



**Statement for the Record**  
**On Behalf of Members of the Partnership to Protect Coverage**  
**House Committee on Education and the Workforce**  
**Subcommittee on Health, Employment, Labor, and Pensions**  
**Hearing on “Reducing health care costs for working Americans and their families”**  
**April 26, 2023**

The 25 undersigned organizations represent more than 120 million people living with a pre-existing condition in the US. Collectively, we have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that are critical components of any discussion aimed at improving or reforming our healthcare system.

Our organizations share three principles that we use to help guide our work on healthcare to continue to develop, improve upon, or defend the programs and services our communities need to live longer, healthier lives.<sup>i</sup> These principles state that healthcare must be adequate, affordable, and accessible.

With these principles at the forefront, we write to convey our concerns about two items on the committee's agenda: association health plans (AHPs) and creating an excepted benefit exemption for telehealth-only plans. Many of our organizations documented our concerns with these types of plans in the report: *Under-covered: How "Insurance-Like" Products Are Leaving Patients Exposed.*<sup>ii</sup> We offer the following information to help guide the committee's work. We look forward to partnering with you to make healthcare more accessible, affordable, and adequate for patients and their families.

### **Association Health Plans**

Current law allows employers to work together to form a multiple employer welfare arrangement (MEWA) to provide certain benefits to their employees. An AHP — a health benefit plan sponsored by an employer-based association — is one type of MEWA.

Some AHPs can be classified as large employers and are therefore not subject to critical patient protections and state insurance regulations. This can pose risks to employers and their employees. The track record of AHPs and MEWAs in reliably providing comprehensive coverage for consumers is quite poor. According to state insurance regulators, these entities have a long history of fraud and "[making] money at the expense of their participants." State insurance regulators also say AHPs "have been notoriously prone to insolvencies."<sup>iii</sup>

AHPs are not required to provide comprehensive coverage or cover the Essential Health Benefits (EHB). AHPs may also charge higher premiums based on occupation (a loophole that allows discrimination based on gender and other factors<sup>iv</sup>) or even health status in some cases. As a result, these plans expose enrollees to high financial and health risks, and exacerbate rural and/or regional health disparities. Meanwhile, marketing these products can be confusing or misleading and can cause individuals to enroll in plans that do not align with their medical needs or expectations.

AHPs also pose risks to the many consumers who do not enroll in them. AHPs can siphon away healthy individuals from state individual and small-group markets by leveraging the regulatory advantages they enjoy. This leaves the individual and small group markets smaller and with a larger proportion of individuals with pre-existing conditions, leading to higher premiums and fewer plan choices for those who depend on those markets to access comprehensive coverage.

In 2018, the administration issued a rule that made it easier for small businesses to form an AHP that qualifies as a single large employer under ERISA, allowing them to more easily circumvent the patient and consumer protections that apply to the small group market. Though a federal court blocked the key provisions of that rule, the litigation is still pending, which has created significant confusion across stakeholders and state regulators. The current administration has signaled its intent to regulate AHPs this year.

As Congress contemplates the role AHPs play in our healthcare system today, we urge you to work with the administration and states to set common-sense restrictions that protect patients, consumers, and employers — limiting low-value plans rather than allowing them to proliferate further.

### **Telehealth as an Excepted Benefit**

Telehealth has long been a vital care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care

services. However, the COVID-19 pandemic has highlighted the role of telehealth in helping patients continue to receive timely and safe healthcare services and treatments from their providers. Telehealth – including telemedicine and telemental health – can help reduce gaps in access to services and care, including access to primary care and specialized providers, when in-person visits are not a safe or feasible option. Today, nothing prevents an employer or health insurance carrier from offering telehealth coverage in conjunction with their health coverage, and many do.

Telehealth can and should be used to increase patient access to care and our organizations have issued principles to aid lawmakers in setting appropriate policies to achieve that goal.<sup>v</sup>

We are concerned with the proposal to create a new excepted benefit for telehealth services. Excepted benefits are a category of coverage exempt from most federal and state standards that apply to health insurance. This means that a telehealth excepted benefit could discriminate against patients with a pre-existing condition by refusing to cover certain treatments, charging more for coverage, or denying coverage altogether.

Excepted benefits coverage can take many forms, including disease-specific policies like cancer-only, dental, and fixed indemnity plans. These plans are designed to supplement a major medical insurance plan. They are NOT comprehensive coverage and in many cases, they are not allowed to coordinate with other coverage. These products are often exempted from federal regulation and primary regulation authority lies at the state level. While telehealth is an important coverage, it is insufficient on its own without major medical health insurance.

