Pennsylvania Association of Realtors®

The Voice for Real Estate in Pennsylvania

500 North 12th Street
Lemoyne, PA 17043-1213
800.555.3390 toll-free
717.561.1303 phone
717.561.8796 fax
www.PARealtor.org

3/5/2018

Mr. Alexander Acosta
Secretary of Labor
U.S. Department of Labor
900 Constitution Avenue NW
Washington, D.C. 20210

Re: "Definition of Employer under Section 3(5) of ERISA-Association Health Plans," RIN 1210-AB85 or Docket ID No. 2017-28103 (submitted electronically)

Dear Secretary Acosta:

The Pennsylvania Association of Realtors® represents 33,000 across the commonwealth. As self-employed individuals, it is often difficult for real estate professionals to find affordable health care coverage when costs are continually rising and insurance options are diminishing. The Department of Labor's notice of proposed rulemaking has the potential to increase health insurance options, which is greatly welcomed by real estate professionals and their families.

As a Realtor® for more than 40 years, I've experienced difficulties with the high cost of health insurance. As president of our organization, I've heard from many members that their costs for health insurance have more than tripled in the last five years, making it increasingly difficult for self-employed individuals to be able to afford insurance themselves and their families. It's not only older members who are suffering, but members who are under age 30 and trying to find affordable insurance without more than a $10,000 deductible. Many have resigned to signing their young children up for the Children's Health Insurance Program (CHIP). We've attached some of their stories to this letter.

The rule proposes to provide more affordable choices for independent contractors by modifying the definition of "employer" to include "working owners." This is essential to enabling real estate professionals to participate in an AHP in the large group market, rather than being forced to purchase in the more costly and volatile individual insurance market. Large group plans typically have more flexibility in plan design and offer greater negotiating power to bargain for lower premiums – benefits that are key to reducing health care costs. The rule would also protect consumers enrolling in these plans by prohibiting discrimination based on health status.

However, the proposed rule includes provisions that may restrict many self-employed persons from seeking more affordable insurance in an AHP. For example, working owners are excluded

from eligibility if they have an offer of coverage from a spouse's employer subsidized group health plan. Coverage available through a spouse's employer may not be the most affordable option for a family. Eliminating this requirement will provide more insurance choices for many real estate professionals and their families.

The need for affordable health insurance options remains a top concern among practicing real estate professionals. Allowing working owners to participate in AHPs will offer new options for health insurance coverage, providing much needed relief that will support the real estate industry as a whole. Ensuring the proposed rule does not impose burdensome, unnecessary requirements on working owners is also essential. Thank you for the opportunity to comment on this proposed rule.

Sincerely,

Todd H. Umbenhauer
President

Pennsylvania Realtor® examples of high costs of purchasing health insurance:

Anne of Exton writes:

In 2011, I was paying approximately $700/month for Keystone Health Plan East for one person with a $1,000 deductible. In 2010, I got a part-time evening job at Wegmans to supplement my income. After one year with Wegmans, they offered part-time employees health coverage with BC/BS of Rochester for $84/month with a $500 deductible. It provided excellent coverage!
When the Affordable Care Act came in, Wegmans quit offering coverage to part-time employees, so I quit and got KHPE again to the tune of $855/month for one person with a $1,500 deductible. I now qualify for Medicare. I discovered during my one-year physical that those questions they ask you like: Do you feel safe at home? Do you use drugs? which takes approximately three minutes, they charge Medicare $30-$35 for each question as well as for 15-minute interviews, which never happened! I got the pneumococcal vaccine, not only do they charge for the vaccine, but $30 for the person who gave it to you.

Kristyn from Waynesboro writes:

When we were searching for health insurance for 2018, we struggled greatly. My husband quit his job at the end of 2017 (he was employed with FedEx), which left us without insurance. I went to the marketplace to find insurance, but the cheapest conforming plan was $900/month with a $14,300 deductible to cover myself (27-year-old, non-smoking female), my husband (28-year-old, non-smoking male) and my daughter (4 months old). That is completely unreasonable for us, since we barely use insurance. The only time we even used his was for my medical bills when having our daughter last year.
So, we are awaiting her application to CHIP to be approved through the state. We will pay full (CHIP is for any Pennsylvania kid, no matter what income the parents have, just different rates apply depending on your income). My husband and I opted for a non-conforming, short-term plan just to give us some minor coverage. It does not cover maternity if I were to get pregnant again, but when we called into our local hospital, a self-pay C-section with a three-day stay was only estimated to be a little over $11,000. So, it didn't make sense for us to opt for a conforming plan with an out-of-pocket even higher than that, PLUS pay the monthly premiums.
This has been a real sore spot for us this year! I would love if there would be some sort of plan we could all get on together since we are "self-employed," but in a setting that isn't TRULY each on their own, business-wise.

