March 6, 2018

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

To Whom It May Concern:

The Duke Health Justice Clinic and North Carolina AIDS Action Network (NCAAN) appreciate the opportunity to provide comments to the proposed Department of Labor rule, Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans.

The Duke Health Justice Clinic provides free legal services and policy advocacy on behalf of people living with HIV in North Carolina. NCAAN is a statewide advocacy organization that aims to improve the lives of people living with HIV/AIDS and affected communities. We write on behalf of the 34,187 individuals living with HIV in North Carolina.

We strongly urge the Department of Labor not to adopt the proposed rule. If implemented, this rule will cause North Carolinians living with HIV and other chronic conditions to:

1. have higher health care costs;
2. lack access to the treatment they need;
3. face a higher risk of medical bankruptcy;

North Carolinians living with HIV and other chronic conditions will have higher health care costs

The proposed rule will result in adverse selection in the small group and individual markets in North Carolina, resulting in higher premiums for people living with HIV.

Under the rule, association health plans (AHPs) and health insurers in the Affordable Care Act (ACA) marketplace will compete in the same individual and small group markets, but be subject to different rules. AHPs will be exempt from complying with regulations governing the ACA marketplace. In particular, AHPs will not have to cover the ACA's list of essential benefits; thus,

they will be able to offer skimpy benefits packages that will not be attractive to people with high health care costs, such as people living with HIV.[1] AHPs will also be able to structure their eligibility rules, benefits, and marketing practices to attract a healthier risk pool and discourage enrollment by people with expensive conditions. For example, an AHP plan could discourage people living with HIV from enrolling in their plan by not covering HIV medications, or by not covering prescription drugs at all. Because people living with HIV require antiretroviral medications to survive, and they will choose not to enroll in the plan.

Because of the AHPs' skimpier benefits and healthier risk pools, they will able to charge lower premiums than plans subject to the ACA. The lower premiums will attract healthy individuals. North Carolinians with costly pre-existing conditions, such as people living with HIV who need more comprehensive health care coverage, will have to stay in the ACA exchange.

This adverse selection will result in higher premiums for North Carolinians living with HIV and other chronic conditions. The proportion of people with higher health care costs in the ACA risk pool will increase, leading to higher premiums for the individuals left in the ACA marketplace.[2] This type of cost spiral has occurred in states that have implemented rules similar to the one proposed here. For example, in the 1990s, Kentucky exempted its AHPs from complying with the benefit and rating requirements that applied to its individual and small-group markets.[3] Individuals and small businesses with healthy workforces went to the cheaper AHPs, and premiums skyrocketed for the people with pre-existing conditions left behind.[4]

More North Carolinians living with HIV and other chronic conditions will lack access to health coverage.

If the proposed rule is implemented, more North Carolinians living with HIV and other chronic conditions will lack access to health insurance that covers their treatments. Under the rule, AHPs will have a strong incentive not to cover HIV treatment, and Marketplace insurance will become unaffordable for many North Carolinians living with HIV. The same result is likely for other people with costly medical conditions.

The proposed rule incentivizes AHPs not to cover treatments for HIV and other chronic conditions. Under the rule, an AHP's premiums are based on its overall enrollment pool. If the AHP has a healthier risk pool than the ACA risk pool, it will be able offer cheaper premiums than issuers offering ACA compliant plans. Thus, an AHP has an incentive to achieve lower

---

[1] See 11 NCAC 18.0101 et seq. (providing no state-level essential benefits requirement for AHPs in North Carolina)

[2] Letter from American Academy of Actuaries to the Employee Benefits Security Administration Office of Regulations and Interpretations, Feb. 9, 2018, <http://actuary.org/files/publications/AHP_modeling_considerations_02092018.pdf.>

[3] Kentucky Department of Insurance, *Kentucky's Market Report on Health Insurance in 1997,* <http://www.commonwealthfund.org/~/media/files/publications/blog/2017/ky-market-report-on-health-1997-1.pdf?la=en>

[4] Id.

premiums by discouraging people with expensive pre-existing conditions, such as people with HIV, from enrolling in their plans. Although the proposed rule states that an AHP cannot discriminate against people with pre-existing conditions, AHPs can easily skirt this protection by structuring their eligibility rules, benefits, and marketing practices to discourage individuals living with HIV from signing up for their plans. By excluding medical goods or services needed by people with costly conditions such as HIV, AHPs can prevent such persons from enrolling and keep their premiums low. For people living with HIV, this can be accomplished easily by excluding HIV medications.

