March 6, 2017

Re: Patient Protection and Affordable Care Act; Market Stabilization, Proposed Rule, RIN 0938-AT14

The National Center for Transgender Equality (NCTE) submits these comments on the proposed rule. NCTE advocates for the over 1.4 million Americans who are transgender. Recent research indicates that transgender Americans are more likely to be uninsured, and 33% of transgender Americans report having avoided seeking health care in the last year because of cost.[1]

NCTE has significant concerns about the proposed rule's effect on consumers' ability to enroll in quality, comprehensive, affordable health coverage through the marketplaces. Overall, the proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provide

If implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks;
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that would actually disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals are far from the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

[1] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

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Lastly, NCTE is deeply disturbed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This unduly short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations; many affected parties will likely be unable to weigh in with comments.

Guaranteed Availability of Coverage (§147.104)

The NPRM proposes allowing issuers in the individual or group market to refuse coverage to an individual (or employer) who owes the issuers premiums from the prior 12 months, unless and until the individual (or employer) pays the premium debt in full. This change should not be adopted. This conflicts with the statute, which says that issuers generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. This change would bar people, many of them with limited incomes, from accessing coverage and the financial assistance for which they are eligible as a result of premium shortfalls during the prior year. Under this proposed rule, only those who can rapidly come up with a possibly significant sum of money by a given deadline can be guaranteed access to health coverage. In some parts of the country, people who owe back premiums to one issuer could then seek coverage with a different issuer, but that would not be possible in areas with only one issuer offering individual coverage. Strangely, in a proposed rule aimed at providing greater stability in the insurance market, this policy would likely deter *healthier* people who get behind in their premiums from enrolling, since often-healthy younger people are more likely to miss bill payments in general. This could weaken the overall health of the coverage pool in a similar way as the proposed changes to SEPs.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[2]

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- The issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify

[2] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrolment declines gradually throughout the year, a sign that enrollees leave the market during the year for many reasons, including obtaining other coverage. See: http://www.cbpp.org/research/health/marketplace-grace-periods-working-as-intended

affected consumers in the notice recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

Open Enrollment Periods (§155.410)

NCTE strongly urges CMS to keep the length of open enrollment periods to three months, as is was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about *and* enroll in coverage within the given timeframe. If the rule is finalized, there will limited time for affected consumers to learn about the changed length. We know that consumers continue to have gaps in knowledge about the coverage options available to them and we believe a three-month open enrollment period should continue in order to ensure eligible consumers enroll.

We also have concerns about consumers' ability to gain in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer pans. We appreciate that CMS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand.[3] Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[4] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[5]

NCTE supports CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[6] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[7]

Special Enrollment Periods (SEPs) (§155.420)

Overall, NCTE is very disappointed about the proposed changes to SEPs and urge you not to finalize them. In order to ensure that healthy people enroll in coverage, thus bringing down the cost of coverage overall, enrollment rules and procedures should strive to make it *easier*, not *harder*, to enroll in coverage. Estimates show that less than 5 percent of eligible consumers enrolled in coverage through SEPs in 2015,[8] and we are

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[3] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[4] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[5] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

[6] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[7] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[8] Stan Dorn, *Helping Special Enrollment Periods Work under the Affordable Care Act* (Washington: Urban Institute, June 2016), available online at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

concerned that these new requirements will likely result in even fewer eligible consumers accessing coverage using an SEP.

Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, we *still* have not been provided with any evidence that ineligible people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to follow through.[9] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will complete the process.

NCTE is disappointed in the proposal to expand pre-enrollment verification. No evaluation or analysis of the impact of the numerous changes – specifically increased verification requirements – that have already been implemented for the FFM has been conducted. We do, however, appreciate that the preamble requests comment on whether a small percentage of enrollees should be retained outside of the pre-enrollment verification process in order to evaluate the impact of these processes and we strongly urge CMS to do so.

NCTE is also strongly opposed to requiring prior coverage for the marriage SEP and rules that limit the ability of currently enrolled consumers to change plans. Currently, enrolled consumers who are newly eligible for premium tax credits (PTCs) may select a plan from any available metal level. This is important so that individuals and families experiencing life changes can gain access to financial assistance or can adjust to loss of subsidies and still afford coverage. For example, someone who experiences an increase in income may receive a reduced premium credit and/or lose access to cost-sharing reductions during the course of the year. This warrants the chance to change metal levels if they choose.

It is critical that eligible consumers successfully finish the SEP verification process with minimal burden. The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the bar be higher, consistent with the streamlined eligibility and enrollment process envisioned by current law. For example, in cases such as birth, denial of Medicaid or CHIP, or loss of Medicaid or CHIP eligibility, SEP applicants' coverage should *not* be pended. Instead, their attestation should be accepted with eligibility verified afterward in order to ensure continuity of their health care and coverage. Further, we seek clarification about the timeline for building effective electronic verification systems and recommend that there are strong manual systems in place should electronic verification not be ready by June 2017 or should electronic verification not work for all consumers. We also want to emphasize that marketplaces, not issuers, should continue conducting SEP verification, consistent with the law.

HHS requested comment on strategies that would increase the chances of consumers completing the overall verification process. One strategy HHS should use is to conduct robust outreach through email and calls to consumers who have not yet completed the process. Another strategy would be for the federal government to again require certificates of creditable coverage (which used to be required under HIPAA) so there is a reasonable way for people to obtain the proof of eligibility. Currently, there is no assurance that individuals will be able to obtain such proof of coverage, much less in the time frame suggested, and we are aware of cases when people's former employers have not provided it upon request. Yet, under the proposed rule, people's coverage would be held up and possibly denied for failure to submit such proof.

The proposed rule also requests comments about changes to SEPs for state-based marketplaces (SBMs). NCTE urges the Administration to not require SBMs to align with the federal process for pre-enrollment verification, nor with the other SEP changes proposed in this regulation. States should have the flexibility to create policies and processes that work for them. Because the federal government is rushing ahead with policies that risk reducing enrollment of eligible people, including those who are healthy, it is critical to allow states to take other approaches that fit their specific needs. This serves the dual purposes of ensuring that more eligible people are able to access coverage without undue hassles in SBMs and allows the federal government to benefit from the information that states find as they adopt their own policies. We also note that SEPs largely apply on a market

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[9] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

wide basis, and states continue to have authority over their individual and small-group insurance markets and can implement issuer standards and other rules that are more protective of consumers and that do not impede the application of federal law.

Continuous Coverage

According to the preamble, the Administration is considering various proposals that could be established that would "promote continuous enrollment in health coverage" without gaps and discourage people from "waiting until illness occurs to enroll in coverage."

One idea discussed would require individuals applying for a special enrollment period to show they have had health coverage for significant period of time (perhaps six to 12 months) without a gap of more than 60 days and then to be denied access to coverage through an SEP if they can't show they have had "continuous coverage." Another example discussed is a requirement that individuals who are not able to provide evidence of prior "continuous coverage" without a gap could face insurer practices – such as a waiting period before benefits begin or a late enrollment penalty—that have not been allowed in the individual market since enactment of the ACA. These ideas would serve as impediments to people getting coverage, overburden consumers, and would conflict with current law.

Unless legislation changes the guaranteed availability requirements of the ACA, issuers still generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. There is no basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty (through the ACA's individual mandate). It is unfair to create another penalty that would withhold future coverage because a person has been uninsured. Imposing a waiting period on some consumers' benefits or making them wait "at least 90 days" for their coverage to be effectuated is completely inconsistent with guaranteed availability. Late enrollment penalties or surcharges conflict both with guaranteed availability and the requirement that premiums vary only based on certain specified factors; whether a person has been uninsured in the past is not an allowable rating factor, for example.

The ideas suggested in the preamble would also inflict serious harm on many consumers. Breaks in coverage are fairly common today, a fact that has been borne out by numerous studies.[10,11] Imposing late fees, waiting periods before benefits begin, or other barriers to accessing coverage mean that some people will not get the coverage or the health care services that they need. Current law already has restrictions that protect against adverse selection: limiting enrollment to specified periods and the individual mandate penalty are two examples. In addition, the proposals floated in the preamble would likely reduce overall enrollment in coverage, particularly among healthier people. Therefore, the ideas floated here actually raise the risk of making the risk pool worse and health coverage less affordable overall. To truly promote continuous coverage, an open and accessible system – not a closed and onerous one – is needed to ensure that people successfully obtain coverage when they are first eligible and maintain it over time. The process for changing coverage should be as smooth and as swift as possible, and the government should avoid placing harmful restrictions on people's ability to make these transitions successfully – particularly in ways that conflict with the law.

Levels of Coverage (Actuarial Value) (§156.140)

NCTE strongly opposes the proposal to broaden the allowed *de minimis* variation in actuarial value (AV) for each plan metal level to -4/+2 percent. This policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower

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[10] Some 36 percent of Americans ages 4 to 64 (89 million people) went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once, according to a study by the Commonwealth Fund: http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance

[11] Nearly one-quarter of people with pre-existing health conditions (31 million people) experienced at least one month without health coverage during 2014, according to data from the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[12]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[13]

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today *or* purchase coverage with hundreds to thousands of dollars in higher cost-sharing- either way they will have to pay much more for coverage and care.

The preamble of the proposed rule even acknowledges the harm that many consumers will experience, stating: "*A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government*, " and "*The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risk associated with high medical costs.*"

The administration should not proceed with a policy that will knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current *de minimis* actuarial value requirement of -2/+2 percent be maintained for all metal levels. We note that a broader level of variation is no longer *de minimis* and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare different plan options and also to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

If the administration is insistent on pursuing a policy to allow for lower value plans, however, we strongly urge that such change be limited to bronze level coverage. We strongly disagree with the assumption that the remaining uninsured are only looking for coverage with lower premiums, as many people, including young adults, report being just as concerned about high cost-sharing.[14] As such, we are skeptical that reducing the floor of bronze coverage offered in the marketplace will attract a large number of new enrollees. However, if the premise of this proposed policy change is to expand marketplace offerings to include more barebones coverage than is currently available on the marketplace, lowering the minimum actuarial value for *only* bronze level coverage achieves that and does so without undercutting vital financial assistance.

Network Adequacy (§156.230)

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[12] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

[13] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: **http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for**.

[14] Liz Hamel, Jamie Firth, Larry Levitt, Gary Claxton and Mollyann Brodie, *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Washington, DC: Kaiser Family Foundation, May 20, 2016), available online at http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/ and Kara Brandeisky, *Why Millennials Hate Their Least Expensive Health Care Option,* Time Magazine (Dec 8, 2014), available online at http://time.com/money/3614626/millennials-health-insurance-high-deductible/.

NCTE has long advocated for adequate provider networks that allow coverage enrollees to get the care they need, when they need it. A common complaint of both Democratic and Republican officials, including in Speaker Ryan's 2016 health care plan "A Better Way," is that provider networks are sometimes too narrow to meet consumers' needs.[15] If the Administration aims to promote adequate provider networks,[16] implementing the proposed rule will not achieve that goal, but will result in narrower networks.

Instead of HHS continuing to do its job to protect consumers from bait and switch products that can't fulfill guarantees to deliver access to care, under this rule the agency shirks its responsibilities and claims state oversight can ensure network adequacy. But currently, nearly half of states have no metrics in place to assess whether marketplace plans provide adequate networks.[17] This rule will gut the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allow states that have no adequacy metrics to maintain authority for provider network review.

This rule would take the health care system backwards in time to 2014, before HHS implemented critical network adequacy reviews that currently protect patients. The rule fails to describe how consumers' access to providers will be impacted by the removal of federal network adequacy review. We are interested in understanding how HHS will ensure consumers have the same or better access to providers in all states if this proposal is implemented.

NCTE urges HHS to maintain the implementation of §156.230 as it stands now, as proposed changes to defer to state oversight will result in insurers selling health plans that do not include sufficient numbers and types of providers to serve enrollees. The proposed changes to network adequacy would jeopardize the health and financial security of consumers and we urge HHS to reject them.

Essential Community Providers (§156.235)

Like section 156.230, section 156.235 will narrow networks for consumers. This section decreases FFE insurers' accountability to include in their networks Essential Community Providers (ECPs) — those that serve predominately low-income, medically underserved individuals. This section is a giveaway to insurance companies, which under the proposed rule will be allowed to travel back in time to 2014 and only contract with 20 percent of ECPs in their service area.

NCTE is concerned that this provision will be particularly harmful to LGBT consumers and their families, who are more likely to rely on ECPs. This is both because LGBT Americans are more likely to have low incomes and because they face barriers related to stigma, discrimination, and lack of cultural competence with other providers.[18]

Page 10996 of the proposed rule describes the impact of this section directly, showing that consumers will bear burdens so that insurers can cut corners:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

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[15] Speaker Paul Ryan, *A Better Way* (Washington, DC: U.S. House of Representatives, June 2016), available online at: https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf

[16] Claire McAndrew, *Network Adequacy 101* (Washington, DC: Families USA, October 2014), available online at: http://familiesusa.org/product/network-adequacy-101-explainer

[17] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act:
State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

[18] *See*, *e.g.,* James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality; Institute of Medicine of the National Academies, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.nap.edu/openbook.php?record_id=13128&page=69.

States around the country like Connecticut and Montana, and their participating issuers, have achieved far higher ECP inclusion benchmarks.[19] This proposed modification for ECP inclusion in FFE networks signals that HHS and the Administration overall lack commitment to vulnerable marketplace enrollees and to network adequacy. We urge rejection of a change in the ECP standard to 20 percent and instead recommend increasing the threshold over the next 3 years until it reaches 75 percent.

Conclusion

In closing, we urge HHS to maintain critical consumer protections and to limit or abandon provisions in the proposed rule that would roll back those protections. Thank you for your consideration.

[19] Cristina Jade Peña, Laurie Sobel, and Alina Salganicoff, *Federal and State Standards for "Essential Community Providers" under the ACA and Implications for Women's Health* (Washington, DC: Kaiser Family Foundation, 2015), available online at: http://kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/

Comment separator page. Next comment follows.

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March 7, 2017

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RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

We have included our comments on specific sections below. But before providing specific comments, we want to raise significant concerns about the proposed rule's overall effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces. This rule, if finalized, will weaken consumer protections while lowering premium tax credits which undermines -- a rather than strengthens -- the Health Insurance Marketplace.

The proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides. If implemented, the proposed rule would:

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- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks; and
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals do not provide the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are strongly dismayed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment

on the proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

I. § 147.104 – Guaranteed Availability of Coverage

HHS seeks comments about its proposed premium payment policy, which would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy, particularly for lower income individuals.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and HHS does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

And beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, and other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with an issuer but faced numerous administrative and bureaucratic hurdles to do so.

It may also be due to issuer or marketplace error that leads to an assumed non-payment. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage since they could lose their employment and need to come back for marketplace coverage but should not be subject to repayment.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[1]

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues,

[1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrollment declines gradually throughout the year, a sign that enrollees leave the market over time for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.

- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

And if HHS were to proceed with this policy, we also recommend that this policy be limited to annual renewals and that consumers enrolling during a Special Enrollment Period (SEP) should not be subject to this policy. The mere fact that a consumer is eligible for an SEP means the consumer is facing a change in circumstance. For example, if a consumer stopped paying premiums in September of one year and gets an SEP to re-enroll in the middle of the next year, the consumer should not have to pay back premiums when there has been a significant time lapse between the events.

Further, we provide additional suggestions to provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" to this policy such that consumers who can demonstrate significant financial hardship that caused the consumer to stop paying premiums, the issuer would not be permitted to apply new premium payments to past unpaid premiums. Consumers could document such a hardship by providing a narrative explanation as to why he stopped paying premiums. Since the NPRM would already allow consumers to enroll in another plan and thus

issuers would not always recoup past premiums from these consumers, it seems that allowing a consume the option to stay with the same plan – which may be important to the consumer because of the network or particular providers – is a second option that would provide a compromise for the consumer and issuer.

Also, information about repayment should be clearly noted on the Plan Compare tool so that consumers would have that information before they enroll. Second, it should be noted in the Eligibility Determination Notice since consumers could change plans if open enrollment or a special enrollment period remains open.

II. § 155.410 – Initial and Annual Open Enrollment Periods

We are concerned about the shortening of the annual open enrollment period. While we recognize a shorter enrollment period was planned for 2018, given all the potential changes that consumers have to digest this year, we believe that keeping a longer open enrollment period would be beneficial to consumers as well as issuers. We believe the benefits – enrolling more consumers – outweigh the perceived costs of having consumers enroll for less than a full year (if they enroll after December 15).
HHS notes that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance. Thus the policy change could just as easily lead to a sicker pool, at least in the short term, if young, healthy people end up missing the new deadline for signing up. HHS acknowledges this uncertainty but it does not sufficiently explain why a positive result (decreased adverse selection, improved stability of the exchanges) is more likely than a negative result (increased adverse selection, reduced stability of the exchanges) with a shorter enrollment period.

We are also concerned about the proposed shortened enrollment period due to the added burdens it will put on navigators and assisters. Many navigators and assisters already work long hours and weekends throughout the current open enrollment period to meet the demand. Shortening the period will make it even more difficult to reach and serve all consumers.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[2] As Florida Blue Cross Blue Shield noted, ending open enrollment in

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[2] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

December “forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest.”[3]

We support CMS’s plan “to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame.” However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[4] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[5]
We also strongly recommend that HHS not require state based marketplaces (SBMs) to a shorter enrollment period. The SBMs are in the best position to determine their own enrollment periods which may factor in state-specific issues.

III. § 155.420 – Special Enrollment Periods

We have strong concerns about the proposed pre-enrolment verification process, particularly since it will include 100% of SEP applicants and because HHS has not released a full evaluation and analysis of the post-enrollment verification pilot operated in 2016. First, before requiring all applicants to verify their eligibility, it is important to identify any real or perceived limitations of verification that need to be addressed. Second, if the post-enrollment analysis finds that many eligible consumers are deterred or unable to complete verification, HHS should ensure these issues are fixed in a pilot of pre-enrollment verification. Overall, any required verification – whether for enrollment, data matching, or an SEP – needs to be easy and simple or eligible individuals will be deterred from enrolling. If the process is not easy, it is likely that those in more dire need of health insurance, rather than individuals who may be healthier and want coverage to avoid paying a tax penalty,

[3] See Florida Blue Cross Blue Shield’s comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.
[4] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.
[5] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

will likely complete the process. For SEPs, we recognize that a disproportionate number of sicker individuals obtaining coverage through SEPs could disrupt the risk pool and lead to unanticipated higher costs. If a major concern for issuers is the higher costs associated with those coming in through SEPs, however, other interventions exist that would not burden consumers or presume fraudulent applications. For example, HHS' changes to the risk adjustment costs in 2018 and beyond to address higher than expected costs of those not enrolled for the full year would address this problem without assuming that those obtaining mid-year coverage through an SEP are ineligible and need to prove eligibility pre-enrollment.

To keep consumer engagement and trust high – an essential component to the success of the marketplaces – while preserving affordability, any SEP eligibility verification should be narrowly targeted only to instances of suspected ineligibility or fraud and should use electronic verification rather than requiring paper documentation. While we understand the balance the FFM must strike between plans and consumers to achieve affordability, we believe that mandatory SEP pre-eligibility verification will have a chilling effect on many eligible individuals. Excessive documentation requests may be a deterrent to potentially eligible applicants who would help spread the risk and HHS should take care not to discourage participation. Problems and consumer frustration with other verification processes already exist – such as lengthy times between document submission and review, trouble uploading verifications, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues because consumers cannot directly reach those conducting the reviews. Adding pre-eligibility verification may jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the FFM such that only the sickest and costliest consumers pursue SEPs. At the same time, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

As the NPRM preamble notes, some commenters to the 2018 Payment Notice suggested that additional steps to determine SEP eligibility worsen the problem by creating new barriers to enrollment. Yet based on issuer feedback, HHS is proposing to increase the scope of the pre-enrollment verification. We believe this should not be done unless and until the prior pilot analysis adequately identifies what cause and effect pre-eligibility verification may have on individuals and the marketplace as a whole. Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to

follow through.[6] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will take the steps necessary to complete the process.
Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

a. Electronic Verification

We do appreciate that HHS recognizes it will make every effort to verify eligibility through automated electronic means. It is not at all clear that the FFM would be technically or operationally capable of implementing an SEP verification process consistent with the Affordable Care Act's vision of a real-time, streamlined eligibility and enrollment system. HHS has already acknowledged that eligible individuals sometimes forgo coverage because they encounter difficulty securing and providing the documents requested to verify their eligibility when they have a data matching issue.[7] We cannot afford this result to duplicate with SEP verification.
As an example, consumers who are eligible for the permanent move SEP who have been enrolled in a QHP should not have to provide documentation of their "original" address. Yet this was required as part of the post-eligibility verification. Consumers provide this information during enrollment and burdens should not be added to submit documentation merely because HHS is unable to access this information.
Before implementing a pilot, HHS should establish systems for an automatic check with issuers and public programs (Medicaid, CHIP, Medicare) about whether a consumer lost creditable coverage. Consumers should not be responsible for tracking down documentation to show that coverage was lost when this information is readily available

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[6] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.
[7] *Strengthening the Marketplace – Actions to Improve the Risk Pool* (June 8, 2016), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending.

from issuers. Only if electronic verification is inconclusive, or if a consumer disputes the result, should documentation be required.

b. Timeframes for document verification

We appreciate that HHS will provide consumers 30 days to provide documentation. We do ask that HHS also provide consumers with the opportunity to request an extension of that time period if they have difficulty obtaining certain documentation within that timeframe. This could allow the consumer to continue with an SEP application without losing eligibility merely due to difficulties obtaining documentation. If the consumer's SEP application is instead denied, the consumer may not be eligible at a later date due to the length of time from the qualifying event even if the consumer truly is eligible. We also strongly urge HHS to establish specific timeframes for evaluating documents as part of a pre-eligibility verification pilot. Without specific timeframes, consumers would not have necessary information to ascertain when a decision will be made, when to follow-up if they have not received a decision, and how to proceed if a decision is adverse. We also recommend that if a consumer submits documents, and the review by the FFM is not completed within 15 days, that the SEP must be granted so that consumers are not suffering without health insurance for lengthy periods of time. This could be done conditionally to give the FFM additional time for document review but it would balance the needs of the consumer for health insurance by preventing significant delays in enrollment. Under this situation, the process would continue similar to post-eligibility verification.

As we have previously stated, we strongly believe that HHS should implement a model of verification more closely aligned with the IRS and should evaluate this as part of a pilot. Consumers already attest under penalties of perjury to the information provided in their applications. Rather than require pre-eligibility verification submission, HHS should only request documents from the specific consumers who will be audited (and this subset of consumers must be randomly selected and not based on any personally identifiable characteristics or claims data). Requiring 100% pre-eligibility verification seems unnecessary, burdensome for consumers, and adds additional processing and storage burdens for the FFM to receive, review, classify and store the documents.

c. Study of Pre-Enrollment Verification

HHS asked for comment whether a small percentage of individuals should be exempt from the pre-enrollment verification process to conduct a study. We strongly support this suggestion. The excluded population must be statistically significant so that an appropriate and legitimate comparison may be made between the two groups.

Further, HHS asked for comment about strategies HHS should take to increase the chances that healthier individuals complete the pre-eligibility verification. We strongly recommend that HHS eliminate the need for verifying any SEPs based on birth/adoption/foster care placement and marriage. Given the nature of the circumstances under which these SEPs arise, it is hard to imagine that many consumers will be seeking an SEP for these categories if not truly eligible. At a minimum, HHS should consider excluding from a pre-eligibility verification pilot unless and until the process for verifying loss of MEC and permanent move SEPs is implemented effectively and efficiently.

d. State Based Exchanges

HHS requested comment on whether SBMs should be required to conduct pre-enrollment verification. We believe the answer to this should be no. SBMs should be able to determine their own policies and processes for SEPs, just as they have the authority to adopt SEPs that the FFM does not use. States need the ability to respond to their individual market needs and we do not see a need for a uniform national policy in this situation, especially since we have significant concerns about HHS' policies on this topic.

e. Changing Plan Levels

We believe HHS' proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1) While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. HHS's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We thus oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry

practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

For example, adding a dependent or getting married likely alters the amount of APTC and possibly cost-sharing reductions (CSR) which can impact what plan enrollees wish to enroll in. As another example, a pregnant woman may have enrolled in a silver plan but if she gives birth to a child with special needs or complex medical conditions, she may want to change coverage to a gold or platinum plan to obtain a higher level of coverage. Or a woman may enroll in a platinum plan concerned she may have a high risk pregnancy but after the pregnancy, may want to move back to a silver plan. As another example, an individual may gain a dependent who has a disability and the plan selection should not be limited to merely adding the dependent to the enrollee's same plan or same level plan.

HHS seeks comment on whether an individual gaining an SEP due to new eligibility for cost-sharing reductions should be limited to only enroll in a silver QHP. While we recognize that most individuals newly eligible for cost-sharing reductions would benefit from enrolling in a silver plan to gain the benefits of the cost-sharing reductions, some consumers may have valid reasons for wanting to enroll in other metal plans and should not be restricted just because they have enrolled through an SEP since if they enrolled during open enrollment, they would be able to forego the silver plan and cost-sharing assistance if they so wished. That said, we do recognize the benefits of enrolling in a silver plan and thus believe consumers should receive sufficient information about the potential downsides of enrolling in a different metal plan to make an informed choice. But ultimately, consumers should have the choice.

We recognize HHS may have concerns about individuals using an SEP to "simply switch levels of coverage during the coverage year." But with the limitations of the eligibility verification and that switching plans comes with other potential problems for consumers – resetting deductibles and out-of-pocket costs – we believe consumers should have the choice and opportunity to do what is right for themselves and their families rather than be limited by regulation to continuing enrollment in the same plan. We also believe HHS should provide SBMs the option to utilize these limitations rather than be forced to adopt them. As mentioned above, SBMs know their states and their markets and may have valid reasons not to adopt similar restrictions.

f. Payment of Past Premiums

We are concerned that HHS proposes allowing an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe this is discriminatory, in particular, against low-income consumers who may not have had the ability to pay premiums if they incurred significant medical costs before meeting a deductible or out-of-pocket maximum.

Other reasons may exist why an issuer believes a consumer has not paid premiums when the consumer actually has or attempted to. We have worked with a number of consumers who received erroneous bills and attempted to work with their insurer to determine the correct amounts to pay. Sometimes insurers did not accurately credit the amount of a tax credit or cost-sharing reduction, sometimes insurers did not match consumer's payments with the consumer's account, sometimes insurers cancelled a consumer's coverage despite a consumer paying. Due to the potential for insurer error, we believe that if HHS is going to permit insurers to reject enrollment, two preconditions must be met:

1. The insurer must provide verification to HHS and the consumer of the non-payment;
2. The insurer must allow the consumer a reasonable opportunity to dispute the insurer's information and provide documentation of payment.

Secondly, even if an insurer does verify that a consumer did not pay premiums, we believe HHS should provide a waiver of this requirement for consumers who can document paying significant out-of-pocket costs for care or other relevant circumstances during the time premiums were not paid. For example, if a consumer incurred health care bills that exceeded the premium amounts, we believe the consumer should not have to repay the premiums since meeting the deductible may have been out-of-reach for the consumer. Or if the consumer can document a job loss or having suffered a serious medical incident that prevented paying the premiums, this should also be accepted for a waiver of paying past premiums. While we recognize insurers need to receive timely premiums, we also recognize that there must be a balance when consumers are unable to pay their bills due to exceptional circumstances and that other avenues exist for helping insurers compensate for consumers such as these.
We are also concerned about this proposal from a geographical perspective. That is, this proposal can discriminate against consumers merely due to where they live. If the consumer lives in a geographical area with only one issuer (which is the case in a number of counties across the country), these consumers will have no alternative but to enroll in a plan where they must first pay back premiums or be rejected. Consumers in geographic areas with a choice of plans may be able to enroll in a different plan and

thus not be subject to the back payment requirement. We do not believe that a policy that likely will be implemented to the detriment of consumer merely based on geography should be adopted by HHS.

HHS also stated that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and thus HHS should ensure that any verification must provide consumers with an opportunity to provide additional or contrary information that may negate information from an insurer.

g. *Marriage SEP*

HHS proposes that if a consumer is newly enrolling through the Exchange pursuant to an SEP obtained for marriage that at least one spouse demonstrate having had minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage. We are concerned about this limitation for a number of reasons.

First, some individuals who marry may have been ineligible for Exchange coverage during the 60 days prior. This is especially likely in Medicaid non-expansion states. Both individuals may have been below 100% FPL in an non-expansion state and thus in the coverage gap. A marriage could increase their joint income to over 100% FPL and make them both newly eligible for coverage yet the proposed rule would not allow them to enroll. This also has a geographical bias since many of the states that did not expand Medicaid are in the southern part of the country which also has the higher uninsured rates and higher rates of poverty.

We do appreciate the recognition of an exception for individuals living abroad or in a U.S. territory. We strongly urge HHS to maintain this exception and not to require an onerous burden of proof to document a foreign or territorial residence.

h. *Permanent Move SEP*

We have similar concerns about the requirement for prior coverage as a predicate for obtaining a permanent move SEP. Some individuals may not have been eligible for coverage in the area they moved from (e.g. a Medicaid non-expansion state) and thus should not be penalized and made ineligible for an SEP.

Further, individuals who are survivors of domestic violence may have been prevented by their abuser from obtaining coverage. If these individuals permanently move away

from their abusers, they should not be prevented from newly enrolling in coverage because they did not have prior coverage. While they may have a separate eligibility path as a survivor of domestic violence, there may be reasons survivors do not know about the alternative pathway and come in through an SEP.

IV. § 156.140 – Levels of Coverage (Actuarial Value)

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

We believe this policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[8]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis

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[8] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[9]

Instead, we encourage HHS to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to HHS can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds HHS's authority and undermines the plain meaning of the statute.

Contrary to the proposed rule's assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee's income. Any reduction in gross premium amounts will

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[9] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of $25,000. This individual's expected contribution towards premiums is 6.8% of income or $1,700. If the person selects the benchmark plan, his/her net premium will be $1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with HIV, hepatitis C, and other chronic conditions who depend on access to plans with a higher actuarial value to defray high cost sharing. Consider three possible silver benchmark plans:[10]

Benchmark Plan Costs, 2018						
Actuarial Value	Gross Premium	Deductible	Maximum Out-of-Pocket	Co-Insurance	Advance Premium Tax Credit	Net Enrollee Premium*
70	$4,138	$1,600	$7,200	30%	$2,438	$1,700
68	$4,020	$2,100	$7,200	30%	$2,320	$1,700
66	$3,902	$2,750	$7,200	30%	$2,202	$1,700

* *Examples assume consumer enrolls in the benchmark second lowest cost sliver level plan; net premium amount would increase if consumer enrolled in a higher AV plan*

While reductions in actuarial value reduce gross premiums, they do not reduce the net enrollee premium when selecting the benchmark plan resulting in less purchasing power for the consumer. Deductible increases allowed by the actuarial value reductions, however, will discourage enrollment, leading to a death spiral.

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[10] Actuarial values were calculated using the 2018 Actuarial Value Calculator for silver plans. Premiums assume 85 percent of costs are medical and 15 percent are administrative. Advance premium tax credit is based on a $25,000 income for a single 35 year-old enrollee, resulting in a $1,700 expected annual contribution from the enrollee and a $2,438 tax credit on average nationwide. This example assumes enrollment in the benchmark second lowest-cost sliver level plan. The applicable income percentage and gross premium for the 70 percent actuarial value plan were calculated using the Kaiser Family Foundation's 2017 Health Insurance Marketplace Calculator.

To stabilize the Marketplaces, HHS should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Under the plans above, using the 70 percent actuarial value plan as the benchmark would result in a 15 percent net enrollee premium reduction for enrollment in the 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease will likely spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan.

Impact of Requiring 70 Percent Actuarial Value (AV) Benchmark Plan					
Actuarial Value	Gross Premium	Advance Premium Tax Credit (70 AV benchmark)	Net Enrollee Premium ($)	Net Enrollee Premium Reduction (%, compared to benchmark contribution of $1,700)	Increased Deductible (compared to $1,600 under 70 AV benchmark)
68	$4,020	$2,438	$1,582	7.0%	$500
66	$3,902	$2,438	$1,464	13.9%	$1,150

While we do not support expanding the de minimis actuarial value threshold to -4/+2 percent, if HHS finalizes this proposal, calculating the advance premium tax credit from plans with a true 70 percent actuarial value will reduce net enrollee premiums and encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

HHS must require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. HHS is given authority, however, to modify the out-of-pocket reduction only if it would "result in an increase in the plan's share of the total allowed costs of benefits provided under the plan" above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that HHS establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. HHS, then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We support the February 24, 2012 Actuarial Value and Cost-Sharing Reductions Bulletin's explanation for not establishing cost-sharing reduction plans with a 70 percent actuarial value for these enrollees, but this explanation depended on the availability of 70 percent actuarial value plans for these enrollees. We encourage HHS to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and HHS should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace

enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

V. § 156.230 – Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. We have commended HHS for these steps, which are crucial to making the promise of care in the Affordable Care Act real. NHeLP has written extensively about the importance of network adequacy for low-income consumers, in particular.[11] Over time, HHS has made significant improvements to the regulations at sections 155.1050 and 156.230, in defining the network adequacy standards to which QHPs will be held. As a result, we have seen fewer lawsuits and consumer complaints regarding network adequacy issues in QHPs with each year the Exchanges operate. Even still, we have urged HHS to adopt more stringent regulations in this area, as the current regulations do not fully ensure that consumers who enroll in QHPs will have access to adequate networks.[12]

Thus, the proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

a. HHS should not rely on state reviews for network adequacy

[11] *See, e.g.,* ABBI COURSOLLE, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE REGULATIONS: NETWORK ADEQUACY & ACCESS (2016), http://www.healthlaw.org/publications//Brief-3-MMC-Final-Reg; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to J.P. Wieske, Nat'l Assn. Ins. Comm'nrs (Jan. 12, 2015), http://www.healthlaw.org/publications/search-publications/NAICS-Comment; NHELP, NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), *available at* http://www.healthlaw.org/issues/medicaid/network-adequacy-in-medicaid-managed-care.

[12] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. 13-18 (Oct. 6, 2016), http://www.healthlaw.org/issues/medicaid/services/Comments-ACA-Benefit-Payment-Parameters.

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires HHS of HHS to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated HHS of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged HHS with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

We appreciate that HHS's current proposal will require issuers (save MSP issuers) in the FFE to meet HHS's "reasonable access standard," or state standards approved by HHS. While we support HHS's leaving the states and OPM with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, HHS must establish a clear national floor for network adequacy in these regulations, and monitor compliance with those national standards itself. HHS should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. Leaving network adequacy standards to the discretion of states has resulted in consumer protections varying widely across state lines. The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

b. HHS's "reasonable access" standard is not a sufficient measure of network adequacy.

