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March 6, 2018

Ms. Jeanne Klinefelter Wilson  
Deputy Assistant Secretary  
Employee Benefits Security Administration  
Department of Labor  
U.S. Department Labor  
200 Constitution Ave., NW  
Washington, DC 20210

**RE: Definition of "Employer" under Section 3(5) of ERISA – Association Health Plans – RIN 1210-AB85**

Dear Deputy Assistant Secretary Wilson:

The Leukemia and Lymphoma Society (LLS) appreciates the opportunity to comment on proposed changes to the definition of "employer" as it relates to Association Health Plans (AHPs). LLS serves the needs of blood cancer patients by working to find cures for leukemia, lymphoma, Hodgkin's disease, and multiple myeloma, and by ensuring that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. We recognize that small businesses often struggle to provide affordable insurance coverage to their employees and believe that the federal government and states should take steps to ensure that more Americans have access to health insurance coverage that best meets the needs of these employers, their employees, and other participants in the individual and small group insurance market.

We are deeply concerned that this proposed rule could result in the proliferation of lower quality coverage options and further destabilize the exchange market. The exchange marketplace ensures that people at all levels of healthcare need can access coverage, and its stability is dependent upon having a balance of sicker and healthier individuals purchasing coverage. Avalere Health projects that approximately 3.2 million people would shift out of the individual and small group markets into AHPs by 2022 if the rule is finalized as proposed.<sup>1</sup> The people who leave the individual and small group markets are likely to be healthier because AHPs will be able offer options that have greater appeal to younger, healthier people (e.g., plans that do not cover prescription drugs). Not everyone, however, will be able to access coverage, or coverage that meets their needs, through AHPs. Many older and/or sicker people, along with those who cannot access care through an AHP, will remain in the exchanges, leading to an unhealthier risk pool.

In such a scenario, insurers will increase premiums and cost-sharing in the exchanges to adjust for the change in population; Avalere Health projects that, by 2022, premiums would rise by 3.5 percent and 0.5 percent in the individual and small group markets, respectively, due to unhealthier risk pools.<sup>2</sup> In the short term, those left in exchange plans will struggle even more to afford care and, in the long term, there will be significant destabilization in the market and an increase in the number of uninsured people. By 2022, Avalere Health estimates that 140,000 additional people could

<sup>1</sup> Avalere Health. "Association Health Plans Projected to Enroll 3.2M Individuals." February 2018. Available online at: <http://avalere.com/expertise/managed-care/insights/association-health-plans-projected-to-enroll-3.2m-individuals>

<sup>2</sup> Ibid.

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become uninsured as a result of the proposed rule, when compared with current law.<sup>3</sup> We urge the administration to take additional steps to stabilize the exchange market if it moves forward with this proposed rule. We also recommend that the Department of Labor (DOL) institute additional concrete patient protections to prevent discrimination against sicker individuals by AHPs.

In addition, LLS cautions DOL that weakening states' ability to regulate AHPs, a group among which there is a history of fraud and abuse, could increase the likelihood that bad actors will take advantage of small business owners seeking insurance coverage. Though the proposed rule does have the potential to increase the number of options available to some consumers, there is real risk that it could decrease the coverage options available to others. A weakened exchange market combined with the risk of unpaid claims among AHPs, could result in higher out-of-pocket costs for many patients—especially those who rely on their coverage to access vital and costly healthcare services.

### **Definition of “Employer”**

We agree that steps need to be taken to encourage small business to provide insurance coverage and to make it easier for those that choose to do so to offer affordable plan options. Yet, it is not enough that coverage be affordable – it must also be meaningful. As we outline in our Principles for Meaningful Coverage, patients, particularly those with cancer, must be able to have peace of mind that the plan options from which they can choose are all required to offer at least a minimum standard for quality, such as adequate networks and a baseline “floor” for covered benefits.

While there may be benefits in allowing businesses that choose to join an AHP to be considered as one large group plan, we are concerned that the corresponding decrease in the coverage standards to which these employers must adhere will mean that employees who seek coverage through these AHPs will be presented primarily with plan options that offer lower premiums, but also significantly less generous coverage. For example, premiums may be lower because plan options do not cover certain essential health benefits. Though these lower premium plans may suit the needs of some employees, they likely will not meet the needs of people with blood cancer or other serious illnesses. It is imperative that consumers have the tools and information they need to compare the tradeoffs between lower premium plans and plans that offer more robust coverage.

