COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
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March 6, 2018

The Honorable R. Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

*Re: Definition of Employer—Small Business Health Plans (RIN 1210-AB85)*

Dear Secretary Acosta:

We write to provide our comments in response to the Notice of Proposed Rulemaking (NPRM) published by the Department of Labor (DOL) on January 5, 2018, which loosens the existing criteria regarding association health plans (AHPs). We are concerned that the NPRM overturns the Department's longstanding standards around the application of the Employee Retirement Income Security Act (ERISA), and with that, eliminates the application of existing consumer protections under the Affordable Care Act (ACA).

As noted in the NPRM, under current law, health insurance coverage offered through a group or association to individuals or small employers is generally treated like individual or small group coverage. This means these plans must cover essential health benefits, are prohibited from charging consumers more based on health status, and must comply with a number of the consumer protections under the ACA. Under current DOL sub-regulatory guidance, there are narrow circumstances where employer association health coverage is treated as a single ERISA-covered plan. For example, an association must have sufficient common economic or representational interest – or "commonality of interest" – to be considered a bona fide group or association of employers. These criteria help protect against cherry-picking only healthy consumers for the sole purpose of providing health coverage that has nothing to do with actual employment.

As the Department knows, association health plans are not a new idea. In fact, they have been studied at length, including by the Congressional Budget Office, which found that they would have almost no impact on increasing health coverage.[1] Other impact assessments have found that they are likely to exacerbate adverse selection and shift costs onto workers. Although AHPs would be offered in competition with other small group and individual market plans, they would

[1] "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts" Congressional Budget Office, January 2000.

operate under different rules. This is likely to fragment the market as lower-cost groups and individuals would move to establish an AHP, and higher-cost groups and individuals would remain in traditional insurance plans. Such adverse selection would result in higher premiums in non-AHP plans. Ultimately, many experts have concluded that it is likely that higher-cost (sicker or older) groups would find it more difficult to obtain coverage.[2] And in fact, the experience of Kentucky illustrates these risks. In the mid-1990s, AHPs in Kentucky were exempt from benefit and rating requirements that applied in traditional markets. Insurers abandoned the traditional markets and individuals and employers with healthy workers shifted to AHPs, with premiums dramatically increasing for those left behind.[3] Experts predict similar results are likely under this proposed rule. An actuarial analysis examining the impact of the rule on the District of Columbia found that the small group market could see up to a 25.8 percent increase in premiums.[4]

We appreciate the Department's inclusion of some nondiscrimination protections, such as a prohibition on rating based on health status. However, these provisions are woefully inadequate and would do little to mitigate the discriminatory practices that could be utilized by AHPs under the proposal. Pursuant to the NPRM, it appears that AHPs would still be able to vary premiums based on gender, occupation and industry, age, and group size – practices that are generally prohibited or restricted in the small group market currently. In addition to openly permitting discrimination based on these factors, AHPs would be exempt from the essential health benefit requirement and could easily use discriminatory practices in benefit design. Plans could, for example, exclude maternity coverage or coverage of mental health and substance use disorders. In fact, the proposed rule explicitly states that some association health plans, "*might thrive by delivering savings to members by other means, such as by offering less comprehensive benefits.*" Protections against discriminatory marketing practices would also not apply to AHPs, enabling AHPs to use marketing tactics to discourage enrollment by populations with high-cost or complex health care needs, women, or simply firms with older business owners and workers.

For many of the same reasons outlined above, we are also gravely concerned about this proposal's potential impact on individuals with preexisting conditions. Under this rule, individuals with preexisting conditions could find that AHPs – exempt from the essential health benefit requirement – are not comprehensive enough to cover the services they need. As older, sicker, and higher cost consumers or consumers with preexisting conditions remain in the traditional market and healthier and lower cost consumers leave the traditional market for cheaper AHPs with skimpy benefits, premiums in the traditional market could skyrocket. This will make it difficult for individuals with preexisting conditions to obtain affordable coverage, leaving them worse off than they are now.

Additionally, the proposal could leave consumers exposed to fraud and insolvency with fewer protections. Our concerns are rooted in evidence and experience, where similar arrangements to

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[2] See e.g, "Association Health Plans" The American Academy of Actuaries, February 2017.
[3] K. Lucia and S. Corlette, "President Trump's Executive Order: Can Association Health Plans Accomplish What Congress Could Not?" To the Point, The Commonwealth Fund, October 10, 2017.
[4] Letter from Ryan Schultz, Oliver Wyman, to Mila Kofman, Executive Director, DC Health Benefit Exchange Authority, February 21, 2018.

those allowed under the NPRM have resulted in great harm to America's small businesses and workers. The history of multiple employer welfare arrangements (MEWAs) offers insight into the challenges that AHPs could face. Recognizing that it was both appropriate and necessary for states to establish, apply, and enforce state insurance laws with respect to MEWAs, Congress amended ERISA to provide an exception to ERISA's broad preemption provisions by specifically allowing for state regulation of MEWAs.[5] Despite this increased oversight, solvency problems persist. In 2001, Sunkist Growers, Inc., a licensed MEWA in California covering 23,000 people, became insolvent.[6] When New Jersey's Coalition of Automotive Retailers, a longstanding MEWA covering 20,000 people, became insolvent in 2002, it had $15 million in outstanding medical bills.[7] Given this history, we fear that this NPRM will be used to erode the increased oversight that Congress found necessary to better protect consumers. While the NPRM appears to maintain some semblance of state oversight, it also calls into question whether that protection will be maintained.[8] It is unclear whether state consumer protections would work in practice. We reiterate that any erosion of state consumer protections, oversight, or regulatory function – as contemplated in the NPRM – would only further jeopardize the health and security of consumers.

For all of these reasons, we believe that this rule only moves us in the wrong direction – a slightly better deal for a few, a bad deal for many, and a very bad deal for those with preexisting conditions. We urge the Department to withdraw its proposed rule and instead work to protect the health coverage of millions of workers and their families.

Sincerely,

**ROBERT C. "BOBBY" SCOTT**
Ranking Member

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Ranking Member
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[5] P.L. 97-473
[6] M. Kofman, E. Bangit, and K. Lucia, "MEWAs: The Threat of Plan Insolvency and Other Challenges" The Commonwealth Fund, March 1, 2004.
[7] *Id.*
[8] See pg. 625 of NPRM.

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