HHS has never explained how its "reasonable access" standard is measured or monitored. Thus we have little information to assess whether the "reasonable access" standard has been successful in ensuring access in the past. We are therefore

disappointed that HHS is proposing to revert to this standard, rather than adopting precise quantitative standards that would help insurance regulators, consumers, providers, and advocates to evaluate what constitutes "reasonable access." We recommend that HHS instead move forward with its prior proposal of establishing a national baseline for time and distance standards.

c. *HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.*

We disagree with HHS's proposed approach of replacing time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their accreditation does not replace the existence of such standards.[13] Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We have previously urged HHS to adopt more stringent standards, including specific time and distance standards.[14] In 2015, we commended HHS for taking the step to establish specific time and distance standards for QHPs, and urged HHS to adopt these standards in regulation, rather than its Letter to Issuers.[15] We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

VI. § 156.235 – Essential Community Providers

We urge HHS not to reduce the percentage requirement for ECPs. In the past, we have expressed our appreciation for HHS's continuing efforts to ensure that QHP networks include essential community providers (ECPs), including by requiring issuers to enter contracts with at least 30% of available ECPs in the service area.[16] We encouraged HHS to consider increasing the percentage required in future years.[17] Instead, HHS is proposing to go backward, and reduce the percentage to only 20%. This reduction

[13] For a discussion of the role that accrediting agencies can play in this regard, see Letter from Emily Spitzer, Nat'l Health Law Prog., to CMS Desk Officer 11-14 (June 18, 2012), http://www.healthlaw.org/publications/search-publications/nhelp-comments-on-ffe-and-state-and-state-partnership-exchanges.

[14] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 59-61 (Dec. 21, 2015), http://www.healthlaw.org/issues/health-care-reform/2017-Parameters.

[15] *Id.*

[16] Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 10 (Jan. 15, 2016), http://www.healthlaw.org/issues/health-care-reform/exchanges/Comments-Draft-2017-Letter.

[17] *Id.*

represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

We also urge HHS to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

VII. Applicability of Executive Order 13771

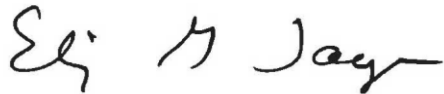
We do not support the goals of Executive Order 13771 that requires repeal of two regulations for any new regulation. That said, the NPRM includes a finding that this proposal does not trigger the requirements of EO 13771 and we believe this decision

should also apply to the rule once finalized. Making a change between a NPRM and a final rule would prevent public comment on the reasons for a change in the decision.

VIII. Conclusion

Thank you for consideration of our comments. If you have any questions, please contact Mara Youdelman, Youdelman@healthlaw.org or 202-289-7661,

Sincerely,



Elizabeth G. Taylor
Executive Director

Comment separator page. Next comment follows.

NATIONAL
IMMIGRATION
LAW CENTER

March 7, 2017

Patrick Conway
Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. The National Immigration Law Center (NILC) is recognized for its expertise in the intersection of health care and immigration laws and policies, offering technical assistance, training, and publications to government agencies, labor unions, non-profit organizations, and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

We have significant concerns about the proposed rule's overall effect on immigrant and other consumers' ability to enroll in quality, comprehensive, affordable health coverage through the marketplaces.

While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, the proposed rule does not provide the correct or appropriate solutions to the problem. If implemented, the Administration's proposals could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage.

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I. § 147.104 – Guaranteed Availability of Coverage

HHS's proposed premium payment policy would allow issuers to require consumers to pay past due premiums before resuming coverage (with the same issuer) in a subsequent year. We strongly disagree with this policy, which will have a disproportionate burden on lower income individuals. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

Moreover, we believe the proposed reinterpretation of the guaranteed availability provision is unlawful. The statutory language is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods. HHS does not have authority to expand these restrictions to include prior non-payment of premiums. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

Beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We are aware of numerous situations in which consumers paid their premiums but the issuers failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, or failed to cancel consumers' plans when requested. Consumers who attempted to fix these issues with their issuers often faced numerous administrative and bureaucratic hurdles. These administrative errors were no fault of the consumers, but could be interpreted as a consumer's failure to pay premiums.

Consumers living in areas where only one issuer participates in the marketplace would be disproportionately affected by such a rule. While consumers living in areas with multiple issuers could enroll in a different issuer's plan, consumers in areas with only one issuer would be unable to obtain health coverage without repayment of past premiums, even if the existence or amount of that debt was disputed.

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking

effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information.

- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a specified amount. HHS should supply standard language for this notice.
- Issuers should be required reinstate coverage if a consumer is making, or agrees to make, payments on prior months' premiums.
- Consumers who have disputed a bill or otherwise attempted to resolve a disagreement with an issuer regarding an amount of premiums owed should not be prevented from restarting coverage due to nonpayment of the disputed amount.

Any notices issued under the proposed rule must meet the standards for accessibility by persons with limited proficiency in English under 45 CFR §155.205(c).

Further, any such policy must provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" for consumers who can document paying significant out-of-pocket costs for healthcare or other relevant circumstances, such as the loss of employment, during the time premiums were not paid.

II. § 155.410 – Initial and Annual Open Enrollment Periods

We are concerned about the proposal to reduce the length of the annual open enrollment period. While we recognize the efficiencies gained by having consumers enroll for a full year (by enrolling before December 15th), past experience has shown that consumers, navigators and assisters need more than a month and a half to complete enrollments.

HHS argues that shortening the open enrollment period will limit adverse selection and leave insurers with a healthier pool. But people with existing medical needs can be expected to be the most diligent about signing up for insurance. A shorter open enrollment period could easily lead to a less-healthy, costlier risk pool.

Further, ending the open enrollment period in December, when many consumers have heightened financial constraints and are distracted by the holiday season, is

problematic.[1] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[2]

We also urge HHS not to require state based marketplaces (SBMs) to adopt a shorter enrollment period. The SBMs are in the best position to determine their own enrollment periods which may factor in state-specific issues.

III. § 155.420 – Special Enrollment Periods

We have strong concerns about the proposal to require pre-enrollment verification of eligibility for SEPs. Any requirement for verification has the potential to depress enrollment and should be implemented in a manner designed to be the least burdensome to consumers. Immigrant consumers, in particular, have experienced a great deal of frustration with existing verification processes, such as lengthy times between document submission and review, trouble uploading documents, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues. Adding pre-eligibility verification could jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the Federally Facilitated Marketplace (FFM) such that only the sickest and costliest consumers pursue SEPs. In addition, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

Consumers already attest under penalties of perjury to the information provided in their applications. Rather than require pre-eligibility verification submission, HHS should conduct post-eligibility audits of randomly selected consumers, as does the IRS. The information from such audits could be used to identify whether any particular basis of eligibility for an SEP was associated with fraud and required more monitoring. Unlike pre-eligibility verification, this approach would not create a barrier to enrollment. Requiring pre-eligibility verification would be unnecessary and burdensome for both consumers and the FFM.

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[1] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[2] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.

Changing Plan Levels

We believe HHS' proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1) While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We thus oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

New Eligibility for Cost-Sharing Reductions

HHS seeks comment on whether an individual gaining an SEP due to new eligibility for cost-sharing reductions should be limited to enrollment in a silver Qualified Health Plan (QHP). While we recognize that most individuals newly eligible for cost-sharing reductions would benefit from enrolling in a silver plan, some consumers may have valid reasons for wanting to enroll in other metal-level plans. That said, we recognize the benefits of enrolling in a silver plan and believe consumers who are eligible for CSRs need additional information about the benefits of enrolling in a silver plan, both during SEPs and at initial enrollment. We frequently encounter consumers who are income-eligible for CSRs and are struggling to meet the out of pocket expenses associated with a bronze plan they selected because of its lower premium.

Payment of Past Premiums

As noted earlier, we oppose the proposal to allow an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe that such a requirement would be particularly burdensome to low-income consumers and those who reside in markets where there is only one issuer.

HHS states that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and likewise oppose this proposal.

Marriage SEP

HHS proposes that if a consumer is newly enrolling through the Exchange pursuant to an SEP obtained for marriage that at least one spouse demonstrate having had minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage. We are concerned about this limitation for a number of reasons.

First, some individuals who marry may have been ineligible for Exchange coverage during the 60 days prior. This is especially likely in Medicaid non-expansion states. Both individuals may have been below 100% FPL in a non-expansion state and thus in the coverage gap. A marriage could increase their joint income to over 100% FPL and make them both newly eligible for coverage yet the proposed rule would not allow them to enroll.

We do appreciate the recognition of an exception for individuals living abroad or in a U.S. territory. We strongly urge HHS to maintain this exception and not to require an onerous burden of proof to document a foreign or territorial residence. Moreover, individuals who come to the United States with ‘fiancé visas’ are required to get married with 90, not 60 days and are likely to be in the U.S. for more than 60 days on the date of their marriage, despite having previously resided abroad. The exception should be made consistent with the 90-day time period.

Permanent Move SEP

We have similar concerns about the requirement for prior coverage as a predicate for obtaining a permanent move SEP. Some individuals may not have been eligible for

coverage in the area they moved from (e.g. a Medicaid non-expansion state) and thus should not be penalized and made ineligible for an SEP.

Elimination of Certain SEPs Affecting Immigrants

HHS proposes to eliminate several SEPs established to address errors that occurred during the early years of the Affordable Care Act's (ACA's) implementation. These include an SEP for lawfully present immigrants with incomes below 100% of the FPL who are eligible for marketplace coverage because their immigration status makes them ineligible for Medicaid. Marketplace eligibility for this group of consumers is not widely understood, and many affected consumers have experienced lengthy delays in enrollment. It is no way clear that the need for this SEP has ended, and it should remain available until there is evidence that this group of consumers is accessing coverage without delay.

State Based Exchanges

HHS requested comment on whether SBMs should be required to conduct pre-enrollment verification. We oppose pre-enrollment verification of eligibility for SEPs in SBMs because it is a barrier to enrollment. In the event pre-enrollment verification is adopted on the FFM, SBMs should be able to determine their own policies and processes for SEPs, just as they have the authority to adopt SEPs that the FFM does not use. States need the ability to respond to their individual market needs and we do not see a need for a uniform national policy in this situation, especially since we have significant concerns about HHS' policies on this topic.

IV. § 156.140 – Levels of Coverage (Actuarial Value)

We oppose the proposed expansion of the de minimis actuarial value (AV) variations. We believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

We believe this proposal would open the door for insurers to sell plans with higher deductibles, and would reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy would shift significant costs to families, either through higher premiums or higher cost-sharing, and would likely reduce enrollment due to cuts in financial assistance. The proposed rule would do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it would likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent seems like a small adjustment, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[3]

This policy would be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage would effectively reduce the size of the premium tax credits these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[4] Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with HIV, hepatitis C, and other chronic conditions who depend on access to plans with a higher actuarial value to defray high cost sharing.

Moreover, the proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds the Secretary's authority and undermines the plain meaning of the statute.

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[3] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

[4] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

V. § 156.230 – Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. The proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and to cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to healthcare through Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need, without delay.

HHS should not rely on state reviews for network adequacy

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires the Secretary of HHS to establish network adequacy requirements for

health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated the Secretary of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged the Secretary with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

HHS must establish a clear national floor for network adequacy, and monitor compliance with those national standards itself. The Secretary should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.

We disagree with HHS's proposal to replace time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their accreditation does not replace the existence of such standards.[5] Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

[5] For a discussion of the role that accrediting agencies can play in this regard, see Letter from Emily Spitzer, Nat'l Health Law Prog., to CMS Desk Officer 11-14 (June 18, 2012), http://www.healthlaw.org/publications/search-publications/nhelp-comments-on-ffe-and-state-and-state-partnership-exchanges.

VI. § 156.235 – Essential Community Providers

We urge HHS not to reduce the percentage requirement for essential community providers (ECPs) to 20% of a plan's network. ECPs play an essential role in delivering healthcare to immigrant communities. ECPs' linguistic and cultural capacity often surpasses that of other health providers in their area. Many are trusted community institutions that provide space for community meetings and information and referrals that help recent immigrants integrate into their new communities.

The proposed percentage reduction would harm beneficiaries without providing any meaningful reduction in issuer costs. The vast majority of issuers have been able to establish networks with 30 percent ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks to conform with the 30% requirement, demonstrating that there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through dangerous interruptions in treatment and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

Thank you for consideration of our comments. If you have any questions, please contact Gabrielle Lessard, lessard@nilc.org.

Respectfully,

Gabrielle Lessard
Senior Policy Attorney

Comment separator page. Next comment follows.

As someone who recently went through the experience of enrolling in a plan on the California ACA health insurance exchange after moving back to California, I'm concerned that these new rules would place undue burdens on people trying to enroll in health plans. The requirement that people who enroll in a plan outside of the standard open enrollment season provide supporting documentation would have been an extra burden for me that would have slowed my enrollment in a health plan after moving back to California from living abroad. While I understand that insurance companies want to make sure people aren't taking advantage of the special enrollment provision, I urge the Department of Health and Human Services to either get rid of the requirement for supporting documentation or make it very easy for consumers by being flexible in the type of documents you will accept and speedy in approving the documentation. If I had had to wait for weeks while waiting for approval of supporting documentation I submitted with my application, I could have faced the risk of having no health insurance for an extended period.

I also want to express my disapproval with shortening the regular enrollment period. There can be all sorts of obstacles for people to sign up, and having gone through the process I know it can be stressful. Giving people less time seems certain to reduce the number of people enrolled and make things harder for people trying to gain access to affordable health care.

Finally, I'm concerned about allowing insurers to cover a smaller share of expected costs. I have a Silver plan and even then it is a struggle to pay for all my medical bills, which quickly add up if you have to have even a small procedure like an endoscopy. I can only imagine how little an insurer would cover at a lower level plan. What's the point of having insurance if you still can't afford the medical bills when something goes wrong?

Please consider the needs of vulnerable patients in making these new rules.

Comment separator page. Next comment follows.

Planned Parenthood®
Care. No matter what.

Planned Parenthood Federation of America

Planned Parenthood®
Act. No matter what.

Planned Parenthood Action Fund

March 7, 2017 –

VIA ELECTRONIC TRANSMISSION

The Honorable Thomas Price
Acting Administrator Patrick Conway
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: **CMS-9929-P; Patient Protection and Affordable Act; Market Stabilization**

Dear Secretary Price and Acting Administrator Conway:

Planned Parenthood Federation of America (Planned Parenthood) and Planned Parenthood Action Fund (the Action Fund) are pleased to submit these comments in response to the Market Stabilization proposed rule, released by the Department of Health and Human Services (the Department) on February 15, 2017 and published in the federal register on February 17, 2017 at 82 Fed. Reg. 10980 et. seq. As a trusted women's health care provider and advocate, Planned Parenthood supports the Department's commitment to seeking input from stakeholders as it continues to implement the Affordable Care Act (ACA) and ensure that qualified health plans (QHPs) in the Marketplace provide consumers throughout the nation with access to quality, affordable health care.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States (U.S.). Each year, Planned Parenthood's more than 650 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to nearly three million patients. One in five women in the U.S. has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL). Because many of Planned Parenthood patients are eligible to purchase their health insurance coverage through the Marketplaces, we have a special interest in ensuring that these individuals can enroll in QHPs that are able to meet their needs.

It is important that the Department continue to implement the statutory requirements of the ACA. In particular, we ask the Department to maintain the current length of the open enrollment period, remove barriers to accessing special enrollment periods, and maintain a strong federal network adequacy standard.

I. Section 155.410 – Initial and Open Enrollment Periods

The Department should, at a minimum, maintain the existing length of the open enrollment period.

The ACA requires, as codified at 42 U.S.C. § 18031(c)(6)(B), that the Secretary establish annual open enrollment periods. The most recent open enrollment period, which lasted from November 1 until January 31, provided a sufficient time for outreach and enrollment. We urge the Department not to significantly shorten the annual open enrollment period to November 1 through December 15. Limiting the open enrollment will not result in a healthier risk pool, but instead will result in fewer consumers enrolling in coverage during the open enrollment period – or fewer consumers enrolling in coverage at all. Unlike the Medicare population or those who have employer-sponsored insurance, consumers needing to purchase insurance on the Marketplace are not as naturally defined, and thus are not as easy to reach. A longer enrollment period will allow insurers and the Marketplaces additional time to reach consumers, and provide consumers additional time to shop for, select, and enroll in a QHP.

In fact, the remaining uninsured rate could be reduced with more effective outreach and enrollment efforts, according to a recent study.[1] The ACA has resulted in significant gains in insurance coverage with an additional 22 million individuals gaining insurance coverage and the uninsured rate being at an all time low; however, 32 million nonelderly people remain uninsured in the United States (the majority of whom are in working families). According to a recent study, nearly half of the uninsured are eligible for financial assistance on the Marketplace, but there is evidence that the majority of people in this population are unaware of the Marketplace or that financial assistance is available to purchase affordable insurance. A shorter open enrollment period limits the timeframe in which enrollment efforts can be conducted.

A shorter enrollment period will result in an older, sicker risk pool, resulting in significantly greater costs to insurance issuers. Young adults between 18 to 34 years old constitute the largest portion of the uninsured, and this population tends to be the healthiest, and thus, the most economically favorable to insure as they typically access the least health care services. Thus, a shorter enrollment period will not only negatively impact consumers access, but will also result in a more expensive risk pool, ultimately, increasing costs to issuers, the health care system, and American taxpayers.

II. Section 155.420 - Special Enrollment Periods

A. *We encourage the Department not to expand the pre-enrollment verification process for individuals seeking to enroll during an SEP.*

The ACA requires, as codified under 42 U.S.C. § 18031(c)(6)(C), the Department to establish special enrollment periods for the federal Marketplace whereby consumers who meet qualifying circumstances can enroll in coverage outside of the annual open enrollment period. The Department's proposals to expand the verification process to all consumers seeking to enroll during a SEP will further limit the number of consumers enrolling during a SEP and increase costs for the health care system. Marketplace enrollment already includes substantial verification processes. Moreover, currently few people who are eligible for SEPs are actually using them to enroll; a recent estimate found only five percent of those who are eligible for a SEP are enrolled during a SEP.[2] Increasing the verification processes will only result in people lacking access to care and will further increase

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[1] L. Blumberg, et. al., Urban Institute, Who are the Remaining Uninsured, and What do their characteristics Tell Us About How to Reach Them (March 2016), http://www.urban.org/sites/default/files/publication/79051/2000691-Who-Are-The-Remaining-Uninsured-And-What-Do-Their-Characteristics-Tell-Us-About_How-To_Reach_Them.pdf.

[2] S. Dorn, Urban Institute, Helping Special Enrollment Periods Work under the Affordable Care Act 1 (June 2016).

costs to our nation's healthcare system.

Annually over 33 million consumers lose coverage between open enrollment periods, for various reasons such as loss of employment.[3] Without SEPs, many individuals—most who unexpectedly find themselves uninsured—would almost certainly remain uninsured until the next enrollment period. A delay in enrolling in coverage could result in healthy individuals, including women of reproductive age, not being able to access essential care, such as preventive screenings, acute care, and prenatal services. The proposed rule estimates that an additional 650,000 individuals would have their enrollment delayed - this delay will result in more consumers forgoing or delaying care and needing to access costly treatment for a condition that could have been prevented or treated earlier. For instance, a delay in coverage could result in an enrollee delaying a HIV screening and not accessing antiretrovirals until their HIV has progressed and requires more costly and invasive treatment. A delay in accessing care is not only bad for the enrollee's health, but also bad for the insurance risk pool if consumers do not access care until it is most expensive.

Further, the Department is proposing to require individuals who are seeking to enroll in a SEP based on a recent move to submit additional documentation to prove previous and new addresses and evidence of prior coverage, and consumers seeking to enroll during an SEP due to marriage to prove at least one spouse had minimum essential coverage in the last 60 days. Both of these additional requirements, as well as the pre-enrollment verification process, will disproportionately impact young people and adversely impact the risk pool**.** Young adults are more likely to experience life transitions that could result in loss of coverage mid-year, such as moving for a job (which may not have health insurance) or getting married. Younger adults, who are also more likely to be healthier and contribute positively to the risk pool, are the least likely to complete the enrollment process through the Marketplace when they experience difficulty applying. In 2015, younger people were about a quarter less likely to finalize their enrollment than older consumers, a factor that has had a negative impact on the Marketplace's risk pool. Thus, additional verification processes have the potential to disproportionately impact young people and have a negative impact on the risk pool.

Moreover, it is not clear the FFM would be technically or operationally capable of implementing an SEP verification process in a manner consistent with the ACA's vision of a real-time, streamlined eligibility and enrollment system. We appreciate the Department's proposal to verify an individual's eligibility for SEPs electronically. However, CMS has not explained how the Department would verify eligibility for each SEP, how the operational side of the pre-verification process would operate. The proposed rule estimates that there will be additional administrative costs to the federal government from having a more rigorous verification process. Lastly, the Department proposes to only allow consumers to set their plan effective date one month after the application date so that the consumer can avoid paying retroactively for coverage they were not able to access while their documentation was pending. It is very realistic that it could take the Marketplace longer than a month to verify documentations. Only permitting the enrollee to set an effective date one month after originally assigned, regardless of when they receive an eligibility determination, could result in the enrollee owing retroactively for coverage that they were not able to access while their verification was pending.

B. *The Department should not limit the plans available to individuals who qualify for SEPs.*

The proposed rule would require individuals to enroll their dependent into the plan in which the enrolling

[3] S. Dorn, Helping Special Enrollment Periods Work under the Affordable Care Act (June 2016), http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

consumer is already enrolled or alternatively, the enrollee may enroll the dependent into a plan at the same metal level as the consumer's plan. Further, the proposed rule would only permit an individual who qualifies for a SEP based on gaining a dependent, who is also newly eligible for cost-sharing reductions, to be enrolled in a silver level plan.

If adopted, these proposals would disproportionately burden women. Individuals who qualify for a SEP based on gaining a dependent do so because they have given birth, adopted a child, or had a child placed for foster care in the home. After such a significant life change, the individual (most likely a woman) and the new dependent may have different health needs that a previous plan does not accommodate. For instance, a woman who has recently given birth may have experienced complications during birth may now have medical needs not covered under her previous health plan.

The proposed rule would also limit plan options for enrollees seeking to enroll in a SEP based on other qualifying life events such as gaining access to a new health insurance market based on a move or losing minimum essential coverage. This proposal does not represent a solution to an undocumented concern and, if adopted, would lessen competition in the health insurance marketplace among consumers that require a new health plan due to changing life circumstances. In short, this proposal only limits consumers ability to choose the plan that best meets consumers' and their families' needs.

C. *The Department should not exclude individuals who have experienced a gap in coverage due to non-payment.*

The Department's proposal to prohibit a consumer from enrolling in a SEP for loss of coverage when the loss of coverage was due to non-payment of premiums would disproportionately impact low or moderate-income consumers. An individual should not be completely blocked from accessing coverage during an SEP because they have had difficulty paying their premiums in the past. This could lead to individuals not being able to access coverage at all if they are in a state where there are no individual plans sold outside of the Marketplace. In states where individual plans are sold outside of the Marketplace, consumers would be blocked from accessing the financial assistance available on the Marketplace. Eighty-five percent of consumers rely on the financial assistance available on the Marketplace to purchase plans.[4] Given the gap in earning for women - U.S. women employed full time losea total of $840 billion annual - women may be more likely to have missed a premium payment and disproportionately impacted by being blocked from enrolling in coverage.[5] Those who have had difficulty affording insurance are the very individuals who need the financial assistance available on the Marketplace.

III. Section 156.230 - Network Adequacy Standards

The Department should continue to meet its obligation to ensure that qualified health plans provide reasonable access to providers.

Demonstrating Congress's focus on ensuring access to health care providers, the ACA requires health plans to maintain a network that is sufficient in number and types of providers to assure that all covered services are

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[4] A. Simmons et.al., Dept. of Health & Hum. Servs., ASPE Issue Brief - The ACA: Promoting Better Health for Women 2 (June 14, 2016), https://aspe.hhs.gov/sites/default/files/pdf/205066/ACAWomenHealthIssueBrief.pdf.

[5] National Partnership for Women and Families, America's Women and the Wage Gap (Oct. 2016), http://www.nationalpartnership.org/research-library/workplace-fairness/fair-pay/americas-women-and-the-wage-gap.pdf.

accessible without unreasonable delay. In particular, the ACA requires the Department to establish network adequacy requirements for insurers seeking QHP certification.[6] The Department should continue to articulate and enforce federal network adequacy requirements. It is a departure from the statute for the Department to solely rely on states to assess QHPs provider networks.

Network adequacy is a key component to ensuring meaningful health care access and a critical element to ensuring an efficient (and cost-contained) health care system. Yet, consumer experiences in accessing providers vary across states, with some state standards assessing travel time and distance, others provider-to-enrollee ratios, others appointment wait time, and the extended hours of operation.[7] Further, states' processes to regulate and assess plan's provider networks also vary. This variety highlights the need for a federal minimum floor to which insurers must adhere and helps ensure that consumers can still participate in a competitive and quality health insurance market regardless of where they live. It is also not sufficient under the statute to rely on accrediting bodies to assess provider networks. Moreover, from a policy perspective, the proposed accrediting body standard is a piecemeal approach to assessing provider networks. The Department must establish a strong network adequacy standard for Marketplace issuers in all states, including the FFM, SBM-FPs, state-based Marketplaces, and Partnership Marketplaces.

Currently, consumers experience problems accessing needed care, according to a study published in the New England Journal of Medicine. Women, in particular, have difficulty finding plans that provide them sufficient access to the health care providers they need. Specifically, the study found that 13 percent of qualified health plans did not have a provider in network for at least one specialty within a 100 mile radius, including some plans that did not have an OB/GYN.[8] Nearly, 60 percent of women report seeing their OB/GYN regularly, and 35 percent describe their OB/GYN provider as their main source of care. Indeed, for many women, OB/GYNs are their gateway to the broader health care system.[9] Network adequacy standards must be strong and ensure that networks are sufficient to meet women's health needs and provide timely access to providers that specialize in women's primary health care, including family planning care, women's preventive services, and pregnancy-related care. Relying on existing state standards, unfortunately, will not remedy existing network adequacy challenges and, in particular, will continue to create a health care system that does not reflect the unique needs of women.

To ensure that Marketplace enrollees across the country have timely access to appropriate, geographically accessible providers who can deliver the health services covered under their plans, the Department should not only continue its current practice of using time and distance standards to assess provider networks, but also adopt stronger network adequacy standards in regulation to uphold and meaningfully implement the statutory requirements for network adequacy under the ACA. The Department should establish a broad set of metrics and criteria that includes, but is not limited to: time and distance standards; provider-to-enrollee ratio minimums;

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[6] 42 U.S.C. § 18031(c)(1)(B). Also, section 156.230(a)(2) of the federal regulations requires all issuers offering Marketplace plans to maintain a network that is sufficient in number and types of providers to assure that all covered services are accessible without unreasonable delay.

[7] J. Giovanelli, Commonwealth Fund, Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks (May 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

[8] Dorner SC, Jacobs DB, Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA.*2015; 314 (16):1749-1750. doi:10.1001/jama.2015.9375, available at http://jama.jamanetwork.com/article.aspx?articleid=2466113#Discussion.

[9] PerryUndem Research & Communication. "Women & OB/GYN providers". Research conducted for Planned Parenthood Federation of America, November 2013.

availability of providers accepting new patients; assessment of the range of provider types in a plan's network; and appointment wait time standards. Recognizing the existing challenges for women's health access, it is critical that federal network adequacy standards also include metrics that ensure access to a broad range of women's health services, including family planning services and pregnancy-related care. Improving upon the existing federal network adequacy standards will help ensure that plan networks meet the needs of consumers and provide timely access to covered services. This will ultimately help the healthcare system because it will prevent people from accessing care when they are sickest and care is most expensive.

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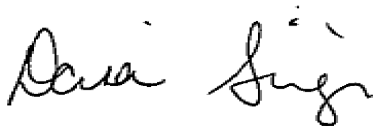
Thank you for the opportunity to comment on the Market Stabilization rule. If you have any questions, please do not hesitate to contact me at 202-973-4800.

Respectfully submitted,



Dana Singiser
Vice President of Public Policy and Government Relations
Planned Parenthood Action Fund
Planned Parenthood Federation of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005

Comment separator page. Next comment follows.

February 28, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929- P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: RIN 0938-AT14 Patient Protection and Affordable Care Act; Market Stabilization

Raising Women's Voices for the Health Care We Need is a national initiative working to ensure that the health care needs of women and our families are addressed as the Affordable Care Act is implemented. We have a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, women with disabilities, and members of the LGBTQ community. We place a priority on asking women to share their experiences navigating the health care system. Because of women's roles as arrangers of health care for our families, we believe women are grassroots experts in what is wrong with the current health system and what it will take to fix it.

We appreciate the opportunity to provide comments to the Department of Health and Human Services (HHS) on the proposed rule regarding market stabilization for the individual and small group markets.

We understand that the uncertainty caused by the current health policy debate in Congress may have implications for the stability of the individual health insurance market in many states. We support federal and state efforts to allay uncertainty among both issuers and consumers and to increase robust competition in the Marketplaces for the 2018 plan year. However, we believe that curbing vital consumer protections with regard to affordability and access is not the way to address stability and that many of the proposed changes to individual market regulation, if enacted, will in fact serve to limit enrollment and competition in the individual market and thereby harm consumers who depend on the marketplace for coverage.

To promote robust enrollment and competition in the individual health insurance market, we urge HHS to consider the recommendations and comments detailed below.

OPEN ENROLLMENT PERIOD LENGTH (45 CFR §155.410(e))
We recognize that eventually moving to an open enrollment period that does not cross two plan years will be administratively simpler and more efficient. However, we are concerned that given the uncertainty and confusion that surrounded the final days of the 2017 open enrollment period as well as the ongoing uncertainty that congressional health policy debates have caused, the 2018 plan year is too soon to dramatically shorten the open enrollment period and will ultimately prevent robust enrollment and a balanced risk pool.

We urge HHS to maintain the existing open enrollment period, **or at least allow open enrollment until December 31, 2017**. If HHS decides to move forward with a shortened open enrollment period for the 2018 plan year, we strongly support additional consumer outreach and education activities to ensure that consumers understand the new timeline and the importance of enrolling in coverage. This includes additional resources for Health Insurance Navigators and other assisters and a robust educational campaign to promote enrollment.

SPECIAL ENROLLMENT PERIODS (45 CFR §155.420)
Special Enrollment Periods (SEPs) have been an important consumer protection to ensure access to health insurance following a significant life event or evidence of extenuating circumstances that prevented enrollment during the open enrollment period. Absent evidence of abuse (which has not been documented or shown), we do not support proposals that seek to limit availability of SEPs.

We urge HHS to maintain current SEP application and verification standards. Creating burdensome documentation requirements before someone may enroll in a plan, particularly absent evidence of consumers abusing SEPs, will only serve as an enrollment barrier for individuals who have in fact had a qualifying life event. We believe that the current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, should be left in place.

As we noted in October, we remain concerned with administrative barriers intended to prevent fraud that instead hamper enrollment of eligible people. It is not surprising that insurers report higher medical claims costs among people who enroll using SEPs than they see among people who enroll during the annual open enrollment period: people who expect to need medical care are the most motivated to seek out information about and follow through on enrollment through an SEP. **Healthier people are more likely to drop out of the enrollment process if they must take additional steps to document or prove their eligibility for an SEP.** Thus, the current post-enrollment confirmation process started in July likely makes the insurance pool sicker instead of healthier. Furthermore, if the drop in special enrollment period plan selections in 2016 as reported by CMS in the September 2016 FAQ is not due to the curtailment of fraudulent enrollment but rather to the healthiest and thus least motivated people giving up in the face of additional paperwork requirements, then the confirmation process undermines the pool.

Furthermore, the proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to “accept every employer and individual in the State that applies for such coverage.” (42 U.S.C. § 300gg–1) While issuers “may restrict enrollment … to open or special enrollment periods,”

this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that: defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

CONTINUOUS COVERAGE

As we stated above, we believe that continuous coverage requirements are antithetical to the guaranteed issue consumer protections of the ACA. Imposing waiting periods before enrollment, pre-existing condition exclusions, and penalties for people who experience a gap in insurance coverage will harm consumers, particularly those who may be living with disabilities or with serious chronic conditions who are more likely to experience changes in employment and life circumstances throughout the year. Additionally, we note that individuals who need care but are denied coverage due to such rules are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on.

GUARANTEED AVAILABILITY (45 CFR §147.104)

The proposed reinterpretation of the guaranteed availability provision is unlawful and outside the Secretary's authority. We encourage the Secretary to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and the Secretary does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace

(FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and the Secretary must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments. The Secretary should establish procedures, however, for past due premiums to be pro-rated and added to the insurance premiums for the following year (or partial year, in the case of a special enrollment period) for the enrollee. This would allow issuers to recoup past due premiums while respecting the statutory requirement to accept all applicants. Consistent with statute, issuers could not deny or terminate enrollment for failure to pay the pro-rated past due amount if the current premium is paid; the pro-rated repayment option simply facilitates an issuer's collection of debts that could be recouped under other legal remedies.

Pro-rating the past due amount will facilitate beneficiary re-payment and enrollment in the prior issuer's plan, as requiring the full past due amount at enrollment may be financially impossible for many enrollees. We urge the Secretary to develop clear procedures to notify consumers beneficiaries of past due amounts at the time of plan selection, the pro-rated repayment schedule, and an opportunity to contest the past due amount.

Importantly, many consumers only have access to plans from one issuer due to limited Marketplace competition. Under the Secretary's proposal, if these consumers are unable to fully repay past due premiums upon enrollment, they will be completely unable to obtain any coverage. We believe the possibility of such lockouts could have a chilling effect on enrollment by healthier individuals, especially those with limited incomes, because they might worry that if they do not maintain continuous coverage they will never again be able to purchase insurance and access care when they need it. Pro-rated repayment plans will facilitate these consumers' re-entry into the insurance market, supporting Marketplace stability. Without affordable repayment plans, these consumers may postpone enrollment until they are sick, increasing adverse selection. Clear guidelines on pro-rated re-payment plans are necessary to protect consumers and encourage them to re-enter the marketplace, particularly in jurisdictions with only one issuer.

We support the Secretary's proposal to allow issuers to develop a premium payment threshold policy. Issuers could, for example, allow a beneficiary to pay 60 percent of the past due amount in one payment at enrollment and have the balance of the past due amount forgiven rather than participate in an installment re-payment. Issuers should be allowed to experiment with these repayment models so long as they offer an annualized installment option for the full past due amount. The issuer must be required to provide consumers with a clear and consumer-friendly explanation of all repayment options when the issuer enrolls the past-due consumer.

