American Heart Association | American Stroke Association

Advocacy Department

March 5, 2018

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

Ms. Jane Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor

Dear Secretary Acosta and Deputy Assistant Secretary Wilson:

On behalf of the American Heart Association (AHA) and the American Stroke Association (ASA), we appreciate this opportunity

Indeed, the connection between health insurance and health outcomes is clear and thoroughly documented. Americans with CVD risk factors who lack health insurance, or are underinsured, have higher mortality

stable network of providers and plan features. Guaranteed access to preventive services -- without cost-sharing -- should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing a plan.

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Association Health Plans will have on the individuals and families we represent. While AHPs can offer more affordable coverage, they frequently lack important standards that shield patients from unnecessary risk including financial protections and coverage for essential health benefits.

It is a sad fact that AHPs have a long history of fraud and insolvency targeting small employers and individuals. Many plans collected premiums for health insurance

the expanded AHP market.[10] Even with increased oversight, fraudulent insurance sold through associations remained a problem with enormous financial ramifications. Researchers found that between 2000 and 2002, 144 operations left over 200,000 policyholders with over $252 million in medical bills.[11] Four of the largest operations left 85,000 people with over $100 million in unpaid medical bills.[12] For consumers and patients, the results were disastrous: some victims were forced into bankruptcy; others have lifelong physical conditions as a result of delayed or foregone medical care.[13]

AHPs also have a long history of financial instability and insolvency when medical claims H[FHHG WKH DVVRFLDWLRQ¶V DELOLW\ WR SD\ 7KHUH DUH QR guarantee that AHPs will remain financially stable, even though the proposed regulation could allow AHPs to cover millions more individuals and small employers. The Department has itself acknowledged that it does not have the capacity to act as a resource to consumers facing financial or legal issues as a result of these plans. It is unclear to the AHA how the government could offer reasonable assurances to consumers that they would not be harmed should these plans be allowed to proliferate.

We are extremely concerned that should the proposed regulation be enacted as written, it will once again leave consumers and patients in AHP arrangements with insufficient coverage, unpaid medical bills, lifelong health implications, and no resources to challenge or seek remediation for these issues ±just as AHPs did before the ACA provided appropriate oversight and protection. We are fundamentally concerned with AHPs overall ability to provide sound financial protection to patients and deliver on their responsibilities to make high quality care available to patients when needed. As such, the American Heart Association asks the administration to withdraw the rule.

Essential Health Benefits & Network Adequacy

7KH $+$¶V SULQFLSOHV GLFWDWH WKDW KHDOWK FDUH FRYHU services and treatments patients need, including those with unique and complex medical needs. It is paramount that protections for these patients be preserved, including the essential health benefits (EHB) packages, the ban on annual and lifetime caps, and restrictions on premium rating. We are deeply concerned that the AHPs facilitated by this proposed rule would offer inadequate, even discriminatory, coverage to the communities we represent.

One of the most troubling aspects of Association Health Plans is that they do not have to comply with EHB coverage requirements that are the core of the ACA. This proposed rule would accomplish this by regulating AHPs as if they are Employee Retirement Income Security Act (ERISA)-governed, large-group health plans, sometimes known as single multi-employer plans that are exempt from many o I WKH $&$¶V FRYHUDJH requirements.

This is deeply concerning because patients with CVD rely on these coverage requirements for access to medically necessary care. Prior to the passage of the ACA and creation of the ten EHB categories, CVD patients would routinely be denied coverage for medically necessary care. Individuals would discover they were not

[10] ibid
[11] ibid
[12] ibid
[13] ibid

covered for emergency room services, adequate rehabilitation and habilitative benefits and patients with chronic illnesses would be denied coverage for life-improving, sometimes even life-saving, medications after the fact. According to the Kaiser Family Foundation, approximately 27 percent of American adults have a condition that would result in being denied health coverage.[14] Many of our patients who would once again face these same coverage denials within AHPs under this proposed rule, resulting in entirely inadequate coverage. This is unacceptable to the American Heart Association and its volunteers.

AHPs would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant QHPs must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, rehabilitation and habilitation, preventive, and emergency services, AHPs are not required to comply with these life-saving standards.

This is particularly concerning for the AHA as many of our patients need access to emergency services, outpatient care, rehabilitation, and specialty physicians. These important and medically necessary physicians and health services can also be some of the most expensive. Without regulation and oversight of network adequacy within AHPs, the physicians and services CVD patients rely on could be excluded from AHP provider networks altogether. For example, AHPs ma \ F K R R V H W R H [F O X G H D O O F K L O G U H cardiologists, or specialty clinics from their provider networks. In addition, AHPs would not be prohibited from including facilities too far away from beneficiaries to be truly accessible.

Anti-Discrimination

We are pleased that the proposed rule applies the HIPAA nondiscrimination provisions in § 2590.702(a) and § 2590.702(b) to AHPs. The nondiscrimination provisions continue to prevent AHPs from discriminating based on health status related factors against H P S O R \ H U P H P E H U V R U H P S O R \ H U V ¶ H P S O R \ H H V R U G H S H Q G H

associations, which offer health coverage, premiums will increase for the remaining S R R[17] O ´

Over time, as younger and healthier individuals leave the marketplace, premiums will O L N H O \ L Q F U H D V H D Q G I H Z H U L V V X H U [illegible] W K H P D U N H W V H J P H Q W D W [illegible] difficult for high- F R V W L Q G L Y L G X D O V D Q G J U [illegible] substandard insurance products to the detriment of the comprehensive plans sold in the individual insurance market, is unacceptable by any standard that values the health of $ P H U L F D ¶ V S D W L H Q W V

State Preemption & Oversight

The proposed rule raises questions about preemption of state law and future regulatory authority. While the Department states that the proposed rules do not alter existing ERISA statutory provisions governing multiple employer welfare arrangements, we are concerned that the proposed rules will have the result of preempting existing and future eff R U W V E \ V W D W H V W R U H J X O D W H W K H P 7 K H S U R S R V H G U X O H E H W U H D W H G D V O D U J H V L Q J O H H P S O R \ H U S O D Q V F U H D W H V F 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.[19]

States must maintain the ability to protect patients and manage their insurance markets. The American Heart Association opposes preemption of state law. We urge DOL 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; we strongly urge the Department to preserve that essential role.

Conclusion

The American Heart Association is committed to the continued implementation of federal health policy in a way that reflects our principles of patient access to affordable, understandable, and adequate healthcare. The weakening of oversight and consumer S U R W H F W L R Q V W D Q G D U G V L Q F O X G H G L Q ' 2 / ¶ V S U R S R V H G U X O meaningful coverage in a number of ways for vulnerable patients, including those with cardiovascular disease and stroke. We are concerned that this rule, combined with the

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[17] National Association of Insurance Commissioners, Consumer Alert: Association Health Plans are Bad for Consumers, available at http://www.naic.org/documents/consumer_alert_ahps.pdf.

[18] $ P H U L F D Q $ F D G H P \ R I $ F W X D U L H V 3 , V V X H % U L H I $ V V R F L D W L R Q + H at http://www.actuary.org/content/association-health-plans-0.

[19] Lucia, K. & Corlette, S. (2018, January 24.) Association Health Plans: Maintaining State