March 6, 2018

Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
Attention: Definition of Employer-Small Business Health Plans RIN 1210–AB85

Re: Definition of ‘‘Employer’’ Under Section 3(5) of ERISA—Association Health Plans

Dear Deputy Assistant Secretary Wilson:

DaVita appreciates the opportunity to provide comments on the Department of Labor proposed rule on Association Health Plans. The DaVita patient population includes more than 194,600 patients who have been diagnosed with end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning all 50 States and the District of Columbia, the DaVita Kidney Care network includes more than 2,445 locations. DaVita's nationwide network is staffed by 70,800 teammates (employees). Our comprehensive, in-center care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists. DaVita is eager to ensure that individuals with ESRD are treated fairly and equitably in the individual and small group market.

BACKGROUND

End Stage Renal Disease (ESRD), or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual’s kidneys are functioning at 10%–15% of their normal capacity or below and, therefore, cannot sustain life. Kidneys are vital organs that remove toxins from the blood and perform other functions that support the body, such as balancing fluid and electrolytes, and producing certain hormones. When kidneys fail, they cannot effectively perform these functions, and renal replacement therapy, such as dialysis or a kidney transplant, is necessary to sustain life.

The most common type of dialysis is hemodialysis, which is predominantly performed in specialized outpatient facilities. Hemodialysis is a therapy that filters waste products, removes extra fluid, and balances electrolytes (sodium, potassium, bicarbonate, chloride, calcium, magnesium and phosphate), replacing the mechanical functions of the kidney. Traditional in-center hemodialysis is generally performed a minimum of three times a week for approximately four hours each session. Due to the significant impact of dialysis treatment on the body, the resulting fragility of those with the disease, and the amount of time involved in treatment, access to the renal replacement therapy modality that is right for the individual is of critical importance.

The concerns expressed in this comment letter relate to the following issues:

- **Viable Individual Market is Critical for ESRD Patients**
- **Association Health Plan (AHP) Proposed Rule Will Undermine the Individual Market**
- **Need for a New Market Stabilization Effort**

VIABLE INDIVIDUAL MARKET IS CRITICAL FOR ESRD PATIENTS

ESRD Patients Have the Right to Keep or Choose Individual Market Coverage

DaVita has worked closely since enactment of the Affordable Care Act (ACA) to ensure ESRD patients, and those who will develop ESRD, have access to the individual market if they choose to purchase or maintain coverage in that market. These clarifications have included:

- The ability of ESRD patients under age 65 to choose Marketplace coverage;[1] and
- The eligibility of ESRD patients under age 65 for advance premium tax credits (APTCs) and cost-sharing reductions (CSRs).[2]

Pursuant to Section 226A of the Social Security Act (SSA), individuals who are medically determined to have ESRD are eligible (but not required) to enroll in Medicare the third month after the month in which a regular course of renal dialysis is initiated. Specifically, although Section 226A of the SSA allows individuals who are medically determined to have ESRD to enroll in Medicare, *they must first file an application under the law in order to be "entitled to benefits under part A and eligible to enroll under part B of title XVIII."* Further, should an ESRD patient under age 65 choose not to apply for Medicare benefits under 226A, they incur no penalty for choosing to delay Medicare enrollment since they never trigger the initial enrollment period. U.S. Department of the Treasury and CMS policies affirm that such patients can choose Marketplace coverage and may be eligible for APTCs and CSRs. DaVita strongly supports the ability of ESRD patients to choose the coverage that is right for them.

Individual Market Coverage is an Important Option for ESRD Patients

It is worth describing why an ESRD patient would want to obtain individual market coverage. For many patients, factors they consider when deciding whether to continue with their individual market plan coverage or enroll in Medicare are both clinical and financial. The following are examples of such considerations:

- The benefit of continuity of coverage by remaining enrolled in the same individual market plan;
- The potential additional costs involved with applicable premiums, deductibles and coinsurance responsibilities in light of the need to enroll in Medicare Parts A, B, and D;
- Additional costs of having to purchase separate insurance coverage for the patient's family;
- The inability to obtain Medi-Gap insurance in many states for ESRD patients under 65;
- Limitations on the ability to obtain coverage for ancillary services through Medicare such as

[1] IRS Notice 2013-41 (link available here). See also: "Frequently Asked Questions Regarding Medicare and the Marketplace, Updated August 28, 2014" (link available here).
[2] Ibid

dental or vision coverage, which may be vital for patients considering a transplant;[3]

- Enrollment in Medicare Part A means individuals will lose any advanced premium tax credits (APTCs) or cost-sharing reductions (CSR) they presently receive under an Exchange plan;
- Individuals on a current transplant list could potentially lose their place on the waiting list if the transplanting facility or provider does not accept Medicare;
- Individuals who enroll in Medicare due to ESRD cannot later change their mind and "opt-out" of Medicare enrollment without significant financial risk for amounts expended by Medicare during the period of enrollment; and
- The fact that many providers do not accept **new** Medicare patients.[4]

AHP PROPOSED RULE WILL UNDERMINE THE INDIVIDUAL MARKET

The AHP proposed rule would restructure the current health insurance market in two fundamental ways. First, the proposed rule would redefine "commonality of interest" of employer members of a group or association to be established by: 1) employers being in the same trade, industry, line of business or profession or 2) employers being in the same region, even if that region includes more than one state (e.g. the Washington Metropolitan area of Washington D.C. and portions of Virginia and Maryland). The proposed rule also clarifies that nationwide industry organizations, such as trade associations, can sponsor nationwide AHPs. Second, the proposed rule would allow sole proprietors to qualify as both an employer and employee of a trade or business for purposes of participating in an association health plan.