The Administration allowed employers to offer stand-alone telehealth benefits during the COVID-19 pandemic health emergency as a means to give individuals not eligible for their employer plan access to at least some care during the pandemic. However, employers were not allowed to offer the stand-alone telehealth benefit to individuals who could enroll in their employer plan, nor did the guidance exempt these stand-alone benefits from all consumer protections.

What the committee is considering goes well beyond that guidance. Employers would be able to offer the stand-alone benefit as an alternative to their comprehensive plan. Low-wage workers, in particular, would be at risk of enrolling in the lower-cost telehealth plan, thinking it will provide comprehensive coverage when it won't.

Even in the best-case scenario, where an individual enrolls in a comprehensive employer plan and the telehealth-only policy, we fear a telehealth-only policy could create significant frustration and confusion for consumers who need in-person care to diagnose and treat their symptoms. Consider the scenario of a patient who sees a provider via telehealth and then in person, as many do in the course of receiving a diagnosis and treatment. Then imagine navigating two separate insurance companies to receive that care – two sets of paperwork, two sets of prior authorization, two sets of network limitations, two sets of cost-sharing responsibilities, and so on. Not to mention the telehealth provider and in-person provider may be two different providers within two different medical systems. As a result, the telehealth provider would not necessarily have access to the patient's medical history and thus would be hampered in their ability to adequately treat and diagnose the patient.

Lastly, we want to draw the committee's attention to a concerning trend. In recent years, excepted benefits have been marketed and sold – sometimes bundled – as replacements for traditional health insurance.<sup>vi</sup> This can lead to significant consumer confusion and a false sense of security for people who believe they've purchased high-quality coverage, only to find substantial gaps and higher out-of-pocket costs when they use their plan.

## Conclusion

We look forward to continuing to work with Congress to expand affordable, accessible, and adequate healthcare coverage for patients.

Sincerely,

American Cancer Society Cancer Action Network  
American Heart Association  
American Lung Association  
Asthma and Allergy Foundation of America  
CancerCare  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Hemophilia Federation of America  
Immune Deficiency Foundation  
Lupus Foundation of America  
Muscular Dystrophy Association  
National Alliance on Mental Illness  
National Coalition for Cancer Survivorship  
National Eczema Association  
National Health Council  
National Hemophilia Foundation  
National Multiple Sclerosis Society  
National Organization for Rare Disorders  
National Patient Advocate Foundation  
National Psoriasis Foundation  
Pulmonary Hypertension Association  
Susan G. Komen  
The AIDS Institute  
The Leukemia & Lymphoma Society  
The Mended Hearts, Inc.

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<sup>i</sup> Consensus Healthcare Reform Principles. <https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/PPC-Coalition-Principles-FINAL.pdf>.

<sup>ii</sup> Under-Covered: How “Insurance-Like” Products Are Leaving Patients Exposed. <https://www.ils.org/advocate/under-covered-how-insurance-products-are-leaving-patients-exposed>.

<sup>iii</sup> National Association of Insurance Commissioners. (2018, March 6). NAIC Letter to Employee Benefits Security administration, U.S. Department of Labor Definition of Employer—Small Business Health Plans RIN 1210- AB85-. NAIC. [https://www.naic.org/documents/index\\_health\\_reform\\_section\\_180306\\_comments\\_assoc\\_plan\\_nprm.pdf](https://www.naic.org/documents/index_health_reform_section_180306_comments_assoc_plan_nprm.pdf)

<sup>iv</sup> Patient Groups Comments on RIN 1210-AB85; Definition of “Employer” Under Section 3(5) of ERISA— Association Health Plans (2018, August 22). <https://www.lung.org/getmedia/9d61d488-e40c-4af5-90e4-4bc5d2754dbe/partner-comments-dol-re-rin-1210-ab85.pdf>.

<sup>v</sup> Principles for Telehealth Policy. [https://www.lung.org/getmedia/ac136df2-5984-46b6-9503-8523f71f5425/FINAL-Principles-for-Telehealth-Policy- 8 27 2020-\(003\).pdf](https://www.lung.org/getmedia/ac136df2-5984-46b6-9503-8523f71f5425/FINAL-Principles-for-Telehealth-Policy- 8 27 2020-(003).pdf).

<sup>vi</sup> Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk. <https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk>.