ACTUARIAL VALUE DE MINIMIS VARIATION (45 CFR §156.135)

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that

the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to “account for differences in actuarial estimates.” (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is “to help issuers design new plans for future plan years, thereby promoting competition in the market.” The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation “to account for differences in actuarial estimates.” The proposed expansion exceeds the Secretary’s authority and undermines the plain meaning of the statute.

Contrary to the proposed rule’s assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee’s income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of $25,000. This individual’s expected contribution towards premiums is 6.8% of income or $1,700. If the person selects the benchmark plan, his/her net premium will be $1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax

credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

NETWORK ADEQUACY

We oppose any proposal that erodes critical network adequacy standards and that would jeopardize access to providers. While we support efficient and non-duplicative monitoring and enforcement of insurance standards between state and federal regulators, we do not support using accreditation as a substitute for regulator enforcement. Because accreditation standards are not readily accessible, it will be impossible to determine adequate compliance with the ACA's network adequacy requirements with the only requirement being that plans have been accredited.

The proposal to defer network adequacy review to external accreditors is contrary to statute. The Secretary "shall, by regulation, establish criteria for the certification of health plans" to "ensure a sufficient choice of providers." (42 U.S.C. § 18031) These criteria must be subject to the full notice and comment requirements of the regulatory process. The proposed deferral to private standards, however, does not meet the requirements for criteria established by regulation, as the public is unable to review and comment on these private standards.

In states with robust network adequacy standards and review processes that are at least as protective as the ACA's federal standards and the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act (#74), we support deference to the state regulatory process. This must include quantitative time and distance standards. However, absent evidence of robust state monitoring and enforcement of network adequacy, HHS must step in to review plan justification of compliance with federal standards.

COMPRESSED PUBLIC COMMENT PERIOD

Finally, we would like to express concern that the public comment period for this proposed rule was so compressed. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the significant proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Thank you for your consideration of our comments. If you have any questions regarding these comments, please contact Sarah Christopherson, policy advocacy director for Raising Women's Voices and the National Women's Health Network (schristopherson@nwhn.org).

Sincerely,

Raising Women's Voices for the Health Care We Need

Comment separator page. Next comment follows.

I am writing to comment on CMS-9929-P. There are several proposed rule changes to the Affordable Care Act that are of concern. See my comments to the sections included in the bill.

First, we propose changing the dates for open enrollment in the individual market for the benefit year starting January 1, 2018, from a range of November 1, 2017, to January 31, 2018 (the previously established open enrollment period for 2018), to a range of November 1, to December 15. This change would require individuals to enroll in coverage prior to the beginning of the year, unless eligible for a special enrollment period, and is consistent with the open enrollment period established for the open enrollment periods for 2019 and beyond.

Shortening the time for enrollment would in effect provide a barrier to the number of people able to get coverage. Six weeks is not enough time for some who don't have a computer or transportation or need help in completing the enrollment, especially those who are older or with health conditions to get enrolled. This will destabilize the marketplace even further leading to increase cost of health care insurance and use of higher care alternatives such as the emergency departments.

The proposed amendments in this rule are also intended to affirm the traditional role of States in overseeing their health insurance markets while reducing the regulatory burden of participating in Exchanges for issuers. The first of these proposals relates to network adequacy review for QHPs. The modified approach would not only lessen the regulatory burden on issuers, but also would recognize the primary role of States in regulating this area.

Reducing regulations such as the essential health benefits will in fact mean insurance companies would not cover benefits that Americans need such as screening and preventive care. This would take away decisions from patients and doctors and give those decisions to insurance companies. In addition it would create different levels of care based on what state you live in and what that states coverage is. Less expensive provider networks will result in lower enrollment, especially for younger, healthier adults and that will increase premiums

The second we are proposing to add new paragraph (d)(2)(i)(A) to require that, if consumers are newly enrolling in QHP coverage through the Exchange through the special enrollment period for marriage, at least one spouse must demonstrate having had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage. However, we recognize that individuals who were previously living abroad or in a U.S. territory may not have had access to coverage that is considered minimum essential coverage in accordance with 26 CFR 1.5000A1(b) prior to moving to the U.S. Therefore, we propose that, when consumers are newly enrolling in coverage during the coverage year through the special enrollment period for marriage, at least one spouse must either demonstrate that they had minimum essential coverage or that they lived outside of the U.S. or in a U.S. territory for 1 or more days during the 60 days preceding the date of the marriage. This proposed change would only apply in the individual market. We seek comment on this proposal.

Again this proposal is creating a barrier to obtaining healthcare. There is no legitimate reason for requiring one spouse to have coverage prior to getting married.

For example, this rule proposes changes that would require consumers to demonstrate prior coverage to qualify for the special enrollment period for marriage in proposed paragraph (d)(2)(i)(A) and would generally limit plan selection to the same plan or level of coverage when an enrollee qualifies for a special enrollment period during the coverage year in proposed paragraph (a)(4). However, we believe that the differences in the markets – and the impacts of

This is creating barriers to coverage which will only serve to increase the number of people who will remain uninsured and thus increase ED visits. This will not create a large enough pool to keep the cost and deductibles low. Creating barriers such as pre-enrollment verification for special enrollment periods will result in lower enrollment especially from younger, healthier adults which will increase premiums for a plan that provides less coverage.

Third, we propose to expand the verification requirements related to the special enrollment period for a permanent move in paragraph (d)(7). This special enrollment period is only available to a qualified individual or enrollee who has gained access to new QHPs as a result of a permanent move *and* had coverage for 1 or more days in the 60 days preceding the move, unless he or she is moving to the U.S. from abroad or a U.S. territory. Currently, we require documentation to show a move occurred, and accept an attestation regarding having had prior coverage or moving from abroad or a U.S. territory. To ensure that consumers meet all the requirements for this special enrollment period, we propose to require that new applicants applying for coverage through this special enrollment period submit acceptable documentation to the FFEs and SBE-FPs to prove both their previous and new addresses and evidence of prior coverage, if applicable, through the pre-enrollment verification process. If finalized, we intend to release guidance on what documentation would be acceptable. We seek comment on this proposal.

By creating all these documentation regulations you have effectively reduce the number of people who will apply for healthcare. In addition you will be creating higher costs by increasing the documentation audit from 50% to 100%. If you are worried about people gaming the system it would be better to implement incentives to keep healthy people in the marketplace such as choice and affordable premiums with essential coverage. One way that could be implemented is providing Medicare for all Americans.

HHS is also interested in whether policies are needed for the individual market similar to those that existed under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA), which required maintenance of continuous, creditable coverage without a 63-day break in the group market if individuals wished to avoid the pre-existing condition exclusions, and allowed waiting periods to be imposed under certain circumstances. Although the HIPAA rules did not require that individuals maintain coverage, the rules were

designed to provide an important incentive for individuals to enroll in coverage year-round, not just when in need of health care services; reduce adverse selection; and help prevent premiums from climbing to levels that would keep most healthy individuals from purchasing coverage.

This fails to protect millions of Americans with pre-exiting conditions by limiting their access to healthcare if they can't afford the premiums. By requiring continuous coverage and creating barriers to obtaining that coverage you are effectively giving insurance companies that approval to charge a 30% penalty on premiums for an entire year. That will only decreases the number of Americans that can afford healthcare. This is a great deal for insurance companies but not so much for Americans.

Although none of their networks met the 30 percent ECP threshold, all of these justifications were deemed sufficient, and each network would have met the 20 percent threshold. We anticipate that issuers will readily be able to contract with at least 20 percent of ECPs in a service area.

This means that people living in rural areas will have to drive farther to get healthcare from providers in their plan. Reducing the ECP threshold to 20% will limit consumer's ability to obtain providers in their locality. This will increase out of pocket costs for consumers, especially those in rural areas. Without regulations to guarantee that every provider is qualified to provide services consumers will be left on their own to determine if the provider in the ECF is meeting basic provider standards.

As finalized in the 2018 Payment Notice, §156.140(c) permits a de minimis variation of +/ − 2 percentage points, except if a bronze health plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), the allowable variation in AV for such plan is −2 percentage points and +5 percentage points. We established this additional flexibility for certain bronze plans in the 2018 Payment Notice to provide a balanced approach to ensure that a variety of bronze plans can be offered, including high deductible health plans, while ensuring that bronze plans can remain at least as generous as

catastrophic plans. As discussed in the EHB Rule, our intention with the de minimis variation of +/−2 percentage points was to give issuers the flexibility to set cost-sharing rates that are simple and competitive while ensuring consumers can easily compare plans of similar generosity. While the de minimis range is intended to allow plans to float within a reasonable range and is not intended to freeze plan designs preventing innovation in the market, it was also intended to mitigate the need for annual plan redesign, allowing plans to retain the same plan design year to year while remaining at the same metal level.

At this time, we believe that further flexibility is needed for the AV de minimis range for metal levels to help issuers design new plans for future plan years, thereby promoting competition in the market. In addition, we believe that changing the de minimis range will allow more plans to keep their cost sharing the same from year to year. Although the AV Calculator is not a pricing tool, changing the de minimis range could also put downward pressure on premiums. Thus, we anticipate that this flexibility could encourage healthier consumers to enroll in coverage, improving the risk pool and increasing market stability. For these reasons, we believe that changing the AV de minimis range would help retain and attract issuers to the nongrandfathered individual and small group markets, which would increase competition and help consumers. Therefore, we propose amending the definition of de minimis included in

§156.140(c), to a variation of - 4/+2 percentage points, rather than +/- 2 percentage points for all non-grandfathered individual and small group market plans that are required to comply with AV. Under the proposed standard, for example, a silver plan could have an AV between 66 and 72 percent. We believe that a de minimis amount of -4/+2 percentage points would provide the necessary flexibility to issuers in designing plans while striking the right balance between

ensuring comparability of plans within each metal level and allowing plans the flexibility to use convenient and competitive cost-sharing metrics.

Changing the variation of the de minimis from+/-2 to -4/+2 percentage points will reduce the coverage of each level of insurance while keeping the insurance in the same tier. This will make it very difficult for consumers to compare plans and will decrease the coverage for the same tier level coverage. The change in the calculation will benefit insurance companies by not having to adhere to the stricter guidelines but there is no evidence that that cost reductions will trickle down to the consumer by lower premium costs.

Comment separator page. Next comment follows.

JANICE D. SCHAKOWSKY
9TH DISTRICT, ILLINOIS

COMMITTEE ON ENERGY AND COMMERCE
Subcommittees:
Ranking Member, Commerce, Manufacturing, and Trade
Health
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March 7, 2017

Mr. Patrick Conway
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-9929-P – Patient Protection and Affordable Care Act; Market Stabilization

Dear Mr. Conway:

As representative of the 9th Congressional District, my staff and I have spent a great deal of time helping my constituents understand and utilize the many benefits provided under the Affordable Care Act (ACA). I agree that there is a need to stabilize and strengthen the current market, especially in light of Republican-led, Congressionally-imposed restrictions on ACA-provided mechanisms designed to achieve that goal. However, I do not believe we should achieve market stability at the expense of consumer choice and affordability, as I believe this proposed rule would do. I urge you to withdraw this proposed regulation and look instead for market stabilization measures that do not reduce consumer protections and shift costs to individuals and families.

Guaranteed Availability

The guaranteed availability proposal would expand the circumstances in which individuals who have outstanding premium payments owed from the prior 12 months could be denied coverage, allowing an insurer to deny coverage not just for the product on which the outstanding debt is owed but on any product the issuer sells. The issuer could demand full repayment before providing access to coverage.

The ACA is designed to expand guaranteed availability and coverage, specifically stating that issuers "must accept every employer and individual in the State that applies for coverage." That should not be read as an invitation to forego premium payments, and there is little evidence that people abuse the current system by failing to make premium payments in the knowledge that they have guaranteed access to a different plan in the future. However, it is important to note that there are many reasons why individuals might miss premium payments, including income limitations, cognitive problems, changes in eligibility, or even billing disputes with the insurer. Allowing a full repayment requirement -- rather than a reasonable repayment plan – and application to any plan sold by the issuer will increase the number of uninsured Americans.

Denying guaranteed access to health coverage is not just harmful to individuals and families, it would shift costs to taxpayers and providers who treat those who become uninsured as a result – the very situation the ACA was trying to avoid. Moreover, while the stated intention is to stabilize the individual and small group markets, this would in fact weaken the already unstable market and be especially detrimental to low-income individuals and families. That is because healthy young people are more likely to miss bill payments, and would consequently be most likely to lose coverage. This would leave an older and sicker population in the risk pool, which would then raise premiums and prevent healthy young people from enrolling in marketplace plans, directly contradicting the purpose of the ACA and the proposed rule.

Open Enrollment

Similarly, CMS's proposal to shorten the open enrollment period in half would again, undermine rather than strengthen the stability of the risk pool. While the health insurance marketplaces were fully implemented three years ago, there is still a gap in knowledge among consumers. While CMS intends to "conduct extensive outreach" to warn about the shorter enrollment period, it is unclear what that would entail. This would also severely limit the capacity of navigators and in-person assisters, who were already in high demand in previous open enrollment periods. Moreover, given the confusion of the current ACA replacement efforts, it is a certainty that many consumers will mistakenly believe that they do not have an enrollment option. A shortened open enrollment period would give less time to correct that information and allow interested consumers to enroll.

Rather than shortening the open enrollment period for the 2018 plan year, I believe that CMS should use this year to bolster its public education and outreach capacity, including efforts to differentiate between Exchange and Medicare enrollment, in order to make sure the groundwork is laid for shorter open enrollment periods in the future.

Special Enrollment Periods

I agree that Special Enrollment Periods (SEPs) should be used for their intended purposes, not as a fallback for failure to enroll when eligible. However, while there is no supportive evidence of abuse of special enrollment periods, there is evidence that too few rather than too many eligible individuals are enrolling through SEPs. That evidence corresponds with the experience of my office, which has been working to help constituents with the SEP process.

I strongly believe that we should be making the SEP process easier, not harder. I believe that the expansion of pre-enrollment verification from 50% to 100% moves in the wrong direction, especially when combined with the new "pending" provisions. I am not convinced that there will be the staff and resources necessary to handle the increase in workload (CMS estimates that 650,000 individuals will be "delayed" or "pended" under the proposed changes).

The verification requirements will also hinder the efforts of stabilizing the market. Additional paperwork would be burdensome for younger consumers, who we need in order to stabilize the risk pool. In fact, CMS reported that only 55 percent of those 18 to 24 completed the process of providing additional paperwork for SEP enrollment in 2016 (compared to 73 percent of applicants age 55-64).

Finally, I am concerned about restrictions on the ability to change metal levels. Life changes such as marriage and a new child may have significant impacts on income and health needs, and those utilizing the SEP process should be able to make changes in coverage to reflect them.

Network Adequacy and Essential Community Providers

One of the biggest concerns facing my constituents is the question of narrow networks, and I believe that we need to improve access by strengthening – not weakening – existing standards. Instead, I strongly believe that the proposed changes would make the situation even worse by relying solely on state agencies, superceding time and distance requirements, and allow the use of outside external accreditation entities. Despite numerous complaints, the State of Illinois has not utilized its authority to require network adequacy. As a result, for example, there is no plan offered in my Congressional district that includes Lurie Children's Hospital, meaning that children who need specialized care are required to go elsewhere, even if they had previously bee treated at Lurie's for their very serious, ongoing needs. Allowing subjective rather than qualitative measures of adequacy in this instance would compound the problem. Finally, I am deeply concerned that a process that should be transparent, open and publicly-accountable will be conducted in private given reliance on private accreditation entities.

I also oppose weakening of the essential community provider (ECP) requirements, reducing the 30% standard to 20% and allowing issuers to use an expanded write-in process to use ECPs not on the HHS list. The ECP provision is designed to ensure access to critical safety-net providers, including community health centers, women's health clinics, and facilities caring for vulnerable populations. Reducing the standard and allowing issuer substitutions would not only reduce access, it would make it easier for issuers to "game the system" by excluding ECPs serving higher-cost populations.

The proposed rule would make significant changes that would greatly harm access to health care under the guise of providing market stability. It was not Congressional intent to reduce access to providers in an attempt to encourage issuers to enter or remain in the market.

Actuarial Value

I firmly oppose the proposed changes to actuarial value (AV) that could, according to the proposed rule itself, "reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial

risk associated with high medical costs." The AV system was designed to establish benefit standards, and the current allowed AV variation of -2/+2 is designed to be *de minimus.* While market stability is an important goal, that is not the purpose of AV and it should not be used to shift more cost and risks away from issuers and onto the backs of individuals and families. According to a report by Families USA, "President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense," for example, the result of moving from the AV from 68 percent to 66 percent could result in a $1,000 increase in a deductible.

Increasing the financial burden on individuals and families through cost-sharing is neither appropriate nor necessary.

Continuous Coverage

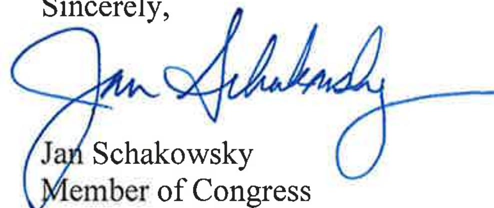
Under the proposed rule, HHS asked:

> "whether policies are needed for the individual market similar to those that existed under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) which required maintenance of continuous, creditable coverage without a 63-day break in the group market if individuals wished to avoid the pre-existing condition exclusions, and allowed waiting periods to be imposed under certain conditions."

Congress was certainly aware of the HIPAA provision when crafting the ACA, and rejected it. Many Americans face gaps in coverage due to circumstances such as job loss, caregiving responsibilities, financial difficulties, illness or disability. The HIPAA 63-day requirement meant that they were unprotected from pre-existing condition exclusions that could have devastating health and financial implications for them. Instead of utilizing the continuous coverage requirement, the ACA imposes a financial penalty under the individual mandate. That – not denial of care – is a more appropriate mechanism for encouraging enrollment, one that doesn't punish individuals who face difficult circumstances with the loss of necessary medical care.

Again, while I support the goal of market stability, I believe that the provisions in the proposed rule would not only fail to achieve that goal, but would be harmful to consumers by reducing their access to providers while raising their out-of-pocket costs. I urge you to reject them and to look for other ways to obtain market stability.

Sincerely,



Jan Schakowsky
Member of Congress

Comment separator page. Next comment follows.

The biggest problem is pre-verifying a SEP due to loss of coverage. I am an insurance agent and I see major problems with this rule change that will make life much more difficult for me and for consumers. I ask you not to implement the SEP verification changes.

Current law requires insurance companies to send proof of coverage documents with the termination date only AFTER coverage has ended. Most of the people I help enroll have not gotten those notices yet but they know coverage is ending because either Medicaid or their employer has told them so. It is already a pain to submit the documents during the 30 day window (because there is mailing time and we have to upload the documents several times. And then they aren't processed for weeks). It will be impossible for people to prove they have a SEP before the termination of their coverage. They would have to wait to get the notice, and would then have at least 1 month gap in coverage, but likely 2 months. This will not work for older people and people with disabilities, who cannot wait for coverage.

Please do not implement this pre-verification rule change. I understand the idea behind it, but it is already very difficult to do as is. The verification rules for SEPs are already very tight. If anything I hoped this administration would loosen the rule. As written, the new rule is unrealistic.

No documents available.

Comment separator page. Next comment follows.

Dear Health and Human Services,

I am writing to comment on CMS-9929-P . There are several proposed rule changes to the Affordable Care Act that are of concern.

1. Reducing the Enrollment Period from 3 months to 6 weeks will cause more Americans to remain uninsured. The reason cited is to improve the risk pool because it would reduce opportunities for adverse selection by those who learn they will need services which shows the purpose is to reduce the number that are insured. While there may indeed be issues with people gaming the system the resolution of that issue does not lie in reducing the enrollment period; it lies in increasing the incentive for all people to sign up for health insurance.

2. Increasing the enrollment verification from 50% to 100% for those using special enrollment periods will increase costs of running the Health Exchange. Many companies use sampling for quality control, and it would be a much less expensive option to use sampling, rather than using 100% verification. Is this rule change designed to protect Americans who need insurance, or to protect insurance companies?

3. Allowing insurers to apply a premium payment to past debt for those people who enroll with the same insurer makes insurance more expensive and hurts people who need insurance. This rule does not seem to be about gaming but rather about getting more money into the coffers of insurance companies. Those people who have subsidized premiums are generally living on the edge, paycheck to paycheck, and if they are unable to pay the premiums, I venture there is a reason other than trying to game the system.

4. Increasing the de minimis variation in the actuarial values allows insurance companies to change the value of the plans. It has been a benefit of the Health Care Exchange to have plans with minimum coverage requirements and easily comparable. It seems these rule changes are targeted to prevent gaming of the system so that folks dont choose to become insured only when they have a health need. While gaming may be a problem, the solution lies in increasing the penalty for choosing the risk of

remaining uninsured. Or better yet, a single payer system so that risk is spread over all people, healthy and sick. We need rule changes that will DRIVE HEALTHY PEOPLE INTO THE HEALTH CARE EXCHANGE. That is a solution that will benefit all Americans, and benefit insurance companies as well. Preventative care, including medication, is much less expensive than care in the ER. For instance, prior to the advent of the Affordable Care Act, consider this true story: A person with diabetes can not afford to go to the doctor and can not afford diabetes medication. That person gets a cut on their foot, which results in infection, because this is a complication of diabetes. The person can not afford to go to the doctor for that infection, which gets worse. That person ends up in the ER, and is hospitalized, with no insurance. The infection spreads, and the person has an above knee amputation of the leg. The hospital bills are very high, and are uncompensated care the hospitals must bear. The person ends up in a nursing home, paid for by nursing home medicaid. The person is now on social security disability, and can not work the rest of his life. If he leaves the nursing home, he will use food stamps and housing assistance for the rest of his life. ACCESS TO INSURANCE AND PREVENTATIVE CARE WOULD HAVE COST CITIZENS MUCH LESS! If you are concerned about gaming the system use incentives for health people to sign up to spread the risk; better yet, use a single payer system like Medicare for All.

Thank you for your time.

Sincerely,

Sara Baker
Athens, GA 30605

No documents available.

Comment separator page. Next comment follows.

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March 7, 2017

Patrick Conway
Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. The Sargent Shriver National Center on Poverty Law (Shriver Center) advocates for quality comprehensive, accessible, and affordable health care coverage and services for all populations experiencing poverty. In particular, we have a special focus and expertise in Medicaid policy as well as policy implementing the Affordable Care Act Marketplace, which provides subsidized health care coverage to Illinois residents with household income under 400% of the poverty level. We provide training and technical assistance to thousands of enrollment professionals in Illinois who assist consumers to enroll in health care programs including Medicaid and the Marketplace and to access financial assistance.

We have included our comments on specific sections below. In addition to these specific comments, we want to raise significant general concerns about the proposed rule's overall effect on consumers' ability to enroll in quality, comprehensive, affordable health coverage through the marketplaces. Our extensive experience working with enrollment assisters and with consumers in Illinois over the past four years informs our overall opinion that these proposed rules will cause substantial harm - especially to low income consumers who have less access to consistent employment and employer insurance; experience frequent variations in income; and have less attachment to a traditional labor market.

The proposed rule, if finalized, would add enrollment restrictions that make coverage *less* comprehensive and *more* expensive for Illinois consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides. If implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;

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- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks; and
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals do not provide the appropriate solution to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are strongly dismayed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

I. § 147.104 – Guaranteed Availability of Coverage

HHS seeks comments about its proposed premium payment policy, which would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy, particularly for lower income individuals.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and HHS does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small

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Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize that there is a potential of adverse selection if beneficiaries only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

Beyond the dubious legality of the proposed rule, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, and other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with an issuer but faced numerous administrative and bureaucratic hurdles to do so.

A record of non-payment of a premium may also be due to issuer or marketplace error. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In our experience in Illinois, we have encountered multiple examples of consumers attempting to cancel coverage and the Marketplace erroneously failing to cancel or record the request. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage since they could lose their employment and need to come back for marketplace coverage but should not be subject to repayment.

Therefore, the implementation of a rule that will block consumers from enrolling and obtaining insurance due to a record of non-payment that could be inaccurate or was through no fault of their own is both unfair and counter to the goal of getting consumers to make regular payments and stay insured.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment. In Illinois, we now have several counties primarily in rural areas in which there is only one carrier available.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[1]

[1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrollment declines gradually throughout the year, a sign that enrollees leave the market over

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If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

And if HHS were to proceed with this policy, we also recommend that this policy be limited to annual renewals and that consumers enrolling during a Special Enrollment Period (SEP) should not be subject to this policy. The mere fact that a consumer is eligible for an SEP means the consumer is facing a change in circumstance. For example, if a consumer stopped paying premiums in September of one year and gets an SEP to re-enroll in the middle of the next year, the consumer should not have to pay back premiums when there has been a significant time lapse between the events.

Further, we provide additional suggestions to provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" to this policy such that consumers who can demonstrate significant financial hardship that caused the consumer to stop paying premiums, the issuer would not be permitted to apply new premium payments to past unpaid premiums. Consumers could document

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time for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

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such a hardship by providing a narrative explanation as to why he stopped paying premiums. Since the NPRM would already allow consumers to enroll in another plan and thus issuers would not always recoup past premiums from these consumers, it seems that allowing a consume the option to stay with the same plan – which may be important to the consumer because of the network or particular providers – is a second option that would provide a compromise for the consumer and issuer.

Also, information about repayment should be clearly noted on the Plan Compare tool so that consumers would have that information before they enroll. Second, it should be noted in the Eligibility Determination Notice since consumers could change plans if open enrollment or a special enrollment period remains open.

II. § 155.410 – Initial and Annual Open Enrollment Periods

We are concerned about the shortening of the annual open enrollment period. While we recognize a shorter enrollment period was planned for 2018, given all the potential changes that consumers have to digest this year, we believe that keeping a longer open enrollment period would be beneficial to consumers as well as issuers. We believe the benefits – enrolling more consumers – outweigh the perceived costs of having consumers enroll for less than a full year (if they enroll after December 15). HHS notes that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance during the abbreviated enrollment period. Thus, the policy change could just as easily lead to a pool that is adversely selected to mostly include the sickest people, at least in the short term, if young, healthy people end up missing the new deadline for signing up. HHS acknowledges this uncertainty but it does not sufficiently explain why a positive result (decreased adverse selection, improved stability of the exchanges) is more likely than a negative result (increased adverse selection, reduced stability of the exchanges) with a shorter enrollment period.

We are also concerned about the proposed shortened enrollment period due to the added burdens it will put on navigators and assisters. Many navigators and assisters already work long hours and weekends throughout the current open enrollment period to meet the demand. Shortening the period will make it even more difficult to reach and serve all consumers. Through our technical assistance center for enrollment assisters in Illinois and appointment tool, we regularly see, during open enrollment, long waiting lists for appointments and requests for enrollment assistance appointments that exceed the availability. Since Illinois is no longer able to fund an independent state assister program due to the end of the state establishment grants, Illinois is dependent on the federally funded Navigators and unfunded CACs.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[2] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[3]

[2] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[3] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.

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We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[4] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[5]

III. § 155.420 – Special Enrollment Periods

We have strong concerns about the proposed pre-enrolment verification process, particularly since it will include 100% of SEP applicants and because HHS has not released a full evaluation and analysis of the post-enrollment verification pilot operated in 2016. First, before requiring all applicants to verify their eligibility, it is important to identify any real or perceived limitations of verification that need to be addressed. Second, if the post-enrollment analysis finds that many eligible consumers are deterred or unable to complete verification, HHS should ensure these issues are fixed in a pilot of pre-enrollment verification. Overall, any required verification – whether for enrollment, data matching, or an SEP – needs to be easy and simple or eligible individuals will be deterred from enrolling. If the process is not easy, it is likely that those in dire need of health insurance, rather than individuals who may be healthier and want coverage to avoid paying a tax penalty, will likely complete the process. For SEPs, we recognize that a disproportionate number of sicker individuals obtaining coverage through SEPs could disrupt the risk pool and lead to unanticipated higher costs. If a major concern for issuers is the higher costs associated with those coming in through SEPs, however, other interventions exist that would not burden consumers or presume fraudulent applications. For example, HHS' changes to the risk adjustment costs in 2018 and beyond to address higher than expected costs of those not enrolled for the full year would address this problem without assuming that those obtaining mid-year coverage through an SEP are ineligible and need to prove eligibility pre-enrollment.

To keep consumer engagement and trust high – an essential component to the success of the marketplaces – while preserving affordability, any SEP eligibility verification should be narrowly targeted only to instances of suspected ineligibility or fraud and should use electronic verification rather than requiring paper documentation. While we understand the balance the FFM must strike between plans and consumers to achieve affordability, we believe that mandatory SEP pre-eligibility verification will have a chilling effect on many eligible individuals. Excessive documentation requests may be a deterrent

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[4] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[5] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

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to potentially eligible applicants who would help spread the risk and HHS should take care not to discourage participation. Problems and consumer frustration with other verification processes already exist – such as lengthy times between document submission and review, trouble uploading verifications, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues because consumers cannot directly reach those conducting the reviews. Through our technical assistance center, we often have referrals of complex cases in which we need to assist the consumer in filing an appeal with the Marketplace or requesting a casework review because they cannot upload verification documents. Adding pre-eligibility verification may jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the FFM such that only the sickest and costliest consumers pursue SEPs. At the same time, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

As the NPRM preamble notes, some commenters to the 2018 Payment Notice suggested that additional steps to determine SEP eligibility worsen the problem by creating new barriers to enrollment. Yet based on issuer feedback, HHS is proposing to increase the scope of the pre-enrollment verification. We believe this should not be done unless and until the prior pilot analysis adequately identifies what cause and effect pre-eligibility verification may have on individuals and the marketplace as a whole.
Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to follow through.[6] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will take the steps necessary to complete the process.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. We work with populations that have variable employment and income; this proposed requirement is aimed at the most vulnerable working populations who are trying to move themselves out of poverty. They are mainly getting part time or variable seasonal employment and attempting to move up to full employment. During the interim, they are most likely to cycle on and off of coverage and not be able to get into the Marketplace. These are also generally young healthy consumers who we want to encourage to stay covered and balance the risk pool. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

a. Electronic Verification

[6] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

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We do appreciate that HHS recognizes it will make every effort to verify eligibility through automated electronic means. It is not at all clear that the FFM would be technically or operationally capable of implementing an SEP verification process consistent with the Affordable Care Act's vision of a real-time, streamlined eligibility and enrollment system. HHS has already acknowledged that eligible individuals sometimes forgo coverage because they encounter difficulty securing and providing the documents requested to verify their eligibility when they have a data matching issue.[7] We cannot afford this result to duplicate with SEP verification. Our state Medicaid system has already experienced significant problems and delays in implementing a real time benefits eligibility application system. Illinois is still revising their application and renewal systems and needs time to get to full implementation. The extra burden of verifying Medicaid eligibility or more likely Medicaid denials and terminations to meet the strict SEP requirements in the Marketplace will be a logistical burden. In our experience, it is already very difficult for our clients to prove Medicaid termination or denials in time to enroll in the Marketplace and stay continuously covered.

As an example, consumers who are eligible for the permanent move SEP who have been enrolled in a QHP should not have to provide documentation of their "original" address. Yet this was required as part of the post-eligibility verification. Consumers provide this information during enrollment and burdens should not be added to submit documentation merely because HHS is unable to access this information. Before implementing a pilot, HHS should establish systems for an automatic check with issuers and public programs (Medicaid, CHIP, Medicare) about whether a consumer lost creditable coverage. Consumers should not be responsible for tracking down documentation to show that coverage was lost when this information is readily available from issuers. Only if electronic verification is inconclusive, or if a consumer disputes the result, should documentation be required.

b. Timeframes for document verification

We appreciate that HHS will provide consumers 30 days to provide documentation. We do ask that HHS also provide consumers with the opportunity to request an extension of that time period if they have difficulty obtaining certain documentation within that timeframe. This could allow the consumer to continue with an SEP application without losing eligibility merely due to difficulties obtaining documentation. If the consumer's SEP application is instead denied, the consumer may not be eligible at a later date due to the length of time from the qualifying event even if the consumer truly is eligible. We also strongly urge HHS to establish specific timeframes for evaluating documents as part of a pre-eligibility verification pilot. Without specific timeframes, consumers would not have necessary information to ascertain when a decision will be made, when to follow-up if they have not received a decision, and how to proceed if a decision is adverse. We also recommend that if a consumer submits documents, and the review by the FFM is not completed within 15 days, that the SEP must be granted so that consumers are not suffering without health insurance for lengthy periods of time. This could be done conditionally to give the FFM additional time for document review but it would balance the needs of the consumer for health insurance by preventing significant delays in enrollment. Under this situation, the process would continue similar to post-eligibility verification.

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[7] *Strengthening the Marketplace – Actions to Improve the Risk Pool* (June 8, 2016), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending.

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As we have previously stated, we strongly believe that HHS should implement a model of verification more closely aligned with the IRS and should evaluate this as part of a pilot. Consumers already attest under penalties of perjury to the information provided in their applications. Rather than require pre-eligibility verification submission, HHS should only request documents from the specific consumers who will be audited (and this subset of consumers must be randomly selected and not based on any personally identifiable characteristics or claims data). Requiring 100% pre-eligibility verification seems unnecessary, burdensome for consumers, and adds additional processing and storage burdens for the FFM to receive, review, classify and store the documents.

c. Study of Pre-Enrollment Verification

HHS asked for comment whether a small percentage of individuals should be exempt from the pre-enrollment verification process to conduct a study. We strongly support this suggestion. The excluded population must be statistically significant so that an appropriate and legitimate comparison may be made between the two groups.

Further, HHS asked for comment about strategies HHS should take to increase the chances that healthier individuals complete the pre-eligibility verification. We strongly recommend that HHS eliminate the need for verifying any SEPs based on birth/adoption/foster care placement and marriage. Given the nature of the circumstances under which these SEPs arise, it is hard to imagine that many consumers will be seeking an SEP for these categories if not truly eligible. At a minimum, HHS should consider excluding from a pre-eligibility verification pilot unless and until the process for verifying loss of MEC and permanent move SEPs is implemented effectively and efficiently.

d. Changing Plan Levels

We believe HHS' proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1) While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We thus oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

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For example, adding a dependent or getting married likely alters the amount of APTC and possibly cost-sharing reductions (CSR) which can impact what plan enrollees wish to enroll in. As another example, a pregnant woman may have enrolled in a silver plan but if she gives birth to a child with special needs or complex medical conditions, she may want to change coverage to a gold or platinum plan to obtain a higher level of coverage. Or a woman may enroll in a platinum plan concerned she may have a high risk pregnancy but after the pregnancy, may want to move back to a silver plan. As another example, an individual may gain a dependent who has a disability and the plan selection should not be limited to merely adding the dependent to the enrollee's same plan or same level plan.

