



June 21, 2023

The Honorable Kevin McCarthy
 Speaker
 U.S. House of Representatives
 2468 Rayburn House Office Building
 Washington, DC 20515

The Honorable Hakeem Jeffries
 Leader
 U.S. House of Representatives
 2433 Rayburn House Office Building
 Washington, DC 20515

Re: Patient community concerns about the detrimental impact of policies included in HR 2868, the Association Health Plans Act; HR 2813, the Self-Insurance Protection Act, and HR 3799, the CHOICE Arrangement Act

Dear Speaker McCarthy and Leader Jeffries,

On behalf of the millions of patients and consumers across the country with serious, acute and chronic health conditions, our organizations urge you to oppose HR 2868, HR 2813, and HR 3799, which threaten access to quality, affordable healthcare coverage.

The 23 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.ⁱ These principles state that healthcare must be adequate, affordable, and accessible.

With these principles at the forefront, we write to convey our concerns about three bills that have recently been moved out of the Rules Committee and will soon be considered on the House floor: HR 2868, the Association Health Plans Act; HR 2813, the Self-Insurance Protection Act, and HR 3799, the CHOICE Arrangement Act. In the report “Under-covered: How ‘Insurance-Like’ Products Are Leaving Patients Exposed,” many of our organizations documented our concerns with health insurance products that are not required to comply with the patient protections enacted in the Affordable Care Act.ⁱⁱ We are concerned that policies included in the legislation considered today would decrease the number of consumers enrolled in comprehensive health insurance plans and threaten access to quality, affordable healthcare for the patients and consumers we represent.

H.R. 2868, the Association Health Plans Act

Current law allows employers to work together to form a multiple employer welfare arrangement (MEWA) to provide certain benefits to their employees. An Association Health Plan (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.”ⁱⁱⁱ

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^{iv}) 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.

Despite the harm AHPs can pose to those who enroll in them as well as those who remain in comprehensive insurance plans, the Association Health Plans Act would promote additional enrollment in AHPs for groups that cannot use them today. We believe additional enrollment in AHPs by small employers and the self-employed will weaken patient and consumer protections and lead to higher costs for consumers who rely on comprehensive insurance.

HR 2813, the Self-Insurance Protection Act

Stop-loss insurance is intended to be used as a tool to protect a health plan sponsor—typically an employer—from unpredictably high losses due to unexpected claims. As such, it can be an important tool to promote stability for sponsors of health insurance plans, particularly sponsors providing coverage for small numbers of insured individuals, whose unique health needs sometimes necessitate very expensive health services.

We are concerned that HR 2813 would remove an important level of consumer and patient protection by eliminating the ability of states to exercise oversight of stop-loss plans. State insurance commissioners play an important role in the health insurance marketplace. Removing states' ability to regulate stop-loss coverage would lead to less oversight of these plans, which would increase the likelihood of misleading marketing and other fraudulent practices that would prove harmful to employers purchasing stop-loss coverage as well as their employees.

HR 3799, the CHOICE Arrangement Act

In lieu of offering a traditional group health plan, employers may provide contributions, on a pre-tax basis, to their employees to subsidize the direct purchase of individual market health coverage.

The choice to offer these individual coverage health reimbursement arrangements (ICHRA) is available to employers right now, and has been for several years. Yet interest appears to be modest. It is possible take-up has been limited simply because the arrangement is still relatively new, and enrollment may expand with time. It is also possible that, for employers, the value proposition of ICHRAs is less than some anticipated. We note that commonly cited benefits of ICHRAs — including predictable costs for employers and multiple plan options for employees — can be achieved through traditional employer coverage mechanisms and benefit designs.

Troublingly, however, ICHRAs have introduced new risks, both for workers with employer coverage and for consumers who rely on the individual market. ICHRAs provide employers an opportunity to reduce their costs by moving older and sicker workers off of job-based coverage and into the individual market.^v These shifts potentially disrupt access to care for employees and make the individual market risk pool more expensive to insure, raising premiums.

The regulatory framework governing ICHRAs recognizes these dangers and includes provisions to mitigate them. For example, to reduce the ability of employers to offer ICHRAs selectively to only their sicker employees, federal rules require employers to treat all members of a particular class of workers the same for purposes of ICHRA eligibility. Still, the leeway given to employers to tailor these classifications is substantial, and it allows employers to create subgroups of workers based on characteristics that are proxies for health status. The rules also lack safeguards that would prevent an employer from using administrative loopholes to segment its workforce for ICHRA purposes based on otherwise impermissible factors. For these reasons, we have encouraged federal regulators to collect and publish data that would shed light on how employers are using these arrangements and the effectiveness of the nondiscrimination guardrails.

Against this backdrop, HR 3799 would create “custom health option and individual care expense” (CHOICE) arrangements, a new tax-advantaged arrangement similar to but apparently legally distinct from ICHRAs. To the extent HR 3799 is intended merely to codify the established regulatory framework for ICHRAs, we believe doing so is unwarranted at this time. Moreover, the bill's convoluted approach is likely to increase confusion and uncertainty.

Of additional concern, it appears HR 3799 incorporates the ICHRA rules selectively, in a manner that could intensify the risks posed by these arrangements. As we observed above, the nondiscrimination

provisions in the existing regulatory framework are essential but insufficient to prevent employers from using ICHRAs to shift higher-cost workers to the individual market. HR 3799 does nothing to address these shortcomings. On the contrary, it would omit from statute key protections designed to safeguard consumers and the individual insurance market from the downsides of these arrangements.

Conclusion

We urge lawmakers to reject the three bills referenced above and, instead, partner with organizations like ours to identify opportunities to expand affordable, accessible, and adequate healthcare coverage for patients. If you have questions or would like to discuss this further, please contact Brian Connell VP, Federal Affairs with The Leukemia & Lymphoma Society at brian.connell@lls.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Asthma and Allergy Foundation of America
CancerCare
Child Neurology Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Muscular Dystrophy Association
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society

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

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

ⁱⁱⁱ 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

^{iv} 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>.

^v Linke Young C, Levitis J, Fiedler M. Evaluating the Administration’s Health Reimbursement Arrangement Proposal. USC-Brookings Schaeffer Initiative for Health Policy. https://www.brookings.edu/wp-content/uploads/2018/12/Linke-Young_Levitis_Fiedler_HRA-paper_12.11.18.pdf. Published December 2018.