Arch from Pittsburgh writes:

I'm a veteran so, fortunately, I have health coverage through the Veterans Administration. My wife, Erin, however, is not a veteran. Her coverage is $580/month with a $6,400 deductible. (We think that's a bit much for single-payer coverage.)

Beth from Wayne writes:

I wanted to share our personal story of our health coverage issues. Both my husband and I are self-employed. We were under the Affordable Care Act for two years. Premiums were OK the first year, and our insurance was OK. The second year, the premiums really increased (about 20 percent) and they dropped our prior plan, and we took a plan that had a higher deductible for a much higher premium. We also ran into a hitch with eligibility. They claimed my husband was not eligible after we signed up, claiming he was an illegal alien. We thought it was a joke, since he was born and raised

here, and he has his birth certificate to prove it. It took us almost a year of fighting until we finally got them to correct it. Finally, last year, we bought a plan outside of the marketplace. The coverage was horrible, but the premium was not too high. We had a $12,000 deductible. We got the renewal for this year, and that plan went up over 30 percent. We did not renew. We ended up buying an indemnity plan that is affordable, but I am really not sure how the benefits will pay. Fingers crossed. Would love an alternative plan that could be for Realtors®.

Frank from Bethlehem writes:

I have Capital Blue Cross and my cost is $991/month, and they keep taking my prescriptions off the list of medications covered. I used to pay a monthly fee of $331 for my insurance, but over the past four years, that has increased to $991.

Bill from Philadelphia writes:

The main concern regarding health insurance for us is affordability and options. The following are the monthly premiums we have paid since 2011:

2011 Keystone Health Plan East	$940
2012 Keystone Health Plan East	$870
2013 Keystone Health Plan East	$948
2014 Keystone Health Plan East	$1,033
2015 Keystone Health Plan East	$1,233
2016 Aetna	$1,040
2017 Keystone Health Plan East	$1,128
2018 Keystone Health Plan East	$1,358

You'll notice a drop in 2012, that's because we changed the plan to a lower premium/higher deductible. In 2016, we switched to Aetna in order to lower our premium, but the following year Aetna was no longer offered in Pennsylvania and our only choice was Independence Blue Cross. Their premium jumped significantly for 2018. Also, up until 2016, we had a family plan. Our youngest child turned 26 that year, so the 2017 and 2018 plans are for only two people.

What's really frustrating is the deductibles and out-of-pocket expenses. We pay a very high monthly premium and then many things are not covered until deductibles are met. As you can see, the premiums are extremely high and make it very difficult to afford insurance.

Kim from Tamaqua writes:

I am a member of the Schuylkill Board of Realtors® and am thrilled to have been asked to give input on the health insurance debacle that we, as self-employed people, are enduring with the unacceptable monthly premiums we are forced to pay for health insurance. This year, mine with Capital Blue Cross went to $1,055/month for medical. My dental is just under $29/month and I dropped vision coverage because monthly outgoing insurance money just has to stop.

In 2016, medical was $795/month, and it went to $967/month in 2017, and now $1,055/month. And at $1,055/month, I have a $60 office visit co-pay, $85 specialist copay, and urgent care and ER

both fall under the deductible. And that is a $7,350 deductible that pretty much EVERYTHING applies to before they start to pay anything. And they call this insurance? I'll pay $12,660 to have health insurance, but the only thing covered is an annual physical and mammogram. If I need to use my insurance, I could be out $20,000 ($1,055/month and $7,350 deductible) before anything is paid. When Capital Blue Cross advertises, "live fearless," they sure aren't talking about me.

I am 58 years old and healthy. I need to work until I'm 65 to get off of this ludicrous health insurance and get on Medicare. Why isn't anyone asking the providers to take less? I needed physical therapy for a shoulder injury. I skipped the X-ray (deductible), skipped the cortisone shot (deductible) and opted for a one-time physical therapy treatment (supposed to be a co-pay of $85, and the balance covered). Their recommendation of six therapy visits would have been $85 co-pay per visit, and they suggested six times. That's $510… with insurance. They worked with me and in one visit, gave me exercises I could do at home to forgo the crazy co-pays. I asked the orthopedist what a cortisone shot cost, so I can decide if it's worth it, and they had no idea of the cost. Talk about a disconnect in understanding how we have to make decisions for our health based on cost (with insurance)!