HHS seeks comment on whether an individual gaining an SEP due to new eligibility for cost-sharing reductions should be limited to only enroll in a silver QHP. While we recognize that most individuals newly eligible for cost-sharing reductions would benefit from enrolling in a silver plan to gain the benefits of the cost-sharing reductions, some consumers may have valid reasons for wanting to enroll in other metal plans and should not be restricted just because they have enrolled through an SEP since if they enrolled during open enrollment, they would be able to forego the silver plan and cost-sharing assistance if they so wished. That said, we do recognize the benefits of enrolling in a silver plan and thus believe consumers should receive sufficient information about the potential downsides of enrolling in a different metal plan to make an informed choice. But ultimately, consumers should have the choice.

We recognize HHS may have concerns about individuals using an SEP to "simply switch levels of coverage during the coverage year." But with the limitations of the eligibility verification and that switching plans comes with other potential problems for consumers – resetting deductibles and out-of-pocket costs – we believe consumers should have the choice and opportunity to do what is right for themselves and their families rather than be limited by regulation to continuing enrollment in the same plan.

We also believe HHS should provide SBMs the option to utilize these limitations rather than be forced to adopt them. As mentioned above, SBMs know their states and their markets and may have valid reasons not to adopt similar restrictions.

e. Payment of Past Premiums

We are concerned that HHS proposes allowing an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe this is discriminatory, in particular, against low-income consumers who may not have had the ability to pay premiums if they incurred significant medical costs before meeting a deductible or out-of-pocket maximum.

Other reasons may exist why an issuer believes a consumer has not paid premiums when the consumer actually has or attempted to. We have worked with a number of consumers who received erroneous bills and attempted to work with their insurer to determine the correct amounts to pay. Sometimes insurers did not accurately credit the amount of a tax credit or cost-sharing reduction, sometimes insurers did not match consumer's payments with the consumer's account, sometimes insurers cancelled a consumer's coverage despite a consumer paying. Due to the potential for insurer error, we believe that if HHS is going to permit insurers to reject enrollment, two preconditions must be met:

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1. The insurer must provide verification to HHS and the consumer of the non-payment;
2. The insurer must allow the consumer a reasonable opportunity to dispute the insurer's information and provide documentation of payment.

Secondly, even if an insurer does verify that a consumer did not pay premiums, we believe HHS should provide a waiver of this requirement for consumers who can document paying significant out-of-pocket costs for care or other relevant circumstances during the time premiums were not paid. For example, if a consumer incurred health care bills that exceeded the premium amounts, we believe the consumer should not have to repay the premiums since meeting the deductible may have been out-of-reach for the consumer. Or if the consumer can document a job loss or having suffered a serious medical incident that prevented paying the premiums, this should also be accepted for a waiver of paying past premiums. While we recognize insurers need to receive timely premiums, we also recognize that there must be a balance when consumers are unable to pay their bills due to exceptional circumstances and that other avenues exist for helping insurers compensate for consumers such as these.

We are also concerned about this proposal from a geographical perspective. That is, this proposal can discriminate against consumers merely due to where they live. If the consumer lives in a geographical area with only one issuer (which is the case in a number of counties across the country), these consumers will have no alternative but to enroll in a plan where they must first pay back premiums or be rejected. Consumers in geographic areas with a choice of plans may be able to enroll in a different plan and thus not be subject to the back payment requirement. We do not believe that a policy that likely will be implemented to the detriment of consumer merely based on geography should be adopted by HHS. As mentioned previously, in Illinois, consumers in rural and ex-urban areas are most likely to now have only one plan available to them.

HHS also stated that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and thus HHS should ensure that any verification must provide consumers with an opportunity to provide additional or contrary information that may negate information from an insurer.

f. Marriage SEP

HHS proposes that if a consumer is newly enrolling through the Exchange pursuant to an SEP obtained for marriage that at least one spouse demonstrate having had minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage. We are concerned about this limitation for a number of reasons.

First, some individuals who marry may have been ineligible for Exchange coverage during the 60 days prior. This is especially likely in Medicaid non-expansion states. Both individuals may have been below 100% FPL in an non-expansion state and thus in the coverage gap. A marriage could increase their joint income to over 100% FPL and make them both newly eligible for coverage yet the proposed rule would not allow them to enroll. This also has a geographical bias since many of the states that did not expand Medicaid are in the southern part of the country which also has the higher uninsured rates and higher rates of poverty.

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We do appreciate the recognition of an exception for individuals living abroad or in a U.S. territory. We strongly urge HHS to maintain this exception and not to require an onerous burden of proof to document a foreign or territorial residence.

g. Permanent Move SEP

We have similar concerns about the requirement for prior coverage as a predicate for obtaining a permanent move SEP. Some individuals may not have been eligible for coverage in the area they moved from (e.g. a Medicaid non-expansion state) and thus should not be penalized and made ineligible for an SEP.

Further, individuals who are survivors of domestic violence may have been prevented by their abuser from obtaining coverage. If these individuals permanently move away from their abusers, they should not be prevented from newly enrolling in coverage because they did not have prior coverage.

IV. § 156.140 – Levels of Coverage (Actuarial Value)

We oppose the proposed expansion of the de minimus actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

We believe this policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[8]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy

[8] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

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Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[9]

Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds the Secretary's authority and undermines the plain meaning of the statute.

Contrary to the proposed rule's assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee's income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of $25,000. This individual's expected contribution towards premiums is 6.8% of income or $1,700. If the person selects the benchmark plan, his/her net premium will be $1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial

[9] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

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value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with HIV, hepatitis C, and other chronic conditions who depend on access to plans with a higher actuarial value to defray high cost sharing. Consider three possible silver benchmark plans:[10]

Benchmark Plan Costs, 2018						
Actuarial Value	Gross Premium	Deductible	Maximum Out-of-Pocket	Co-Insurance	Advance Premium Tax Credit	Net Enrollee Premium*
70	$4,138	$1,600	$7,200	30%	$2,438	$1,700
68	$4,020	$2,100	$7,200	30%	$2,320	$1,700
66	$3,902	$2,750	$7,200	30%	$2,202	$1,700

* *Examples assume consumer enrolls in the benchmark second lowest cost sliver level plan; net premium amount would increase if consumer enrolled in a higher AV plan*

While reductions in actuarial value reduce gross premiums, they do not reduce the net enrollee premium when selecting the benchmark plan resulting in less purchasing power for the consumer. Deductible increases allowed by the actuarial value reductions, however, will discourage enrollment, leading to a death spiral.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Under the plans above, using the 70 percent actuarial value plan as the benchmark would result in a 15 percent net enrollee premium reduction for enrollment in the 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease will likely spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium

[10] Actuarial values were calculated using the 2018 Actuarial Value Calculator for silver plans. Premiums assume 85 percent of costs are medical and 15 percent are administrative. Advance premium tax credit is based on a $25,000 income for a single 35 year-old enrollee, resulting in a $1,700 expected annual contribution from the enrollee and a $2,438 tax credit on average nationwide. This example assumes enrollment in the benchmark second lowest-cost sliver level plan. The applicable income percentage and gross premium for the 70 percent actuarial value plan were calculated using the Kaiser Family Foundation's 2017 Health Insurance Marketplace Calculator.

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costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan.

Impact of Requiring 70 Percent Actuarial Value (AV) Benchmark Plan					
Actuarial Value	Gross Premium	Advance Premium Tax Credit (70 AV benchmark)	Net Enrollee Premium ($)	Net Enrollee Premium Reduction (%, compared to benchmark contribution of $1,700)	Increased Deductible (compared to $1,600 under 70 AV benchmark)
68	$4,020	$2,438	$1,582	7.0%	$500
66	$3,902	$2,438	$1,464	13.9%	$1,150

While we do not support expanding the de minimis actuarial value threshold to -4/+2 percent, if the Secretary finalizes this proposal, calculating the advance premium tax credit from plans with a true 70 percent actuarial value will reduce net enrollee premiums and encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

The Secretary must require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. The Secretary is given authority, however, to modify the out-of-pocket reduction only if it would "result in an increase in the plan's share of the total allowed costs of benefits provided under the plan" above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that the Secretary establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. The Secretary, then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We support the February 24, 2012 Actuarial Value and Cost-Sharing Reductions Bulletin's explanation for not establishing cost-sharing reduction plans with a 70 percent actuarial value for these enrollees, but this explanation depended on the availability of 70 percent actuarial value plans for these enrollees. We encourage the Secretary to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and the Secretary should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

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Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

V. § 156.230 – Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. We have commended HHS for these steps, which are crucial to making the promise of care in the Affordable Care Act real. NHeLP has written extensively about the importance of network adequacy for low-income consumers, in particular.[11] Over time, HHS has made significant improvements to the regulations at sections 155.1050 and 156.230, in defining the network adequacy standards to which QHPs will be held. As a result, we have seen fewer lawsuits and consumer complaints regarding network adequacy issues in QHPs with each year the Exchanges operate. Even still, we have urged HHS to adopt more stringent regulations in this area, as the current regulations do not fully ensure that consumers who enroll in QHPs will have access to adequate networks.[12]

Thus, the proposals set forth in the preamble to this regulation would represent a step backward for guaranteeing network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

In Illinois, we saw this issue heightened in 2016 when none of the larger teaching hospitals in the Chicagoland area were included in Marketplace plans. This was incredibly disruptive to patients in the midst of treatments for chronic diseases.

a. HHS should not rely on state reviews for network adequacy

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires the Secretary of HHS to

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[11] *See, e.g.,* ABBI COURSOLLE, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE REGULATIONS: NETWORK ADEQUACY & ACCESS (2016), http://www.healthlaw.org/publications//Brief-3-MMC-Final-Reg; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to J.P. Wieske, Nat'l Assn. Ins. Comm'nrs (Jan. 12, 2015), http://www.healthlaw.org/publications/search-publications/NAICS-Comment; NHELP, NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), *available at* http://www.healthlaw.org/issues/medicaid/network-adequacy-in-medicaid-managed-care.

[12] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. 13-18 (Oct. 6, 2016), http://www.healthlaw.org/issues/medicaid/services/Comments-ACA-Benefit-Payment-Parameters.

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establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated the Secretary of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged the Secretary with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

We appreciate that HHS's current proposal will require issuers (save MSP issuers) in the FFE to meet HHS's "reasonable access standard," or state standards approved by HHS. While we support HHS's leaving the states and OPM with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, HHS must establish a clear national floor for network adequacy in these regulations, and monitor compliance with those national standards itself. The Secretary should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. Leaving network adequacy standards to the discretion of states has resulted in consumer protections varying widely across state lines. The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

b. *HHS's "reasonable access" standard is not a sufficient measure of network adequacy.*

HHS has never explained how its "reasonable access" standard is measured or monitored. Thus we have little information to assess whether the "reasonable access" standard has been successful in ensuring access in the past. We are therefore disappointed that HHS is proposing to revert to this standard, rather than adopting precise quantitative standards that would help insurance regulators, consumers, providers, and advocates to evaluate what constitutes "reasonable access." We recommend that HHS instead move forward with its prior proposal of establishing a national baseline for time and distance standards.

c. *HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.*

We disagree with HHS's proposed approach of replacing time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their

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accreditation does not replace the existence of such standards.[13] Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We have previously urged HHS to adopt more stringent standards, including specific time and distance standards.[14] In 2015, we commended HHS for taking the step to establish specific time and distance standards for QHPs, and urged HHS to adopt these standards in regulation, rather than its Letter to Issuers.[15] We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

VI. § 156.235 – Essential Community Providers

We urge HHS not to reduce the percentage requirement for ECPs. In the past, we have expressed our appreciation for HHS's continuing efforts to ensure that QHP networks include essential community providers (ECPs), including by requiring issuers to enter contracts with at least 30% of available ECPs in the service area.[16] We encouraged HHS to consider increasing the percentage required in future years.[17] Instead, HHS is proposing to go backward, and reduce the percentage to only 20%. This reduction represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

[13] For a discussion of the role that accrediting agencies can play in this regard, see Letter from Emily Spitzer, Nat'l Health Law Prog., to CMS Desk Officer 11-14 (June 18, 2012), http://www.healthlaw.org/publications/search-publications/nhelp-comments-on-ffe-and-state-and-state-partnership-exchanges.
[14] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 59-61 (Dec. 21, 2015), http://www.healthlaw.org/issues/health-care-reform/2017-Parameters.
[15] *Id.*
[16] Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 10 (Jan. 15, 2016), http://www.healthlaw.org/issues/health-care-reform/exchanges/Comments-Draft-2017-Letter.
[17] *Id.*

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We also urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

VII. Applicability of Executive Order 13771

We do not support the goals of Executive Order 13771 that requires repeal of two regulations for any new regulation. That said, the NPRM includes a finding that this proposal does not trigger the requirements of EO 13771 and we believe this decision should also apply to the rule once finalized. Making a change between a NPRM and a final rule would prevent public comment on the reasons for a change in the decision.

VIII. Conclusion

Thank you for consideration of our comments. If you have any questions, please contact Stephani Becker, stephanibecker@povertylaw.org or Stephanie Altman, stephaniealtman@povertylaw.org.

Comment separator page. Next comment follows.

In response to the four proposed steps "[t]o improve the risk pool and promote stability in the individuals insurance market," I would like to voice my concerns over unaccounted for costs to the proposed changes:

1)Change of dates for open enrollment period. This change impacts those without strong monthly cash flow. As you know, December is high-time for the holidays and many Americans use year-end bonuses and savings to purchase goods for their loved ones. According to a 2013 study conducted by Bankrate and reported by CNN, 76% of Americans live paycheck-to-paycheck and cannot incur the additional expense of a health insurance premium on top of their holiday expenses. Forcing Americans to choose between showing affection to their loved ones and paying for their health insurance is not a viable solution to the health insurance marketplace's issues (more on that at the end). Furthermore, investors in the stock market would agree that Q4 results tend to bear the most weight for the retail industry. Redirecting consumption elsewhere is harmful to that industry and risks potential downstream cost-cutting measures, including personnel layoffs. This would then, in turn, qualify a great deal of Americans for special enrollment periods in the very exchange the government is trying to fix!

2)Increasing pre-enrollment verification from 50% to 100%. I agree that this change needs to be put into place as it is common practice amongst insurers to go through this process. My concern lies in the difficulty many Americans will have in securing proper documentation and the costs associated with those materials. Pre-enrollment verification should be a cost that the consumer does not bear. Rather, the companies in the lucrative health insurance market should bear the cost of verifying whether consumers applying to special period enrollment are eligible for insurance. Perhaps reducing the cost of the first monthly premium payment for those Americans who have difficulty in obtaining documentation would help offset some of the consumer burden in this transaction. The difficulties of low-income Americans must

be considered at a top priority for any changes to existing policy.

3)Enforcing indebted premium payments from insured Americans. This makes sense from the perspective of the insurance company - we need to mitigate risk by encouraging more people to enroll in the insurance market. The method by which individuals should be held responsible, however, remains unknown. Will insurance companies expect upfront payment prior to receiving medical services? Will a cancer patient seeking chemotherapy be denied coverage for services rendered by the hospital? How does that impact the hospital's revenue and downstream operations? Will they be able to afford to provide quality care if they are not receiving payment for upwards of 10% of their patient base? Additioanlly, this also places a greater financial burden onto the patient as they are now balancing past due payments, high deductibles, future monthly premiums, co-pays, and all other health-related costs. Per my first comment, the 76% of Americans living paycheck-to-paycheck will find no reprieve from high healthcare costs with this rule if there is not oversight on how past due premiums are collected.

4)Increasing de minimis variation in AVs. This sounds like a ploy to allow insurers to offer plans that cover less than they already do. Americans will only accept plans that are broader in coverage and cheaper than their existing plans. Silver plans in the state of MO for a 26 year old, non-smoking male begin at $193 per month. If there is a way to reduce that cost without reducing the benefits coverage, then increasing the de minimis variation will be useful. Otherwise it is simply another way to thwart access to quality healthcare for Americans.

For what it is worth, the rules proposed are a good starting point. But the real issue is that there is little incentive for healthy individuals to enter the market in the first place. With annual out-of-pocket expenditures exceeding $5,000, paying the $695 individual mandate is a no-brainer alternative for those with weak cash flow. Economic theory would suggest that increasing the mandate to a much higher figure

while doing more to expand the tax credits would be a greater incentive to encourage healthy individuals to purchase plans on the exchange. This provides two-way pressure onto the consumer - a disincentive to forego coverage and an incentive to purchase coverage.

Thank you for your consideration of my comments.

Shaun Vaid
St. Louis, MO
No documents available.

Comment separator page. Next comment follows.

SOUTH CAROLINA appleseed LEGAL JUSTICE CENTER

March 3, 2017

Patrick Conway
Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. SC Appleseed Legal Justice Center advocates on behalf of low and moderate income consumers in our state. For over 30 years we have provided advocacy on access to quality, affordable healthcare for the people of South Carolina.

We have included our comments on specific sections below. But before providing specific comments, we want to raise significant concerns about the proposed rule's overall effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces.

The proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides. If implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;

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- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks; and
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals do not provide the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are strongly dismayed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Guaranteed Availability of Coverage

HHS seeks comments about its proposed premium payment policy, which would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy,

particularly for lower income individuals. We are putting a burden on individuals and most likely taking away their only ability to receive coverage.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and HHS does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

And beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, and other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with an issuer but faced numerous administrative and bureaucratic hurdles to do so.

It may also be due to issuer or marketplace error that leads to an assumed non-payment. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage

since they could lose their employment and need to come back for marketplace coverage but should not be subject to repayment.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring.

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.

- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

And if HHS were to proceed with this policy, we also recommend that this policy be limited to annual renewals and that consumers enrolling during a Special Enrollment Period (SEP) should not be subject to this policy. The mere fact that a consumer is eligible for an SEP means the consumer is facing a change in circumstance. For example, if a consumer stopped paying premiums in September of one year and gets an SEP to re-enroll in the middle of the next year, the consumer should not have to pay back premiums when there has been a significant time lapse between the events.

Further, we provide additional suggestions to provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" to this policy such that consumers who can demonstrate significant financial hardship that caused the consumer to stop paying premiums, the issuer would not be permitted to apply new premium payments to past unpaid premiums. Consumers could document such a hardship by providing a narrative explanation as to why he stopped paying premiums. Since the NPRM would already allow consumers to enroll in another plan and thus issuers would not always recoup past premiums from these consumers, it seems that allowing a consume the option to stay with the same plan – which may be important to the consumer because of the network or particular providers – is a second option that would provide a compromise for the consumer and issuer.

Also, information about repayment should be clearly noted on the Plan Compare tool so that consumers would have that information before they enroll. Second, it should be noted in the Eligibility Determination Notice since consumers could change plans if open enrollment or a special enrollment period remains open.

Initial and Annual Open Enrollment Periods

We are concerned about the shortening of the annual open enrollment period. While we recognize a shorter enrollment period was planned for 2018, given all the potential

changes that consumers have to digest this year, we believe that keeping a longer open enrollment period would be beneficial to consumers as well as issuers. We believe the benefits – enrolling more consumers – outweigh the perceived costs of having consumers enroll for less than a full year (if they enroll after December 15).
HHS notes that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance. Thus the policy change could just as easily lead to a sicker pool, at least in the short term, if young, healthy people end up missing the new deadline for signing up. HHS acknowledges this uncertainty but it does not sufficiently explain why a positive result (decreased adverse selection, improved stability of the exchanges) is more likely than a negative result (increased adverse selection, reduced stability of the exchanges) with a shorter enrollment period.

We are also concerned about the proposed shortened enrollment period due to the added burdens it will put on navigators and assisters. Many navigators and assisters already work long hours and weekends throughout the current open enrollment period to meet the demand. Shortening the period will make it even more difficult to reach and serve all consumers. It will also make it difficult for brokers and agents to fully participate in the process as they will be engaged in both Medicare and non-Exchange open enrollment at that time. Ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment. We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help. Understanding how access to insurance is confusing at best and paralyzing for those who have not had the benefit of being educated to understand the intricacies of insurance coverage, we must do all we can to help consumer's make their choice.

Special Enrollment Periods

We have strong concerns about the proposed pre-enrolment verification process, particularly since it will include 100% of SEP applicants and because HHS has not released a full evaluation and analysis of the post-enrollment verification pilot operated in 2016. First, before requiring all applicants to verify their eligibility, it is important to identify any real or perceived limitations of verification that need to be addressed. Second, if the post-enrollment analysis finds that many eligible consumers are deterred or unable to complete verification, HHS should ensure these issues are fixed in a pilot of pre-enrollment verification. Overall, any required verification – whether for enrollment, data matching, or an SEP – needs to be easy and simple or eligible individuals will be deterred from enrolling. If the process is not easy, it is likely that those in more dire need of health insurance, rather than individuals who may be healthier and want coverage to avoid paying a tax penalty, will likely complete the process. For SEPs, we recognize that a disproportionate number of sicker individuals obtaining coverage through SEPs could disrupt the risk pool and lead to unanticipated higher costs. If a major concern for issuers is the higher costs associated with those coming in through SEPs, however, other interventions exist that would not burden consumers or presume fraudulent applications. For example, HHS' changes to the risk adjustment costs in 2018 and beyond to address higher than expected costs of those not enrolled for the full year would address this problem without assuming that those obtaining mid-year coverage through an SEP are ineligible and need to prove eligibility pre-enrollment.

To keep consumer engagement and trust high – an essential component to the success of the marketplaces – while preserving affordability, any SEP eligibility verification should be narrowly targeted only to instances of suspected ineligibility or fraud and should use electronic verification rather than requiring paper documentation. While we understand the balance the FFM must strike between plans and consumers to achieve affordability, we believe that mandatory SEP pre-eligibility verification will have a chilling effect on many eligible individuals. Excessive documentation requests may be a deterrent to potentially eligible applicants who would help spread the risk and HHS should take care not to discourage participation. Problems and consumer frustration with other verification processes already exist – such as lengthy times between document submission and review, trouble uploading verifications, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues because consumers cannot directly reach those conducting the reviews. Adding pre-eligibility verification may jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the FFM such that only the sickest

and costliest consumers pursue SEPs. At the same time, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

As the NPRM preamble notes, some commenters to the 2018 Payment Notice suggested that additional steps to determine SEP eligibility worsen the problem by creating new barriers to enrollment. Yet based on issuer feedback, HHS is proposing to increase the scope of the pre-enrollment verification. We believe this should not be done unless and until the prior pilot analysis adequately identifies what cause and effect pre-eligibility verification may have on individuals and the marketplace as a whole. Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

a. *Electronic Verification*

We do appreciate that HHS recognizes it will make every effort to verify eligibility through automated electronic means. It is not at all clear that the FFM would be technically or operationally capable of implementing an SEP verification process consistent with the Affordable Care Act's vision of a real-time, streamlined eligibility and enrollment system. Some low-income consumers that are eligible sometimes forgo coverage because they encounter difficulty securing and providing the documents requested to verify their eligibility when they have a data matching issue. We cannot afford this result to duplicate with SEP verification.

As an example, consumers who are eligible for the permanent move SEP who have been enrolled in a QHP should not have to provide documentation of their "original" address. Yet this was required as part of the post-eligibility verification. Consumers provide this information during enrollment and burdens should not be added to submit documentation merely because HHS is unable to access this information.

Before implementing a pilot, HHS should establish systems for an automatic check with issuers and public programs (Medicaid, CHIP, Medicare) about whether a consumer lost creditable coverage. Consumers should not be responsible for tracking down documentation to show that coverage was lost when this information is readily available from issuers. Only if electronic verification is inconclusive, or if a consumer disputes the result, should documentation be required.

b. Timeframes for document verification

We appreciate that HHS will provide consumers 30 days to provide documentation. We do ask that HHS also provide consumers with the opportunity to request an extension of that time period if they have difficulty obtaining certain documentation within that timeframe. This could allow the consumer to continue with an SEP application without losing eligibility merely due to difficulties obtaining documentation, which may be of no fault of their own. If the consumer's SEP application is instead denied, the consumer may not be eligible at a later date due to the length of time from the qualifying event even if the consumer truly is eligible.

c. Payment of Past Premiums

We are concerned that HHS proposes allowing an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe this is discriminatory, in particular, against low-income consumers who may not have had the ability to pay premiums if they incurred significant medical costs before meeting a deductible or out-of-pocket maximum.

Other reasons may exist why an issuer believes a consumer has not paid premiums when the consumer actually has or attempted to. We have worked with a number of consumers who received erroneous bills and attempted to work with their insurer to determine the correct amounts to pay. Sometimes insurers did not accurately credit the amount of a tax credit or cost-sharing reduction, sometimes insurers did not match consumer's payments with the consumer's account, sometimes insurers cancelled a consumer's coverage despite a consumer paying. Due to the potential for insurer error, we believe that if HHS is going to permit insurers to reject enrollment, two preconditions must be met:

1. The insurer must provide verification to HHS and the consumer of the non-payment;

2. The insurer must allow the consumer a reasonable opportunity to dispute the insurer's information and provide documentation of payment.

Secondly, even if an insurer does verify that a consumer did not pay premiums, we believe HHS should provide a waiver of this requirement for consumers who can document paying significant out-of-pocket costs for care or other relevant circumstances during the time premiums were not paid. For example, if a consumer incurred health care bills that exceeded the premium amounts, we believe the consumer should not have to repay the premiums since meeting the deductible may have been out-of-reach for the consumer. Or if the consumer can document a job loss or having suffered a serious medical incident that prevented paying the premiums, this should also be accepted for a waiver of paying past premiums. While we recognize insurers need to receive timely premiums, we also recognize that there must be a balance when consumers are unable to pay their bills due to exceptional circumstances and that other avenues exist for helping insurers compensate for consumers such as these.
We are also concerned about this proposal from a geographical perspective. That is, this proposal can discriminate against consumers merely due to where they live. If the consumer lives in a geographical area with only one issuer (which is the case in a number of counties across the country), these consumers will have no alternative but to enroll in a plan where they must first pay back premiums or be rejected. Consumers in geographic areas with a choice of plans may be able to enroll in a different plan and thus not be subject to the back payment requirement. We do not believe that a policy that likely will be implemented to the detriment of consumer merely based on geography should be adopted by HHS.

HHS also stated that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and thus HHS should ensure that any verification must provide consumers with an opportunity to provide additional or contrary information that may negate information from an insurer.

Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. This is especially important in states like South Carolina where we have many people living in rural areas with limited transportation available outside of their towns or counties. SC Appleseed commends HHS for these efforts, which are crucial to making the promise of care in the Affordable Care Act real.

The proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. South Carolina does very little to protect consumers in our insurance market and we do not anticipate that our regulators would step in to ensure network adequacy if this rule is implemented. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

Essential Community Providers

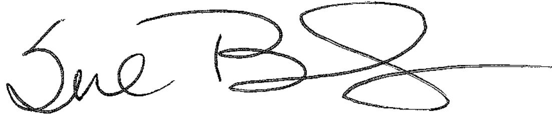
We urge HHS not to reduce the percentage requirement for ECPs. Instead, HHS is proposing to go backward, and reduce the percentage to only 20%. This reduction represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

We also urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

Thank you for consideration of our comments. If you have any questions, please contact Sue Berkowitz, sberk@scjustice.org. Thank you for your consideration,



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Comment separator page. Next comment follows.

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Empowered Families: Educated, Engaged, Effective!

SPAN & Family Voices-New Jersey comments to the Department of Health and Human Services on the Patient Protection and Affordable Care Act; Market Stabilization

March 7, 2017

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act; Market Stabilization. Family Voices is a national network that works to "*keep families at the center of children's healthcare*." The NJ State Affiliate Organization for Family Voices is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, Parent to Parent USA affiliate, and chapter of the Federation of Families for Children's Mental Health.

While SPAN provides information, training, technical assistance, parent to parent support, advocacy, and leadership development for all NJ families of children ages birth to 21, our priority is on children at greatest risk due to disability, special health care or emotional needs, poverty, discrimination based on race, culture, language, immigrant status, or economic status, or involvement in the child welfare or juvenile justice systems. Thus, we are particularly concerned with ensuring that the needs of children with special healthcare needs and their families are adequately addressed in federal, state and local policies and practices.

SUMMARY:

I. Executive Summary

We understand that there are concerns with issuer exit and increasing rates, and special enrollment periods as a potential source of adverse selection. To address this, we understand that the proposal is to shorten open enrollment to "a range of November 1, to December 15." Another proposal to prevent adverse selection in special enrollment is to increase "preenrollment verification of eligibility". A third proposal is to "allow issuers to apply a premium payment to an individual's past debt owed for coverage from the same issuer enrolled in within the prior 12 months". The last proposal is to "increase the de minimis variation in the actuarial values (AVs) used to determine metal levels of coverage for the 2018 plan year."

II. Background

A. Legislative and Regulatory Overview

1. Market Rules
2. Exchanges
3. Special Enrollment Periods
4. Actuarial Value

B. Stakeholder Consultation and Input

We appreciated the historical summary of market rules, exchanges, special enrollment periods, actuarial value, and description of stakeholder input.

III. Provisions of the Proposed Rule

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability of Coverage (§ 147.104)

We understand that there were "concerns about the potential for individuals with histories of non-payment to take advantage of guaranteed availability by declining to make premium payments for coverage at the end of a benefit year." We acknowledge that there is a proposal to modify "the guaranteed availability rules with respect to nonpayment of premiums." We appreciate that the "proposal would not prevent the individual or employer from enrolling in coverage with a different issuer, or affect the ability of any individual other than the person contractually responsible for the payment of premium to purchase coverage, whether from the same or different issuer." We understand that states are encouraged but not required "to adopt a similar approach, with respect to any State laws that might otherwise prohibit this practice." We understand that due to "grace periods and termination of coverage, individuals with past due premium would generally owe no more than 3 months of premiums."

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Initial and Annual Open Enrollment Periods (§ 155.410)

We understand that "beginning on January 1, 2018 would begin on November 1, 2017 and extend through January 31, 2018; and that the open enrollment period for benefit years beginning on January 1, 2019 and beyond would begin on November 1 and extend through December 15 of the calendar year preceding the benefit year." We are concerned that the shorter enrollment may affect the number of individuals having access to care. We disagree that "this shorter open enrollment period may have a positive impact on the risk pool because it will reduce opportunities for adverse selection by those who learn they will need services in late December or January" as individuals can't predict when health issues will arise.

2. Special Enrollment Periods (§ 155.420)

We understand that there are concerns that special enrollment "undermines the incentive for enrolling in a full year of coverage through the annual open enrollment period and increases the risk of adverse selection from individuals who wait to enroll until they are sick." But we disagree with this concern as again individuals cannot predict life events which will necessitate special enrollment. We understand that there were "added warnings on *HealthCare.gov* regarding inappropriate use of special enrollment periods. We also eliminated several special enrollment periods and tightened certain eligibility rules." We understand that there is a proposal to "increase the scope of preenrollment verification of special enrollment periods." During this time "consumers' enrollment would be 'pended' until verification of special enrollment period eligibility is completed." We understand that consumers would have "30 days

to provide documentation, and would be able to upload documents into their account on *HealthCare.gov* or send their documents in the mail." We understand that self-attestation was insufficient however we would suggest retroactive coverage to the effective date as well as exceptions for certain circumstances such as domestic violence in which a safety issue would override the need for documentation. We understand that "State-based Exchanges that do not currently conduct pre-enrollment verification of special enrollment period eligibility consider following this approach as well."

Although we understand that the proposal is the "address concerns about potential adverse selection" we are concerned about timely health care access. We also understand that there are concerns that "Exchange enrollees are utilizing special enrollment periods to change plan metal levels based on ongoing health needs during the coverage year, and that this is having a negative impact on the risk pool." We would like data on the percentage of the population in the Exchange in which this occurs.

As a result, we comprehend that there is a proposal to "limit the ability of existing Exchange enrollees to change plan metal levels during the coverage year." This would "apply in the individual market outside the Exchanges, but would not apply in the group market." We are concerned that for "special enrollment periods administered on the Exchange, the Exchange would limit the plan selection choices." We strongly disagree with this determination as again individuals cannot predict life events requiring special enrollment and should have the same choices as all enrollees.

We further understand that "if the QHP's business rules do not allow the new dependent to enroll, the Exchange may allow the enrollee and his or her new dependent to enroll in another QHP within the same level of coverage (or an ''adjacent'' level of coverage, if no such plans are available)" but we question under which circumstances this is not allowed. We understand that "if an enrollee or his or her dependent is not enrolled in a silver level QHP and becomes newly eligible for cost-sharing reductions and qualifies for the special enrollment periods…the Exchange may allow the enrollee and dependent to enroll in only a QHP at the silver level." Again we strongly disagree with this as there should still be consumer choice but would suggest a reminder to enrollees that they would be eligible for cost-sharing if they chose a silver plan. We acknowledge that for an "enrollee who qualifies for the remaining special enrollment periods… the Exchange must only allow the enrollee and his or her dependents to make changes to their enrollment in the same QHP or to change to another QHP within the same level of coverage." We understand that "This proposal ensures that enrollees who qualify for a special enrollment period or are on an application where an applicant qualifies for a special enrollment period to newly enroll in coverage are not using this special enrollment period to simply switch levels of coverage during the coverage year." Again, we don't' think consumers can use life events in this manner if there is pre-enrollment verification this adds unnecessary restrictions. Lastly we are deeply concerned with the proposal to "exclude the special enrollment period in paragraph (d) (8) for Indians and their dependents" and would like clarification the rationale for this.

We understand that there is a proposal to "allow consumers to request a later coverage effective date than originally assigned if his or her enrollment was delayed due to an eligibility

verification and the consumer would be required to pay 2 or more months of retroactive premium in order to effectuate coverage or avoid termination of coverage due to nonpayment of premiums." We understand that this would allow "consumers to start their coverage 1 month later than their effective date would ordinarily have been." However, we strongly think that consumers should have the choice of retroactive coverage as well, as delays were due to no fault of their own.

We also comprehend that "in order to ensure that a special enrollment period for loss of minimum essential coverage in paragraph (d) (1) is not granted in cases where an individual was terminated for nonpayment…permit the issuer to reject an enrollment." We understand that there are concerns that "consumers are opting not to enroll in QHP coverage during the annual open enrollment period and are instead newly enrolling in coverage during the coverage year through the special enrollment period for marriage." We disagree with this in principle as we don't believe consumers plan marriage around health coverage. There is a proposal that "at least one spouse must demonstrate having had minimum essential coverage…for 1 or more days during the 60 days preceding the date of marriage." We appreciate the recognition that "individuals who were previously living abroad or in a U.S. territory may not have had access to coverage that is considered minimum essential coverage." To address this, we understand that the proposal is "at least one spouse must either demonstrate that they had minimum essential coverage or that they lived outside of the U.S. or in a U.S. territory for 1 or more days during the 60 days preceding the date of the marriage. This proposed change would only apply in the individual market."