We note that most ESRD patients are considered disabled and unlikely to benefit from the provisions relating to sole-proprietors and new "commonality of interest" tests for AHPs. Indeed, a growing number of ESRD patients in the individual market are individuals who have developed ESRD after purchase of their individual market coverage and are simply hoping to maintain the coverage they have. For these patients, the proposed rule does not represent a new way to gain health insurance coverage. On the contrary, the proposed rule threatens to undermine the insurance coverage they currently have. We appreciate the Department of Labor's acknowledgement in the proposed rule that this regulation will contribute to instability in the Exchanges, as follows:

- *By expanding AHPs, this proposed rule aims to provide many more individuals access to the potentially more stable and affordable large group market. However,* ***to the extent that AHPs prove particularly attractive to younger or lower cost individuals, they may contribute to some Exchanges' instability****.*

Stakeholders such as the National Association of Insurance Commissioners, the National Governors Association, the National Conference of Insurance Legislators, and over 1,000 state government, business, labor, consumer, and provider groups also have expressed concerns about AHPs and their potential to fragment existing health insurance markets.[5] Moreover, we note that the items listed in the proposed rule as risk-mitigating to the adverse selection caused by the proposed rule are, for the

[3] Dental infections are a leading obstacle to kidney transplant eligibility, so for some dialysis patients dental coverage is a necessity.

[4] "Boccuti, C., C. Fields, G. Casillas, et al. 2015. Primary care physicians accepting Medicare: A snapshot. Data note. Washington, DC: Kaiser Family Foundation. http://kff.org/medicare/issue-brief/primary-care-physiciansacceptingmedicare-a-snapshot/.

[5] "The Association Health Plan Proposed Rule: What It Says And What It Would Do," Health Affairs Blog, January 5, 2018. Accessed 2/5/2018 at: https://www.healthaffairs.org/do/10.1377/hblog20180104.347494/full/

most part, not risk-mitigating. These include the following items:

- **ACA Individual Mandate.** Although the proposed rule lists the ACA's requirement that essentially all individuals acquire coverage as reducing the susceptibility to adverse selection, in fact, Public Law No: 115-97, the Tax Cuts and Jobs Act, effectively eliminated the individual mandate.
- **Administrative Savings.** Because, as the proposed rule acknowledges, individuals would move from the individual market to the group market, it is plans in the group market, not the individual market, that will benefit from administrative savings and economies of scale.
- **Exchange Subsidies.** While Exchange subsidies are the only real protection afforded to individuals remaining in the individual market subsequent to the finalization of the AHP proposed rule, this of course only would be a protection for those individuals eligible for such subsidies. Importantly, over the long-term, the adverse selection caused by finalizing the AHP proposed rule could contribute to a death spiral in the individual market as fewer (and sicker) individuals remain in Exchanges, premiums consequently increase, and subsidy payments skyrocket.
- **Non-Discrimination Rules.** While the proposed rule references that AHP health coverage is subject to currently existing non-discrimination rules, these rules do not mitigate the fact that current non-discrimination rules are not adequately enforced in the individual market. Since the enactment of the Affordable Care Act, DaVita and the kidney care community have worked to identify and address a variety of plan designs intended to discriminate against ESRD patients and remove such patients from plan rolls. These plan designs include:
    - *Undermining Patient Choice.* As noted above, improper individual plan designs aimed at removing ESRD patients from plan rolls violate Treasury and HHS guidance. In general, individuals who have responsibly paid into a private plan for coverage when they are healthy should expect such insurance will be there for them should they get sick. This principle is no less true for ESRD patients and there are particular reasons (noted earlier in the letter) why such patients may wish to maintain their coverage. In some cases, however, insurers have chosen to deny charitable premium assistance for low-income ESRD patients in order to prevent those patients from maintaining or choosing the coverage that is right for them.
    - *Providing Inadequate Networks.* We know based on the evidence of the last several years that network adequacy for ESRD patients has been a critical concern. For example, in our review of health plans since the beginning of 2014, certain outlier plans have opted not to have *any* in-network dialysis providers.
    - *Prematurely Moving to the "Secondary" Position.* In some cases, insurers will assume the "secondary" payer position in cases where an ESRD patient has no other coverage.