The only other option I had for health insurance (Geisinger) was about $100/month less, and none of my doctors were participating, nor any in my area. So, let's offer me to pay a crazy amount for coverage and force me to use doctors who know nothing about me. Or I could have paid hundreds more per month and had something like a $4,000 deductible with another plan from Capital Blue Cross. So, $1,055/month was the best option. That's a mortgage payment!

I am not passionate about anything, but I am about this. How about the providers taking less, too, and having a stake in this? How about giving those of us who pay for a health membership to stay healthy, get a discount on our monthly premiums? Incentives to reward folks who stay healthy will cost the insurance company less in the long run.

I would love to see some type of group option for us.

Karlene from Warren wrote:

I started out with a Blue Cross Blue Shield plan in 2015 that was great. I paid $445/month and had a $500 deductible. Then the Affordable Care Act was implemented and Blue Cross Blue Shield did away with the plan. Note: I did not say the Affordable Care Act did away with it, it was the insurance company Blue Cross Blue Shield that eliminated the plan. At which point, that same plan's fees went to over $800/month and raised the deductible.

I was forced to go to the marketplace. At the time, I was not making as much money as now and was able to get a tax credit for the plan listed below. My portion after applying My tax credit was $211/month.

Select Plan Period:

01/01/2016 - 12/31/2016 Hix PPO Silver

Plan Name: Advantage Silver

Annual Deductible: $2,500.00
Standard Service Co-Pay: $50
Specialist Co-Pay: $100
Emergency Co-Pay: $600
Pharmacy Co-Pay:

The following year, I no longer qualified for a tax credit in the marketplace and was forced to change to this policy. I paid $534.42/month.

Select Plan Period:

01/01/2017 - 12/31/2017 Hix PPO Silver

Plan Name: Advantage Silver

Annual Deductible: $3,250.00
Standard Service Co-Pay: $10
Specialist Co-Pay: $70
Emergency Co-Pay: $750
Pharmacy Co-Pay:

To keep the same plan for 2018, my cost would have been $307/month and a $4,100 deductible increase. This is the insurance company making these increases, NOT the Affordable Care Act! SAME PLAN AS ABOVE:

UPMC Health Plan · UPMC Advantage Silver $3,500/$25 - Pre

Silver | PPO | Plan ID: 16322PA0040008

Estimated monthly premium	Deductible	Out-of-pocket maximum	Copayments / Coinsurance
$841.79	**$3,500** Individual Total	**$7,350** Individual Total	Emergency room care: $ Generic drugs: $20 Primary doctor: $25 Specialist doctor: $75

Since I could afford that type of an increase I was forced to go with the plan listed below. For which I pay:

Invoice Date	Invoice Number	Insurance Type	Due Date	Amount Due
1/16/2018	000015427249	Medical	2/1/2018	$585.39

Select Plan Period:

01/01/2018 - Open Hix PPO Bronze

Plan Name: Advantage Bronze

Annual Deductible: $6,950.00
Standard Service Co-Pay: $35
Specialist Co-Pay: $0
Emergency Co-Pay: $0
Pharmacy Co-Pay: $30/30%/50%/50%

Keep in mind, UPMC is now the only one offering insurance in the marketplace. I have tried outside providers and their monthly fees and deductibles are even higher.
Here is an issue I am currently dealing with. I had a CT scan in December, and the hospital turned it into the 2017 insurance (of which I was not close to meeting the deductible). The bill was $2,228, the insurance company paid $200. I got a bill to pay $2,028. I called the hospital to see why it was so high, and ask what it would have cost me if I paid out of pocket. I was told if they had not turned into insurance, I would have paid $1,158 out of pocket. I told the hospital to retract the claim and I would pay the bill in full. They said I would have to talk to the insurance. I spoke with insurance and they said sure they can retract the claim, I called the hospital, they said they could not do that I pushed the issue and currently awaiting a callback. So, by using my insurance, I was going to be charged an additional $869. What am I paying the $595 a month for?
If they retract the insurance claim, I will pay the $1,158 in full. If they do not retract the claim, I will pay $5 a month for 33 years to pay off the $2,028 bill. The games the insurance companies and hospital are playing with people are ridiculous.
I have very strong opinions on health care. I had a 26-year-old niece who was diagnosed with kidney cancer while she was pregnant. If it had not been for some of the provisions set forth in the Affordable Care Act, it would have left her husband and two-year old child in a horrible situation after she passed. Because of the Affordable Care Act, there was no lifetime limit, so she was able to have all the surgeries to prolong her time, without causing them to lose everything they owned. She did not lose insurance due to pre-existing conditions.
I also feel if employers were not the ones burdened with supplying health care for employees, we would have more full-time jobs instead of part-time and wages would increase. I feel every American should have the same healthcare we pay for that our Congress people have!