We acknowledge that "HHS acknowledges that this rule proposes changes for special enrollment periods in the individual market that differ from the rules regarding special enrollment periods in the group market." We again disagree with the proposal to "limit plan selection to the same plan or level of coverage when an enrollee qualifies for a special enrollment period." We seek data to clarify why "Employer-sponsored coverage is generally a more stable risk pool." We do not understand why this necessitates "tighter restrictions on special enrollments and the ability to change plans for current enrollees better addresses the unique challenges faced in the individual market."

We understand that there is a proposal to "expand the verification requirements related to the special enrollment period for a permanent move." We also understand that "This special enrollment period is only available to a qualified individual or enrollee who has gained access to new QHPs as a result of a permanent move *and* had coverage for 1 or more days in the 60 days preceding the move, unless he or she is moving to the U.S. from abroad or a U.S. territory." The requirement is "to prove both their previous and new addresses." Again here we are concerned about domestic violence situations.

It is understood that there is a proposal to "significantly limit the use of the exceptional circumstances special enrollment period." The proposal is to discontinue special enrollment for:

- "Consumers who enrolled with advance payments of the premium tax credit that are too large because of a redundant or duplicate policy;

- Consumers who were affected by a temporary error in the treatment of Social Security Income for tax dependents;
- Lawfully present non-citizens that were affected by a temporary error in the determination of their eligibility for advance payments of the premium tax credit
- Lawfully present non-citizens with incomes below 100% FPL who experienced certain processing delays; and
- Consumers who were eligible for or enrolled in COBRA and not sufficiently informed about their coverage options."

We disagree with discontinuing special enrollment for "temporary errors," "processing delays," and consumers who were "not sufficiently informed about their coverage options." None of these circumstances were due to consumer error.

3. Continuous Coverage

We understand that there is a proposal of "a longer 'look back' period." This could include "prior coverage for 6 to 12 months, except that we might consider an individual to have had prior coverage, even if there was a small gap in coverage (for example, up to 60 days). " We disagree with this as many families with fluctuating incomes can go off and on insurance so when they have no coverage they should be eligible. Another proposal would be that "individuals who are not able to provide evidence of prior coverage… exception could allow them to enroll in coverage if they otherwise qualify for a special enrollment period, but impose a waiting period of at least 90 days before effectuating enrollment." Again we would ask this to be waived in exceptional circumstance such as domestic violence.

We understand that while HIPAA (Health Insurance Portability and Accountability Act) of 1996 didn't require maintenance of coverage, it did require "continuous, creditable coverage without a 63-day break in the group market if individuals wished to avoid the pre-existing condition exclusions." We strongly disagree with this proposal as it will slowly erode on of the main protections consumers have today regarding guaranteed issue and not allowing rescission of policies.

4. Enrollment Periods Under SHOP

We understand that these changes apply to "special enrollment periods in the individual market only' and that they "do not apply to special enrollment periods under the Small Business Health Options Program (SHOP). "

5. Exchange Functions: Certification of Qualified Health Plans (Part 155, Subpart K)

We understand that the Department will "issue separate guidance to update the QHP certification and look forward to this with great interest.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Levels of Coverage (Actuarial Value) (§ 156.140)

We acknowledge that a plan's "coverage level, or actuarial value (AV), is determined based on its coverage of the EHB for a standard population" Currently the ACA requires "a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent; a gold plan to have an AV of 80 percent; and a platinum plan to have an AV of 90 percent." In addition under the ACA the Secretary is authorized "to develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." We understand that "HHS established that the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is +/-2 percentage points." This includes the exception "if a bronze health plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan… the allowable variation in AV for such plan is -2 percentage points and +5 percentage points." We understand that this was to "ensure that a variety of bronze plans can be offered, including high deductible health plans, while ensuring that bronze plans can remain at least as generous as catastrophic plans." However we disagree with this as then the bronze plan becomes a catastrophic or "bare bones" policy, not a true bronze plan. We understand this was done "to give issuers the flexibility to set cost-sharing rates that are simple and competitive while ensuring consumers can easily compare plans of similar generosity" but we see this as higher rates for less care.

We understand that there is a proposal to change "the AV de minimis range for metal levels to help issuers design new plans for future plan years." It is postulated that "changing the de minimis range will allow more plans to keep their cost sharing the same from year to year…changing the de minimis range could also put downward pressure on premiums." We strongly disagree with this as premiums historically continue to rise. We comprehend that the proposal is "amending the definition of de minimis…to a variation of -4/+2 percentage points, rather than +/- 2 percentage points for all nongrandfathered individual and small group market plans that are required to comply with AV." This means that "a silver plan could have an AV between 66 and 72 percent." We strongly disagree with changing this amount as our experience has been that the minimum becomes the new maximum so it's the "ceiling not the floor."

We note that "For the 2018 AV Calculator, we made several key updates…including updating the claims data underlying the continuance tables that represent the standard population to reflect more current claims data." We understand that "all previous versions of the AV Calculator had been using 2010 (pre-Affordable Care Act) claims data and the 2018 AV Calculator is using 2015 (post- Affordable Care Act) claims data." We disagree that the "proposed flexibility in the de minimis range is also intended to help provide some stability to those plans that are being impacted by the updates to the AV Calculator."

We understand that the proposal is "to provide the increased flexibility in the *de minimis* range starting with the 2018 AV Calculator. We seek comment on whether making the change effective for the 2019 plan year would be preferable…" As stated above we disagree with the changes in the de minimis range.

We understand that there is not a proposal to "modify the *de minimis* range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent.)" We understand that there is consideration "whether the ability for an issuer to offer a standard silver level plan at an AV of

66 would require a plan variation to be offered at an AV of 70 or some other mechanism to provide for cost-sharing reductions for eligible individuals with household incomes that are more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved" which makes sense but again disagree in general with changing the de minimis level.

2. Network Adequacy (§ 156.230)

We understand that there is a proposal to "rely on State reviews for network adequacy in States in which an FFE is operating, provided the State has a sufficient network adequacy review process, rather than performing a time and distance evaluation." Although our state currently has no federal oversight on network adequacy, this proposal is deeply concerning as a recent report from the Office of the State Auditor demonstrated that 4 out of 5 NJ HMOs had inadequate networks.[i] We understand that there is also a proposal for "States that do not have the authority and means to conduct sufficient network adequacy reviews." In this case HHS would "rely on an issuer's accreditation (commercial or Medicaid) from an HHS recognized accrediting entity. HHS has previously recognized 3 accrediting entities for the accreditation of QHPs: the National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care." We strongly agree with the proposal to "further coordinate with States to monitor network adequacy, for example, through complaint tracking." We are interested in the intention to "release a proposed timeline."

3. Essential Community Providers (§ 156.235)

We understand that Essential Community Providers (ECP) "serve predominantly low-income and medically underserved individuals." We understand that there are two proposals regarding the stipulation "that a plan has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that the network includes as participating practitioners at least a minimum percentage, as specified by HHS." Originally this was set as a minimum percentage of 20 percent but was increased on 2015 to 30 percent. The proposal, with which we disagree, is to return to the 20 percent. The rationale is that it will "substantially lessen the regulatory burden on issuers…this proposal would result in fewer issuers needing to submit a justification to prove that they include in their provider networks a sufficient number and geographic distribution of ECPs to meet the standard." There must have been good cause to raise the minimum to 30 percent and we strongly oppose regressing to previous levels for administrative convenience which will have a negative impact on consumers.

We also understand that "for plan year 2018, we propose that an issuer's ECP write-ins would count toward the satisfaction of the ECP standard only for the issuer that wrote in the ECP on its ECP template, provided that the issuer arranges that the written-in provider has submitted an ECP petition to HHS by no later than the deadline for issuer submission." We also acknowledge that "if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider networks in future years."

IV. Collection of Information Requirements

We understand that comment is sought on the need for information collection; accuracy of estimates; quality, utility, and clarity of information, and minimizing the information collection burden. Our comments on each of these fall under the sections pertaining to ICRs below.

A. ICRs Regarding Verification of Eligibility for Special Enrollment Periods (§ 155.420)

We understand that the “pre-enrollment verification of eligibility for all categories of special enrollment” would affect “an additional 650,000 individuals.” It is estimated that this would increase the annual burden in the amount of “130,000 hours with an equivalent cost of $5,306,600. We question if this cost is justifiable for the small amount in individuals affected.

B. ICRs Regarding Network Adequacy Reviews and Essential Community Providers (§ 156.230, § 156.235)

We acknowledge that this proposal would “reduce the burden related to the time and distance evaluation for issuers…by 15 hours per issuer on average. It is noted that this is the “equivalent reduction in cost of $192,500.” However we have expressed our concerns regarding state monitoring of network adequacy above. We also understand that stand-alone dental issuers would have to submit plans at “an annual equivalent cost of $9,625.”

V. Response to Comments

We understand the HHS is unable to acknowledge or respond to comments due to the large volume of comments received.

VI. Regulatory Impact Analysis

A. Statement of Need

Although we understand the rationale is regarding the “decrease in the number of participating issuers and… increases in premiums” we do not believe this approach will address this concern for the reasons stated above.

B. Overall Impact

We understand that this proposal “meets the definition of ‘significant rule ‘ under Executive Order 12866. Therefore, HHS has provided an assessment of the potential costs, benefits, and transfers associated with this proposed rule.” As stated in our comments we do not believe that consumers are “gaming” the system or can predict life events so this will not affect “adverse selection and incentivize consumers to maintain continuous coverage.” We question whether the expense on special enrollment reviews is worthwhile and are concerned that less health care access due to delays will actually increase costs as conditions will be more severe and less treatable. Most importantly we are concerned with the potential human cost due to delays of

increased morbidity and mortality. Issuers would experience a reduction in costs related to network adequacy reviews.

C. Impact Estimates and Accounting Table

We appreciated Table 2 regarding “HHS’s assessment of the benefits, costs, and transfers.” Under *benefits*, we strongly disagree that this will result in “improved health and protection from the risk of catastrophic medical expenditures” due to delays as well is decreasing the de minimis standard. We also strongly disagree that this will result in “cost savings due to reduction in medical service provision” as ultimately this will increase costs due to lack of health care access for prevention and treatment. We also strongly disagree that there will be “Cost savings to issuers from not having to process claims while enrollment is ‘pended’ during pre-enrollment verification of eligibility” and if consumers have to pay retroactively, coverage should have a corresponding retroactive effective date. We understand that there will be cost savings due to the shortened enrollment period but question whether this will increase special enrollment requests.

Regarding *costs*, we again disagree with less “harms to health and reduced protection form the risk of catastrophic medical expenditures” for the reasons stated above. A single serious health even could bankrupt an uninsured family while they wait for coverage. We do agree that there could be increased costs if enrollment increases but again health expenditures overall are less for the insured due to access to preventive care and early treatment. We strongly agree that there will be “Decreased quality of medical services (for example, reductions in continuity of care due to lower ECP threshold).” We also agree that there will be increased costs regarding special enrollment verification, costs to issuers for plan redesign, and costs regarding outreach on the shortened enrollment period.

With regard to *transfers*, we strongly disagree that there will be “Transfers, via premium reductions, from special enrollment period abusers to all other enrollees” as we believe there is a small percentage of “abusers” and that premiums will rise in any case. We agree that there will be “Transfers related to changes in actuarial value from enrollees to issuers and, via possible reductions in subsidies” which means consumers will get less benefits and lower subsidies.

1. Guaranteed Availability of Coverage

We understand that the proposal will “require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past due premium owed to that issuer after the applicable due date for coverage in the prior 12- month period in order to resume coverage from that same issuer.” We acknowledge that of the “21 percent of consumers stopped premium payments in 2015…. Approximately 87 percent of those individuals repurchased plans in 2016, while 49 percent of these consumers purchased the same plan they had previously stopped payment on.” We understand that overall “one in ten enrollees had their coverage terminated due to non-payment of premiums in 2016.”

2. Open Enrollment Periods

We agree that a "shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period" which would not mitigate adverse selection.

3. Special Enrollment Periods

We understand that the proposal "would increase the scope of pre-enrollment verification, strengthen and streamline the parameters of several existing special enrollment periods, and limit several other special enrollment periods" However we do not regard this as streamlining special enrollment but rather as an additional obstacle resulting in delays. We that "an additional 650,000 individuals having their enrollment delayed or 'pended' annually until eligibility verification is completed" which again will result in coverage delays. We do not agree that there is the possibility of pre-enrollment verification causing "premiums to fall and all individuals hat inappropriately enrolled via special enrollment periods continue to be covered, there would be a transfer from such individuals to other consumers" as premiums will rise regardless. We do agree that "if some individuals are no longer able to enroll via special enrollment period, they would experience reduced access to health care" resulting ultimate in higher costs, and increased morbidity/mortality.

4. Levels of Coverage (Actuarial Value)

We strongly disagree with "amending the de minimis range…to a variation of -4/+2 percentage points, rather than +/-2 percentage points for all non-grandfathered individual and small group market plans." We also strongly disagree with changing "the de minimis range for the expanded bronze plans from +5/-2 percentage points to +5/-4 percentage points." We understand that there will be no change to "the de minimis range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent.)" We strongly agree that this would "reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs." We do not agree that providing "issuers with additional flexibility could help stabilize premiums." Insurers already use "loopholes" to avoid their responsibility in providing care at the expense of consumers.

5. Network Adequacy

As stated previously, we strong disagree with HHS deferring to "State's reviews in States with authority and means to assess issuer network adequacy" as network inadequacy is already existent and affects consumer health particularly in the areas of specialty care, pediatrics, and mental health.

6. Essential Community Providers

Again, as stated above we strongly oppose the proposal to reduce ECPs back down to 20 percent as this will adversely affect access to care to already vulnerable and underserved populations.

7. Uncertainty

We strongly disagree that "premiums would tend to fall if more young and healthy individuals obtain coverage" as historically they continue to rise. We agree that "shortened open enrollment period, pre-enrollment verification for special enrollment periods, reduced actuarial value of plans, less expansive provider networks result in lower enrollment, especially for younger, healthier adults, it would tend to increase premiums."

C. Regulatory Alternatives Considered

We were disappointed as this section merely offered the option of maintaining the status quo for all areas with the only alternatives being the proposals offered. That being the case, we would prefer no changes at all.

E. Regulatory Flexibility Act

We understand that it was calculated that "entities with average annual receipts of $38.5 million or less would be considered small entities for these North American Industry Classification System codes." We further understand that "approximately 97 out of 528 issuers of health insurance coverage nationwide had total premium revenue of $38.5 million or less." We agree that this is an overstatement as "almost 74 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that would result in their revenues exceeding $38.5 million."

F. Unfunded Mandates

We understand that while HHS has been unable to quantify all costs, it is expected that "the combined impact on State, local, or Tribal governments and the private sector to be below the threshold."

G. Federalism

We agree that "this proposed regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets." We also understand that some of these effects are mitigated as "States have choices regarding the structure, governance, and operations of their Exchanges." In addition there is no requirement that "State-based Exchanges engage in pre-enrollment verification" or for states to conduct network adequacy reviews.

H. Congressional Review Act

We agree that "This proposed rule is subject to the Congressional Review Act provisions" and understand that "the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller for review."

I. Reducing Regulation and Controlling Regulatory Costs

We acknowledge that it has been determined that “this proposed rule is not a ‘significant regulatory action that imposes costs’ and thus does not trigger the above requirements of Executive Order 13771.’’

Thank you again for the opportunity to comment to HHS on the Patient Protection and Affordable Care Act; Market Stabilization.

Sincerely,

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To empower families and inform and involve professionals and other individuals interested in the healthy development and education of children, to enable all children to become fully participating and contributing members of our communities and society.

[i] https://www.healthmanagement.com/wp-content/uploads/012517-HMA-Roundup.pdf#nameddest=hma-roundup

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I oppose the proposed requirements that narrow special enrollment periods for the ACA. People who need to purchase insurance during a special enrollment period are often facing major life transitions, such as the birth of a baby or the loss of a job. The proposed requirement that proof be submitted prior to gaining coverage places an undue burden on people who may already be facing significant stress. The old rule, which allowed people to sign up and submit evidence of the life change and their qualification for the special enrollment period later is a better option because it ensures that Americans who are facing difficult life transitions will not become uninsured. Imagine having a baby born pre-maturely and having to be cared for in the NICU. Most people would want to add that baby to their insurance immediately and later, when their baby was out of danger, provide the documentation.

I am also concerned that the proposed rules would lead to subsidies decreasing. The proposal to increase the margin of error on coverage from 2% to 4% sounds like a minor change, but it means that the second cheapest silver plan could drop to 66% of coverage. This would mean that while subsidies would not increase, the cost of plans would increase. As somebody who is currently using the ACA (my husband owns a small business and I work in a full-time temp job that does not provide benefits) and receiving a subsidy, this would be a severe hardship for us. I am a cancer survivor and my husband has type 1 diabetes, which requires regular medical care and insulin. We cannot afford to choose a high deductible plan because we know that we would end up paying thousands of dollars in medical costs out of pocket. We need good coverage that is affordable. In the future, I hope that we will not need a subsidy, but while we do it does not make sense to penalize us with either premiums we cannot afford or a plan that does not provide full coverage. Under those conditions, my husband would need to close his small business and get a job with benefits so we could purchase the insurance that provides the coverage we need.

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Comments on CMS-9929-P

(155.410 (e)) With regard to the proposed change in the Enrollment period for 2018, I am concerned that State markets such as New York State of Health be required to accept enrollments for the full period: November 1, 2017 to December 15, 2017. In New York State for 2017 Enrollment, enrollments were not accepted until November 15, 2016. If that occurred again for 2018 Enrollment, the ending date of December 15 would only allow one month, during a holiday period. The enrollment periods for every state need to be at least one and one-half months.

(155.420) With regard to changes in the Special Enrollment Periods, this rule is premature. You are conducting two pilot projects to both retrospectively and prospectively audit or verify eligibility. But before you have the results, you are preemptively requiring eligibility checks for everyone. As you note, creating new barriers to enrollment will more likely deter healthier, less-motivated individuals. In addition, without knowing whether this increased verification will be useful, you are imposing $5,306,600 in additional costs. I would urge you to get and analyze the data from your current pilot projects before moving forward on these verification requirements. I will note that my own experience in providing information when my income declined was frustrating. Although I was projecting my 2017 income, New York State required irrelevant information about my previous income despite the fact that I had discussed why circumstances had changed. They used this irrelevant information to decrease my subsidy. While this will all come "out in the wash" when I file my 2017 income tax, it deprives me of current income in a time of reduced overall income. To assert, as you do in your Collection of Information Requirements, that the proposed provisions would not impose any additional burden on consumers is nonsensical. Clearly imposing more verification requirements will impose considerably greater burdens on consumers.

(156.140) I strongly oppose the proposed increase in the AV de minimis range for metal levels for either 2018 or 2019. Consumers are already faced with myriad choices. The metal ranges AV percentages give them some indication of what they are buying and its implications for their total health care spending. Allowing plans to provide more than 2% less than those stated levels

is destructive to consumer's ability to make sensible choices.

(156.230) I also strongly oppose dropping the time and distance criteria for establishing network adequacy. Network adequacy is already among the most problematic decision for consumers. Eliminating quantifiable measurements for vague state or accreditation criteria is anti-consumer.

(156.235) The proposed lessening of standards for ECPs and for the inclusion of ECPs in QHPs are similarly anti-consumer. These changes will decrease access for predominantly low-income and medically underserved individuals. I strongly oppose these proposed changes.

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Submitted electronically

March 7, 2017

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Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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RE: Patient Protection and Affordable Care Act; Market Stabilization (CMS-9929-P)

Dear Acting Administrator Conway:

Thank you for the opportunity to comment on the proposed Market Stabilization rule. These comments are jointly submitted by the Office of the Health Care Advocate and the Vermont Low-Income Taxpayer Clinic, both of which are projects of Vermont Legal Aid.

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. The HCA handles over 4,000 cases per year. The HCA also engages in a wide variety of consumer protection activities on behalf of the public, including before Vermont Health Connect, other state agencies, and the Vermont legislature.

The Vermont Low-Income Taxpayer Clinic is a low-income taxpayer clinic funded under section 7526 of the Internal Revenue Code. The Clinic educates, represents, and advocates for low-income individuals on federal tax matters.

General Comments

In general, we are concerned that the proposed rule will negatively impact consumers' ability to enroll in good-quality, comprehensive, and affordable health coverage. The proposed rule would add enrollment restrictions and make coverage less comprehensive and more expensive for consumers. The enrollment restrictions are unlikely to further their stated purpose of stabilizing the health insurance marketplaces, and instead will likely reduce enrollment by healthy young adults. HHS's assessment of the benefits, costs, and transfers associated with this proposed regulation is inadequate and does not support the need for this proposed rule.

We are also disappointed by the unusually short comment period for this proposed rule. In light of the multiple significant changes being proposed, 20 days is not sufficient for stakeholders to thoroughly analyze and comment on this proposed rule.

HHS should open a new comment period to allow stakeholders to analyze how pending budget reconciliation legislation unveiled on March 6, 2017,[1] affects the proposed rule.

Guaranteed Availability of Coverage - § 147.104

The Department of Health and Human Services (HHS) proposes to allow issuers to refuse to enroll a consumer in any insurance product, if the consumer has an unpaid premium bill from the past 12 months' enrollment with that issuer. Also, issuers who allow enrollments in that situation would be able to attribute premium payments to the prior year's unpaid bill. In contrast, current HHS guidance distinguishes between the sale of a new insurance product (which is subject to the statutory guaranteed issue requirement) and the renewal of a consumer's existing plan (which is not).[2]

The proposed change would violate the Affordable Care Act's guarantee of coverage availability. The proposed reinterpretation of the guaranteed availability provision is unlawful and beyond HHS's statutory authority. An issuer "must accept every employer and individual in the State that applies for such coverage."[3] Enrollment may only be restricted to open or special enrollment periods. HHS does not have authority to add a new restriction for prior non-payment of premiums.

CMS Marketplace enrollment statistics do not support some issuers' speculation that consumers might be deliberately failing to pay premiums at the end of the year.[4] No evidence of significant gaming has been presented by issuers. Instead, only anecdotes have been cited. This is consistent with our experience interacting with thousands of healthcare consumers per year. We do not see our clients gaming the system; they do not understand the system well enough. In Vermont, the enrollment system has also been too dysfunctional for anyone to game.

Operational Concerns: If the proposed reinterpretation is adopted, we predict that it will lead to consumers who have paid their bills being wrongfully denied enrollment and losing needed medical care.

Vermont's exchange, Vermont Health Connect (VHC), has suffered from widespread billing and other operational problems.[5] (In Vermont, exchange enrollees must pay their premiums through the exchange rather than directly to the issuer.) Consumers frequently complain of being billed the

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[1] *Ways and Means Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://waysandmeans.house.gov/american-health-care-act/; *Energy and Commerce Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://energycommerce.house.gov/news-center/press-releases/energy-and-commerce-republicans-release-legislation-repeal-and-replace.

[2] *Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual, Section 6.3 Terminations for Non-Payment of Premiums, available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf.

[3] 42 U.S.C. § 300gg–1(a).

[4] See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016. See particularly Figure 1, *Enrollees Leave Marketplace Health Plans Gradually Throughout the Year*.

[5] *See*, Strategic Solutions Group LLC, *Recommendations for the Future of the Vermont Health Benefit Exchange* (Dec. 21, 2016), pp. 12-27, available at http://www.leg.state.vt.us/jfo/Future_of_VHC_Exchange.aspx.

wrong amount, having their payments rejected or not applied correctly, and other problems. The HCA routinely represents consumers attempting to resolve billing problems that are not their fault. The access to care problems that this causes would be compounded if issuers could deny enrollment altogether or attribute current-year premiums to a prior year's debt. This currently happens to renewed consumers, and would happen more widely if it also affected consumers who changed plans with the same issuer.

> Case example: Mr. H called us when he found out that his family plan had been cancelled. He had discovered the cancellation when he took his children to the doctor and was told that they had no coverage. We looked into the issue and found that he had been terminated for non-payment. When Mr. H's payment record was reviewed, though, it showed that he had paid all his premiums. The family had dropped their dental coverage, which had created an error in the billing system that ultimately caused him to be terminated, even though he was up-to-date with his payments. Because there was no basis for a non-payment termination, we got the family's coverage reinstated.

The Vermont exchange also has a history of failing to terminate coverage promptly upon request. This can lead to issuer records showing several months of unpaid premiums. In 2014 and 2015, the exchange had serious trouble processing terminations and was unable to do so within 15 days of a consumer request. This problem was compounded by incorrect tax reporting and failure to enforce the grace period regulations. During the 2016 tax season, we saw many examples of Forms 1095-A incorrectly showing more than one month of unpaid premiums due. Initially the exchange said this was because the grace period termination rules were permissive, not mandatory.

While the Vermont exchange has improved its processing times greatly in the past year, and now says it is enforcing the HHS grace period rules, nonpayment records are not always accurate. If the proposed reinterpretation is adopted, consumers must be given an opportunity to dispute the amount and existence of the debt.

Most low-income consumers do not have the ability to pay their premium twice in one month. If a premium payment is attributed to a prior year's debt, the consumer may not be able to pay the current premium. This may lead to nonpayment terminations and long periods of consumers going without insurance until the next open enrollment period.

If the proposed reinterpretation of guaranteed issue is adopted, we believe at a minimum the following safeguards should be adopted:

1. Notice. The issuer's repayment policy should be clearly noted on the exchange website so that consumers have that information when comparing plans. Second, it should be noted in the eligibility determination notice since consumers could change plans if open enrollment or a special enrollment period remains open. Third, the issuer should be required to provide notice of the policy on its website, to new enrollees, and in all dunning notices.
2. Premium payment thresholds should be permitted. See comment below. Issuer flexibility in this area benefits both issuers and consumers.
3. Hardship exceptions. Exceptions should be required for hardship situations, including but not limited to domestic violence, falling victim to a crime, being unable to pay due to a medical emergency, incarceration, and financial hardships.

4. Reiterate the maximum debt following a nonpayment termination. HHS should reiterate that when a subsidized enrollee's coverage is terminated at the conclusion of the 90-day grace period, the person would normally owe no more than their share of the premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers and state-based exchanges that the grace period termination rules at section 155.430(d)(4) are mandatory.

We do not believe the reinterpretation, if adopted, should apply to special enrollment periods.

Premium Payment Threshold: Comments were requested on whether issuers should be permitted to enact a premium payment threshold policy, whereby a consumer would be considered in good standing upon payment of a threshold percentage or amount of past due premiums. We strongly support flexibility for issuers to set a reasonable tolerance for premium payments, both in general and if the proposed reinterpretation of guaranteed availability is adopted.

Open Enrollment Dates - § 155.410

The open enrollment period should continue through the month of January 2018, or at least until January 15. We believe the window of time after January 1 is critical to capturing consumers who forgot to enroll on time or misunderstood the enrollment process. For example, there may be consumers who *thought* they were enrolled or renewed, and it will not be until January when they seek medical care that they figure out they were not enrolled, or that they were enrolled in the wrong plan. In our experience, consumers with enrollment problems usually discover them when they attempt to fill a prescription or visit a medical provider. Consumers also regularly discover problems when they receive their January premium bill, which is often received after December 15.

We do not believe Vermont consumers are ready for a much shorter enrollment period in 2017. The HCA heard from many consumers with enrollment questions and problems after December 15, 2016. In addition, there are many fewer navigators than there were in 2014, and shortening the enrollment period would make it more difficult for them to reach and serve all consumers requesting help. For example, there is only one navigator left in Windham County, Vermont, and she also serves part of Windsor county. With further navigator grant cuts proposed, it is even less likely that consumers will get the help they need during a shortened enrollment period.

HHS explains that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are generally the most diligent about signing up for insurance. We believe the policy change could just as easily lead to a sicker pool, if young, healthy people end up missing the new deadline.

Further, ending the open enrollment period in mid-December is problematic because it is when many consumers face financial pressures and distractions due to the holiday season.[6] Many of our clients worry about "how to pay for Christmas" for their children. As Blue Cross Blue Shield of Florida noted, ending open enrollment in December "forces consumers to make financial decisions

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[6] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

when their debt is at its highest levels and their interest in their health is at the lowest."[7] We agree with this assessment based on our experience assisting Vermont consumers.

Special Enrollment Periods - § 155.420

We are seriously concerned that the proposed verification requirements will deter eligible consumers from accessing health insurance, to the detriment of the market and to the goals of the Affordable Care Act (ACA). We disagree with the proposed changes to special enrollment period verification, because they are not based on solid evidence. Rather than strengthening the risk pool, they will more likely weaken it by discouraging mid-year enrollment by younger, healthier people. HHS should not take that risk without evidence-based analysis.

Significant changes in enrollment verification should not be adopted prior to a full evaluation and analysis of the post-enrollment verification pilot and the random sampling audits conducted by HHS in 2016. HHS should continue its previous plan to conduct a pre-enrollment verification pilot in 2017. Then, HHS can take appropriate steps against fraudulent enrollments, informed by actual data.

The fact that mid-year enrollees have higher health costs on average is not proof that special enrollment period (SEP) enrollments are fraudulent or erroneous. Consumers who lose health insurance mid-year will compare the cost of a Marketplace plan with the tax penalty for remaining uninsured, and some choose not to sign up. It is contrary to the aims of the ACA to address this by establishing barriers that discourage *eligible* consumers from enrolling. Aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that were put into place in 2016: twenty percent fewer consumers enrolled using in SEPs, and younger consumers were less likely than older ones to follow through.[8] These young consumers tend to be healthier and are the very people we need to encourage to enroll in coverage. These new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will take the steps necessary to complete the process.

Given the dramatic effects of the 2016 SEP changes, it is inaccurate to say that the proposed changes will have no increased burden on consumers. On the contrary, they will increase consumer burden significantly. Not only will verification requirements be expanded, but enrollment will be pended while verification is conducted. We doubt that exchanges (at least Vermont's) will have the capacity to electronically verify many (if any) SEPs in realtime; therefore many consumers will experience a delay in access to medical care while paper verification is submitted and processed. This is extremely concerning.

HHS's cost analysis must include the impact on consumers and providers of pended enrollments, including missed medical appointments, delayed medical care, and the need to pay out of pocket while enrollment is pending. We anticipate these will be significant costs to consumers subject to pre-enrollment verification, particularly if it involves submission and review of paper documents.

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[7] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.

[8] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

Also, HHS's cost analysis should include the individual and systemic costs of *eligible* consumers going uninsured due to an inability or unwillingness to complete the verification process.

We disagree with HHS's statement that pre-enrollment verification would reduce costs for issuers. In Vermont, issuers regularly complain about having to process retroactive claims and retroactively effective enrollments. At best, issuers' costs under pre-enrollment verification would be neutral. HHS's cost analysis should also include the increased time spent by medical providers having to re-bill claims after the fact, and time that consumers will have to spend requesting that their claims be re-billed.

HHS justifies the proposed changes by "strong issuer feedback and the potential to help stabilize" the marketplace. Since SEP enrollees have higher-than-average costs, issuers have an incentive to request restrictions on SEP enrollments regardless of consumer eligibility; issuer interests are not aligned in this area with the public health goals of the ACA. It seems highly unlikely that restricting enrollment is the missing piece needed to stabilize the market, given the uncertainty in Congress around the future of the ACA, and given the pending lawsuit challenging cost-sharing reduction payments to issuers.

In our experience, most consumers are confused by the exchange regulations, and do not understand the system well enough to try to game it. In Vermont, we have not seen SEPs being abused by consumers. There is a lot of confusion about how long SEPs last, and some consumers have called HCA after missing the deadline.

Erroneous enrollments do sometimes result from exchange or assistor error. We support HHS's efforts to conduct pilots and studies to better understand enrollment dynamics, the composition of the SEP enrollee population and the causes thereof, and the effects of pre-and post-enrollment verification requirements. If the proposed changes are implemented, we support the exclusion of a statistically significant population for study purposes.

We believe pre-enrollment verification would result in fewer enrollments, especially among consumers who do not expect to need much health care. In our experience, enrollment barriers have a significant deterrent effect on consumers who are on the fence regarding getting coverage. We have seen this with consumers abandoning the application process after not being able to complete it in one session. Consumers who know that they will need medical care, on the other hand, will gather the necessary documents and complete the SEP enrollment process.

If HHS finalizes its proposed changes to SEPs, it should permit state-based marketplaces to establish their own verification rules or pilot programs. We disagree with HHS's proposal to encourage state-based marketplaces to adopt pre-enrollment verification.

<u>Implementation Suggestions</u>: If the proposed verification changes are adopted, we have several concerns and suggestions for implementation.

- Verification should only be required in suspicious individual cases or for situations with a higher likelihood of erroneous enrollment. We believe that the birth/adoption/foster care placement SEP should be excluded from blanket verification requirements.

- HHS should not adopt pre-enrollment verification requirements until the exchanges are operationally capable of electronically verifying at least prior public coverage (including Medicaid, CHIP, Medicare) and prior QHP coverage nationwide.
- A statistically significant population should be excluded for study purposes.
- State-Based Marketplaces should be permitted to establish their own verification rules including verification pilot programs. They should not be required to conduct pre-enrollment verification.
- Consumers should continue to have flexibility to request later coverage effective dates if their enrollment is delayed by the verification process. We object to the proposal to limit this choice to one month maximum, when there is no time limit placed on the exchanges to process verification documents. Consumers should be able to request a coverage effective date as late as necessary to limit their retroactive premiums to one month. This will tie the limit to the promptness of the exchange's verification process.
- Any additional SEP changes made by HHS (including those discussed below) should be optional for State-Based Marketplaces.

Changing Plan Levels: We oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event. Life changes such as birth and marriage may significantly alter the amount of cost-sharing reductions and advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs.

An individual who gains a new dependent should be permitted to take that dependent's medical needs into account when deciding which insurance plan to choose, as well as the family's financial situation. In some cases it would be simply cruel to restrict a new parent of a special needs child to the metal level they chose during open enrollment, at which time they may not have expected to have a baby at all.[9] An unexpected dependent also has a significant financial impact on a family. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs.

The potential for adverse selection is already adequately addressed by the requirement to qualify for an SEP (based on non-medical criteria) in the first place. We support the use of studies and pilot projects to investigate issuer claims of malfeasance. The ACA provides for special enrollment periods, and issuers simply need market experience and data to price their plans accordingly.

