

March 6, 2018

The Honorable Alexander Acosta
Secretary
U.S. Department of Labor
200 Independence Avenue, NW
Washington, DC 20210

Ms. Jeanne Klinefelter Wilson
Deputy Assistant Secretary for Policy
Employee Benefits Security Administration
U.S. Department of Labor
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 and Deputy Assistant Secretary Wilson:

Thank you for this opportunity to comment on the Department of Labor’s (the Department) proposed rule on Association Health Plans (AHPs). The National Multiple Sclerosis Society (the Society) urges the Department *not* to finalize this proposed rule and instead to focus its efforts on protecting people living with chronic illnesses or disabilities to ensure their continued access to more affordable, adequate, and understandable health care coverage. Moreover, we respectfully request the Department convene a public hearing on the proposed rule to enable a more extensive and transparent airing of perspectives by all stakeholders.

Like all organizations representing the interests of people with special health needs, we have a unique perspective on what individuals and families need to manage their conditions and live their best lives. MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling, to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. Most people with MS are diagnosed between the ages of 20 and 50, with at least two to three times more women than men being diagnosed with the disease.

To inform our advocacy on policies impacting access to care for persons with MS, the Society developed a set of [Principles for Access to Quality MS Care](#). When the Society’s principles have aligned with those of other organizations, we have joined forces to amplify our voice and shared perspective. At present, we are among the collective voice representing over one hundred million Americans living with chronic illness working to reform and improve the nation’s healthcare system.¹ The priorities advanced by this strategic alliance are as follow: (1) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need including all the services in the essential health benefit package; (2)

¹ Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. Enrollment should be easy to understand, and benefits should be clearly defined.

We are deeply concerned about the impact the Department's proposed rule on AHPs will have on individuals living with MS and their families. While AHPs can offer less costly coverage, they frequently do not adhere to important standards, including financial protections and coverage for essential health benefits. AHPs also have a long history of fraud and insolvency which have historically harmed small employers and individuals the most. Many of these plans collected premiums for health insurance coverage that did not exist and did not pay medical claims --leaving businesses, individuals, and providers with millions of dollars in unpaid bills. For consumers and patients, the results were disastrous. We are extremely concerned that the proposed rule will once again leave American families and their families in the lurch with insufficient coverage, unpaid medical bills, and lifelong health implications – just as many of these plans did before the Affordable Care Act (ACA) was passed.

In the proposed rule, the Department recommends eliminating and/or altering critically important health plan standards and regulatory structures that have served to protect patients and consumers, including those related to benefit structure, cost, and oversight. We are deeply concerned these proposed policies will inevitably result in a return to widespread adverse selection, uncompensated care for providers, medical bankruptcies, under-insurance and un-, or under-treated health care needs. Should you decide to proceed, then any modifications should, at a minimum:

- Require AHPs to comply with the Essential Health Benefits (EHBs) coverage requirements to ensure coverage adequacy, as well as protections from lifetime and annual caps, and annual out-of-pocket maximums;
- Allow the employees of businesses that choose to enroll AHPs to remain eligible for premium tax credits to encourage market choice;
- Require AHPs to provide clear consumer information, including details about coverage, costs, and plan policies, prior to enrollment; and
- Clarify and bolster state regulation of AHPs.

Adequacy

Healthcare coverage for people with MS must be adequate, covering the comprehensive package of services and treatments they need to live their best lives. It is paramount that protections including EHB packages, the ban on annual and lifetime caps, and restrictions on premium rating all be preserved. We are deeply concerned that the AHPs created by this proposed rule could offer entirely inadequate, even discriminatory, coverage. We are also concerned that some of the proposals included in the proposed rule would make it more difficult for prospective plan members to understand their options and make informed choices about the coverage they select.

Essential Health Benefits (EHBs)

One of the most troubling aspects of Association Health Plans is that they are not required to comply with EHB coverage requirements created under the ACA. This proposed rule would regulate AHPs as if they were *Employee Retirement Income Security Act* (ERISA)-governed large-group health plans (sometimes referred to as single multi-employer plans) that do not have to comply with many of the ACA's coverage and adequacy requirements.

This is deeply concerning because those individuals we represent rely on the current law's coverage requirements for access to medically necessary care. Prior to the passage of the ACA and creation of the ten EHB categories, people with MS routinely found themselves enrolled in plans that failed to provide coverage for the complex health care needs that MS demands. We often heard from individuals and families upon discovering that they were not covered for such essential components of quality MS care as specialty pharmaceuticals, neurology care, rehabilitation therapies, MRIs or durable medical equipment.

