



**Association of
American Medical Colleges**
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Submitted electronically via www.regulations.gov.

March 5, 2018

Ms. Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
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 Ms. Klinefelter Wilson:

The Association of American Medical Colleges (the AAMC or Association) welcomes this opportunity to comment on the Department of Labor’s (DOL’s or Agency’s) proposed rule entitled “Definition of “Employer” Under Section 3(5) of ERISA – Association Health Plans,” 83 *Fed. Reg.* 614 (January 5, 2018).

AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Together, these institutions and individuals are the American academic medicine community.

AAMC appreciates DOL’s efforts to improve the availability of affordable health insurance coverage in the individual and small group markets. We agree that consumers must have access to high-quality, high-value health care providers, and addressing ways to make health insurance more affordable is one way to achieve this goal. However, the AAMC is concerned that the proposal to exempt association health plans (AHPs) from individual and small group market regulations will allow AHPs to offer less comprehensive insurance products; segment the insurance market, leading to de-stabilization and premium increases for sicker individuals; leave patients with inferior health insurance coverage, potentially limiting access to care; and, leave

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providers who treat these patients either underpaid or not paid at all. The Association urges DOL to not finalize the rule as proposed.

Americans have benefited from the opportunity to purchase affordable health insurance coverage through the individual marketplace. Recent robust enrollment numbers for 2018 show that consumers are committed to securing coverage through the marketplaces, and indicate that the current marketplace rules are working, though revisions are needed to address premium increases. AAMC believes that efforts should be made to improve the individual and small group marketplaces, rather than creating a new insurance option. We urge DOL to work with stakeholders to improve the current individual and small group marketplace by finding ways to bolster insurer participation, stabilize premiums, and ensure robust health insurance coverage options for all Americans.

Support Efforts to Stabilize the Health Insurance Market

Under current law and regulations, health insurance coverage provided through an employer trade association, or similar organization, to individuals and small employers is generally regulated under the same federal standards that apply to insurance coverage sold by health insurance issuers directly to individuals and small employers, unless the coverage sponsored by the association constitutes a single ERISA-covered plan. DOL is proposing to remove these existing restrictions thereby allowing a group or association to be treated as a single employer plan under ERISA. If an AHP is treated as a single large group health plan, as with other large group health plans, the AHP will not be subject to many protections currently afforded by the ACA insurance market reforms and regulatory requirements that individual and small group insurance plans must meet.

AAMC understands the need for regulatory flexibility to ensure the availability of affordable insurance options, and supports the goal of reduction of regulatory burden. However, the proposal to treat AHPs as large group employers to enable them to “avoid many of the PPACA’s costly requirements” (83 *Fed. Reg.* 615) will permit these groups to offer less comprehensive plans than are currently offered in the individual and small group markets. These plans often have narrow provider networks, high deductibles and other cost-sharing that patients deal with when faced with serious illness or injury. The new rules relaxing current requirements has the potential to destabilize the individual and small group markets jeopardizing health insurance options for millions of Americans. By increasing access to AHPs, younger and healthier individuals and groups seeking cheaper, lower-quality health insurance options will likely abandon the existing marketplace, driving up costs for older and less healthy consumers that remain and jeopardizing the stability of the individual market. AAMC urges DOL not to finalize this proposed rule but instead work to improve the current health insurance marketplace to ensure that all consumers have access to high-value insurance options.

Currently, employers in the association are required to have some commonality, such as a similar line of work, unrelated to the provision of health benefits. Under these new rules, employers

could form AHPs solely to provide health insurance and would permit AHPs to be defined by the principal place of business within a geographic region, such as a metropolitan area, even if the metropolitan area includes more than one state. Under this flexibility, the region could be drawn to exclude certain high-cost areas or employees. The large scope of these new AHPs, potentially encompassing entire states or regions, magnifies the destabilizing impact they could have on existing insurance markets. The AAMC urges DOL to retain current restrictions on the size and definition of AHPs so as to minimize their unintended consequences.

Require AHPs Offer Essential Health Benefits

Part of the ACA's goal to offer comprehensive health care coverage for all Americans included the requirement to provide coverage for certain items and services, including these essential health benefits (EHBs): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.¹ By setting this standard of benefits, consumers are assured of a uniform level of coverage among of health plans, and it prohibits insurers from cutting benefits just to reduce costs. Currently, association health plans are required to cover all of the ACA's mandated benefits, preventing these plans from creating a benefits package designed to attract mostly young and health customers.