The proposal to limit plan metal level changes during SEPs is prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage."[10] While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage." HHS does not have the statutory authority to limit which plans an SEP enrollee can choose.

[9] In 2006, 49% of pregnancies were unintended. See, Centers for Disease Control and Prevention, at https://www.cdc.gov/reproductivehealth/unintendedpregnancy/.
[10] 42 U.S.C. § 300gg–1.

Payment of Past-due Premiums: Consumers do not qualify to enroll in an SEP for loss of minimum essential coverage if that loss was due to nonpayment of premiums. It is reasonable to require exchanges to develop electronic verification systems for this factor. However, if issuers are permitted to reject enrollments on this basis, the exchange should be required to notify the consumer of this and give the consumer the opportunity to contest the issuer's records as part of an appeal of the SEP denial. In addition to notice and the opportunity to appeal, hardship exceptions should be adopted, including but not limited to domestic violence, falling victim to a crime, being unable to pay due to a medical emergency, incarceration, and financial hardships.

As explained above, we object to HHS's proposal to allow issuers to reject SEP enrollees who have an unpaid premium bill from coverage in the prior 12 months. This is prohibited by the ACA's guaranteed issue requirement.

Marriage and Permanent Move SEPs: Requiring evidence of continuous coverage for marriage and permanent move SEPs is prohibited by statute.[11] The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage."[12] While issuers "may restrict enrollment … to open or special enrollment periods," this does not allow any continuous coverage requirement.

The proposed continuous coverage requirement will lead to hardship and an increase in the uninsured population. Individuals may not have been eligible for affordable coverage prior to marriage or prior to their move. This is particularly likely in Medicaid non-expansion states.

If this proposal is adopted, we support an exception for individuals living abroad or in a U.S. territory. HHS should not impose expensive and time-consuming proof to document a foreign or territorial residence.

Continuous Coverage

HHS requests comments on policies in the individual market that would promote continuous coverage, and also on whether continuous coverage requirements are needed. We strongly object to requiring continuous coverage as a condition of enrollment in the individual market. This would move health insurance in the U.S. backwards rather than forwards. HIPAA's continuous creditable coverage requirement caused great hardship for low-income individuals who for various reasons had not been able to maintain health insurance coverage.

HHS can and should promote continuous coverage by funding consumer education, outreach and adequate enrollment assistance, and by reaching out to under-enrolled populations.

The ACA already contains a punitive mechanism for promoting continuous coverage: the individual shared responsibility provision.[13] The Internal Revenue Service recently signaled to the public that it is not serious about enforcing this provision, by backtracking on plans to reject so-called "silent" tax

[11] The requirement of prior coverage was added to the permanent move SEP in an interim final rule published May 11, 2016. 81 Fed. Reg. 29,146. It is not currently part of the marriage SEP.
[12] 42 U.S.C. § 300gg–1.
[13] 26 U.S.C. § 5000A.

returns that fail to address the individual shared responsibility provision.[14] This suggests that continuous coverage requirements are not needed and purported concerns may not be real. Even if the concerns are real, the federal government cannot intentionally create a problem by refusing to enforce the main continuous coverage mechanism in the ACA, and then use that problem as an excuse to create a different mechanism through regulation.

Proposed budget reconciliation legislation was unveiled on March 6, 2017 that would replace the individual shared responsibility provision with a premium penalty for people who lack of continuous coverage.[15] We do not believe this is good policy, but that is a decision that Congress can make. HHS does not have the ability to write a different continuous coverage penalty into the ACA's health insurance eligibility and enrollment provisions.

Actuarial Value - § 156.140

We oppose the proposed expansion of the de minimis actuarial value (AV) variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

The proposed reduction in the minimum AV of silver level plans is particularly bad, because it would reduce the amount of premium tax credits *for all consumers* by reducing the "second-lowest-cost silver plan" upon which the subsidy is based.[16] This would reduce the buying power of consumers who receive advance payments of the premium tax credit. This is a significant issue for the marketplace, since 84 percent of enrollees receive APTC.[17]

A Families USA analysis recently found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[18] In addition, a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[19] Consumers already complain to us that it's hardly

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[14] *See* IRS.gov, Individual Shared Responsibility Provision, at https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision (last updated Feb. 15, 2017) ("the IRS has decided to make changes that would continue to allow electronic and paper returns to be accepted for processing in instances where a taxpayer doesn't indicate their coverage status.") *See also* Michael Hiltzik, *Trump's IRS stages a stealth attack on Obamacare*, Los Angeles Times, Feb. 15, 2017, *available at* http://www.latimes.com/business/hiltzik/la-fi-hiltzik-irs-obamacare-20170215-story.html; Dan Mangan, *IRS won't reject tax returns if they do not include Obamacare disclosures*, CNBC, Feb. 15, 2017, *available at* http://www.cnbc.com/2017/02/15/irs-wont-reject-tax-returns-if-they-do-not-include-obamacare-disclosures.html.

[15] *Ways and Means Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://waysandmeans.house.gov/american-health-care-act/; *Energy and Commerce Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://energycommerce.house.gov/news-center/press-releases/energy-and-commerce-republicans-release-legislation-repeal-and-replace.

[16] *See* 26 U.S.C. § 36B.

[17] CMS, First Half of 2016 Effectuated Enrollment Snapshot (Oct. 19, 2016), available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html.

[18] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

[19] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Center on Budget and Policy Priorities, Feb 2017), available at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

worth paying premiums when they are unlikely to meet their deductible or maximum out-of-cost limit. The proposed slide in AV standards would exacerbate this perception of unaffordability and reduce enrollment by healthy adults. These costs must be included in HHS's cost-benefit analysis of the regulation.

The proposed expansion of the de minimis actuarial value variations is unlawful. The allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates."[20] However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds the Secretary's authority and violates the plain meaning of the statute.

While we do not support expanding the de minimis actuarial value threshold, if HHS finalizes this proposal, the benchmark premiums for the premium tax credit should still be based on plans with a true 70 percent actuarial value, or on a minimum variation such as 68% that meets the statutory requirement of only accounting for differences in actuarial estimates.

We appreciate HHS raising the question of whether its proposed change to AV standards implicates the ACA's requirement to reduce cost-sharing for all enrollees with income up to 400 percent of the poverty line, up to specified actuarial values. The ACA requires the Secretary to establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent.[21] Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. Therefore, HHS should require issuers to offer 70 percent actuarial value cost-sharing reduction plans for eligible enrollees, unless the issuer offers a plan with a 70 percent actuarial value. This would maximize issuer flexibility in benefit design, allowing issuers to respond to consumer preferences and increase competition in the marketplace.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans with an AV of 73, 87 and 94 percent. HHS should extend this requirement to 70 percent AV plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the poverty line.

Thank you for considering these comments.

Sincerely,

Christine Speidel
Staff Attorney, Office of the Health Care Advocate
Director, Vermont Low-Income Taxpayer Clinic

[20] 42 U.S.C. § 18022(d)(3).
[21] 42 U.S.C. § 18071.

Comment separator page. Next comment follows.

President Trump promised a better health program that covers more people for less cost, and the proposed new rules would break that promise and the trust of the people who voted for President Trump. The authors of this rule are well aware they are breaking the promise to the American People including listing some of the costs as follows:

Harms to health and reduced protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical conditions (if health insurance enrollment decreases)
Cost due to increases in medical service provision (if health insurance enrollment increases)
Decreased quality of medical services (for example, reductions in continuity of care due to lower ECP threshold)
Administrative costs incurred by the federal government and by States that start conducting verification of special enrollment period eligibility

These rules jeopardize health coverage for those who depend on it and break President Trump's promises, which will erode the voting public's trust in this President and the US government.
No documents available.

Comment separator page. Next comment follows.

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Submitted March 7, 2017 via www.regulations.gov

Re: CMS-9929-P: Patient Protection and Affordable Care Act; Market Stabilization

Dear Sir or Madam:

The Virginia Poverty Law Center (VPLC) appreciates the opportunity to comment on the proposed rule, "Patient Protection and Affordable Care Act; Market Stabilization" (CMS-9929-P), published in the *Federal Register* on February 17, 2017.

Founded in 1978, VPLC is a nonpartisan, nonprofit organization that coordinates and leads efforts to seek justice in civil legal matters for lower income Virginians. Since the launch of the Health Insurance Marketplace (Marketplace) in 2013, VPLC and its community-based partners have provided more than 110,000 Virginians with free, unbiased assistance with the health insurance application and enrollment process.

Today, Virginia enjoys a stable and competitive Marketplace[1]. Eleven insurance carriers currently offer plans on the Marketplace in Virginia and this is the same number of carriers as last year. Robust competition has resulted in a wide variety of comprehensive health plan options for consumers, and during the most recent open enrollment period more than 400,000 Virginians selected a health plan. Since the passage of the Patient Protection and Affordable Care Act (ACA), Virginia has seen a 20% reduction in the number of uninsured Virginians, and the current uninsured rate is at a historical low.

While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, the proposed rule, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people

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[1] Martz, Michael. (2016, October 27). Virginia, Richmond region fare relatively well in health insurance analysis. *Richmond Times-Dispatch*. ("The availability of insurance options will remain relatively robust and increases in premiums relatively low").

will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Under the Affordable Care Act (ACA) we have made unprecedented coverage gains and continuing this success should be the priority moving forward. Providing meaningful access to coverage as well as strong consumer protections that ensure coverage is high quality and affordable will not only preserve the impressive coverage gains the ACA has made, but will also contribute to a robust and stable Marketplace.

Lastly, we are strongly dismayed by the decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Detailed comments on the proposed rule follow below. If you have any questions or concerns regarding VPLC's comments, contact Deepak Madala (deepak@vplc.org) or Sara Cariano (sara@vplc.org) at (804) 432-0199.

Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

Guaranteed Availability of Coverage (§ 147.104)

The proposed rule would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy, particularly for lower income individuals.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through ordinary collection procedures.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and HHS does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

And beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, or had other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with a plan but faced numerous administrative and bureaucratic hurdles to do so.

It may also be an issuer or marketplace error that leads to an assumed non-payment. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage. In the future, if they need to come back for marketplace, they should not be subject to any repayment.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.

Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

Initial and Annual Open Enrollment Periods (§ 155.410)

We strongly urge HHS to keep the length of open enrollment periods to three months, as it was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about and enroll in coverage within the given timeframe. If the rule is finalized, there will be limited time for affected consumers to learn about the changed length. The most motivated, often sickest, consumers will diligently enroll, but healthier and younger consumers are less likely to be aware of the change and miss the new deadline. We know that consumers continue to have gaps in knowledge about the coverage options available to them and we believe a longer open enrollment period should continue in order to ensure that all eligible consumers enroll.

We also have concerns about consumers' ability to gain in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer plans. We appreciate that HHS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand.[2] Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[3] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[4]

We support HHS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements

[2] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (*Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[3] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[4] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[5] We urge HHS to provide more detail about what these activities will include. We also urge HHS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[6]

If HHS determines it necessary to end open enrollment on December 15, we propose that open enrollment begin on October 1, as the first open enrollment did. An earlier start date would provide enough time to consumers to learn about any Marketplace or plan changes before enrolling, limit adverse selection that may occur as the result of a shortened open enrollment period, and allow for Navigators, in-person assisters, certified application counselors, brokers and agents to provide assistance to more consumers; yet all plans would begin on January 1. It will provide stability by both allowing more people to enroll, creating a larger risk pool, and avoiding shortened plan years and churn that occurs from people changing plans after December 15.

Special Enrollment Periods (§ 155.420)

We've served consumers throughout Virginia and have yet to see evidence of consumer abuse of special enrollment periods (SEPs). We do, however, regularly see significant gaps in knowledge about the Marketplace and enrollment processes among eligible consumers. Very few people who are eligible for SEPs know that they are eligible and even less are able to navigate the enrollment process without in-person assistance.

A recent study from the Urban Institute confirms our experience and puts the SEP-enrolled population at just five percent of those who are eligible.[7] Given these facts, we do not believe consumers are gaming a system they know little about. HHS should work to support a balanced risk pool by increasing enrollment in SEPs. This can be accomplished by:

- Supporting public education and marketing campaigns that increase awareness of and enrollment in SEPs – especially among young adults. Nearly all of the past and current marketing efforts by the Marketplace and QHP issuers have occurred during open enrollment periods. More of these efforts need to occur between open enrollment periods to promote SEP enrollment opportunities.

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[5] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[6] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[7] Dorn, Stan, "Helping Special Enrollment Periods Work under the Affordable Care Act," June 2016.

- Increasing funding for Navigators and other enrollment assistance professionals. Based on our experience, consumers who are eligible for SEPs often require a navigator, agent/broker, CAC, or other enrollment professional to help them apply for and enroll in coverage.
- HHS should work with federal and state agencies that serve the unemployed to increase awareness of SEPs among consumers who lose employment-based coverage. We have worked extensively with displaced workers through Virginia's Workforce Centers and Rapid Response program. We have found awareness of SEPs very limited when people are losing employment-based coverage. Employers provide lots of information about Cobra, but little to nothing on more affordable FFM options.

SEPs are important mechanisms to ensure that individuals maintain coverage year-round without any gaps and should be marketed widely and be easy for consumers to access. People's life circumstances change throughout the year and SEPs are needed to assure families are insured when those changes occur. Through our work we regularly see the importance of SEPs and the protections they offer. Any changes that serve to delay enrollment jeopardize one of the ACA's most important and popular protections – an individual's ability to gain coverage "right away" following a life event and maintain continuous coverage. If additional burdens are going to be placed on the consumer there should be additional protections provided for them as well.

Pre-enrollment verification requirements will further limit access to SEPs and they may jeopardize the integrity of the market mix by ensuring that only the sickest and costliest consumers pursue SEPs. If pre-enrollment verification requirements are implemented, then a number of protections are needed to ensure that consumers understand what is happening and are able to avoid gaps in coverage.

- The Marketplace should provide clear and accurate notices that inform people about their rights and responsibilities and information about any additional actions they need to take to secure coverage using an SEP.
- A timeframe for the Marketplace to review documentation should be set. If the documents are not reviewed within this timeframe, the consumer should be allowed to enroll.
- If an enrollment is delayed due to the verification processes, retroactive coverage and/or a hardship exemption should be available to enrollees who are later verified.
- There should be a smooth confirmation process in place before the pre-enrollment verification process is launched that relies on external data sources to verify eligibility before requesting additional information from the consumer.
- We strongly recommend that any pre-enrollment verification processes still allow someone to select a plan, even if they cannot fully enroll in the plan before verified. We assist many consumers who live in rural areas or have mobility or transportation difficulties. Consumers are less likely to finish the process of

enrolling when we require more than one appointment. Only the most motivated and in need of medical care will do this, while those who do not have an urgent need for coverage will not finish the enrollment process.

- We have concerns about the capacity for the Marketplace to quickly verify documents that are submitted. Under the current SEP verification process, only a small percentage of documents are reviewed. We regularly work with consumers who have data matching issues that take a very long time to resolve because documents are not reviewed. We recommend a special group of staff is used to review these documents and that consumers and assisters can communicate with this group to check on the status of documents after they have been submitted or get clarification if a document is not accepted.

We have also found that it is difficult for consumers to get proof of prior coverage from their former insurer or employer. As such, we recommend that HHS require insurers to provide notices when individuals lose coverage or agree to issue a standard proof of coverage document upon request to the Marketplace.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

Levels of Coverage (Actuarial Value) (§ 156.140)

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe this policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing. It will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage by shifting significant costs to families and, as a result, will likely reduce enrollment. Not only would the proposed hurt consumers and increase deterioration of Marketplaces, it is unlawful.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, a Families USA analysis found that

reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[8]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size of the premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[9]

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee's income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. While reductions in actuarial value may reduce gross premiums, they do not reduce the net enrollee premium. Potential enrollees will, however, face higher deductibles and other out-of-pocket expenses for the same cost if de minimis variation is expanded. The impact statement of the proposed rule even states that "*The proposed change in AV could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks with high medical costs."*

As a result, and contrary to the proposed rule's assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by increasing cost-sharing expenses and thus discouraging enrollment of younger and healthier consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment nor offset the increases in cost-sharing.

Further, the proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility

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[8] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

[9] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The proposed expansion exceeds the Secretary's authority and undermines the plain meaning of the statute.

If the Secretary finalizes this proposal, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Using a 70 percent actuarial value plan as the benchmark would result in a significant enrollee premium reduction for enrollment in a 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease would likely spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan. Using this methodology will encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

The Secretary must also require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. The Secretary is given authority, however, to modify the out-of-pocket reduction only if it would "result in an increase in the plan's share of the total allowed costs of benefits provided under the plan" above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that the Secretary establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. The Secretary, then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We encourage the Secretary to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow

issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and the Secretary should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

Network Adequacy (§ 156.230)

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. We commend HHS for these steps, which are crucial to making the promise of care in the Affordable Care Act real. Over time, HHS has made significant improvements to the regulations at sections 155.1050 and 156.230, in defining the network adequacy standards to which QHPs will be held. Even still, we urge HHS to adopt more stringent regulations in this area, as the current regulations do not fully ensure that consumers who enroll in QHPs will have access to adequate networks.[10]

Thus, the proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

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[10] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. 13-18 (Oct. 6, 2016), http://www.healthlaw.org/issues/medicaid/services/Comments-ACA-Benefit-Payment-Parameters.

a. HHS should not rely on state reviews for network adequacy

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires the Secretary of HHS to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated the Secretary of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged the Secretary with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

We appreciate that HHS's current proposal will require issuers (save MSP issuers) in the Marketplace to meet HHS's "reasonable access standard," or state standards approved by HHS. While we support HHS's leaving the states and OPM with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, HHS must establish a clear national floor for network adequacy in these regulations, and monitor compliance with those national standards itself. The Secretary should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. Leaving network adequacy standards to the discretion of states has resulted in consumer protections varying widely across state lines. The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

b. HHS's "reasonable access" standard is not a sufficient measure of network adequacy.

HHS has never explained how its "reasonable access" standard is measured or monitored. Thus we have little information to assess whether the "reasonable access" standard has been successful in ensuring access in the past. We are therefore disappointed that HHS is proposing to revert to this standard, rather than adopting precise quantitative standards that would help insurance regulators, consumers, providers, and advocates to evaluate what constitutes "reasonable access." We

recommend that HHS instead move forward with its prior proposal of establishing a national baseline for time and distance standards.

c. *HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.*

We disagree with HHS's proposed approach of replacing time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their accreditation does not replace the existence of such standards. Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

Essential Community Providers (§ 156.235)

We urge HHS not to reduce the percentage requirement for ECPs. HHS is proposing to go backward, and reduce the percentage from 30 percent to only 20 percent. This reduction represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. Any reduction in ECPs could, however, harm beneficiaries by restricting access to the appropriate specialty care, creating dangerous and costly treatment interruptions, and limiting access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities.

Instead, we urge HHS to strengthen the requirements for ECN providers to be included in all QHP networks by:

- instituting an "any willing provider" requirement for QHPs to contract with ECPs.
- stating explicitly that QHPs may not contract directly with individual providers working within an ECP, but must contract with the ECP as an entity.
- at a minimum, require QHPs to offer legally-compliant, good-faith contracts to all FQHCs in their service area.

If the proposed reduction is finalized, we urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network.

This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

Thank you for considering these comments.

Sincerely,

Deepak Madala

Sara Cariano

Comment separator page. Next comment follows.

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March 7, 2017

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Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

We have included our comments on specific sections below. But before providing specific comments, we want to raise significant concerns about the proposed rule's overall effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces. This rule, if finalized, will weaken consumer protections while lowering premium tax credits which undermines -- a rather than strengthens -- the Health Insurance Marketplace.

The proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides. If implemented, the proposed rule would:

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- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks; and
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals do not provide the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are strongly dismayed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment

on the proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

I. § 147.104 – Guaranteed Availability of Coverage

HHS seeks comments about its proposed premium payment policy, which would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy, particularly for lower income individuals.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and HHS does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

And beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, and other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with an issuer but faced numerous administrative and bureaucratic hurdles to do so.

It may also be due to issuer or marketplace error that leads to an assumed non-payment. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage since they could lose their employment and need to come back for marketplace coverage but should not be subject to repayment.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[1]

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues,

[1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrollment declines gradually throughout the year, a sign that enrollees leave the market over time for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.

- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

And if HHS were to proceed with this policy, we also recommend that this policy be limited to annual renewals and that consumers enrolling during a Special Enrollment Period (SEP) should not be subject to this policy. The mere fact that a consumer is eligible for an SEP means the consumer is facing a change in circumstance. For example, if a consumer stopped paying premiums in September of one year and gets an SEP to re-enroll in the middle of the next year, the consumer should not have to pay back premiums when there has been a significant time lapse between the events.

Further, we provide additional suggestions to provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" to this policy such that consumers who can demonstrate significant financial hardship that caused the consumer to stop paying premiums, the issuer would not be permitted to apply new premium payments to past unpaid premiums. Consumers could document such a hardship by providing a narrative explanation as to why he stopped paying premiums. Since the NPRM would already allow consumers to enroll in another plan and thus

issuers would not always recoup past premiums from these consumers, it seems that allowing a consume the option to stay with the same plan – which may be important to the consumer because of the network or particular providers – is a second option that would provide a compromise for the consumer and issuer.

Also, information about repayment should be clearly noted on the Plan Compare tool so that consumers would have that information before they enroll. Second, it should be noted in the Eligibility Determination Notice since consumers could change plans if open enrollment or a special enrollment period remains open.

II. § 155.410 – Initial and Annual Open Enrollment Periods

We are concerned about the shortening of the annual open enrollment period. While we recognize a shorter enrollment period was planned for 2018, given all the potential changes that consumers have to digest this year, we believe that keeping a longer open enrollment period would be beneficial to consumers as well as issuers. We believe the benefits – enrolling more consumers – outweigh the perceived costs of having consumers enroll for less than a full year (if they enroll after December 15).
HHS notes that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance. Thus the policy change could just as easily lead to a sicker pool, at least in the short term, if young, healthy people end up missing the new deadline for signing up. HHS acknowledges this uncertainty but it does not sufficiently explain why a positive result (decreased adverse selection, improved stability of the exchanges) is more likely than a negative result (increased adverse selection, reduced stability of the exchanges) with a shorter enrollment period.

We are also concerned about the proposed shortened enrollment period due to the added burdens it will put on navigators and assisters. Many navigators and assisters already work long hours and weekends throughout the current open enrollment period to meet the demand. Shortening the period will make it even more difficult to reach and serve all consumers.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[2] As Florida Blue Cross Blue Shield noted, ending open enrollment in

[2] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

December “forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest.”[3]

We support CMS’s plan “to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame.” However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[4] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[5]
We also strongly recommend that HHS not require state based marketplaces (SBMs) to a shorter enrollment period. The SBMs are in the best position to determine their own enrollment periods which may factor in state-specific issues.

III. § 155.420 – Special Enrollment Periods

We have strong concerns about the proposed pre-enrolment verification process, particularly since it will include 100% of SEP applicants and because HHS has not released a full evaluation and analysis of the post-enrollment verification pilot operated in 2016. First, before requiring all applicants to verify their eligibility, it is important to identify any real or perceived limitations of verification that need to be addressed. Second, if the post-enrollment analysis finds that many eligible consumers are deterred or unable to complete verification, HHS should ensure these issues are fixed in a pilot of pre-enrollment verification. Overall, any required verification – whether for enrollment, data matching, or an SEP – needs to be easy and simple or eligible individuals will be deterred from enrolling. If the process is not easy, it is likely that those in more dire need of health insurance, rather than individuals who may be healthier and want coverage to avoid paying a tax penalty,

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[3] See Florida Blue Cross Blue Shield’s comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.
[4] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.
[5] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

will likely complete the process. For SEPs, we recognize that a disproportionate number of sicker individuals obtaining coverage through SEPs could disrupt the risk pool and lead to unanticipated higher costs. If a major concern for issuers is the higher costs associated with those coming in through SEPs, however, other interventions exist that would not burden consumers or presume fraudulent applications. For example, HHS' changes to the risk adjustment costs in 2018 and beyond to address higher than expected costs of those not enrolled for the full year would address this problem without assuming that those obtaining mid-year coverage through an SEP are ineligible and need to prove eligibility pre-enrollment.

To keep consumer engagement and trust high – an essential component to the success of the marketplaces – while preserving affordability, any SEP eligibility verification should be narrowly targeted only to instances of suspected ineligibility or fraud and should use electronic verification rather than requiring paper documentation. While we understand the balance the FFM must strike between plans and consumers to achieve affordability, we believe that mandatory SEP pre-eligibility verification will have a chilling effect on many eligible individuals. Excessive documentation requests may be a deterrent to potentially eligible applicants who would help spread the risk and HHS should take care not to discourage participation. Problems and consumer frustration with other verification processes already exist – such as lengthy times between document submission and review, trouble uploading verifications, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues because consumers cannot directly reach those conducting the reviews. Adding pre-eligibility verification may jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the FFM such that only the sickest and costliest consumers pursue SEPs. At the same time, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

As the NPRM preamble notes, some commenters to the 2018 Payment Notice suggested that additional steps to determine SEP eligibility worsen the problem by creating new barriers to enrollment. Yet based on issuer feedback, HHS is proposing to increase the scope of the pre-enrollment verification. We believe this should not be done unless and until the prior pilot analysis adequately identifies what cause and effect pre-eligibility verification may have on individuals and the marketplace as a whole. Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to

follow through.[6] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will take the steps necessary to complete the process.
Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

a. *Electronic Verification*

We do appreciate that HHS recognizes it will make every effort to verify eligibility through automated electronic means. It is not at all clear that the FFM would be technically or operationally capable of implementing an SEP verification process consistent with the Affordable Care Act's vision of a real-time, streamlined eligibility and enrollment system. HHS has already acknowledged that eligible individuals sometimes forgo coverage because they encounter difficulty securing and providing the documents requested to verify their eligibility when they have a data matching issue.[7] We cannot afford this result to duplicate with SEP verification.
As an example, consumers who are eligible for the permanent move SEP who have been enrolled in a QHP should not have to provide documentation of their "original" address. Yet this was required as part of the post-eligibility verification. Consumers provide this information during enrollment and burdens should not be added to submit documentation merely because HHS is unable to access this information.
Before implementing a pilot, HHS should establish systems for an automatic check with issuers and public programs (Medicaid, CHIP, Medicare) about whether a consumer lost creditable coverage. Consumers should not be responsible for tracking down documentation to show that coverage was lost when this information is readily available

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[6] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.
[7] *Strengthening the Marketplace – Actions to Improve the Risk Pool* (June 8, 2016), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending.

from issuers. Only if electronic verification is inconclusive, or if a consumer disputes the result, should documentation be required.

b. Timeframes for document verification

We appreciate that HHS will provide consumers 30 days to provide documentation. We do ask that HHS also provide consumers with the opportunity to request an extension of that time period if they have difficulty obtaining certain documentation within that timeframe. This could allow the consumer to continue with an SEP application without losing eligibility merely due to difficulties obtaining documentation. If the consumer's SEP application is instead denied, the consumer may not be eligible at a later date due to the length of time from the qualifying event even if the consumer truly is eligible. We also strongly urge HHS to establish specific timeframes for evaluating documents as part of a pre-eligibility verification pilot. Without specific timeframes, consumers would not have necessary information to ascertain when a decision will be made, when to follow-up if they have not received a decision, and how to proceed if a decision is adverse. We also recommend that if a consumer submits documents, and the review by the FFM is not completed within 15 days, that the SEP must be granted so that consumers are not suffering without health insurance for lengthy periods of time. This could be done conditionally to give the FFM additional time for document review but it would balance the needs of the consumer for health insurance by preventing significant delays in enrollment. Under this situation, the process would continue similar to post-eligibility verification.

As we have previously stated, we strongly believe that HHS should implement a model of verification more closely aligned with the IRS and should evaluate this as part of a pilot. Consumers already attest under penalties of perjury to the information provided in their applications. Rather than require pre-eligibility verification submission, HHS should only request documents from the specific consumers who will be audited (and this subset of consumers must be randomly selected and not based on any personally identifiable characteristics or claims data). Requiring 100% pre-eligibility verification seems unnecessary, burdensome for consumers, and adds additional processing and storage burdens for the FFM to receive, review, classify and store the documents.

c. Study of Pre-Enrollment Verification

HHS asked for comment whether a small percentage of individuals should be exempt from the pre-enrollment verification process to conduct a study. We strongly support this suggestion. The excluded population must be statistically significant so that an appropriate and legitimate comparison may be made between the two groups.

Further, HHS asked for comment about strategies HHS should take to increase the chances that healthier individuals complete the pre-eligibility verification. We strongly recommend that HHS eliminate the need for verifying any SEPs based on birth/adoption/foster care placement and marriage. Given the nature of the circumstances under which these SEPs arise, it is hard to imagine that many consumers will be seeking an SEP for these categories if not truly eligible. At a minimum, HHS should consider excluding from a pre-eligibility verification pilot unless and until the process for verifying loss of MEC and permanent move SEPs is implemented effectively and efficiently.

d. State Based Exchanges

HHS requested comment on whether SBMs should be required to conduct pre-enrollment verification. We believe the answer to this should be no. SBMs should be able to determine their own policies and processes for SEPs, just as they have the authority to adopt SEPs that the FFM does not use. States need the ability to respond to their individual market needs and we do not see a need for a uniform national policy in this situation, especially since we have significant concerns about HHS' policies on this topic.

e. Changing Plan Levels

We believe HHS' proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1) While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. HHS's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We thus oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry

practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

For example, adding a dependent or getting married likely alters the amount of APTC and possibly cost-sharing reductions (CSR) which can impact what plan enrollees wish to enroll in. As another example, a pregnant woman may have enrolled in a silver plan but if she gives birth to a child with special needs or complex medical conditions, she may want to change coverage to a gold or platinum plan to obtain a higher level of coverage. Or a woman may enroll in a platinum plan concerned she may have a high risk pregnancy but after the pregnancy, may want to move back to a silver plan. As another example, an individual may gain a dependent who has a disability and the plan selection should not be limited to merely adding the dependent to the enrollee's same plan or same level plan.

HHS seeks comment on whether an individual gaining an SEP due to new eligibility for cost-sharing reductions should be limited to only enroll in a silver QHP. While we recognize that most individuals newly eligible for cost-sharing reductions would benefit from enrolling in a silver plan to gain the benefits of the cost-sharing reductions, some consumers may have valid reasons for wanting to enroll in other metal plans and should not be restricted just because they have enrolled through an SEP since if they enrolled during open enrollment, they would be able to forego the silver plan and cost-sharing assistance if they so wished. That said, we do recognize the benefits of enrolling in a silver plan and thus believe consumers should receive sufficient information about the potential downsides of enrolling in a different metal plan to make an informed choice. But ultimately, consumers should have the choice.

We recognize HHS may have concerns about individuals using an SEP to "simply switch levels of coverage during the coverage year." But with the limitations of the eligibility verification and that switching plans comes with other potential problems for consumers – resetting deductibles and out-of-pocket costs – we believe consumers should have the choice and opportunity to do what is right for themselves and their families rather than be limited by regulation to continuing enrollment in the same plan. We also believe HHS should provide SBMs the option to utilize these limitations rather than be forced to adopt them. As mentioned above, SBMs know their states and their markets and may have valid reasons not to adopt similar restrictions.

f. Payment of Past Premiums

We are concerned that HHS proposes allowing an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe this is discriminatory, in particular, against low-income consumers who may not have had the ability to pay premiums if they incurred significant medical costs before meeting a deductible or out-of-pocket maximum.

Other reasons may exist why an issuer believes a consumer has not paid premiums when the consumer actually has or attempted to. We have worked with a number of consumers who received erroneous bills and attempted to work with their insurer to determine the correct amounts to pay. Sometimes insurers did not accurately credit the amount of a tax credit or cost-sharing reduction, sometimes insurers did not match consumer's payments with the consumer's account, sometimes insurers cancelled a consumer's coverage despite a consumer paying. Due to the potential for insurer error, we believe that if HHS is going to permit insurers to reject enrollment, two preconditions must be met:

1. The insurer must provide verification to HHS and the consumer of the non-payment;
2. The insurer must allow the consumer a reasonable opportunity to dispute the insurer's information and provide documentation of payment.

Secondly, even if an insurer does verify that a consumer did not pay premiums, we believe HHS should provide a waiver of this requirement for consumers who can document paying significant out-of-pocket costs for care or other relevant circumstances during the time premiums were not paid. For example, if a consumer incurred health care bills that exceeded the premium amounts, we believe the consumer should not have to repay the premiums since meeting the deductible may have been out-of-reach for the consumer. Or if the consumer can document a job loss or having suffered a serious medical incident that prevented paying the premiums, this should also be accepted for a waiver of paying past premiums. While we recognize insurers need to receive timely premiums, we also recognize that there must be a balance when consumers are unable to pay their bills due to exceptional circumstances and that other avenues exist for helping insurers compensate for consumers such as these.
We are also concerned about this proposal from a geographical perspective. That is, this proposal can discriminate against consumers merely due to where they live. If the consumer lives in a geographical area with only one issuer (which is the case in a number of counties across the country), these consumers will have no alternative but to enroll in a plan where they must first pay back premiums or be rejected. Consumers in geographic areas with a choice of plans may be able to enroll in a different plan and

thus not be subject to the back payment requirement. We do not believe that a policy that likely will be implemented to the detriment of consumer merely based on geography should be adopted by HHS.

HHS also stated that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and thus HHS should ensure that any verification must provide consumers with an opportunity to provide additional or contrary information that may negate information from an insurer.

g. Marriage SEP

HHS proposes that if a consumer is newly enrolling through the Exchange pursuant to an SEP obtained for marriage that at least one spouse demonstrate having had minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage. We are concerned about this limitation for a number of reasons.

First, some individuals who marry may have been ineligible for Exchange coverage during the 60 days prior. This is especially likely in Medicaid non-expansion states. Both individuals may have been below 100% FPL in an non-expansion state and thus in the coverage gap. A marriage could increase their joint income to over 100% FPL and make them both newly eligible for coverage yet the proposed rule would not allow them to enroll. This also has a geographical bias since many of the states that did not expand Medicaid are in the southern part of the country which also has the higher uninsured rates and higher rates of poverty.

We do appreciate the recognition of an exception for individuals living abroad or in a U.S. territory. We strongly urge HHS to maintain this exception and not to require an onerous burden of proof to document a foreign or territorial residence.

h. Permanent Move SEP

We have similar concerns about the requirement for prior coverage as a predicate for obtaining a permanent move SEP. Some individuals may not have been eligible for coverage in the area they moved from (e.g. a Medicaid non-expansion state) and thus should not be penalized and made ineligible for an SEP.

