

Office of Regulations and Interpretations  
Employee Benefits Security Administration, Room N-5655  
U.S. Department of Labor  
200 Constitution Avenue NW, Washington, DC 20210  
Attention: Definition of Employer – Small Business Health Plans RIN 1210-AB85

Re: [RIN 1210-AB85](#), *Definition of “Employer” Under Section 3(5) of ERISA – Association Health Plans*

Dear Sir or Madam:

Hemophilia Federation of America (HFA) is a community-based, grassroots advocacy organization that assists, educates, and advocates for people with bleeding disorders. We are submitting comments in response to the Department of Labor (DOL) proposed rule regarding Association Health Plans (AHPs) published in the Federal Register on January 5, 2018.

Background. Hemophilia and other bleeding disorders are genetic conditions that impair proper blood clotting. People with hemophilia, often the severest of these conditions, take prescription medications (clotting factor or other newer therapies) to treat or avoid painful bleeding episodes that can lead to advanced medical issues, such as joint and muscle damage, or even death. These medicines are highly effective and allow affected individuals to lead healthy and productive lives. However, hemophilia treatments are extremely expensive, costing anywhere from \$250,000 to \$1 million or more annually, depending on the severity of the disorder and whether complications such as an inhibitor are present.

Due to the high cost of treatments, good health insurance is essential for people with bleeding disorders or other chronic health conditions. “Good insurance” means insurance that people can afford, *and* that covers the services and products they need in order to stay healthy. Prior to enactment of the Affordable Care Act (ACA), many individuals with hemophilia lacked access to good insurance: to affordable plans that covered the medications and care necessary to treat or prevent joint- and life-threatening bleeding episodes. Even today, patients too often contend with meager and discriminatory plans that lack meaningful formulary coverage for prescription drugs, impose burdensome prior authorization and step therapy requirements, and entail high out-of-pocket spending. HFA supports regulatory action to solve these problems and to support access to adequate coverage and care.

Unfortunately, the proposed AHP rule moves in the wrong direction, and would hurt rather than help the very people who most need high quality health coverage. By expanding the definition of “employer,” the proposed rule would allow more businesses to join together to form AHPs. These AHPs would qualify as large group coverage under ERISA. As large group coverage, the new AHPs would be exempt from important ACA consumer protections, including essential health benefits (EHB) standards and premium rating restrictions. HFA is concerned that the proposed rule’s AHP expansion would:

- allow the sale of health plans that do not meet people’s needs;
- make room for more covert discrimination in plan design;
- destabilize the individual insurance market, driving up premiums for comprehensive insurance; and
- undermine state authority to safeguard against insurance company abuses.

Discrimination via benefit design; inadequate coverage. The proposed rule, in principle, would ban AHPs from conditioning membership on health factors, and would require them to comply with nondiscrimination rules. But AHPs – as large groups exempt from ACA rating restrictions – *could* vary premiums based on age, gender, industry, and other non-health factors. Of particular concern to a rare disease community, AHPs could also opt to exclude coverage for EHBs. Using this authority, AHPs could adopt the kind of skinny benefit packages that were all too common before the ACA. By excluding coverage for specific providers (e.g., hematologists) or products (e.g., specialty drugs), an AHP could very effectively discourage enrollment by people with expensive health needs. In this way, the proposed rule would reopen numerous avenues for covert or disguised adverse selection against enrollees with rare and expensive health conditions like hemophilia.

Narrow AHP benefit design would cause problems, not only for the people **excluded** due to adverse selection, but also for many individuals who would find themselves **included** in AHPs. Workers whose employers opted into an AHP could discover that their new employer-provided plans don't cover their health needs (for example, an existing bleeding disorder, or a newborn with an unexpected diagnosis of hemophilia or another serious illness). These individuals would find themselves underinsured and facing the very challenges the ACA was designed to address: lack of access to care and/or financial distress due to sky-high medical spending. Workers in these circumstances would also have few options for obtaining alternative, higher quality insurance. If the employer-offered AHP plan counted as “affordable and adequate employer coverage,” the affected workers would not qualify for subsidies to buy other insurance in the individual market.

Market destabilization. Avalere and others have projected that the lower premiums for AHP coverage would attract significant numbers of healthy people away from the traditional individual and small group markets, skewing the insurance risk pool.<sup>1</sup> The people who would remain in the market for comprehensive insurance would be those with the most pressing need for robust health coverage: people with serious and/or chronic health needs. Year by year, premiums would continue to rise and the pool of enrollees would continue to shrink, in a self-reinforcing spiral. DOL itself acknowledges that AHPs “may contribute to some Exchanges’ instability” [83 Fed. Reg. 630] to the extent that they attract younger and healthier enrollees, and consign people with significant health needs to an increasingly expensive market for ACA-compliant coverage.

Effect on state regulatory authority. The proposed rule creates substantial uncertainty about the scope of state authority over AHPs. Could state regulators enforce requirements that go above and beyond the federal AHP standards? Or would federal law preempt state regulation of association plans? Who would have regulatory or enforcement authority over plans sold across state lines? These questions take on added importance given the troubled past history

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<sup>1</sup> Avalere estimates that up to 3.2 million people would move from ACA-compliant plans to AHPs if the proposed rule were to go into effect. According to their projections, the AHP rule would cause premiums to rise in the ACA individual and small group markets relative to current law, resulting in 130,000 people becoming uninsured. “The proposed rule would lead to millions of individuals and small businesses shifting into a new form of coverage, likely reducing their premiums, but leading to higher premiums in the markets they leave behind.” Dan Mendelson et al., “Association Health Plans Projected to Enroll 3.2M Individuals,” (Feb. 28, 2018), <http://avalere.com/expertise/managed-care/insights/association-health-plans-projected-to-enroll-3.2m-individuals>.

of AHPs (insolvency, fraud, mismanagement, and abuse). DOL acknowledges this problematic track record and yet unanswered basic questions about the division of enforcement authority between state and federal regulators.

Conclusion. HFA strongly supports ensuring affordable, good quality health coverage for all Americans. We are concerned that the AHP rule works against that goal. Instead of protecting coverage and care for all, the proposed AHP rule tries to lower premiums for AHP-eligible workers with few health needs – at the expense of people who live with chronic and expensive health conditions including hemophilia. We urge DOL to fundamentally reconsider its approach.

We thank you for the opportunity to comment. If you have any additional questions, or need any additional information, please contact Kim Isenberg, HFA Vice President – Policy, Advocacy and Government Education, at (202)675-6984, or [k.isenberg@hemophiliafed.org](mailto:k.isenberg@hemophiliafed.org).

Sincerely,



Kimberly Haugstad  
President & CEO  
Hemophilia Federation of America