For instance, currently, people choosing among plan options offered by an AHP are often selecting from set of plans that are all regulated by the more stringent state and federal rules governing the individual and small group markets (i.e., plans that are all required to cover all essential health benefits). If the proposed rule is finalized, the AHP to which these individuals belong may be considered a large group plan and be able to offer a wider variety of plan options, including plans with less generous coverage. Without adequate consumer education, people may unwittingly choose less generous plans based only on the premium or deductible amount, not realizing that that the standards for what their plans must cover has changed. In such cases, patients may end up selecting plans that do not best meet their needs and be responsible for covering higher out-of-pocket costs than they anticipated. This could be particularly true for patients who are diagnosed with a serious illness like cancer over the course of a plan year.

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<sup>3</sup> Ibid.

Research has shown that tools like cost calculators can increase the likelihood that patients will select plans that meets their needs.<sup>4</sup> We urge DOL to devote adequate resources to educating consumers and to developing tools so that patients understand what the change in classification for AHPs can mean for them. In addition, we recommend that DOL monitor the impact of the rule, if finalized, on patients with high-cost conditions and make public those findings.

### **Nondiscrimination**

We are pleased that that DOL clarifies in the proposed rule that AHPs may not discriminate based on health factors or on the basis of a medical condition. However, we strongly recommend that DOL implement additional guardrails, beyond those outlined in the proposed rule, to protect patients from discrimination. In particular, we are concerned that AHPs will be permitted to design benefits in such a way that the plan options they provide will be attractive only to younger, healthier individuals and will not meet the needs of those who are older or in worse health (e.g., plans with especially narrow networks and high cost-sharing for services that people with serious or chronic health conditions must access).

For instance, under the proposed rule, an AHP could offer only plans that do not cover prescription drugs; sicker individuals (e.g., those with blood cancers), as well as older individuals, will likely recognize that these plans will not meet their needs and thus will be systematically discouraged from seeking coverage through AHPs. Under this scenario, the proposed rule would not result in more or lower cost plan options for some of the most vulnerable people seeking coverage. While AHPs are not allowed to explicitly discriminate against patients based on their health factors or medical conditions, the lack of standards around plan offerings could, in practice, result in serious discrimination against patients with cancer and other healthcare needs. In addition to including stronger patient protections in the rule, we encourage the administration to develop a series of tests that are subject to notice and comment.

### **Regulation of Association Health Plans**

LLS is also concerned that the proposed rule will erode states' abilities to regulate their own markets, particularly if numerous AHPs qualify as large group employers. Many states have added additional protections and regulations to ensure that the individual and small group markets within the state meet the needs of the states' residents; the proposed rule makes it unclear the extent to which, under ERISA, states will be able to regulate AHPs based on the needs of their residents. We urge DOL to clearly delineate the responsibility for regulating AHPs between state and federal governments and to consider the instances in which states may be better positioned to take the lead in overseeing AHPs. LLS also asks that DOL provide more information about how it will approach AHPs that form in metropolitan areas that span multiple states (e.g., the DC metro area).

Our concern about the balance of federal and state oversight of AHPs is compounded by the history of fraud and claims going unpaid associated with AHPs. Lack of diligent oversight of AHPs can cause real harm to patients, and expanding the scope of those organizations that can qualify as AHPs may increase the probability that bad actors will attempt to defraud small businesses and self-employed individuals seeking coverage. We commend the DOL for the steps it has

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<sup>4</sup> EJ, Hassin R, Baker T, Bajger AT, Treuer G (2013) Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture. PLoS ONE 8(12): e81521. <https://doi.org/10.1371/journal.pone.0081521>

taken in the past to curb fraudulent and insolvent AHPs and urge it to devote more resources to monitoring and enforcement activities if it moves forward with the rule as proposed. In addition, we recommend that the DOL partner closely with states to provide oversight, as many states have had success in regulating this market and preventing abuses.

#### About LLS

LLS is the world's largest voluntary health agency dedicated to the needs of blood cancer patients. Each year, over 150,000 Americans are newly diagnosed with blood cancers, accounting for nearly 10 percent of all newly diagnosed cancers in the United States. The mission of LLS is to find cures for leukemia, lymphoma, Hodgkin's disease, and multiple myeloma and to ensure that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. LLS funds lifesaving blood cancer research, provides free information and support services, and advocates for public policies that address the needs of patients with blood cancer. Since our founding nearly 70 years ago, LLS has invested more than \$1 billion into research for cures, and LLS-funded research has been part of nearly all of the FDA-approved therapies for blood cancer. LLS appreciates the opportunity to offer its comments on the proposed rule. Should you have any questions about our comments or our organization, please do not hesitate to contact Bernadette O'Donoghue by email at [bernadette.odonoghue@lls.org](mailto:bernadette.odonoghue@lls.org) or Brian Connell at [brian.connell@lls.org](mailto:brian.connell@lls.org).

Sincerely,

  
Bernadette O'Donoghue  
Vice President, Public Policy