Further, individuals who are survivors of domestic violence may have been prevented by their abuser from obtaining coverage. If these individuals permanently move away

from their abusers, they should not be prevented from newly enrolling in coverage because they did not have prior coverage. While they may have a separate eligibility path as a survivor of domestic violence, there may be reasons survivors do not know about the alternative pathway and come in through an SEP.

IV. § 156.140 – Levels of Coverage (Actuarial Value)

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

We believe this policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[8]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis

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[8] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[9]

Instead, we encourage HHS to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to HHS can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds HHS's authority and undermines the plain meaning of the statute.

Contrary to the proposed rule's assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee's income. Any reduction in gross premium amounts will

[9] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of $25,000. This individual's expected contribution towards premiums is 6.8% of income or $1,700. If the person selects the benchmark plan, his/her net premium will be $1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with HIV, hepatitis C, and other chronic conditions who depend on access to plans with a higher actuarial value to defray high cost sharing. Consider three possible silver benchmark plans:[10]

Benchmark Plan Costs, 2018						
Actuarial Value	Gross Premium	Deductible	Maximum Out-of-Pocket	Co-Insurance	Advance Premium Tax Credit	Net Enrollee Premium*
70	$4,138	$1,600	$7,200	30%	$2,438	$1,700
68	$4,020	$2,100	$7,200	30%	$2,320	$1,700
66	$3,902	$2,750	$7,200	30%	$2,202	$1,700

* *Examples assume consumer enrolls in the benchmark second lowest cost sliver level plan; net premium amount would increase if consumer enrolled in a higher AV plan*

While reductions in actuarial value reduce gross premiums, they do not reduce the net enrollee premium when selecting the benchmark plan resulting in less purchasing power for the consumer. Deductible increases allowed by the actuarial value reductions, however, will discourage enrollment, leading to a death spiral.

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[10] Actuarial values were calculated using the 2018 Actuarial Value Calculator for silver plans. Premiums assume 85 percent of costs are medical and 15 percent are administrative. Advance premium tax credit is based on a $25,000 income for a single 35 year-old enrollee, resulting in a $1,700 expected annual contribution from the enrollee and a $2,438 tax credit on average nationwide. This example assumes enrollment in the benchmark second lowest-cost sliver level plan. The applicable income percentage and gross premium for the 70 percent actuarial value plan were calculated using the Kaiser Family Foundation's 2017 Health Insurance Marketplace Calculator.

To stabilize the Marketplaces, HHS should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Under the plans above, using the 70 percent actuarial value plan as the benchmark would result in a 15 percent net enrollee premium reduction for enrollment in the 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease will likely spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan.

Impact of Requiring 70 Percent Actuarial Value (AV) Benchmark Plan					
Actuarial Value	Gross Premium	Advance Premium Tax Credit (70 AV benchmark)	Net Enrollee Premium ($)	Net Enrollee Premium Reduction (%, compared to benchmark contribution of $1,700)	Increased Deductible (compared to $1,600 under 70 AV benchmark)
68	$4,020	$2,438	$1,582	7.0%	$500
66	$3,902	$2,438	$1,464	13.9%	$1,150

While we do not support expanding the de minimis actuarial value threshold to -4/+2 percent, if HHS finalizes this proposal, calculating the advance premium tax credit from plans with a true 70 percent actuarial value will reduce net enrollee premiums and encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

HHS must require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. HHS is given authority, however, to modify the out-of-pocket reduction only if it would "result in an increase in the plan's share of the total allowed costs of benefits provided under the plan" above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that HHS establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. HHS, then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We support the February 24, 2012 Actuarial Value and Cost-Sharing Reductions Bulletin's explanation for not establishing cost-sharing reduction plans with a 70 percent actuarial value for these enrollees, but this explanation depended on the availability of 70 percent actuarial value plans for these enrollees. We encourage HHS to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and HHS should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace

enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

V. § 156.230 – Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. We have commended HHS for these steps, which are crucial to making the promise of care in the Affordable Care Act real. NHeLP has written extensively about the importance of network adequacy for low-income consumers, in particular.[11] Over time, HHS has made significant improvements to the regulations at sections 155.1050 and 156.230, in defining the network adequacy standards to which QHPs will be held. As a result, we have seen fewer lawsuits and consumer complaints regarding network adequacy issues in QHPs with each year the Exchanges operate. Even still, we have urged HHS to adopt more stringent regulations in this area, as the current regulations do not fully ensure that consumers who enroll in QHPs will have access to adequate networks.[12]

Thus, the proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

a. HHS should not rely on state reviews for network adequacy

[11] *See, e.g.,* ABBI COURSOLLE, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE REGULATIONS: NETWORK ADEQUACY & ACCESS (2016), http://www.healthlaw.org/publications//Brief-3-MMC-Final-Reg; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to J.P. Wieske, Nat'l Assn. Ins. Comm'nrs (Jan. 12, 2015), http://www.healthlaw.org/publications/search-publications/NAICS-Comment; NHELP, NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), *available at* http://www.healthlaw.org/issues/medicaid/network-adequacy-in-medicaid-managed-care.

[12] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. 13-18 (Oct. 6, 2016), http://www.healthlaw.org/issues/medicaid/services/Comments-ACA-Benefit-Payment-Parameters.

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires HHS of HHS to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated HHS of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged HHS with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

We appreciate that HHS's current proposal will require issuers (save MSP issuers) in the FFE to meet HHS's "reasonable access standard," or state standards approved by HHS. While we support HHS's leaving the states and OPM with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, HHS must establish a clear national floor for network adequacy in these regulations, and monitor compliance with those national standards itself. HHS should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. Leaving network adequacy standards to the discretion of states has resulted in consumer protections varying widely across state lines. The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

b. *HHS's "reasonable access" standard is not a sufficient measure of network adequacy.*

HHS has never explained how its "reasonable access" standard is measured or monitored. Thus we have little information to assess whether the "reasonable access" standard has been successful in ensuring access in the past. We are therefore

disappointed that HHS is proposing to revert to this standard, rather than adopting precise quantitative standards that would help insurance regulators, consumers, providers, and advocates to evaluate what constitutes "reasonable access." We recommend that HHS instead move forward with its prior proposal of establishing a national baseline for time and distance standards.

c. *HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.*

We disagree with HHS's proposed approach of replacing time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their accreditation does not replace the existence of such standards.[13] Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We have previously urged HHS to adopt more stringent standards, including specific time and distance standards.[14] In 2015, we commended HHS for taking the step to establish specific time and distance standards for QHPs, and urged HHS to adopt these standards in regulation, rather than its Letter to Issuers.[15] We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

VI. § 156.235 – Essential Community Providers

We urge HHS not to reduce the percentage requirement for ECPs. In the past, we have expressed our appreciation for HHS's continuing efforts to ensure that QHP networks include essential community providers (ECPs), including by requiring issuers to enter contracts with at least 30% of available ECPs in the service area.[16] We encouraged HHS to consider increasing the percentage required in future years.[17] Instead, HHS is proposing to go backward, and reduce the percentage to only 20%. This reduction

[13] For a discussion of the role that accrediting agencies can play in this regard, see Letter from Emily Spitzer, Nat'l Health Law Prog., to CMS Desk Officer 11-14 (June 18, 2012), http://www.healthlaw.org/publications/search-publications/nhelp-comments-on-ffe-and-state-and-state-partnership-exchanges.

[14] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 59-61 (Dec. 21, 2015), http://www.healthlaw.org/issues/health-care-reform/2017-Parameters.

[15] *Id.*

[16] Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 10 (Jan. 15, 2016), http://www.healthlaw.org/issues/health-care-reform/exchanges/Comments-Draft-2017-Letter.

[17] *Id.*

represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

We also urge HHS to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

VII. Applicability of Executive Order 13771

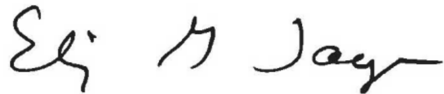
We do not support the goals of Executive Order 13771 that requires repeal of two regulations for any new regulation. That said, the NPRM includes a finding that this proposal does not trigger the requirements of EO 13771 and we believe this decision

should also apply to the rule once finalized. Making a change between a NPRM and a final rule would prevent public comment on the reasons for a change in the decision.

VIII. Conclusion

Thank you for consideration of our comments. If you have any questions, please contact Mara Youdelman, Youdelman@healthlaw.org or 202-289-7661,

Sincerely,



Elizabeth G. Taylor
Executive Director

NHeLP
NATIONAL HEALTH LAW PROGRAM

Comment separator page. Next comment follows.

NATIONAL
IMMIGRATION
LAW CENTER

March 7, 2017

Patrick Conway
Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. The National Immigration Law Center (NILC) is recognized for its expertise in the intersection of health care and immigration laws and policies, offering technical assistance, training, and publications to government agencies, labor unions, non-profit organizations, and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

We have significant concerns about the proposed rule's overall effect on immigrant and other consumers' ability to enroll in quality, comprehensive, affordable health coverage through the marketplaces.

While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, the proposed rule does not provide the correct or appropriate solutions to the problem. If implemented, the Administration's proposals could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage.

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I. § 147.104 – Guaranteed Availability of Coverage

HHS's proposed premium payment policy would allow issuers to require consumers to pay past due premiums before resuming coverage (with the same issuer) in a subsequent year. We strongly disagree with this policy, which will have a disproportionate burden on lower income individuals. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

Moreover, we believe the proposed reinterpretation of the guaranteed availability provision is unlawful. The statutory language is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods. HHS does not have authority to expand these restrictions to include prior non-payment of premiums. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

Beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We are aware of numerous situations in which consumers paid their premiums but the issuers failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, or failed to cancel consumers' plans when requested. Consumers who attempted to fix these issues with their issuers often faced numerous administrative and bureaucratic hurdles. These administrative errors were no fault of the consumers, but could be interpreted as a consumer's failure to pay premiums.

Consumers living in areas where only one issuer participates in the marketplace would be disproportionately affected by such a rule. While consumers living in areas with multiple issuers could enroll in a different issuer's plan, consumers in areas with only one issuer would be unable to obtain health coverage without repayment of past premiums, even if the existence or amount of that debt was disputed.

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking

effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information.

- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a specified amount. HHS should supply standard language for this notice.
- Issuers should be required reinstate coverage if a consumer is making, or agrees to make, payments on prior months' premiums.
- Consumers who have disputed a bill or otherwise attempted to resolve a disagreement with an issuer regarding an amount of premiums owed should not be prevented from restarting coverage due to nonpayment of the disputed amount.

Any notices issued under the proposed rule must meet the standards for accessibility by persons with limited proficiency in English under 45 CFR §155.205(c).

Further, any such policy must provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" for consumers who can document paying significant out-of-pocket costs for healthcare or other relevant circumstances, such as the loss of employment, during the time premiums were not paid.

II. § 155.410 – Initial and Annual Open Enrollment Periods

We are concerned about the proposal to reduce the length of the annual open enrollment period. While we recognize the efficiencies gained by having consumers enroll for a full year (by enrolling before December 15th), past experience has shown that consumers, navigators and assisters need more than a month and a half to complete enrollments.

HHS argues that shortening the open enrollment period will limit adverse selection and leave insurers with a healthier pool. But people with existing medical needs can be expected to be the most diligent about signing up for insurance. A shorter open enrollment period could easily lead to a less-healthy, costlier risk pool.

Further, ending the open enrollment period in December, when many consumers have heightened financial constraints and are distracted by the holiday season, is

problematic.[1] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[2]

We also urge HHS not to require state based marketplaces (SBMs) to adopt a shorter enrollment period. The SBMs are in the best position to determine their own enrollment periods which may factor in state-specific issues.

III. § 155.420 – Special Enrollment Periods

We have strong concerns about the proposal to require pre-enrollment verification of eligibility for SEPs. Any requirement for verification has the potential to depress enrollment and should be implemented in a manner designed to be the least burdensome to consumers. Immigrant consumers, in particular, have experienced a great deal of frustration with existing verification processes, such as lengthy times between document submission and review, trouble uploading documents, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues. Adding pre-eligibility verification could jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the Federally Facilitated Marketplace (FFM) such that only the sickest and costliest consumers pursue SEPs. In addition, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

Consumers already attest under penalties of perjury to the information provided in their applications. Rather than require pre-eligibility verification submission, HHS should conduct post-eligibility audits of randomly selected consumers, as does the IRS. The information from such audits could be used to identify whether any particular basis of eligibility for an SEP was associated with fraud and required more monitoring. Unlike pre-eligibility verification, this approach would not create a barrier to enrollment. Requiring pre-eligibility verification would be unnecessary and burdensome for both consumers and the FFM.

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[1] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[2] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.

Changing Plan Levels

We believe HHS' proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1) While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We thus oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

New Eligibility for Cost-Sharing Reductions

HHS seeks comment on whether an individual gaining an SEP due to new eligibility for cost-sharing reductions should be limited to enrollment in a silver Qualified Health Plan (QHP). While we recognize that most individuals newly eligible for cost-sharing reductions would benefit from enrolling in a silver plan, some consumers may have valid reasons for wanting to enroll in other metal-level plans. That said, we recognize the benefits of enrolling in a silver plan and believe consumers who are eligible for CSRs need additional information about the benefits of enrolling in a silver plan, both during SEPs and at initial enrollment. We frequently encounter consumers who are income-eligible for CSRs and are struggling to meet the out of pocket expenses associated with a bronze plan they selected because of its lower premium.

Payment of Past Premiums

As noted earlier, we oppose the proposal to allow an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe that such a requirement would be particularly burdensome to low-income consumers and those who reside in markets where there is only one issuer.

HHS states that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and likewise oppose this proposal.

Marriage SEP

HHS proposes that if a consumer is newly enrolling through the Exchange pursuant to an SEP obtained for marriage that at least one spouse demonstrate having had minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage. We are concerned about this limitation for a number of reasons.

First, some individuals who marry may have been ineligible for Exchange coverage during the 60 days prior. This is especially likely in Medicaid non-expansion states. Both individuals may have been below 100% FPL in a non-expansion state and thus in the coverage gap. A marriage could increase their joint income to over 100% FPL and make them both newly eligible for coverage yet the proposed rule would not allow them to enroll.

We do appreciate the recognition of an exception for individuals living abroad or in a U.S. territory. We strongly urge HHS to maintain this exception and not to require an onerous burden of proof to document a foreign or territorial residence. Moreover, individuals who come to the United States with ‘fiancé visas’ are required to get married with 90, not 60 days and are likely to be in the U.S. for more than 60 days on the date of their marriage, despite having previously resided abroad. The exception should be made consistent with the 90-day time period.

Permanent Move SEP

We have similar concerns about the requirement for prior coverage as a predicate for obtaining a permanent move SEP. Some individuals may not have been eligible for

coverage in the area they moved from (e.g. a Medicaid non-expansion state) and thus should not be penalized and made ineligible for an SEP.

Elimination of Certain SEPs Affecting Immigrants

HHS proposes to eliminate several SEPs established to address errors that occurred during the early years of the Affordable Care Act's (ACA's) implementation. These include an SEP for lawfully present immigrants with incomes below 100% of the FPL who are eligible for marketplace coverage because their immigration status makes them ineligible for Medicaid. Marketplace eligibility for this group of consumers is not widely understood, and many affected consumers have experienced lengthy delays in enrollment. It is no way clear that the need for this SEP has ended, and it should remain available until there is evidence that this group of consumers is accessing coverage without delay.

State Based Exchanges

HHS requested comment on whether SBMs should be required to conduct pre-enrollment verification. We oppose pre-enrollment verification of eligibility for SEPs in SBMs because it is a barrier to enrollment. In the event pre-enrollment verification is adopted on the FFM, SBMs should be able to determine their own policies and processes for SEPs, just as they have the authority to adopt SEPs that the FFM does not use. States need the ability to respond to their individual market needs and we do not see a need for a uniform national policy in this situation, especially since we have significant concerns about HHS' policies on this topic.

IV. § 156.140 – Levels of Coverage (Actuarial Value)

We oppose the proposed expansion of the de minimis actuarial value (AV) variations. We believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

We believe this proposal would open the door for insurers to sell plans with higher deductibles, and would reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy would shift significant costs to families, either through higher premiums or higher cost-sharing, and would likely reduce enrollment due to cuts in financial assistance. The proposed rule would do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it would likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent seems like a small adjustment, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[3]

This policy would be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage would effectively reduce the size of the premium tax credits these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[4] Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with HIV, hepatitis C, and other chronic conditions who depend on access to plans with a higher actuarial value to defray high cost sharing.

Moreover, the proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to “account for differences in actuarial estimates.” (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is “to help issuers design new plans for future plan years, thereby promoting competition in the market.” The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation “to account for differences in actuarial estimates.” The proposed expansion exceeds the Secretary’s authority and undermines the plain meaning of the statute.

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[3] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump’s Proposed ACA Changes Favor Health Insurers at Consumers’ Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

[4] Aviva Aron-Dine and Edwin Park, *Trump Administration’s New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

V. § 156.230 – Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. The proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and to cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to healthcare through Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need, without delay.

HHS should not rely on state reviews for network adequacy

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires the Secretary of HHS to establish network adequacy requirements for

health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated the Secretary of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged the Secretary with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

HHS must establish a clear national floor for network adequacy, and monitor compliance with those national standards itself. The Secretary should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.

We disagree with HHS's proposal to replace time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their accreditation does not replace the existence of such standards.[5] Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

[5] For a discussion of the role that accrediting agencies can play in this regard, see Letter from Emily Spitzer, Nat'l Health Law Prog., to CMS Desk Officer 11-14 (June 18, 2012), http://www.healthlaw.org/publications/search-publications/nhelp-comments-on-ffe-and-state-and-state-partnership-exchanges.

VI. § 156.235 – Essential Community Providers

We urge HHS not to reduce the percentage requirement for essential community providers (ECPs) to 20% of a plan's network. ECPs play an essential role in delivering healthcare to immigrant communities. ECPs' linguistic and cultural capacity often surpasses that of other health providers in their area. Many are trusted community institutions that provide space for community meetings and information and referrals that help recent immigrants integrate into their new communities.

The proposed percentage reduction would harm beneficiaries without providing any meaningful reduction in issuer costs. The vast majority of issuers have been able to establish networks with 30 percent ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks to conform with the 30% requirement, demonstrating that there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through dangerous interruptions in treatment and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

Thank you for consideration of our comments. If you have any questions, please contact Gabrielle Lessard, lessard@nilc.org.

Respectfully,

Gabrielle Lessard
Senior Policy Attorney

Comment separator page. Next comment follows.

As someone who recently went through the experience of enrolling in a plan on the California ACA health insurance exchange after moving back to California, I'm concerned that these new rules would place undue burdens on people trying to enroll in health plans. The requirement that people who enroll in a plan outside of the standard open enrollment season provide supporting documentation would have been an extra burden for me that would have slowed my enrollment in a health plan after moving back to California from living abroad. While I understand that insurance companies want to make sure people aren't taking advantage of the special enrollment provision, I urge the Department of Health and Human Services to either get rid of the requirement for supporting documentation or make it very easy for consumers by being flexible in the type of documents you will accept and speedy in approving the documentation. If I had had to wait for weeks while waiting for approval of supporting documentation I submitted with my application, I could have faced the risk of having no health insurance for an extended period.

I also want to express my disapproval with shortening the regular enrollment period. There can be all sorts of obstacles for people to sign up, and having gone through the process I know it can be stressful. Giving people less time seems certain to reduce the number of people enrolled and make things harder for people trying to gain access to affordable health care.

Finally, I'm concerned about allowing insurers to cover a smaller share of expected costs. I have a Silver plan and even then it is a struggle to pay for all my medical bills, which quickly add up if you have to have even a small procedure like an endoscopy. I can only imagine how little an insurer would cover at a lower level plan. What's the point of having insurance if you still can't afford the medical bills when something goes wrong?

Please consider the needs of vulnerable patients in making these new rules.

Comment separator page. Next comment follows.

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Act. No matter what.

Planned Parenthood Action Fund

March 7, 2017 –

VIA ELECTRONIC TRANSMISSION

The Honorable Thomas Price
Acting Administrator Patrick Conway
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: **CMS-9929-P; Patient Protection and Affordable Act; Market Stabilization**

Dear Secretary Price and Acting Administrator Conway:

Planned Parenthood Federation of America (Planned Parenthood) and Planned Parenthood Action Fund (the Action Fund) are pleased to submit these comments in response to the Market Stabilization proposed rule, released by the Department of Health and Human Services (the Department) on February 15, 2017 and published in the federal register on February 17, 2017 at 82 Fed. Reg. 10980 et. seq. As a trusted women's health care provider and advocate, Planned Parenthood supports the Department's commitment to seeking input from stakeholders as it continues to implement the Affordable Care Act (ACA) and ensure that qualified health plans (QHPs) in the Marketplace provide consumers throughout the nation with access to quality, affordable health care.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States (U.S.). Each year, Planned Parenthood's more than 650 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to nearly three million patients. One in five women in the U.S. has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL). Because many of Planned Parenthood patients are eligible to purchase their health insurance coverage through the Marketplaces, we have a special interest in ensuring that these individuals can enroll in QHPs that are able to meet their needs.

It is important that the Department continue to implement the statutory requirements of the ACA. In particular, we ask the Department to maintain the current length of the open enrollment period, remove barriers to accessing special enrollment periods, and maintain a strong federal network adequacy standard.

I. Section 155.410 – Initial and Open Enrollment Periods

The Department should, at a minimum, maintain the existing length of the open enrollment period.

The ACA requires, as codified at 42 U.S.C. § 18031(c)(6)(B), that the Secretary establish annual open enrollment periods. The most recent open enrollment period, which lasted from November 1 until January 31, provided a sufficient time for outreach and enrollment. We urge the Department not to significantly shorten the annual open enrollment period to November 1 through December 15. Limiting the open enrollment will not result in a healthier risk pool, but instead will result in fewer consumers enrolling in coverage during the open enrollment period – or fewer consumers enrolling in coverage at all. Unlike the Medicare population or those who have employer-sponsored insurance, consumers needing to purchase insurance on the Marketplace are not as naturally defined, and thus are not as easy to reach. A longer enrollment period will allow insurers and the Marketplaces additional time to reach consumers, and provide consumers additional time to shop for, select, and enroll in a QHP.

In fact, the remaining uninsured rate could be reduced with more effective outreach and enrollment efforts, according to a recent study.[1] The ACA has resulted in significant gains in insurance coverage with an additional 22 million individuals gaining insurance coverage and the uninsured rate being at an all time low; however, 32 million nonelderly people remain uninsured in the United States (the majority of whom are in working families). According to a recent study, nearly half of the uninsured are eligible for financial assistance on the Marketplace, but there is evidence that the majority of people in this population are unaware of the Marketplace or that financial assistance is available to purchase affordable insurance. A shorter open enrollment period limits the timeframe in which enrollment efforts can be conducted.

A shorter enrollment period will result in an older, sicker risk pool, resulting in significantly greater costs to insurance issuers. Young adults between 18 to 34 years old constitute the largest portion of the uninsured, and this population tends to be the healthiest, and thus, the most economically favorable to insure as they typically access the least health care services. Thus, a shorter enrollment period will not only negatively impact consumers access, but will also result in a more expensive risk pool, ultimately, increasing costs to issuers, the health care system, and American taxpayers.

II. Section 155.420 - Special Enrollment Periods

A. *We encourage the Department not to expand the pre-enrollment verification process for individuals seeking to enroll during an SEP.*

The ACA requires, as codified under 42 U.S.C. § 18031(c)(6)(C), the Department to establish special enrollment periods for the federal Marketplace whereby consumers who meet qualifying circumstances can enroll in coverage outside of the annual open enrollment period. The Department's proposals to expand the verification process to all consumers seeking to enroll during a SEP will further limit the number of consumers enrolling during a SEP and increase costs for the health care system. Marketplace enrollment already includes substantial verification processes. Moreover, currently few people who are eligible for SEPs are actually using them to enroll; a recent estimate found only five percent of those who are eligible for a SEP are enrolled during a SEP.[2] Increasing the verification processes will only result in people lacking access to care and will further increase

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[1] L. Blumberg, et. al., Urban Institute, Who are the Remaining Uninsured, and What do their characteristics Tell Us About How to Reach Them (March 2016), http://www.urban.org/sites/default/files/publication/79051/2000691-Who-Are-The-Remaining-Uninsured-And-What-Do-Their-Characteristics-Tell-Us-About_How-To_Reach_Them.pdf.

[2] S. Dorn, Urban Institute, Helping Special Enrollment Periods Work under the Affordable Care Act 1 (June 2016).

costs to our nation's healthcare system.

Annually over 33 million consumers lose coverage between open enrollment periods, for various reasons such as loss of employment.[3] Without SEPs, many individuals—most who unexpectedly find themselves uninsured—would almost certainly remain uninsured until the next enrollment period. A delay in enrolling in coverage could result in healthy individuals, including women of reproductive age, not being able to access essential care, such as preventive screenings, acute care, and prenatal services. The proposed rule estimates that an additional 650,000 individuals would have their enrollment delayed - this delay will result in more consumers forgoing or delaying care and needing to access costly treatment for a condition that could have been prevented or treated earlier. For instance, a delay in coverage could result in an enrollee delaying a HIV screening and not accessing antiretrovirals until their HIV has progressed and requires more costly and invasive treatment. A delay in accessing care is not only bad for the enrollee's health, but also bad for the insurance risk pool if consumers do not access care until it is most expensive.

Further, the Department is proposing to require individuals who are seeking to enroll in a SEP based on a recent move to submit additional documentation to prove previous and new addresses and evidence of prior coverage, and consumers seeking to enroll during an SEP due to marriage to prove at least one spouse had minimum essential coverage in the last 60 days. Both of these additional requirements, as well as the pre-enrollment verification process, will disproportionately impact young people and adversely impact the risk pool**.** Young adults are more likely to experience life transitions that could result in loss of coverage mid-year, such as moving for a job (which may not have health insurance) or getting married. Younger adults, who are also more likely to be healthier and contribute positively to the risk pool, are the least likely to complete the enrollment process through the Marketplace when they experience difficulty applying. In 2015, younger people were about a quarter less likely to finalize their enrollment than older consumers, a factor that has had a negative impact on the Marketplace's risk pool. Thus, additional verification processes have the potential to disproportionately impact young people and have a negative impact on the risk pool.

Moreover, it is not clear the FFM would be technically or operationally capable of implementing an SEP verification process in a manner consistent with the ACA's vision of a real-time, streamlined eligibility and enrollment system. We appreciate the Department's proposal to verify an individual's eligibility for SEPs electronically. However, CMS has not explained how the Department would verify eligibility for each SEP, how the operational side of the pre-verification process would operate. The proposed rule estimates that there will be additional administrative costs to the federal government from having a more rigorous verification process. Lastly, the Department proposes to only allow consumers to set their plan effective date one month after the application date so that the consumer can avoid paying retroactively for coverage they were not able to access while their documentation was pending. It is very realistic that it could take the Marketplace longer than a month to verify documentations. Only permitting the enrollee to set an effective date one month after originally assigned, regardless of when they receive an eligibility determination, could result in the enrollee owing retroactively for coverage that they were not able to access while their verification was pending.

B. *The Department should not limit the plans available to individuals who qualify for SEPs.*

The proposed rule would require individuals to enroll their dependent into the plan in which the enrolling

[3] S. Dorn, Helping Special Enrollment Periods Work under the Affordable Care Act (June 2016), http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

consumer is already enrolled or alternatively, the enrollee may enroll the dependent into a plan at the same metal level as the consumer's plan. Further, the proposed rule would only permit an individual who qualifies for a SEP based on gaining a dependent, who is also newly eligible for cost-sharing reductions, to be enrolled in a silver level plan.

If adopted, these proposals would disproportionately burden women. Individuals who qualify for a SEP based on gaining a dependent do so because they have given birth, adopted a child, or had a child placed for foster care in the home. After such a significant life change, the individual (most likely a woman) and the new dependent may have different health needs that a previous plan does not accommodate. For instance, a woman who has recently given birth may have experienced complications during birth may now have medical needs not covered under her previous health plan.

The proposed rule would also limit plan options for enrollees seeking to enroll in a SEP based on other qualifying life events such as gaining access to a new health insurance market based on a move or losing minimum essential coverage. This proposal does not represent a solution to an undocumented concern and, if adopted, would lessen competition in the health insurance marketplace among consumers that require a new health plan due to changing life circumstances. In short, this proposal only limits consumers ability to choose the plan that best meets consumers' and their families' needs.

C. *The Department should not exclude individuals who have experienced a gap in coverage due to non-payment.*

The Department's proposal to prohibit a consumer from enrolling in a SEP for loss of coverage when the loss of coverage was due to non-payment of premiums would disproportionately impact low or moderate-income consumers. An individual should not be completely blocked from accessing coverage during an SEP because they have had difficulty paying their premiums in the past. This could lead to individuals not being able to access coverage at all if they are in a state where there are no individual plans sold outside of the Marketplace. In states where individual plans are sold outside of the Marketplace, consumers would be blocked from accessing the financial assistance available on the Marketplace. Eighty-five percent of consumers rely on the financial assistance available on the Marketplace to purchase plans.[4] Given the gap in earning for women - U.S. women employed full time losea total of $840 billion annual - women may be more likely to have missed a premium payment and disproportionately impacted by being blocked from enrolling in coverage.[5] Those who have had difficulty affording insurance are the very individuals who need the financial assistance available on the Marketplace.

III. Section 156.230 - Network Adequacy Standards

The Department should continue to meet its obligation to ensure that qualified health plans provide reasonable access to providers.

Demonstrating Congress's focus on ensuring access to health care providers, the ACA requires health plans to maintain a network that is sufficient in number and types of providers to assure that all covered services are

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[4] A. Simmons et.al., Dept. of Health & Hum. Servs., ASPE Issue Brief - The ACA: Promoting Better Health for Women 2 (June 14, 2016), https://aspe.hhs.gov/sites/default/files/pdf/205066/ACAWomenHealthIssueBrief.pdf.

[5] National Partnership for Women and Families, America's Women and the Wage Gap (Oct. 2016), http://www.nationalpartnership.org/research-library/workplace-fairness/fair-pay/americas-women-and-the-wage-gap.pdf.

accessible without unreasonable delay. In particular, the ACA requires the Department to establish network adequacy requirements for insurers seeking QHP certification.[6] The Department should continue to articulate and enforce federal network adequacy requirements. It is a departure from the statute for the Department to solely rely on states to assess QHPs provider networks.

Network adequacy is a key component to ensuring meaningful health care access and a critical element to ensuring an efficient (and cost-contained) health care system. Yet, consumer experiences in accessing providers vary across states, with some state standards assessing travel time and distance, others provider-to-enrollee ratios, others appointment wait time, and the extended hours of operation.[7] Further, states' processes to regulate and assess plan's provider networks also vary. This variety highlights the need for a federal minimum floor to which insurers must adhere and helps ensure that consumers can still participate in a competitive and quality health insurance market regardless of where they live. It is also not sufficient under the statute to rely on accrediting bodies to assess provider networks. Moreover, from a policy perspective, the proposed accrediting body standard is a piecemeal approach to assessing provider networks. The Department must establish a strong network adequacy standard for Marketplace issuers in all states, including the FFM, SBM-FPs, state-based Marketplaces, and Partnership Marketplaces.

Currently, consumers experience problems accessing needed care, according to a study published in the New England Journal of Medicine. Women, in particular, have difficulty finding plans that provide them sufficient access to the health care providers they need. Specifically, the study found that 13 percent of qualified health plans did not have a provider in network for at least one specialty within a 100 mile radius, including some plans that did not have an OB/GYN.[8] Nearly, 60 percent of women report seeing their OB/GYN regularly, and 35 percent describe their OB/GYN provider as their main source of care. Indeed, for many women, OB/GYNs are their gateway to the broader health care system.[9] Network adequacy standards must be strong and ensure that networks are sufficient to meet women's health needs and provide timely access to providers that specialize in women's primary health care, including family planning care, women's preventive services, and pregnancy-related care. Relying on existing state standards, unfortunately, will not remedy existing network adequacy challenges and, in particular, will continue to create a health care system that does not reflect the unique needs of women.

To ensure that Marketplace enrollees across the country have timely access to appropriate, geographically accessible providers who can deliver the health services covered under their plans, the Department should not only continue its current practice of using time and distance standards to assess provider networks, but also adopt stronger network adequacy standards in regulation to uphold and meaningfully implement the statutory requirements for network adequacy under the ACA. The Department should establish a broad set of metrics and criteria that includes, but is not limited to: time and distance standards; provider-to-enrollee ratio minimums;

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[6] 42 U.S.C. § 18031(c)(1)(B). Also, section 156.230(a)(2) of the federal regulations requires all issuers offering Marketplace plans to maintain a network that is sufficient in number and types of providers to assure that all covered services are accessible without unreasonable delay.

[7] J. Giovanelli, Commonwealth Fund, Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks (May 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

[8] Dorner SC, Jacobs DB, Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*.2015; 314 (16):1749-1750. doi:10.1001/jama.2015.9375, available at http://jama.jamanetwork.com/article.aspx?articleid=2466113#Discussion.

[9] PerryUndem Research & Communication. "Women & OB/GYN providers". Research conducted for Planned Parenthood Federation of America, November 2013.

availability of providers accepting new patients; assessment of the range of provider types in a plan's network; and appointment wait time standards. Recognizing the existing challenges for women's health access, it is critical that federal network adequacy standards also include metrics that ensure access to a broad range of women's health services, including family planning services and pregnancy-related care. Improving upon the existing federal network adequacy standards will help ensure that plan networks meet the needs of consumers and provide timely access to covered services. This will ultimately help the healthcare system because it will prevent people from accessing care when they are sickest and care is most expensive.

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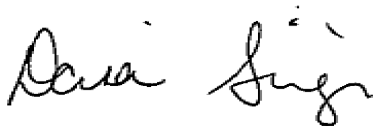
Thank you for the opportunity to comment on the Market Stabilization rule. If you have any questions, please do not hesitate to contact me at 202-973-4800.

Respectfully submitted,



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Comment separator page. Next comment follows.

February 28, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929- P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: RIN 0938-AT14 Patient Protection and Affordable Care Act; Market Stabilization

Raising Women's Voices for the Health Care We Need is a national initiative working to ensure that the health care needs of women and our families are addressed as the Affordable Care Act is implemented. We have a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, women with disabilities, and members of the LGBTQ community. We place a priority on asking women to share their experiences navigating the health care system. Because of women's roles as arrangers of health care for our families, we believe women are grassroots experts in what is wrong with the current health system and what it will take to fix it.

We appreciate the opportunity to provide comments to the Department of Health and Human Services (HHS) on the proposed rule regarding market stabilization for the individual and small group markets.