Under the new proposal, AHPs would be exempt from many ACA requirements. AHPs would be able to offer plans that do not meet a minimum benefits package, excluding coverage for EHBs. As a result, in an effort to provide access to insurance options with low premiums, AHPs could consist of scarce benefit packages that provide inadequate coverage to consumers. We already see the tremendous financial burden in the market caused by inadequate coverage leading to financial instability for patients who are ill. These new regulations will compound this problem for those who seek coverage but are inadequately covered.

The AAMC is concerned that the proposals open the possibility that with "affordability" will come plans that do not meet the needs of consumers when, for example, they face a sudden major unexpected illness or injury. Reducing requirements for AHPs might lower premiums in the short term; however, the benefits included in the plan may actually be so reduced that they are inadequate to provide for coverage of basic health needs. AAMC urges DOL to require that at a minimum, AHPs are required to provide minimum benefits packages that cover the EHBs.

Changes to coverage requirements may exacerbate confusion that consumers face when searching for affordable insurance. Only when patients attempt to receive care will they realize the full impact of these changes. For example, a patient diagnosed with cancer may not realize

¹ <https://www.cms.gov/ccio/resources/data-resources/ehb.html>

that the insurance plan she selected does not provide adequate coverage for cancer treatments until she seeks medical treatment, leaving her with few options for these life-saving services. Or a family may only find out that their newborn's neonatal intensive care unit (NICU) stay is not covered after they are facing extraordinary costs. In addition, patients may be shocked to discover that they do not have coverage, or that the coverage is inadequate, for needed medical treatment such as referrals to specialists. Insufficient coverage for needed health care leads to gaps in seeking needed health care that results in poorer health for patients, the use of high-cost services, such as emergency department visits or hospitalizations that could have been prevented if adequate care were available.

It is not patients alone who will feel the impact less comprehensive insurance coverage. Hospitals and physicians will find themselves treating more patients who are uninsured or underinsured. These patients may forego needed, routine care because of limited benefits or high cost sharing responsibilities with the result that they will be sicker when they do seek care – many waiting until they need to go to an emergency room – and thus will require an increased use of services.

Nondiscrimination Protections Will Not Sufficiently Protect Those with Pre-Existing Conditions

The proposed rule states that “the group health plan sponsored by the group or association must comply with the HIPAA/ACA health nondiscrimination rules” governing eligibility for benefits and premiums for group health plan coverage. (83 *Fed. Reg.* 623-624). The group or association would be prohibited from conditioning membership based on any health factor of an employee, including former employees and family members. While the nondiscrimination rules prohibit overt exclusion from coverage based on pre-existing conditions, lifting standard benefit requirements for AHPs, such as EHBs, will allow an AHP to design a plan with benefits so meager as to naturally exclude those with health needs.

Healthier individuals are more likely to choose cheaper plans with fewer benefits, leaving consumers with greater health needs – *e.g.*, multiple chronic conditions – in plans with more substantial coverage and likely higher premiums. As a result, there will be even less insurer participation and skyrocketing premiums in the individual and small group markets, leaving many consumers with even fewer options for affordable health insurance coverage. AAMC commends DOL for applying the HIPAA/ACA health nondiscrimination rules to AHPs, but cautions that these rules will be insufficient to protect coverage for people with pre-existing conditions.

Ms. Klinefelter Wilson

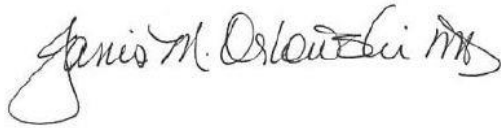
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Conclusion

Thank you for the opportunity to comment on the Association Health Plans proposed rule. We would be happy to work with DOL on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at 202.909.2084 or mmullaney@aamc.org.

Sincerely,

A handwritten signature in cursive script that reads "Janis M. Orlowski M.D." followed by a stylized flourish.

Janis M. Orlowski, M.D., M.A.C.P.
Chief, Health Care Officer, AAMC

cc: Ivy Baer, J.D., M.P.H, AAMC
Mary Mullaney, AAMC