April 21, 2014

Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9949-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule ("Proposed Rule") issued by the Department of Health and Human Services' ("HHS") Center for Medicare and Medicaid Services ("CMS").[1] This Proposed Rule addresses various requirements applicable to health insurance issuers, Affordable Insurance Exchanges ("Exchanges"), and other entities under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("PPACA").[2] Specifically, the Proposed Rule outlines possible standards related to product discontinuation and renewal, standard consumer notices, the modification of the definition of the small group insurance market, the Small Business Health Options Program, and expedited formulary exemptions. These are the areas of greatest concern within this Proposed Rule for the Chamber and our member companies.

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of

[1] Proposed Rule, 79 Fed. Reg. 15808-15879 (March 21, 2014) (to be codified at 45 C.F.R. pts 146, 147, 148 et al. [hereinafter referred to as the "Proposed Rule"] http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf.
[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter referred to as "PPACA"].

business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – is represented. These comments have been developed with the input of member companies with an interest in improving the health care system.

OVERVIEW

The Chamber has six areas of substantive concerns with the Proposed Rule. To address these concerns, we first recommend that the final rule includes a broader definition of what constitutes a "uniform modification." Second, we urge HHS to permit greater flexibility and defer to employers in determining the content and timing of required notices. Third, we generally agree with HHS's proposals regarding excepted benefits, but urge HHS to allow any individuals with minimum essential coverage to purchase hospital or other indemnity insurance in the individual market. Fourth, we caution against expanding the definition of small group. Fifth, we recommend against imposing an expedited formulary exceptions request at this time. Finally, we urge HHS to focus on ensuring that the electronic enrollment infrastructure is fully operational for all Small Business Health Options Programs before incorporating the highly-complex additional functions that an employee choice option would demand. These modifications are necessary to promote efficiency, reduce the burden on employers, minimize confusion and frustration for employees, and allow for meaningful choice and high-quality affordable care.

In addition to these significant substantive concerns, the Chamber has several important procedural concerns with the unorthodox process that HHS has followed in issuing this regulation. We understand the significant number of regulations on the Administration's docket and the broad array of issues that HHS is saddled with promulgating rules to address. We also recognize the time challenges that entities affected by these regulations are grappling with and the compliance challenges they face. However, HHS still has an obligation to follow the law as it relates to regulatory procedure and seems to be shirking this duty repeatedly.

SUBSTANTIVE CONCERNS

I. DEFINITION OF UNIFORM MODIFICATION OF COVERAGE

Under Sections 2702 and 2703 of the Public Health Service Act ("PHS Act") as added by Section 1201 of the PPACA, issuers in the group and individual markets must guarantee the availability and renewability of coverage unless there is an applicable exception. Generally, Section 2702 of the PHS Act requires an issuer (already offering health insurance coverage in the individual or group market in a state) to offer coverage to, and accept, every individual or employer in that state that applies for such coverage. Section 2703 of the PHS Act generally requires an issuer to renew or continue offering coverage in the group or individual market at the option of the plan sponsor or the individual.

The PHS Act provides several exceptions to these requirements which the Proposed Rule further defines. The PHS Act permits an issuer to cease offering a particular product in a market and to discontinue existing blocks of business with respect to the product (product withdrawal). The PHS Act also allows issuers, only at the time of renewal, to modify the health insurance coverage for a product offered to a group health plan or an individual in the individual market, if the

modification is consistent with state law and effective uniformly for all group health plans or individuals with that product (uniform modification of coverage). This Proposed Rule suggests standards defining whether certain changes made by an issuer to the health insurance coverage would be a permissible uniform modification of coverage and therefore not violate the policyholder's renewal right.

The Chamber agrees that the final rule should establish standards for determining when coverage modifications are permissible, while minimizing unnecessary terminations of coverage. This will minimize unnecessary and disruptive product withdrawals that would otherwise occur solely due to modest modifications and adjustments. The final rule must be revised to ensure predictability and continuity for consumers and provide the necessary flexibility for common coverage alterations. However, to achieve this worthwhile goal, the Proposed Rule must be broadened because as written, it establishes an exceedingly high threshold definition of a "uniform modification." As written, it will likely force a significant number of group plans that necessitate modest changes to be classified as discontinued coverage. This will be unnecessarily disruptive to employers and their employees, leading to confusion and frustration that will be exacerbated by the proposed content and delivery of notices.