Short-term, Limited Duration Health Insurance

Finally, we note that still other regulations under consideration pursuant to Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," are likely to cause further instability in the individual marketplace. This includes a February 21, 2018 proposed rule, "Short-Term, Limited Duration Insurance," which proposes two significant changes to current restrictions to short-term limited duration plans:

- Extends the current limitation on short-term limited duration insurance from three months to up to 364 days; and
- Allows for renewals of such insurance on a potentially unlimited basis.[6]

As we explain further in our comments to the Short-Term, Limited Duration proposed rule, these policies effectively would change so-called "short-term, limited duration insurance" *from* health insurance that historically has been available as a way to fill temporary gaps in coverage *to* health insurance that effectively could be purchased as a form of primary insurance that avoids Affordable Care Act requirements. Because these plans would not be required to comply with Affordable Care Act patient protections (as they are not true insurance), their premiums are likely to be lower (although out-of-pocket maximums would be much higher) and, as the proposed rule acknowledges, "individuals who are likely to purchase short-term, limited duration insurance are likely to be relatively young or healthy." As a result, the Short-Term, Limited Duration Insurance proposed rule will almost certainly exacerbate the effects of the AHP proposed rule, causing still more individuals to leave the health insurance Exchanges and further destabilizing coverage for vulnerable ESRD patients and other patients who would remain in the Exchanges. A recent analysis estimates the combined effect of eliminating the individual-mandate penalties and expanding short-term limited-duration policies would increase 2019 ACA-compliant nongroup insurance premiums 18.2 percent on average in the 43 states that do not prohibit or limit short-term plans.[7]

NEED FOR A NEW MARKET STABILIZATION EFFORT

We are concerned that the AHP proposed rule and the Short-Term Limited Duration Insurance (STLDI) proposed rule would destabilize the Exchanges and undo many of the efforts made by this Administration last year through its rulemaking, "Patient Protection and Affordable Care Act; Market Stabilization."[8] In short, any proposals which serve to fragment an individual market risk pool by either moving healthier patients to separate insurance (e.g. AHPs, STLDIs) or sicker patients to separate insurance (e.g. separate high-risk pools) only will serve to undermine health insurance overall. Such fragmentation results in a form of "lowest common denominator" health system where individuals pick the least expensive plan when they are healthy and then try to move to full coverage/low deductible plans when they become ill.

Highly-fragmented risk-pools have other drawbacks as well. Should a previously healthy patient in an AHP or STLDI plan become ill due to a high-cost or catastrophic event, individuals may be left exposed to large deductibles and providers may be left exposed to significant non-payment for services. Moreover, in highly-fragmented risk pools, insurers become little more than claims processors and have little incentive to invest in preventive care. The cumulative consequences of these dynamics result in a health system that costs more, not less. **In sum, we urge you not to finalize the AHP regulation or the STLDI regulation and instead focus on policies to strengthen the individual market for the benefit of both healthy individuals and patients who have become ill.**

In contrast, we appreciate the Administration's efforts in 2017 through the proposed rule, "Patient Protection and Affordable Care Act; Market Stabilization," to stabilize the individual market through

[6] 83 FR 7437

[7] The Urban Institute, *The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, February 2018.

[8] 82 FR 18346

a series of efforts to "provide needed flexibility to help attract healthy consumers to enroll in health insurance coverage, improving the risk pool and bringing stability and certainty to the individual and small group market."[9] We believe further action in 2018 could build upon these efforts. For example, the bipartisan proposal put forth by Senators Alexander and Murray would make significant progress towards stabilizing the individual marketplace by restoring cost-sharing reductions (CSR) payments. Multiyear action is needed to maintain the availability and affordability of individual health insurance plans upon which millions of Americans count on for the medical care they need. To this end, we also are pleased the Alexander/Murray proposal provides needed funding for outreach, education, and enrollment assistance. A recent report by America's Health Insurance Plans (AHIP) estimates such policies could result in substantial reductions in premiums in the individual market in 2019.[10]

In addition, we believe policies included in Affordable Care Act legislation considered in 2017 also could serve to strengthen the individual market, maintain a strong single-risk pool, and meet the Administration's objective of lowering premiums for certain individuals. For example, both the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA) included provisions that would have allowed the current age-rating for individual and small group coverage of 3:1 (allowing plans to vary premiums by no more than a 3-to-1 ratio for adults aged 21 and older) to be changed to 5:1. Under certain drafts, states would have had the option to implement ratios different than the 5:1 ratio as well. Applying wider age-rating bands to ACA-compliant plans could strike a reasonable balance between policy objectives by reducing premiums for younger, healthier individuals, but also encouraging the provision of preventive care and protecting patients and providers from catastrophic costs. **We would support policies, such as the aforementioned, to strengthen the individual market for the benefit of both healthy individuals and patients who have become ill.**

Our comments reflect our sincere desire to make sure that the individual marketplace is a viable option not just for younger and healthier individuals, but also for individuals who have had continuous coverage and responsibly paid into insurance for years with the expectation that it will be there for them should they get sick. DaVita thanks the Department of Labor for providing the opportunity to provide comments on the AHP proposed rule, and we look forward to continuing to work with the Administration to ensure affordable, high-quality healthcare of their choice is available for all consumers, including vulnerable ESRD patients.

Sincerely,

LeAnne Zumwalt
Group Vice President

[9] 82 FR 10981

[10] AHIP, *Factors Influencing 2019 Premiums in the Individual Market*, February 2018