THE KIDNEY CARE COUNCIL

Providers of Quality Care the for Nation's Dialysis Patients

March 6, 2018

VIA WWW.REGULATIONS.GOV

Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration ("EBSA")
Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Re: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans RIN 1210-AB85

Dear Ms. Wilson:

The Kidney Care Council (KCC), the nation's largest association of dialysis providers comprised or urban, rural and suburban treatment facilities, is pleased to provide comments on the proposed regulation under Title I of the Employee Retirement Income Security Act (ERISA) that would broaden the criteria under ERISA section 3(5) for determining when employers may join together in an employer group or association that is treated as the "employer" sponsor of a single "multiple-employer employee welfare plan" and "group health plan" (GHP) as those terms are defined in Title I of ERISA, and thus facilitate the formation of Association Health Plans (AHPs) that ultimately will expand employer and employee access to more affordable, high quality coverage options.

The individuals we serve care deeply about health plan choice. The proliferation of additional, affordable high-quality coverage options is a long-sought goal in our community, and we enthusiastically support policies in the proposed regulation that effectuate that outcome.

The KCC's member companies provide comprehensive dialysis care, in outpatient dialysis centers and in individuals' homes, for individuals with end stage renal disease (ESRD). Individuals with ESRD require dialysis care at least three times per week. The dialytic procedure involves cleaning an individuals' blood, removing toxins that collect in the absence of kidney function. Dialysis is an "essential health benefit" that is necessary for sustaining life.

Individuals with ESRD are eligible for, but not required to, enroll in Medicare, regardless of age.[1] For such individuals with group health plan coverage, a 30-month coordination period in which the

[1] Individuals with ESRD are also eligible for the premium tax credit (PTC). The Internal Revenue Service recognized the difference between mere eligibility for Medicare and enrollment in it. *See* IRS Notice 2013-41 *available at https://www.irs.gov/pub/irs-drop/n-13-41.pdf.* Moreover, the Center for Consumer Information and Insurance Oversight

employer is the primary payer applies, pursuant to the Balanced Budget Act of 1997. Therefore, we support making affordable, high-quality group health plan choices like AHPs more readily available to employers, with the important proviso that AHPs adhere to the current law coordination period, discussed in more detail below. Many of our patients depend on employer group health insurance to continue comprehensive coverage before enrolling in Medicare.

Although KCC supports the proposed regulation, it does so with the caveat that important law and policy designed to preserve and protect choice for individuals with ESRD are recognized and affirmed in the final regulation

Current Law Protections for Individuals with ESRD

Despite automatic eligibility for Medicare, individuals with ESRD who have group health insurance may retain that coverage for up to 30 months under the Medicare Secondary Payer ("MSP") provisions of the Social Security Act ("SSA"). Pursuant to Section 1862(b)(1)(C) of the SSA, a GHP ***may not take into account*** that an individual is entitled to, or eligible for, benefits under Medicare during the 30-month period that begins with the first month in which the individual becomes entitled to ESRD benefits under Medicare (emphasis added).[2]

The MSP provisions ensure the ongoing ability of an individual with ESRD and their dependents to maintain access to patient choice and remain with their group health coverage before enrolling in Medicare.

The individuals we care for frequently choose to remain with their GHP rather than enrolling in Medicare because GHP coverage is often more comprehensive, integrated insurance than Medicare, which has gaps in coverage. GHPs also offer dependent coverage where Medicare does not; and cost sharing in GHPs can be lower than in Medicare.

The KCC believes it is therefore critical that the final rule make clear that AHPs, consistent with other state and federal health insurance laws affecting GHPs, recognize and adhere to the MSP

(CCIIO) has adopted the general principle that Medicare enrollment is voluntary, and that ESRD consumers have the right to retain private coverage/remain in their group health plan *See* Center for Consumer Information and Insurance Oversight, Frequently Asked Questions Regarding Medicare and the Marketplace, August 1, 2014 *available at http://www.cms.gov/Medicare/Eligibilty-and-Enrollment/Medicare-and-the-Marketplace/Dowloads/Medicare-Marketplace_Master_FAQ_8-28-14_v2.pdf*. Further, in its 2016 Letter to Issuers in the Federally-facilitated Marketplaces, CCIIO said: "We also remind issuers that individuals under 65 with end stage renal disease ("ESRD") are not required to sign up for or enroll in Medicare. Further, individuals who do not have Medicare Part A or Part B are eligible to enroll ... in a QHP if the individual meets the eligibility requirements for enrollment." Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, *available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf.*

[2] Under the MSP rules, prohibitions on "taking into account" apply differently to different types of entitlement. Group health plans "of at least 20 employees" may not take into account the age-based Medicare entitlement if an individual or spouse age 65 or older if such individual or spouse is eligible based on current employment status. 42 C.F.R. 411.102(b). A group health plan "of at least 100 employees" may not take into account the disability-based Medicare entitlement of an individual covered under the plan based on current employment status. 42 C.F.R. 411.102(c). ***There is no small group exception on "taking into account" for eligibility based on ESRD diagnosis and GHPs must remain the primary insurer during a coordination period, which is 30 months per the Balanced Budget Act of 1997. 42 C.F.R. 411.102(a) (emphasis added).***

provisions in the SSA by making 30 months of AHP coverage available to individuals with ESRD who have chosen it. We urge the Department to affirmatively state the responsibility of MSP adherence to AHP sponsors in the final regulation.