Modest modifications that broaden benefit choice by expanding provider networks, formularies, new wellness programs and out-of-network options for enrolled participants should be permissible under the uniform modification exception. While we appreciate the importance of informing individuals and employers when significant changes are made to coverage that by law must be "renewed" and "guaranteed," surely the intent wasn't to discourage issuers from enhancing coverage that has been offered. Unless the uniform modification definition is expanded, not only will it lead to significantly more termination notices for routine and beneficial modifications, it will also ironically discourage issuers from enhancing benefits for fear that they will be required to discontinue and reissue products.

II. STANDARD CONSUMER NOTICES

Additionally, HHS is proposing to require issuers to send extremely prescriptive notices to every enrolled employee in a group health plan (and possibly their dependents as well) not only for discontinued plans, but also for renewals where no changes are being proposed. Companies and the issuers that serve them are accustomed to communicating changes in benefit plans to employees in language and at times that are most appropriate for their employees. These prescriptive notice requirements will undermine the ability of employers to determine when and how best to disseminate meaningful and appropriate information to their employees.

Not only will prescribing the content of the notice limit flexibility for employers, but the excessive notification requirements are also likely to cause significant confusion and impose additional resource costs in the realm of employer-sponsored coverage. Whether an issuer discontinues a product or renews an offering does not necessarily mean that this decision will in fact require action on the part of employees. Employers make decisions each year as to which plans they will offer to their employees. Requiring issuers to send discontinuation notices and renewal notices directly to employees will result in a significant amount of employee confusion under a number of different circumstances. For example, an employee who receives a discontinuation notice from an issuer may believe he or she needs to do something affirmatively

to secure coverage. Instead, it may often be the case that the employer is already in the process of purchasing health care coverage through another carrier. In this frequent scenario, it would be more appropriate for the employer to inform the employee of the discontinuation and new coverage options at the same time.

Additionally, an employee receiving a renewal notice generated by the issuer is likely to assume that the current employer-sponsored coverage will continue unchanged, when in fact the employer may be planning coverage or issuer changes. If left unchanged, these notice content and timing requirements will cost companies an excessive and unnecessary amount of time as they trying to clear up confusion and reassure employees about their coverage. Further, for issuers, sending thousands of additional notifications will be unnecessarily costly to comply with a requirement that confers no added benefit to the consumer. Therefore, we strongly recommend that this notice requirement be eliminated in the final rule.

III. EXCEPTED BENEFITS

The Chamber agrees with the premise articulated in the Proposed Rule that the "primary purpose of hospital or other fixed indemnity insurance is considered to be an excepted benefit is that not to provide major medical coverage but to provide a cash replacement benefit for those individuals with other health coverage."[3] As such, and given the individual's shared responsibility requirement to purchase minimum essential coverage, we understand that individuals offered fixed indemnity coverage in the individual market must also have underlying minimum essential coverage in order to fulfill their legal obligation. However, there are several elements in the Proposed Rule that address the issue of indemnity insurance that we do not support.

The Chamber does not believe that it is, or would be, consistent with the general provisions of the PPACA to require that fixed indemnity insurance only be sold to individuals with other health coverage that meets the Essential Health Benefits Requirements. There are likely to be many instances where individuals satisfy the requirement under PPACA to obtain minimum essential coverage (by purchasing coverage through the group market or individual market), but do not have plans that meet the essential health benefit requirements. Individuals that are covered by large group plans, self-insured coverage, grandfathered plans or "transition plan" coverage should also be permitted to purchase hospital or fixed indemnity insurance individually for their own protection.