Discriminatory Plan Design

Under the proposed rule, the Department would maintain one of the most important patient protections for individuals with pre-existing conditions: guaranteed issue. AHPs would not be allowed to turn away individuals seeking to purchase their plan. They would also be required to treat all enrollees within their plan the same way as they do now, and could not deny certain coverage or benefits to one enrollee while offering them to another. These are the same standards under which ERISA-covered employer plans must operate now. We strongly support the application of these protections and thank the Department for including them in the proposed rule.

However, while this proposed rule would not allow AHPs to offer varying benefit designs to enrollees based upon health factors, it would allow AHPs to offer differing coverage to groups of enrollees based on non-health related factors. These factors could include gender, age, employee classifications, locations, or any other non-health criteria that could stratify the plan's beneficiary population. Therefore, AHPs could structure their coverage and benefit designs using "non-health related factors" to effectively exclude entirely classes of beneficiaries with higher rates of illness and disease.

Furthermore, even if AHPs chose to offer uniform coverage to all beneficiaries regardless of any non-health related factor, they would still be allowed to freely structure their benefit design in any way they saw fit. This allowance would once again enable discriminatory plan designs that exclude benefits for enrollees with certain health and preexisting conditions, including MS.

Consequently, under this proposal, AHPs could design a plan that excludes coverage for medically-necessary prescription drugs, certain specialists who treat particularly expensive conditions, or other medically necessary care for individuals with chronic conditions. According to the Kaiser Family Foundation, approximately 27 percent of American adults currently have a condition that would result in being denied health coverage.²

Employees or their dependents could once again face these same coverage denials within AHPs under this proposed rule, resulting in entirely inadequate coverage.

This allowance for discriminatory benefit design completely undermines the guaranteed issue requirement by enabling AHPs to de facto deny coverage to individuals with pre-existing conditions by creating "non-health" classifications with substantially weaker coverage, or by refusing to offer coverage for the specific care they need.

²Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, and Karen Pollitz, "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Found. Issue Brief, Dec. 12, 2016, available at <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>.

Network Adequacy

AHPs would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant Qualified Health Plans (QHPs) must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, neurology, maternity and newborn care, mental health, and emergency services, AHPs are not required to comply with these standards.

This is particularly concerning for us as we represent the individuals who are most in need of access to prescription drugs, rehabilitation and other outpatient care, and specialty physicians. These providers and health services are also often the most expensive. Without regulation and oversight of network adequacy within AHPs, as this proposal would allow, the physicians and services patients rely on could be excluded from AHP provider networks altogether. For example, AHPs may choose to exclude all MS Centers, neurologists, or ophthalmologists from their provider networks. They may also include facilities or specialists in the network that are far too distant, or inaccessible for those confined to wheelchairs, to be accessible.

ACA Section 1557 Nondiscrimination Protections

Under our interpretation of the proposed rule, AHPs would only be required to comply with ACA section 1557 nondiscrimination requirements if the entity offering the plan receives Federal financial assistance.³ Understanding that AHPs may be operated by a variety of entities, we envision many AHPs would be exempt from ACA section 1557 requirements, potentially subjecting our patients to harmful discriminatory policies.

Consumer Education and Transparency

As advocates for a population of patients with lifelong, high-cost health care needs, we are concerned that employers and prospective enrollees of AHPs will not be sufficiently informed about these products prior to enrollment. Our experience prior to passage of the ACA suggests that many (if not most) were confused about what a health insurance policy would and would not cover due to a lack of required transparency, resulting in cases of medical debt and bankruptcy⁴. Patients were also forced in some cases to delay or forgo treatment. We fear a dramatic increase in these outcomes if AHPs are made easily available to consumers without clear transparency about what they do, and do not cover.

Survey data, focus group testing and academic research on Americans' understanding of health insurance reveals serious deficiencies in comprehension of the common language and concepts of health insurance. Research has highlighted evidence of Americans' health and health insurance literacy including: nearly nine out of ten adults had difficulty using health information to make informed decisions about their health⁵; 51 percent of respondents did not understand the basic health insurance terms premium, deductible and copay; and only 16 percent could calculate the cost of an out-of-network lab test.⁶ Consumers Union has cautioned that it is not enough to know the difference between premiums, deductibles, and copays, one must also understand how these costs must be sequenced to understand how health insurance works in the context of real world health care needs.⁷

³ Department of Health and Human Services, "Section 1557: Frequently Asked Questions", available at <https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html# ftnt32>.