In the employment setting, an offer of an AHP by an employer may cause a person living with HIV to find herself without access to affordable insurance that covers needed services. Even though the AHP plan may be cheap, the lower rates are may be achieved by excluding HIV medications, rendering the plan unsuitable for the employee with HIV. Making matters worse, having the offer of AHP coverage may prevent her from purchasing an affordable ACA Marketplace plan that covers her HIV care needs. This is because under the ACA, consumers no longer qualify for a subsidy if they are offered job-based insurance, such as an AHP, that meets minimal value and affordability requirements.[5] Without a subsidy, Marketplace insurance will be unaffordable for many North Carolinians living with HIV. As a result, employees offered an AHP will have no access to suitable, affordable coverage.

The increased number of individuals living with HIV lacking access to coverage will negatively impact public health. Providing adequate health care to people living with HIV, including easy access to HIV specialists and antiretroviral medications, is critical to controlling the HIV epidemic. Without proper health care, people living with HIV may not learn of their HIV status, fail to receive timely or proper care, lack consistent access to antiretroviral medications, develop resistance to medications, and experience a rise in viral loads that makes it easier to transmit HIV.

Further, the proliferation of skimpy AHP plans will also undermine important prevention efforts, notably pre-exposure prophylaxis ("PrEP"). People at risk of HIV infection who are relegated to AHP plans will very likely lack access to this highly effective, but relatively costly prevention tool, resulting in new HIV infections that could have been avoided with adequate coverage for people at risk of HIV.

More North Carolinians living with HIV and others with costly chronic conditions will be at risk of medical bankruptcy

By increasing the number of AHPs in the marketplace, the proposed rule will lead to more North Carolinians with HIV enrolling in AHP plans or having no health coverage. Enrolling in an AHP plan places North Carolinians living with HIV and those with other costly conditions at a greater risk of medical bankruptcy.

AHPs in North Carolina have a long history of leaving consumers with unpaid medical claims. For example, in the early 1990s, the US Government Accountability Office found that AHPs

[5] 26 CFR 1.36B-2

defrauded thousands of North Carolinians and had millions of dollars in unpaid claims.[6] State enforcement authorities were unable to recover most of these funds.[7] These unpaid claims left families with substantial medical debt.[8] To cite but one example, in the 1990s, a North Carolina AHP left the parents of a three-year old leukemia patient with $250,000 dollars in medical debt.[9] Because of similar debt, many families have been forced into bankruptcy.[10]

North Carolinians living with HIV are particularly vulnerable to the risk of bankruptcy due to unpaid medical claims. HIV treatment is expensive.[11] People living with HIV may have tens of thousands of dollars in claims each year.[12]

If this rule is implemented, state regulators will likely be unable to protect North Carolinians living with HIV from being defrauded by unscrupulous AHPs. Under the rule, AHPs will likely proliferate. Given the limited resources of state regulators, we worry that poorly and fraudulently run AHP will slip through enforcement cracks, leaving enrollees with large unpaid medical claims.

***

We appreciate the opportunity to comment on the proposed rule. To ensure that North Carolinians living with HIV and other chronic conditions have access to quality and affordable coverage, we urge the Department of Labor not to adopt the proposed rule. Please contact Allison Rice (rice@law.duke.edu) if we can be of assistance.

Respectfully submitted by:

Allison Rice & Alex Lewis
Duke Health Justice Clinic

Lee Storrow
North Carolina AIDS Action Network

---

[6] U.S. Gen. Accounting Office, HRD-92-40, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, (1992). <https://www.gao.gov/assets/220/215647.pdf

[7] Id.

[8] Id.

[9] Milt Freudenheim, *Fraud is charged in Health Plans*, New York Times, Dec. 12, 1990, <http://www.nytimes.com/1990/12/12/us/fraud-is-charged-in-health-plans.html>

[10] Mila Kofman. Health Policy Institute. *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud.* < https://hpi.georgetown.edu/ahp.html>

[11] See Gebo KA, Fleishman JA, Conviser R, Hellinger J, Hellinger FJ, Josephs JS, Keiser P, Gaist P, Moore RD; HIV Research Network. *Contemporary costs of HIV health care in the HAART era.* AIDS *2010;* 24(17): 2705-2715. < https://www.ncbi.nlm.nih.gov/pubmed/20859193>

[12] Id.