Further, we believe the application of this new requirement must not occur until one year after the final rule is published in the Federal Register to ensure that individuals, carriers and state regulators have sufficient time to implement the new conditions. Finally, the Chamber also believes that the Notice language may be confusing. The Notice will accompany materials for the hospital or fixed indemnity insurance plan and as such is not directly related to the PPACA or its requirement to purchase minimum essential coverage. Therefore, we would suggest that the notice instead state: "This policy is a supplement to health insurance and does not provide the minimum essential coverage that individuals may be required to have under the Patient Protection and Affordable Care Act."

[3] PPACA 79 Fed. Reg. at 15818.

IV. DEFINITION OF SMALL GROUP

The Chamber is exceedingly concerned about a related issue that would mandate additional benefit and rating requirements for coverage offered by a new category of employers, directly impacting coverage affordability for businesses and employees alike. While not specifically addressed in the Proposed Rule, we would like to take this opportunity to recommend that HHS not expand the insurance market definition of "small group" to include groups with up to 100 (or more) individuals. Currently, the PPACA's requirements for community rating, essential benefits and metal-tier levels of coverage do not apply to these "mid-size" employers between 50-100 individuals. Sweeping these additional employers into the small-group market will increase the cost of coverage for these businesses and employees. Therefore, we recommend that HHS preserve the PPACA's existing definition of a small-group as one with 50 individuals or fewer beyond 2016.

V. SHOP EMPLOYEE CHOICE

The Chamber continues to believe that as employers of all sizes assess whether or not to offer health coverage to their employees, the more flexibility that they have in deciding how and what to offer, within the confines of the law, the more likely employers will continue to offer health care coverage to their employees. We continue to hope that the Small Business Health Options Programs (SHOPs) will offer a new venue for employers to review, compare and offer coverage for their employees in the years to come. Certainly, we anticipate the value and benefit of Small Business Health Options Programs and look forward to their functionality across the country. Once these SHOPs are able to "assist qualified employers and facilitate the enrollment of the employees in qualified health plans ("QHPs") offered in the small group market in the state" as intended, they will enable small businesses to make optimal decisions regarding the coverage they offer their employees. [4]

However, despite our conceptual support for SHOPs, we are mindful of the challenges in creating the necessary infrastructure to permit comparison shopping, on-line selection by employers of coverage options and enrollment of individual employees. Given the challenges that the Federally Facilitated SHOP in particular has had during this first year, we caution against adding further functional complexities at this time. To this end, we urge HHS to adopt a simpler waiver process that provides states greater discretion and flexibility in choosing SHOP options that meet local needs and allow for adequate time to ensure basic functionality and operational readiness. States are uniquely positioned to know what is best for their SHOPs without the need for new federal standards.

Given the earlier implementation challenges in the Exchanges/Marketplaces, it is especially important now to have SHOPs that are workable and operationally ready. A simplified waiver process that allows states to make decisions about their local health insurance markets offers the best chance for producing an affordable and successful health coverage system for small businesses and consumers.

[4] PPACA, §1311 (b)

VI. EXPEDITED FORMULARY EXCEPTIONS

Finally, the Proposed Rule also includes a discussion on requiring issuers to render decisions on formulary exceptions requests within 24 hours of receipt. Absent any specific detail as to why this new requirement is necessary, we believe that mandating such an expedited exceptions process is premature. Issuers already make assessments based on the best clinical practices as to when it is appropriate for enrollees to access medications that are not on formulary. Prior to any additional rulemaking on an issue where requirements are already in place, there should be a study of plan operations in the first year of QHP operations to determine if enrollees are experiencing significant problems. If problems are found, only then should HHS examine how to ensure that current requirements for exception requests are understood and being followed, or, if necessary, propose additional regulations addressing specifically identified issues. Imposing a broad mandate at this time is premature and would likely unnecessarily increase costs and negatively impact affordability.