We note that the ACA sought to address many of these concerns by implementing new measures to educate people about health insurance, including the online Marketplaces, the Summary of Benefits & Coverage, Glossary of Health Care Terms, disclosure of Actuarial Value, and for some, access to new professional insurance counselors with no vested interest in consumers' choice of health plan. These resources are helping consumers make more informed choices by presenting and explaining details about coverage, costs, and plan policies. Yet because most of these helpful tools would not be required resources of AHPs, prospective enrollees of AHPs would not benefit from them, improvements in health care and health insurance literacy could be reversed, and more Americans would be at risk of being under-insured once more. This lack of transparency is particularly concerning as it relates to AHPs because of their history of fraud and insolvency. Consumers have grown accustomed to and expect health insurance to be comprehensive and may not even realize these plans to not meet those same standards.

Affordability

Having access to treatments also means they should be affordable, including reasonable premiums and cost-sharing, with protections for individuals with pre-existing conditions from being charged more for their coverage. We are concerned that the proposed policy fails to achieve this aim.

Solvency protections from AHPs

Unfortunately, in the past there have been numerous examples of AHPs that have become insolvent either because the AHP was formed with fraudulent intent or failed to be adequately capitalized. In such instances, consumers – many of whom had serious and chronic diseases – experienced great harm when they were left with significant medical bills after their AHP folded and were unable to pay their claims.⁸ These consumers would have received little to no advance notice that their plan would fail to provide adequate coverage until it was too late.

We are pleased that the proposed rule allows states to impose requirements such as reserve standards and other financial requirements on AHPs. However, this proposal assumes that the states are adequately resourced and motivated to enforce these requirements. In addition, some states may be hesitant to regulate these plans given that questions remain about the extent to which states have the authority to do so.⁹

AHPs are substandard coverage

We are concerned that the proposed rule would allow an AHP to offer non-comprehensive coverage, falling far short of the needs of people with MS. We fear that some employers may offer AHPs to their employees, despite the fact that the overall benefit package may not provide adequate coverage, but would meet the actuarial value for minimum essential coverage (MEC) requirements.¹⁰ Under current law, if an employer offers MEC-compliant coverage, the individual is permitted to enroll in a plan on the marketplace, but would be precluded from advance premium tax credits (APTCs). As a result, individuals – such as those with serious or chronic illnesses – who are offered an AHP through their employer but need comprehensive coverage would be unable to obtain it through the marketplace with the help of

⁸ *ibid.*

⁹ See, K. Lucia and S. Corlette, "Association Health Plans: Maintaining State Authority is Critical to Avoid Fraud, Insolvency, and Market Instability." *To the Point*, The Commonwealth Fund, Jan. 24, 2018, available at <http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>.

¹⁰ 45 C.F.R. § 156.604.

APTCs. To correct this, we urge the Department to amend current regulations to permit an individual who declines an employer-sponsored AHP to be deemed eligible for APTCs based on income.

Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only applies to EHB-covered services. In this proposal, the Department would facilitate the proliferation of health insurance options that do not have to comply with EHB coverage requirements. Therefore, this proposal would once again subject patients to significant financial insecurity due to medical needs. In 2007 alone, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.¹¹ Patients who faced heart transplants, used specialty medications, had complicated pregnancies, a cancer diagnosis, or other rare and complex conditions could easily meet or exceed lifetime and annual caps. For example, prior to the ACA, many children with hemophilia would hit the lifetime limit on coverage under both parents' insurance plans before their 18th birthday, leaving them without coverage options. For these reasons, we strongly urge the Department to consider the financial implications to America's chronically ill population of removing this critical protection.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for QHPs to include an annual out-of-pocket maximum set each year by the Department of Health and Human Services (HHS). For 2017, the annual out-of-pocket limit for an individual is \$7,350, and for a family plan is \$14,700.¹² Similar to the ban on annual and lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. If the Department moves forward with this proposed dramatic expansion of non-EHB compliant AHPs, it will also be subjecting patients with complex and chronic conditions to unaffordable cost-sharing for the medically-necessary services upon which they rely.

Accessibility

The Society firmly believes that coverage and care must be accessible. Everyone needs access to quality and affordable healthcare to manage their health. The connection between access to health insurance and health outcomes is clear and well documented.^{13,14}

Market Segmentation

We are concerned about the impact of the proliferation of AHPs on the individual market overall. We expect that individuals with serious and chronic conditions will continue to enroll in coverage offered through state marketplaces. Conversely, if the Department's proposal is implemented, younger and healthier individuals may be more likely to shop for coverage based on premiums and thus may be more drawn to lower cost AHPs, even though these products will likely have less comprehensive coverage.

