



Our Mission: To drive efforts to cure psoriatic disease and improve the lives of those affected.

March 6, 2018

The Honorable R. Alexander Acosta
U.S. Department of Labor
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
200 Constitution Avenue, NW
Washington, DC 20210

Re: (RIN 1210-AB85): Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans

Dear Secretary Acosta:

On behalf of the more than 8 million Americans living with psoriasis and psoriatic arthritis, the National Psoriasis Foundation (NPF) appreciates the opportunity to comment on the Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans (RIN 1210-AB85) proposed rule. As the patient advocacy organization for the psoriatic disease community for more than 50 years, the NPF is aware that many in our community face challenges accessing the care needed to properly treat and manage their condition. We recognize the Administration’s efforts to expand access to more affordable insurance options. However, we caution that access should not come at the cost of critical patient protections. We are concerned this proposed rule could diminish meaningful health insurance coverage for millions of Americans and risks further destabilizing the individual and small group markets shaped by the Affordable Care Act (ACA). The following letter details our specific concerns and provides some important background on psoriasis and psoriatic arthritis.

Background on Psoriasis and Psoriatic Arthritis

The National Psoriasis Foundation exists to drive efforts toward a cure for psoriasis and psoriatic arthritis and to dramatically improve the health outcomes of individuals living with psoriatic disease. Psoriasis is the most prevalent autoimmune disease in the United States, affecting approximately 3 percent of the adult U.S. population.ⁱ Up to 30 percent of individuals with psoriasis may also develop psoriatic arthritis, an inflammatory form of arthritis that can lead to irreversible joint damage if left untreated.ⁱⁱ Beyond the physical pain and discomfort of these diseases, individuals living with psoriatic disease also face higher incidence of comorbid health conditions including cardiovascular disease,ⁱⁱⁱ diabetes^{iv}, hypertension^v, and stroke^{vi}. A higher prevalence of atherosclerosis^{vii}, Crohn’s disease^{viii}, cancer^{ix}, metabolic syndrome^x, obesity^{xi} and liver disease^{xii} are also found in people with psoriasis, as compared to the general population. In addition, those living with psoriasis have a 39 percent increased risk of being diagnosed with depression than those without the disease, while the risk of a diagnosis of anxiety is 31 percent higher.^{xiii}

As heterogeneous chronic autoimmune diseases, psoriasis and psoriatic arthritis require sophisticated medical care. Without medical management by dermatologists and rheumatologists as well as the tools to control symptoms of the disease, people with psoriatic disease cycle through periods of intense pain, fatigue, unbearable itch, whole-body inflammation, flaking and bleeding of large swaths of the skin, and joint degradation. Additionally, treatments that work for one person may not work for others, and many patients cycle through numerous accepted treatment options throughout their lifetime.^{xiv} As medicine becomes increasingly more personalized, we anticipate that far more patients will encounter such situations. People with psoriatic disease also face barriers to treatment created by insurance policies and practices including narrow provider networks, fail-first or step therapy protocols that prevent or delay access to a clinically recommended therapy, increased patient cost-sharing, and a lack of transparency in benefit design. This had led to 48 percent of psoriasis patients reporting that they do not appropriately treat their disease to its level of severity and 60 percent saying their disease is a problem in their everyday lives.^{xv}

Response to Proposed Expansion of Association Health Plans

Informed by the points above, the NPF is concerned that the proposed expansion of Association Health Plans (AHP) could diminish coverage for those with chronic conditions seeking insurance outside of the ACA marketplace and destabilize the market for insurance in the non-grandfathered individual and small group markets regulated by the ACA. While we recognize the challenges with the marketplace today and appreciate the Administration's interest in developing alternative approaches and options, such options must be able to meet the healthcare needs of persons with chronic conditions like psoriasis and psoriatic arthritis. The chronic and varied nature of the disease and treatment options make the patient protections created by the ACA – particularly the establishment of essential health benefits (EHBs), ban on annual and lifetime limits for EHBs, and the prohibition against discriminating against persons with preexisting conditions – are critically important to our community. These health insurance standards facilitate patient access to the type of comprehensive care necessary to ensure patients can properly manage their conditions.