PROCEDURAL CONCERNS

I. NUMEROUS RULES COMBINED INTO ONE

This Proposed Rule addresses a multitude of distinct policy issues. In fact, it appears HHS has elected to simply lump a series of distinct rulemakings into a single lengthy and convoluted document. From the standpoint of regulatory economic impact analysis requirements under Executive Orders 12866 and 13563, OMB Guidance Circular A-4, the Unfunded Mandates Act and the Regulatory Flexibility Act, each of the distinct elements should be addressed and analyzed separately. The disjointed nature of the proposal is tacitly admitted by HHS on the very first page of the rulemaking notice by the division of information about the rulemaking among staff along topical lines:

> **FOR FURTHER INFORMATION CONTACT:** For general matters and matters related to Parts 146 through 148: Jacob Ackerman, (301) 492–4179. For matters related to reinsurance, under Part 153: Adrianne Glasgow, (410) 786–0686. For matters related to risk corridors, under Part 153: Jaya Ghildiyal, (301) 492–5149. For matters related to noninterference with Federal law and nondiscrimination standards, and Navigator, non-Navigator assistance personnel, and certified application counselor program standards, under Part 155, subparts B and C: Joan Matlack, (301) 492–4223. For matters related to civil money penalties and consumer authorization forms, under Part 155, subpart C: Emily Ames, (301) 492–4246. For matters related to civil money penalties for false or fraudulent information or improper use of information, under Part 155, subpart C: Julia Cassidy, (301) 492–4412. For matters related to enrollment of a qualified individual, under Part 155, subpart E: Jack Lavelle, (410) 786–0639. For matters related to special enrollment periods and exemptions under Part 155, subparts D and G, and matters related to eligibility appeals, under Part 155, subparts F and H: Christine Hammer, (301) 492–4431. For matters related to the Small Business Health Options Program, under Part 155, subpart H: Christelle Jang, (410) 786–8438. For matters related to the required contribution percentage for affordability exemptions, under Part 155, subpart G: Ariel Novick, (301) 492–4309. For matters related to cost sharing, under Part 156, subpart B: Pat Meisol, (410) 786–1917. For matters related to quality standards, under Parts 155 and

156: Nidhi Singh Shah, (301) 492–5110. For matters related to minimum essential coverage, under Part 156, subpart G: Cam Clemmons, (410) 786– 1565. For all other matters related to Parts 155 and 156: Leigha Basini, (301) 492–4380. For matters related to the medical loss ratio program, under Part 158: Julie McCune, (301) 492–4196.

If the subject matter of this rulemaking is so disparate and distinct that it requires 15 separate knowledge-area contacts within the HHS staff to provide information to the public, then it seems reasonable to conclude that this is in fact 15 distinct rulemakings improperly disguised as one. At the very least, compliance with the relevant regulatory process Executive Orders and with the Unfunded Mandates and Regulatory Flexibility statutes requires the agency to separately consider and to publish its findings and reasoning regarding the economic costs and benefits of the standards proposed for each of the 15 separate elements of the proposal that its own instructions delineate. More appropriately, HHS should publish 15 separate rulemakings, each with appropriate periods for public comment.

II. INADEQUATE COMMENT PERIOD AND COST ANALYSIS

Not only is a 30-day public comment period on such a far-reaching, convoluted and complex rulemaking wholly inadequate, but the lack of clarity as to the basis for the economic analysis is also insufficient. In fact, HHS acknowledges that the proposed set of standards is an economically significant rulemaking – having over $100 million impact in cost or transfers in at least one year. The economic cost impact is reported as $49.5 million (at 3% discount rate) as an annualized amount over the period 2014-2018. This implies that the total over the four years covered may be about $200 million. However, by presenting the costs as an annualized amount obscures the fact that much of the cost will be concentrated in the initial year of implementation –2015. HHS should reveal the estimated costs on a year-by-year actual basis, because the concentration of some costs in the initial year is a significant aspect of the economic impact on states, insurers and employers. This concern is especially relevant for small affected entities.

Further, HHS's estimates of costs for the various components of the proposed standards are seriously flawed due to unfounded assumptions regarding time and numbers of affected individuals or operational entities. The following are examples of unfounded assumptions throughout the Department's analysis:

1. For recertification of application counselors, HHS estimates one hour to create and one-half hour each for a manager and an attorney to review the subject request form.[5] These parameters appear to have been invented without any basis in experience or fact. The assumption is arbitrary. It would have been simple for HHS to have conducted an in-house experiment with staff analysts, managers and attorneys to attempt the task. Such an experiment would have provided a credible empirical basis for the required labor time.