¹¹ Himmelstein DU, Throne D, Warren E, Woolhandler S, Medical bankruptcy in the United States, 2007: results of a national study. *Am J Med* 2009 Aug; 122(8): 741-6. Doi.

¹² Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Final Rule, 81 Fed. Reg. 94058 (Dec. 22, 2016).

¹³ Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

¹⁴ McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

Over time, as younger and healthier individuals leave the marketplace, premiums will increase and fewer issuers may participate in a state's marketplace. This could lead to market segmentation that "could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage."¹⁵

Other Concerns

As detailed above, we are very concerned about the impact of this specific regulation. However, when combined with other actions, regulations, and policies pursued by the Administration, their combined impact will destabilize the individual insurance market and increase access to substandard insurance and its alternatives.

Shortening the open enrollment period by half, reducing funds for outreach and advertising, restricting eligibility for Medicaid through waiver approvals, and the repeal of the individual mandate are all affecting the coverage landscape. In addition, the policies in the short term limited-duration insurance proposed rule and policies within the 2019 Notice of Benefit and Payment Parameters proposed rule would allow states to diminish the value of some essential health benefit categories, change the annual out-of-pocket cost maximums and open the door to lifetime and annual caps, all of which will negatively impact individuals and families struggling with chronic, serious, or acute disease. We urge the Administration to work with Congress and organizations like ours to ensure that consumers everywhere have access to affordable *and* high-quality insurance plans while maintaining a strong marketplace.

Protect State Regulatory Authority

The proposed rule raises questions about preemption of state law and future regulatory authority. While the Department states that the proposed rule would not alter existing ERISA statutory provisions governing multiple employer welfare arrangements (MEWAs), we are concerned that the proposed rules will have the result of preempting existing and future efforts by states to regulate them. The proposed rule's new framework allowing AHPs to be treated as single multiple-employer plans creates confusion about states' enforcement authority. In the past, promoters of fraudulent health plans have used this type of regulatory ambiguity to avoid state oversight and enforcement activities that could have otherwise quickly shut down scam operations.¹⁶

States must maintain the ability to protect patients and manage their insurance markets. We urge the Department to clarify that ERISA single employer AHPs, including those that cover more than one state, would have to comply with all state laws in states in which they operate and continue to be subject to state oversight and regulation.

Finally, we strongly oppose any proposal that would exempt AHPs from state regulation. States have long taken the lead in protecting patients by addressing AHP insolvencies and fraud and maintaining competitive markets. States have the history, resources and local expertise to serve in this role and we urge the Department not to take action that would prevent that.

¹⁵ American Academy of Actuaries, "Issue Brief: Association Health Plans", Feb. 2017, available at <http://www.actuary.org/content/association-health-plans-0>.

¹⁶ Lucia, K. & Corlette, S. (2018, January 24.) *Association Health Plans: Maintaining State Authority Is Critical to Avoid Fraud, Insolvency, and Market Instability*. The Commonwealth Fund. Retrieved 8 February 2017, from <http://www.commonwealthfund.org/publications/blog/2018/jan/association-health-plans-state-authority>.

Conclusion

The Society represents people with MS, as well as their family and professional caregivers in urging protections for those living with the disease who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide our recommendations on the proposed rule. However, given the history of AHPs, we are deeply concerned that the rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law – and put those we represent at risk.

We urge the Department not to finalize the AHP proposed rule until the needs of our population are met and instead to focus on lowering premiums for QHPs. Short of this, to protect vulnerable populations, the Department must modify the AHP proposed rule with the following:

- Require AHPs to comply with the Essential Health Benefits coverage requirements to ensure adequacy of coverage, as well as protections from lifetime and annual caps, and annual out-of-pocket maximums
- Allow the employees of businesses that choose to enroll AHPs to remain eligible for premium tax credits to encourage market choice
- Require AHPs to provide clear consumer information, including details about coverage, costs, and plan policies, prior to enrollment
- Clarify and bolster state regulation of AHPs

As leaders in the field of MS care and research, and staunch patient advocates, we look forward to working with the Department of Labor leadership and staff on the direction of such important public policy. Thank you for this opportunity to submit comments on this rule. If you have any questions or would like to discuss these comments further, please contact Kim Calder, Senior Director of Health Policy at Kimberly.Calder@nmss.org or 212-476-0450.

Sincerely,



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