If the use of AHPs is expanded, we believe it is critically important that these protections are put in place to ensure that all AHP beneficiaries have access to healthcare regardless of any preexisting conditions they may have. Because the rule would allow more AHPs to be deemed large group plans for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), we are concerned the policy put forward would mean these plans could evade EHB protections, state review of issuer rate and form filings, and state network adequacy standards, making such products of limited value to persons with chronic conditions like psoriatic disease. While more modest plans may be of interest to a segment of the population that is relatively healthy and not managing a chronic condition, that would not be the case for our community, particularly persons with moderate to severe disease. Further, a recent analysis by Avalere Health found that the changes would not decrease the uninsured population; AHP enrollment growth would come from diverting an estimated 3.2 million healthier insured individuals from the ACA-compliant individual and small group insurance markets.^{xvi}

The NPF applauds the DOL for including provisions in the proposed rule that would prohibit AHPs from restricting membership based on the health status of the potential beneficiaries or their family members and from engaging in medical underwriting practices in which one employer could be charged a higher premium because of an employee's health status. We also appreciate that the rule speaks to the need to ensure an AHP maintains a governance structure. This should help provide necessary structures and safeguards to prevent the formation of AHPs that are not appropriately managed.

These protections, however, are not enough to assuage our concerns, particularly given the checkered past of AHPs that the rule references. We are also concerned that implementation of this proposed rule without actions to bring stability to the individual marketplace will create the perfect storm and lead to further adverse selection in the individual and small group insurance markets. This risk is reinforced by Avalere's analysis and even acknowledged in the proposed rule itself, which states on page 630, "to the extent that AHPs prove particularly attractive to younger or lower cost individuals, they may contribute to some Exchanges' instability." With fewer healthier, lower-cost beneficiaries in the ACA markets, premiums will increase for those who remain, many of whom have chronic conditions and require more robust health plans. This will only further disadvantage those living with psoriatic disease and increase federal costs, as the increased premiums will lead to larger expenditures of federal subsidies.

As you consider changes to the proposed rule, we urge you to take the following actions:

- **Apply EHB requirements to AHPs:** Applying EHB protections would create a meaningful safeguard that the proposal currently lacks. Many in our community recall all too well the questionable benefits packages that existed prior to the ACA and are not interested in returning to those days. We strongly urge the administration to consider applying EHB requirements to AHPs in a revision to the proposed rule.
- **Clarify oversight and enforcement mechanisms:** We are concerned that under the proposed rule, consumers will have little recourse and that AHPs may operate in a grey area outside of ERISA-governed large group plans. The Department acknowledges that it will need to commit additional resources to federal oversight and enforcement. We

encourage the administration to articulate in the final rule exactly how it will step up monitoring of AHPs and address the gaps in these necessary consumer protection areas as part of a revision to the proposal.

- **Federal and State oversight of AHPs:** We also recommend that in a final rule the Department stipulate with precision how it proposes to work with states and other parties to regularly review and audit AHPs to assess quality, member access, and other key questions. Such rigorous and ongoing monitoring must be part of any final rule. For example, the Department should explicitly outline a state's authority to apply marketing, governance, solvency, and state benefit mandates standards to AHPs, particularly with respect to AHPs whose membership extends beyond state boundaries.

Thank you for the opportunity to comment and we hope that our feedback is helpful as you assess how these proposed changes could impact access to care and health outcomes for the psoriatic disease community. If you have any questions about these comments, please contact Jessica Nagro, Federal Government Relations and Health Policy Manager (jnagro@psoriasis.org, 503-546-5559).

Thank you in advance for your consideration.

Sincerely,



Patrick Stone
Vice President, Government Relations and Advocacy
National Psoriasis Foundation

ⁱ Helmick CG, Lee-Han H, Hirsch SC, Baird TL, Bartlett CL. Prevalence of Psoriasis Among Adults in the U.S: 2003–2006 and 2009–2010 National Health and Nutrition Examination Surveys. *American journal of preventive medicine*. 2014;47(1):37-45. doi:10.1016/j.amepre.2014.02.012.

ⁱⁱ Gladman DD, Antoni C, Mease P, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. *Ann Rheum Dis*. 2005;64(suppl 2):ii14–ii17. - See more at: <http://www.rheumatologynetwork.com/psoriatic-arthritis/classification-criteria-psoriatic-arthritis-caspar#sthash.Or6zBLgM.dpuf>

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^v Robinson D Jr., Hackett M, Wong J, Kimball AB, Cohen R, Bala M; the IMID Study Group. Co-occurrence and comorbidities in patients with immune-mediated inflammatory disorders: an exploration using US healthcare claims data, 2001-2002. *Current medical research and opinion*. 2006; 22(5):989-1000. **And:** Armstrong AW, Harskamp CT, Armstrong EJ. The association between psoriasis and hypertension: a systematic review and meta-analysis of observational studies. *Journal of Hypertension*. 2012 Dec 15. [Epub ahead of print]

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- ^{xv} National Psoriasis Foundation. FY15-FY19 Strategic Plan Progress Report.
- ^{xvi} Avalere Health, "Association Health Plans: Projecting the Impact of the Proposed Rule, prepared for America's Health Insurance Plans, Feb. 28, 2018, available at <http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf> (last accessed Mar. 1, 2018)