2. Under the same recertification heading, the estimate of one minute per year per exchange and per each of "5,000 organizations" for recordkeeping is similarly arbitrary and incredible. Again, it was within the power and competence of HHS to have conducted an experiment or otherwise obtained data from which a reasonable estimate could have been obtained.

[5] Proposed Rule, 79 Fed. Reg. at 15854.

3. The estimate that "up to 5,000 designated organizations would develop their own recertification request form" is also arbitrary. HHS does not reveal any reasoning or empirical evidence on which it based that key number. Why not 7,000 or 10,000? This number impacts both the form development and the recordkeeping cost elements.

4. HHS's assertion that it would take a certified application counselor no more than 10 minutes to complete and submit a recertification request is similarly arbitrary and unsupported by any empirical evidence.[6]

5. Under the heading "ICRs Regarding Consumer Authorization", the estimated labor costs for Navigator personnel and other assistance personnel ($20 per hour) and for project leader personnel ($29 per hour) and for senior executives ($48 per hour), are arbitrarily asserted without any empirical evidence or rationale provided.[7] The assertion that the same unfounded amounts have been used by it in previous paperwork burden calculations is not a credible basis.

6. Similarly, the assertion that "it would take a certified application counselor 0.25 hours (15 minutes) to provide consumers with information about the functions a responsibilities of a certified application counselor, obtain their authorizations, and provide any applicable conflict of interest disclosures" is not based on any empirical evidence.[8] HHS could have conducted experiments or surveys to obtain reasonable and credible data for this purpose. The reduction of the 15 minutes referenced above to 10 minutes for its ultimate calculation (because "here we are only estimating the time required to provide consumers with information about the functions and responsibilities … and obtain their authorization") is likewise arbitrary.

7. Under the heading "ICR Regarding Quality Rating System," the assertion that "575 QHP issuers" would be affected is not supported by any empirical data or reasoning. The basis for the estimate that the annual cost to an "issuer who has performance measures data collection experience," would be $117,424 per year and require a total of 1,650 labor hours is unsupported by any evidence of the actual experiences of such issuers. The presentation is also obscure: it does not reveal the estimated hours per labor category and hourly compensation rates applied for the lengthy list of labor categories listed. The reference to "Using the BLS labor category estimates," is inadequate: It is not clear what BLS wage or compensation data series was used and for what year. Similarly, the basis for the assumption that 80 percent of issuers would have such experience is arbitrary and not based on any empirical evidence or reasoning. The estimate of additional costs for those without such experience ($102,500 for the initial year) is likewise without a basis shown in the published analysis.

8. With respect to development of training materials for recertification the estimates of 13 hours distributed across various labor categories to update an online training module is

[6] Proposed Rule, 79 Fed. Reg. at 15855.
[7] Proposed Rule, 79 Fed. Reg. at 15855.
[8] Proposed Rule, 79 Fed. Reg. at 15855-15856.

arbitrary and not based on empirical data or reasoning.[9] Again, it is within the ability of HHS to conduct experiments or research to obtain credible data.

The items listed above are examples of the failure to base cost estimates on credible, empirical data that it could have obtained. Instead, the cost estimates are based on arbitrary guesses or offer no basis or reason for the public to trust such estimates. The estimates provided are based on such de minimis assumptions that it is likely that the actual cost of compliance will be many times the amounts published by HHS.

CONCLUSION

The Chamber urges HHS to reconsider elements of the Proposed Rule and to issue a Final Rule that: expands the definition of what constitutes a uniform modification; allows employers greater flexibility in the content and timing of notices sent to their employees; preserves the current insurance market definition of a group eligible to purchase coverage in the small group market; ensures basic functionality of the SHOP and permits the current formulary exceptions process to continue. We look forward to continuing to work together in the future to reduce unnecessary administrative burdens with the goal of improving efficiencies and reducing costs.

Sincerely,

Randel K. Johnson
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U.S. Chamber of Commerce

Katie Mahoney
Executive Director
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[9] Proposed Rule, 79 Fed. Reg. at 15860.