative expenses or profit. **The AAFP continues to support implementation of MLR requirements since it helps ensure health care resources are focused on patient care rather than insurer profits.** We therefore urge EBSA to apply the MLR policy to AHPs.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,



John Meigs, Jr., MD, FAAFP
Board Chair

About Family Medicine

Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families and communities. Family medicine’s cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient’s integrated care team. More Americans depend on family physicians than on any other medical specialty.