



**National
Multiple Sclerosis
Society**

January 29, 2019

Senator Rob Olson, Chair
Senate Financial Institutions and Insurance
Re: SB 32 Opponent

Chair Olson and Committee Members:

Thank you for this opportunity to comment on SB32 regarding Association Health Plans (AHPs). The National Multiple Sclerosis Society (the Society) opposes this proposed legislation and instead urges the committee 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.

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. Multiple sclerosis (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. 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) 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 this piece of legislation 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 people with chronic illnesses or disabilities such as MS, the results have been disastrous. We are extremely concerned that the proposal will leave Kansas 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.

SB32 could eliminate or alter 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,

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uncompensated care for providers, medical bankruptcies, under-insurance and un-, or under-treated health care needs. Some of our concerns with AHPs are as follows.

Maintaining Coverage for Essential Health Benefits (EHBs)

One of the most troubling aspects of AHPs is that they are not required to comply with EHB coverage requirements created under the ACA. 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.

Use of Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only applies to EHB-covered services. If an AHP does not have to comply with EHB coverage requirements, 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 (Himmelstein, "Medical bankruptcy in the United States", 2007). Kansans living with MS easily meet or exceed lifetime and annual caps because of the costs associated with MS care.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for Qualified Health Plans (QHPs) to include an annual out-of-pocket maximum set each year by the Division of Health and Human Services. For 2017, the annual out-of-pocket limit for an individual is \$7,350, and for a family plan is \$14,700. Similar to the ban on annual and lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. If this bill were to move forward in allowing expansion of non-EHB compliant AHPs, it will also be subjecting patients with complex and chronic conditions such as MS to unaffordable cost-sharing for the medically-necessary services upon which they rely.

Discriminatory Plan Design

Often AHPs can offer varying benefit designs to enrollees based upon 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 entire 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.

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Consequently, if this piece of legislation were to go into law 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 a 2016 Kaiser Family Foundation report (“Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA”), approximately 27 percent of American adults currently have a condition that would result in being denied health coverage. Employees or their dependents could once again face these same coverage denials within AHPs resulting in entirely inadequate coverage.

Allowing 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.

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 bankruptcy. 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.

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.

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. These consumers would have received little to no notice that their plan would fail to provide adequate coverage until it was too late.

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Market Segmentation

We are concerned about the impact the proliferation of AHPs on the individual market will have overall. We expect that individuals with serious and chronic conditions will continue to enroll in coverage offered through the Marketplace. Conversely, if AHPs are 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. Over time, if a significant number of younger and healthier individuals leave the public market, premiums will increase and could result in even fewer issuers in this market. 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.” (American Academy of Actuaries, “Issue Brief: Association Health Plans”, Feb. 2017)

To summarize, given the history of AHPs, we are deeply concerned that SB32 and the subsequent legislation could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law and will potentially put people living with MS at risk. As leaders in the field of MS care and research, and staunch patient advocates, we look forward to working with the Committee on the direction of such important public policy. Thank you for this opportunity to submit comments on this bill. If you have any questions or would like to discuss these comments further, please feel free to contact me.

Sincerely,

A handwritten signature in blue ink that reads "Kari A. Rinker". The signature is fluid and cursive.

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