Enforcement of the MSP Law Is Critical Where GHPs are in Violation of It

Unfortunately, under current law and practice, KCC member companies have observed GHPs in violation of their obligations under MSP, which prematurely forces individuals into Medicare, thereby making an affirmative statement about MSP adherence in the final AHP regulation more critical. For instance, our member companies have noted GHPs:

- ***Misleading patients***. Some plans mislead enrollees by suggesting that federal law requires individuals with ESRD to enroll in Medicare after having been diagnosed with the disease;

- ***Incentivizing patients to shift to Medicare***. Some plans offer to pay Medicare co-insurance amounts or other cost-sharing obligations on behalf of individuals with ESRD if they shift their coverage to Medicare;

- ***Increasing patients' coinsurance obligations***. Some plans reduce provider payments at rates at or slightly above the Medicare rate, forcing patients to pay the difference.

For patients with kidney failure, these kinds of discriminatory, non-conforming GHP tactics have serious consequences for patient care that can result in treatment delays or limits, increased out-of-pocket costs, and requirements for patients to travel great distances to access care three times per week. These outcomes are avoidable with proper application and enforcement of the MSP law, and the KCC wishes to work with the Department and EBSA to prevent circumstances like these as new AHPs enter the market.

To that end, we are encouraged by language in the proposed regulation that specifically indicates "[A]ll of the employers and employees should benefit from prudence and loyalty requirements for those running the AHP, as well as such other protections as reporting and disclosure requirements ***and enforcement***, in the same manner and to the same extent as participants in other ERISA pan arrangements." (emphasis added)[3]

[3] 83 *Fed. Reg.* 4 at 621 (Jan. 5, 2018). Case law discussing ERISA and MSP note that it is possible for an ERISA plan beneficiary to use ERISA's civil enforcement procedures in 29 U.S.C. § 1132 to recover for unpaid benefits resulting from a violation of the MSP statute, in addition to using the MSP statute's enforcement provisions. *Bio-Medical Applications of Tenn. Inc. v. Cent. States Southeast & Southwest Areas Health & Welfare Fund*, 656 F. 3d 277 (6th Cir. 2011). As the Department itself stated in an Advisory Opinion "if an employee benefit plan that provides health benefits is covered by the MSP statute as well as by Title I of ERISA, non-compliance with the MSP statute and any regulations issued thereunder would not be excused on the basis that the plan is in compliance with ERISA." Advisory Opinion 1993-23A.

KCC's Request: Notice and Enforcement in the Final Rule

KCC thus respectfully requests that the final rule affirmatively include in the preamble a statement to the effect that the proposed regulation's non-discrimination provisions build on the existing non-discrimination provisions applicable to group health plans, ***including the MSP law …*** addressing how to apply those rules to association coverage.[4]

EBSA could also follow the Center for Consumer Information and Insurance Oversight's ("CCIIO") approach when it established the SHOP and explicitly state in the preamble to the final rule that employers purchasing GHPs via a AHP must adhere to the Medicare's Secondary Payer law, allowing individuals with ESRD to remain in the group health coverage they have for 30 months.[5]

Conclusion

KCC shares the principle objective of the proposed regulation to expand employer and employee access to more affordable, high quality coverage. We urge the Department to include a statement specific to the applicability of MSP in the AHP environment that is consistent with both regulation and sub-regulatory guidance from CCIIO and the conventional application of MSP to GHPs under ERISA. We agree with the proposed regulation's statement that, under the proposal, "AHPs that meet the regulation's conditions would have a ready means of offering their employer members' employees, a single group health plan subject to the same State and Federal regulatory structure as other ERISA covered employee welfare benefit plans."[6]

KCC is pleased to support the proposed regulation, the expansion of AHPs, and their "same regulatory structure" as other ERISA covered employee welfare benefit plans, a structure that we strongly believe includes the MSP law.

Thank you for the opportunity to comment on the proposed regulation.

Sincerely,

Cherilyn T. Cepriano
President
The Kidney Care Council

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[4] *Id*. at 623. The non-discrimination provisions ensure a level of cohesion and commonality among entities on behalf of common law employers, the common law employers themselves, and the covered employees, as distinguished from commercial insurance arrangements that sell insurance coverage to unrelated common law employers. *Id.* at 624.

[5] 77 *Fed. Reg.* 59 at 18,315 (March 27, 2012). *available at https://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.*

[6] 83 *Fed. Reg.* 4 at 619.