We understand that the uncertainty caused by the current health policy debate in Congress may have implications for the stability of the individual health insurance market in many states. We support federal and state efforts to allay uncertainty among both issuers and consumers and to increase robust competition in the Marketplaces for the 2018 plan year. However, we believe that curbing vital consumer protections with regard to affordability and access is not the way to address stability and that many of the proposed changes to individual market regulation, if enacted, will in fact serve to limit enrollment and competition in the individual market and thereby harm consumers who depend on the marketplace for coverage.

To promote robust enrollment and competition in the individual health insurance market, we urge HHS to consider the recommendations and comments detailed below.

OPEN ENROLLMENT PERIOD LENGTH (45 CFR §155.410(e))
We recognize that eventually moving to an open enrollment period that does not cross two plan years will be administratively simpler and more efficient. However, we are concerned that given the uncertainty and confusion that surrounded the final days of the 2017 open enrollment period as well as the ongoing uncertainty that congressional health policy debates have caused, the 2018 plan year is too soon to dramatically shorten the open enrollment period and will ultimately prevent robust enrollment and a balanced risk pool.

We urge HHS to maintain the existing open enrollment period, **or at least allow open enrollment until December 31, 2017**. If HHS decides to move forward with a shortened open enrollment period for the 2018 plan year, we strongly support additional consumer outreach and education activities to ensure that consumers understand the new timeline and the importance of enrolling in coverage. This includes additional resources for Health Insurance Navigators and other assisters and a robust educational campaign to promote enrollment.

SPECIAL ENROLLMENT PERIODS (45 CFR §155.420)
Special Enrollment Periods (SEPs) have been an important consumer protection to ensure access to health insurance following a significant life event or evidence of extenuating circumstances that prevented enrollment during the open enrollment period. Absent evidence of abuse (which has not been documented or shown), we do not support proposals that seek to limit availability of SEPs.

We urge HHS to maintain current SEP application and verification standards. Creating burdensome documentation requirements before someone may enroll in a plan, particularly absent evidence of consumers abusing SEPs, will only serve as an enrollment barrier for individuals who have in fact had a qualifying life event. We believe that the current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, should be left in place.

As we noted in October, we remain concerned with administrative barriers intended to prevent fraud that instead hamper enrollment of eligible people. It is not surprising that insurers report higher medical claims costs among people who enroll using SEPs than they see among people who enroll during the annual open enrollment period: people who expect to need medical care are the most motivated to seek out information about and follow through on enrollment through an SEP. **Healthier people are more likely to drop out of the enrollment process if they must take additional steps to document or prove their eligibility for an SEP.** Thus, the current post-enrollment confirmation process started in July likely makes the insurance pool sicker instead of healthier. Furthermore, if the drop in special enrollment period plan selections in 2016 as reported by CMS in the September 2016 FAQ is not due to the curtailment of fraudulent enrollment but rather to the healthiest and thus least motivated people giving up in the face of additional paperwork requirements, then the confirmation process undermines the pool.

Furthermore, the proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to “accept every employer and individual in the State that applies for such coverage.” (42 U.S.C. § 300gg–1) While issuers “may restrict enrollment … to open or special enrollment periods,”

this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that: defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

CONTINUOUS COVERAGE

As we stated above, we believe that continuous coverage requirements are antithetical to the guaranteed issue consumer protections of the ACA. Imposing waiting periods before enrollment, pre-existing condition exclusions, and penalties for people who experience a gap in insurance coverage will harm consumers, particularly those who may be living with disabilities or with serious chronic conditions who are more likely to experience changes in employment and life circumstances throughout the year. Additionally, we note that individuals who need care but are denied coverage due to such rules are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on.

GUARANTEED AVAILABILITY (45 CFR §147.104)

The proposed reinterpretation of the guaranteed availability provision is unlawful and outside the Secretary's authority. We encourage the Secretary to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and the Secretary does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace

(FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and the Secretary must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments. The Secretary should establish procedures, however, for past due premiums to be pro-rated and added to the insurance premiums for the following year (or partial year, in the case of a special enrollment period) for the enrollee. This would allow issuers to recoup past due premiums while respecting the statutory requirement to accept all applicants. Consistent with statute, issuers could not deny or terminate enrollment for failure to pay the pro-rated past due amount if the current premium is paid; the pro-rated repayment option simply facilitates an issuer's collection of debts that could be recouped under other legal remedies.

Pro-rating the past due amount will facilitate beneficiary re-payment and enrollment in the prior issuer's plan, as requiring the full past due amount at enrollment may be financially impossible for many enrollees. We urge the Secretary to develop clear procedures to notify consumers beneficiaries of past due amounts at the time of plan selection, the pro-rated repayment schedule, and an opportunity to contest the past due amount.

Importantly, many consumers only have access to plans from one issuer due to limited Marketplace competition. Under the Secretary's proposal, if these consumers are unable to fully repay past due premiums upon enrollment, they will be completely unable to obtain any coverage. We believe the possibility of such lockouts could have a chilling effect on enrollment by healthier individuals, especially those with limited incomes, because they might worry that if they do not maintain continuous coverage they will never again be able to purchase insurance and access care when they need it. Pro-rated repayment plans will facilitate these consumers' re-entry into the insurance market, supporting Marketplace stability. Without affordable repayment plans, these consumers may postpone enrollment until they are sick, increasing adverse selection. Clear guidelines on pro-rated re-payment plans are necessary to protect consumers and encourage them to re-enter the marketplace, particularly in jurisdictions with only one issuer.

We support the Secretary's proposal to allow issuers to develop a premium payment threshold policy. Issuers could, for example, allow a beneficiary to pay 60 percent of the past due amount in one payment at enrollment and have the balance of the past due amount forgiven rather than participate in an installment re-payment. Issuers should be allowed to experiment with these repayment models so long as they offer an annualized installment option for the full past due amount. The issuer must be required to provide consumers with a clear and consumer-friendly explanation of all repayment options when the issuer enrolls the past-due consumer.

ACTUARIAL VALUE DE MINIMIS VARIATION (45 CFR §156.135)
We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that

the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds the Secretary's authority and undermines the plain meaning of the statute.

Contrary to the proposed rule's assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee's income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of $25,000. This individual's expected contribution towards premiums is 6.8% of income or $1,700. If the person selects the benchmark plan, his/her net premium will be $1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax

credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

NETWORK ADEQUACY

We oppose any proposal that erodes critical network adequacy standards and that would jeopardize access to providers. While we support efficient and non-duplicative monitoring and enforcement of insurance standards between state and federal regulators, we do not support using accreditation as a substitute for regulator enforcement. Because accreditation standards are not readily accessible, it will be impossible to determine adequate compliance with the ACA's network adequacy requirements with the only requirement being that plans have been accredited.

The proposal to defer network adequacy review to external accreditors is contrary to statute. The Secretary "shall, by regulation, establish criteria for the certification of health plans" to "ensure a sufficient choice of providers." (42 U.S.C. § 18031) These criteria must be subject to the full notice and comment requirements of the regulatory process. The proposed deferral to private standards, however, does not meet the requirements for criteria established by regulation, as the public is unable to review and comment on these private standards.

In states with robust network adequacy standards and review processes that are at least as protective as the ACA's federal standards and the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act (#74), we support deference to the state regulatory process. This must include quantitative time and distance standards. However, absent evidence of robust state monitoring and enforcement of network adequacy, HHS must step in to review plan justification of compliance with federal standards.

COMPRESSED PUBLIC COMMENT PERIOD

Finally, we would like to express concern that the public comment period for this proposed rule was so compressed. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the significant proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Thank you for your consideration of our comments. If you have any questions regarding these comments, please contact Sarah Christopherson, policy advocacy director for Raising Women's Voices and the National Women's Health Network (schristopherson@nwhn.org).

Sincerely,

Raising Women's Voices for the Health Care We Need

Comment separator page. Next comment follows.

I am writing to comment on CMS-9929-P. There are several proposed rule changes to the Affordable Care Act that are of concern. See my comments to the sections included in the bill.

First, we propose changing the dates for open enrollment in the individual market for the benefit year starting January 1, 2018, from a range of November 1, 2017, to January 31, 2018 (the previously established open enrollment period for 2018), to a range of November 1, to December 15. This change would require individuals to enroll in coverage prior to the beginning of the year, unless eligible for a special enrollment period, and is consistent with the open enrollment period established for the open enrollment periods for 2019 and beyond.

Shortening the time for enrollment would in effect provide a barrier to the number of people able to get coverage. Six weeks is not enough time for some who don't have a computer or transportation or need help in completing the enrollment, especially those who are older or with health conditions to get enrolled. This will destabilize the marketplace even further leading to increase cost of health care insurance and use of higher care alternatives such as the emergency departments.

The proposed amendments in this rule are also intended to affirm the traditional role of States in overseeing their health insurance markets while reducing the regulatory burden of participating in Exchanges for issuers. The first of these proposals relates to network adequacy review for QHPs. The modified approach would not only lessen the regulatory burden on issuers, but also would recognize the primary role of States in regulating this area.

Reducing regulations such as the essential health benefits will in fact mean insurance companies would not cover benefits that Americans need such as screening and preventive care. This would take away decisions from patients and doctors and give those decisions to insurance companies. In addition it would create different levels of care based on what state you live in and what that states coverage is. Less expensive provider networks will result in lower enrollment, especially for younger, healthier adults and that will increase premiums

The second we are proposing to add new paragraph (d)(2)(i)(A) to require that, if consumers are newly enrolling in QHP coverage through the Exchange through the special enrollment period for marriage, at least one spouse must demonstrate having had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage. However, we recognize that individuals who were previously living abroad or in a U.S. territory may not have had access to coverage that is considered minimum essential coverage in accordance with 26 CFR 1.5000A1(b) prior to moving to the U.S. Therefore, we propose that, when consumers are newly enrolling in coverage during the coverage year through the special enrollment period for marriage, at least one spouse must either demonstrate that they had minimum essential coverage or that they lived outside of the U.S. or in a U.S. territory for 1 or more days during the 60 days preceding the date of the marriage. This proposed change would only apply in the individual market. We seek comment on this proposal.

Again this proposal is creating a barrier to obtaining healthcare. There is no legitimate reason for requiring one spouse to have coverage prior to getting married.

For example, this rule proposes changes that would require consumers to demonstrate prior coverage to qualify for the special enrollment period for marriage in proposed paragraph (d)(2)(i)(A) and would generally limit plan selection to the same plan or level of coverage when an enrollee qualifies for a special enrollment period during the coverage year in proposed paragraph (a)(4). However, we believe that the differences in the markets – and the impacts of

This is creating barriers to coverage which will only serve to increase the number of people who will remain uninsured and thus increase ED visits. This will not create a large enough pool to keep the cost and deductibles low. Creating barriers such as pre-enrollment verification for special enrollment periods will result in lower enrollment especially from younger, healthier adults which will increase premiums for a plan that provides less coverage.

Third, we propose to expand the verification requirements related to the special enrollment period for a permanent move in paragraph (d)(7). This special enrollment period is only available to a qualified individual or enrollee who has gained access to new QHPs as a result of a permanent move *and* had coverage for 1 or more days in the 60 days preceding the move, unless he or she is moving to the U.S. from abroad or a U.S. territory. Currently, we require documentation to show a move occurred, and accept an attestation regarding having had prior coverage or moving from abroad or a U.S. territory. To ensure that consumers meet all the requirements for this special enrollment period, we propose to require that new applicants applying for coverage through this special enrollment period submit acceptable documentation to the FFEs and SBE-FPs to prove both their previous and new addresses and evidence of prior coverage, if applicable, through the pre-enrollment verification process. If finalized, we intend to release guidance on what documentation would be acceptable. We seek comment on this proposal.

By creating all these documentation regulations you have effectively reduce the number of people who will apply for healthcare. In addition you will be creating higher costs by increasing the documentation audit from 50% to 100%. If you are worried about people gaming the system it would be better to implement incentives to keep healthy people in the marketplace such as choice and affordable premiums with essential coverage. One way that could be implemented is providing Medicare for all Americans.

HHS is also interested in whether policies are needed for the individual market similar to those that existed under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA), which required maintenance of continuous, creditable coverage without a 63-day break in the group market if individuals wished to avoid the pre-existing condition exclusions, and allowed waiting periods to be imposed under certain circumstances. Although the HIPAA rules did not require that individuals maintain coverage, the rules were

designed to provide an important incentive for individuals to enroll in coverage year-round, not just when in need of health care services; reduce adverse selection; and help prevent premiums from climbing to levels that would keep most healthy individuals from purchasing coverage.

This fails to protect millions of Americans with pre-exiting conditions by limiting their access to healthcare if they can't afford the premiums. By requiring continuous coverage and creating barriers to obtaining that coverage you are effectively giving insurance companies that approval to charge a 30% penalty on premiums for an entire year. That will only decreases the number of Americans that can afford healthcare. This is a great deal for insurance companies but not so much for Americans.

Although none of their networks met the 30 percent ECP threshold, all of these justifications were deemed sufficient, and each network would have met the 20 percent threshold. We anticipate that issuers will readily be able to contract with at least 20 percent of ECPs in a service area.

This means that people living in rural areas will have to drive farther to get healthcare from providers in their plan. Reducing the ECP threshold to 20% will limit consumer's ability to obtain providers in their locality. This will increase out of pocket costs for consumers, especially those in rural areas. Without regulations to guarantee that every provider is qualified to provide services consumers will be left on their own to determine if the provider in the ECF is meeting basic provider standards.

As finalized in the 2018 Payment Notice, §156.140(c) permits a de minimis variation of +/ − 2 percentage points, except if a bronze health plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), the allowable variation in AV for such plan is −2 percentage points and +5 percentage points. We established this additional flexibility for certain bronze plans in the 2018 Payment Notice to provide a balanced approach to ensure that a variety of bronze plans can be offered, including high deductible health plans, while ensuring that bronze plans can remain at least as generous as

catastrophic plans. As discussed in the EHB Rule, our intention with the de minimis variation of +/−2 percentage points was to give issuers the flexibility to set cost-sharing rates that are simple and competitive while ensuring consumers can easily compare plans of similar generosity. While the de minimis range is intended to allow plans to float within a reasonable range and is not intended to freeze plan designs preventing innovation in the market, it was also intended to mitigate the need for annual plan redesign, allowing plans to retain the same plan design year to year while remaining at the same metal level.

At this time, we believe that further flexibility is needed for the AV de minimis range for metal levels to help issuers design new plans for future plan years, thereby promoting competition in the market. In addition, we believe that changing the de minimis range will allow more plans to keep their cost sharing the same from year to year. Although the AV Calculator is not a pricing tool, changing the de minimis range could also put downward pressure on premiums. Thus, we anticipate that this flexibility could encourage healthier consumers to enroll in coverage, improving the risk pool and increasing market stability. For these reasons, we believe that changing the AV de minimis range would help retain and attract issuers to the nongrandfathered individual and small group markets, which would increase competition and help consumers. Therefore, we propose amending the definition of de minimis included in

§156.140(c), to a variation of - 4/+2 percentage points, rather than +/- 2 percentage points for all non-grandfathered individual and small group market plans that are required to comply with AV. Under the proposed standard, for example, a silver plan could have an AV between 66 and 72 percent. We believe that a de minimis amount of -4/+2 percentage points would provide the necessary flexibility to issuers in designing plans while striking the right balance between

ensuring comparability of plans within each metal level and allowing plans the flexibility to use convenient and competitive cost-sharing metrics.

Changing the variation of the de minimis from+/-2 to -4/+2 percentage points will reduce the coverage of each level of insurance while keeping the insurance in the same tier. This will make it very difficult for consumers to compare plans and will decrease the coverage for the same tier level coverage. The change in the calculation will benefit insurance companies by not having to adhere to the stricter guidelines but there is no evidence that that cost reductions will trickle down to the consumer by lower premium costs.

Comment separator page. Next comment follows.

JANICE D. SCHAKOWSKY
9TH DISTRICT, ILLINOIS

COMMITTEE ON ENERGY AND COMMERCE
Subcommittees:
Ranking Member, Commerce, Manufacturing, and Trade
Health
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March 7, 2017

Mr. Patrick Conway
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-9929-P – Patient Protection and Affordable Care Act; Market Stabilization

Dear Mr. Conway:

As representative of the 9th Congressional District, my staff and I have spent a great deal of time helping my constituents understand and utilize the many benefits provided under the Affordable Care Act (ACA). I agree that there is a need to stabilize and strengthen the current market, especially in light of Republican-led, Congressionally-imposed restrictions on ACA-provided mechanisms designed to achieve that goal. However, I do not believe we should achieve market stability at the expense of consumer choice and affordability, as I believe this proposed rule would do. I urge you to withdraw this proposed regulation and look instead for market stabilization measures that do not reduce consumer protections and shift costs to individuals and families.

Guaranteed Availability

The guaranteed availability proposal would expand the circumstances in which individuals who have outstanding premium payments owed from the prior 12 months could be denied coverage, allowing an insurer to deny coverage not just for the product on which the outstanding debt is owed but on any product the issuer sells. The issuer could demand full repayment before providing access to coverage.

The ACA is designed to expand guaranteed availability and coverage, specifically stating that issuers "must accept every employer and individual in the State that applies for coverage." That should not be read as an invitation to forego premium payments, and there is little evidence that people abuse the current system by failing to make premium payments in the knowledge that they have guaranteed access to a different plan in the future. However, it is important to note that there are many reasons why individuals might miss premium payments, including income limitations, cognitive problems, changes in eligibility, or even billing disputes with the insurer. Allowing a full repayment requirement -- rather than a reasonable repayment plan – and application to any plan sold by the issuer will increase the number of uninsured Americans.

Denying guaranteed access to health coverage is not just harmful to individuals and families, it would shift costs to taxpayers and providers who treat those who become uninsured as a result – the very situation the ACA was trying to avoid. Moreover, while the stated intention is to stabilize the individual and small group markets, this would in fact weaken the already unstable market and be especially detrimental to low-income individuals and families. That is because healthy young people are more likely to miss bill payments, and would consequently be most likely to lose coverage. This would leave an older and sicker population in the risk pool, which would then raise premiums and prevent healthy young people from enrolling in marketplace plans, directly contradicting the purpose of the ACA and the proposed rule.

Open Enrollment

Similarly, CMS's proposal to shorten the open enrollment period in half would again, undermine rather than strengthen the stability of the risk pool. While the health insurance marketplaces were fully implemented three years ago, there is still a gap in knowledge among consumers. While CMS intends to "conduct extensive outreach" to warn about the shorter enrollment period, it is unclear what that would entail. This would also severely limit the capacity of navigators and in-person assisters, who were already in high demand in previous open enrollment periods. Moreover, given the confusion of the current ACA replacement efforts, it is a certainty that many consumers will mistakenly believe that they do not have an enrollment option. A shortened open enrollment period would give less time to correct that information and allow interested consumers to enroll.

Rather than shortening the open enrollment period for the 2018 plan year, I believe that CMS should use this year to bolster its public education and outreach capacity, including efforts to differentiate between Exchange and Medicare enrollment, in order to make sure the groundwork is laid for shorter open enrollment periods in the future.

Special Enrollment Periods

I agree that Special Enrollment Periods (SEPs) should be used for their intended purposes, not as a fallback for failure to enroll when eligible. However, while there is no supportive evidence of abuse of special enrollment periods, there is evidence that too few rather than too many eligible individuals are enrolling through SEPs. That evidence corresponds with the experience of my office, which has been working to help constituents with the SEP process.

I strongly believe that we should be making the SEP process easier, not harder. I believe that the expansion of pre-enrollment verification from 50% to 100% moves in the wrong direction, especially when combined with the new "pending" provisions. I am not convinced that there will be the staff and resources necessary to handle the increase in workload (CMS estimates that 650,000 individuals will be "delayed" or "pended" under the proposed changes).

The verification requirements will also hinder the efforts of stabilizing the market. Additional paperwork would be burdensome for younger consumers, who we need in order to stabilize the risk pool. In fact, CMS reported that only 55 percent of those 18 to 24 completed the process of providing additional paperwork for SEP enrollment in 2016 (compared to 73 percent of applicants age 55-64).

Finally, I am concerned about restrictions on the ability to change metal levels. Life changes such as marriage and a new child may have significant impacts on income and health needs, and those utilizing the SEP process should be able to make changes in coverage to reflect them.

Network Adequacy and Essential Community Providers

One of the biggest concerns facing my constituents is the question of narrow networks, and I believe that we need to improve access by strengthening – not weakening – existing standards. Instead, I strongly believe that the proposed changes would make the situation even worse by relying solely on state agencies, superceding time and distance requirements, and allow the use of outside external accreditation entities. Despite numerous complaints, the State of Illinois has not utilized its authority to require network adequacy. As a result, for example, there is no plan offered in my Congressional district that includes Lurie Children's Hospital, meaning that children who need specialized care are required to go elsewhere, even if they had previously bee treated at Lurie's for their very serious, ongoing needs. Allowing subjective rather than qualitative measures of adequacy in this instance would compound the problem. Finally, I am deeply concerned that a process that should be transparent, open and publicly-accountable will be conducted in private given reliance on private accreditation entities.

I also oppose weakening of the essential community provider (ECP) requirements, reducing the 30% standard to 20% and allowing issuers to use an expanded write-in process to use ECPs not on the HHS list. The ECP provision is designed to ensure access to critical safety-net providers, including community health centers, women's health clinics, and facilities caring for vulnerable populations. Reducing the standard and allowing issuer substitutions would not only reduce access, it would make it easier for issuers to "game the system" by excluding ECPs serving higher-cost populations.

The proposed rule would make significant changes that would greatly harm access to health care under the guise of providing market stability. It was not Congressional intent to reduce access to providers in an attempt to encourage issuers to enter or remain in the market.

Actuarial Value

I firmly oppose the proposed changes to actuarial value (AV) that could, according to the proposed rule itself, "reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial

risk associated with high medical costs." The AV system was designed to establish benefit standards, and the current allowed AV variation of -2/+2 is designed to be *de minimus.* While market stability is an important goal, that is not the purpose of AV and it should not be used to shift more cost and risks away from issuers and onto the backs of individuals and families. According to a report by Families USA, "President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense," for example, the result of moving from the AV from 68 percent to 66 percent could result in a $1,000 increase in a deductible.

Increasing the financial burden on individuals and families through cost-sharing is neither appropriate nor necessary.

Continuous Coverage

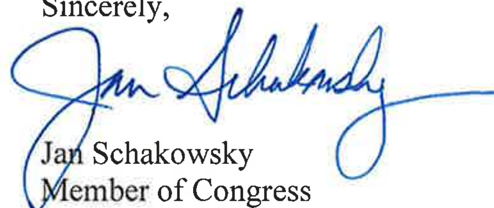
Under the proposed rule, HHS asked:

> "whether policies are needed for the individual market similar to those that existed under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) which required maintenance of continuous, creditable coverage without a 63-day break in the group market if individuals wished to avoid the pre-existing condition exclusions, and allowed waiting periods to be imposed under certain conditions."

Congress was certainly aware of the HIPAA provision when crafting the ACA, and rejected it. Many Americans face gaps in coverage due to circumstances such as job loss, caregiving responsibilities, financial difficulties, illness or disability. The HIPAA 63-day requirement meant that they were unprotected from pre-existing condition exclusions that could have devastating health and financial implications for them. Instead of utilizing the continuous coverage requirement, the ACA imposes a financial penalty under the individual mandate. That – not denial of care – is a more appropriate mechanism for encouraging enrollment, one that doesn't punish individuals who face difficult circumstances with the loss of necessary medical care.

Again, while I support the goal of market stability, I believe that the provisions in the proposed rule would not only fail to achieve that goal, but would be harmful to consumers by reducing their access to providers while raising their out-of-pocket costs. I urge you to reject them and to look for other ways to obtain market stability.

Sincerely,



Jan Schakowsky
Member of Congress

Comment separator page. Next comment follows.

The biggest problem is pre-verifying a SEP due to loss of coverage. I am an insurance agent and I see major problems with this rule change that will make life much more difficult for me and for consumers. I ask you not to implement the SEP verification changes.

Current law requires insurance companies to send proof of coverage documents with the termination date only AFTER coverage has ended. Most of the people I help enroll have not gotten those notices yet but they know coverage is ending because either Medicaid or their employer has told them so. It is already a pain to submit the documents during the 30 day window (because there is mailing time and we have to upload the documents several times. And then they aren't processed for weeks). It will be impossible for people to prove they have a SEP before the termination of their coverage. They would have to wait to get the notice, and would then have at least 1 month gap in coverage, but likely 2 months. This will not work for older people and people with disabilities, who cannot wait for coverage.

Please do not implement this pre-verification rule change. I understand the idea behind it, but it is already very difficult to do as is. The verification rules for SEPs are already very tight. If anything I hoped this administration would loosen the rule. As written, the new rule is unrealistic.

No documents available.

Comment separator page. Next comment follows.

Dear Health and Human Services,

I am writing to comment on CMS-9929-P . There are several proposed rule changes to the Affordable Care Act that are of concern.

1. Reducing the Enrollment Period from 3 months to 6 weeks will cause more Americans to remain uninsured. The reason cited is to improve the risk pool because it would reduce opportunities for adverse selection by those who learn they will need services which shows the purpose is to reduce the number that are insured. While there may indeed be issues with people gaming the system the resolution of that issue does not lie in reducing the enrollment period; it lies in increasing the incentive for all people to sign up for health insurance.

2. Increasing the enrollment verification from 50% to 100% for those using special enrollment periods will increase costs of running the Health Exchange. Many companies use sampling for quality control, and it would be a much less expensive option to use sampling, rather than using 100% verification. Is this rule change designed to protect Americans who need insurance, or to protect insurance companies?

3. Allowing insurers to apply a premium payment to past debt for those people who enroll with the same insurer makes insurance more expensive and hurts people who need insurance. This rule does not seem to be about gaming but rather about getting more money into the coffers of insurance companies. Those people who have subsidized premiums are generally living on the edge, paycheck to paycheck, and if they are unable to pay the premiums, I venture there is a reason other than trying to game the system.

4. Increasing the de minimis variation in the actuarial values allows insurance companies to change the value of the plans. It has been a benefit of the Health Care Exchange to have plans with minimum coverage requirements and easily comparable. It seems these rule changes are targeted to prevent gaming of the system so that folks dont choose to become insured only when they have a health need. While gaming may be a problem, the solution lies in increasing the penalty for choosing the risk of

remaining uninsured. Or better yet, a single payer system so that risk is spread over all people, healthy and sick. We need rule changes that will DRIVE HEALTHY PEOPLE INTO THE HEALTH CARE EXCHANGE. That is a solution that will benefit all Americans, and benefit insurance companies as well. Preventative care, including medication, is much less expensive than care in the ER. For instance, prior to the advent of the Affordable Care Act, consider this true story: A person with diabetes can not afford to go to the doctor and can not afford diabetes medication. That person gets a cut on their foot, which results in infection, because this is a complication of diabetes. The person can not afford to go to the doctor for that infection, which gets worse. That person ends up in the ER, and is hospitalized, with no insurance. The infection spreads, and the person has an above knee amputation of the leg. The hospital bills are very high, and are uncompensated care the hospitals must bear. The person ends up in a nursing home, paid for by nursing home medicaid. The person is now on social security disability, and can not work the rest of his life. If he leaves the nursing home, he will use food stamps and housing assistance for the rest of his life. ACCESS TO INSURANCE AND PREVENTATIVE CARE WOULD HAVE COST CITIZENS MUCH LESS! If you are concerned about gaming the system use incentives for health people to sign up to spread the risk; better yet, use a single payer system like Medicare for All.

Thank you for your time.

Sincerely,

Sara Baker
Athens, GA 30605

No documents available.

Comment separator page. Next comment follows.

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March 7, 2017

Patrick Conway
Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. The Sargent Shriver National Center on Poverty Law (Shriver Center) advocates for quality comprehensive, accessible, and affordable health care coverage and services for all populations experiencing poverty. In particular, we have a special focus and expertise in Medicaid policy as well as policy implementing the Affordable Care Act Marketplace, which provides subsidized health care coverage to Illinois residents with household income under 400% of the poverty level. We provide training and technical assistance to thousands of enrollment professionals in Illinois who assist consumers to enroll in health care programs including Medicaid and the Marketplace and to access financial assistance.

We have included our comments on specific sections below. In addition to these specific comments, we want to raise significant general concerns about the proposed rule's overall effect on consumers' ability to enroll in quality, comprehensive, affordable health coverage through the marketplaces. Our extensive experience working with enrollment assisters and with consumers in Illinois over the past four years informs our overall opinion that these proposed rules will cause substantial harm - especially to low income consumers who have less access to consistent employment and employer insurance; experience frequent variations in income; and have less attachment to a traditional labor market.

The proposed rule, if finalized, would add enrollment restrictions that make coverage *less* comprehensive and *more* expensive for Illinois consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides. If implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;

- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks; and
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals do not provide the appropriate solution to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are strongly dismayed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

I. § 147.104 – Guaranteed Availability of Coverage

HHS seeks comments about its proposed premium payment policy, which would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy, particularly for lower income individuals.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and HHS does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small

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Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize that there is a potential of adverse selection if beneficiaries only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

Beyond the dubious legality of the proposed rule, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, and other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with an issuer but faced numerous administrative and bureaucratic hurdles to do so.

A record of non-payment of a premium may also be due to issuer or marketplace error. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In our experience in Illinois, we have encountered multiple examples of consumers attempting to cancel coverage and the Marketplace erroneously failing to cancel or record the request. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage since they could lose their employment and need to come back for marketplace coverage but should not be subject to repayment.

Therefore, the implementation of a rule that will block consumers from enrolling and obtaining insurance due to a record of non-payment that could be inaccurate or was through no fault of their own is both unfair and counter to the goal of getting consumers to make regular payments and stay insured.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment. In Illinois, we now have several counties primarily in rural areas in which there is only one carrier available.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[1]

[1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrollment declines gradually throughout the year, a sign that enrollees leave the market over

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If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

And if HHS were to proceed with this policy, we also recommend that this policy be limited to annual renewals and that consumers enrolling during a Special Enrollment Period (SEP) should not be subject to this policy. The mere fact that a consumer is eligible for an SEP means the consumer is facing a change in circumstance. For example, if a consumer stopped paying premiums in September of one year and gets an SEP to re-enroll in the middle of the next year, the consumer should not have to pay back premiums when there has been a significant time lapse between the events.

Further, we provide additional suggestions to provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" to this policy such that consumers who can demonstrate significant financial hardship that caused the consumer to stop paying premiums, the issuer would not be permitted to apply new premium payments to past unpaid premiums. Consumers could document

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time for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

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such a hardship by providing a narrative explanation as to why he stopped paying premiums. Since the NPRM would already allow consumers to enroll in another plan and thus issuers would not always recoup past premiums from these consumers, it seems that allowing a consume the option to stay with the same plan – which may be important to the consumer because of the network or particular providers – is a second option that would provide a compromise for the consumer and issuer.

Also, information about repayment should be clearly noted on the Plan Compare tool so that consumers would have that information before they enroll. Second, it should be noted in the Eligibility Determination Notice since consumers could change plans if open enrollment or a special enrollment period remains open.

II. § 155.410 – Initial and Annual Open Enrollment Periods

We are concerned about the shortening of the annual open enrollment period. While we recognize a shorter enrollment period was planned for 2018, given all the potential changes that consumers have to digest this year, we believe that keeping a longer open enrollment period would be beneficial to consumers as well as issuers. We believe the benefits – enrolling more consumers – outweigh the perceived costs of having consumers enroll for less than a full year (if they enroll after December 15). HHS notes that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance during the abbreviated enrollment period. Thus, the policy change could just as easily lead to a pool that is adversely selected to mostly include the sickest people, at least in the short term, if young, healthy people end up missing the new deadline for signing up. HHS acknowledges this uncertainty but it does not sufficiently explain why a positive result (decreased adverse selection, improved stability of the exchanges) is more likely than a negative result (increased adverse selection, reduced stability of the exchanges) with a shorter enrollment period.

We are also concerned about the proposed shortened enrollment period due to the added burdens it will put on navigators and assisters. Many navigators and assisters already work long hours and weekends throughout the current open enrollment period to meet the demand. Shortening the period will make it even more difficult to reach and serve all consumers. Through our technical assistance center for enrollment assisters in Illinois and appointment tool, we regularly see, during open enrollment, long waiting lists for appointments and requests for enrollment assistance appointments that exceed the availability. Since Illinois is no longer able to fund an independent state assister program due to the end of the state establishment grants, Illinois is dependent on the federally funded Navigators and unfunded CACs.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[2] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[3]

[2] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[3] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.

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We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[4] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[5]

III. § 155.420 – Special Enrollment Periods

We have strong concerns about the proposed pre-enrolment verification process, particularly since it will include 100% of SEP applicants and because HHS has not released a full evaluation and analysis of the post-enrollment verification pilot operated in 2016. First, before requiring all applicants to verify their eligibility, it is important to identify any real or perceived limitations of verification that need to be addressed. Second, if the post-enrollment analysis finds that many eligible consumers are deterred or unable to complete verification, HHS should ensure these issues are fixed in a pilot of pre-enrollment verification. Overall, any required verification – whether for enrollment, data matching, or an SEP – needs to be easy and simple or eligible individuals will be deterred from enrolling. If the process is not easy, it is likely that those in dire need of health insurance, rather than individuals who may be healthier and want coverage to avoid paying a tax penalty, will likely complete the process. For SEPs, we recognize that a disproportionate number of sicker individuals obtaining coverage through SEPs could disrupt the risk pool and lead to unanticipated higher costs. If a major concern for issuers is the higher costs associated with those coming in through SEPs, however, other interventions exist that would not burden consumers or presume fraudulent applications. For example, HHS' changes to the risk adjustment costs in 2018 and beyond to address higher than expected costs of those not enrolled for the full year would address this problem without assuming that those obtaining mid-year coverage through an SEP are ineligible and need to prove eligibility pre-enrollment.

To keep consumer engagement and trust high – an essential component to the success of the marketplaces – while preserving affordability, any SEP eligibility verification should be narrowly targeted only to instances of suspected ineligibility or fraud and should use electronic verification rather than requiring paper documentation. While we understand the balance the FFM must strike between plans and consumers to achieve affordability, we believe that mandatory SEP pre-eligibility verification will have a chilling effect on many eligible individuals. Excessive documentation requests may be a deterrent

[4] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[5] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

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to potentially eligible applicants who would help spread the risk and HHS should take care not to discourage participation. Problems and consumer frustration with other verification processes already exist – such as lengthy times between document submission and review, trouble uploading verifications, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues because consumers cannot directly reach those conducting the reviews. Through our technical assistance center, we often have referrals of complex cases in which we need to assist the consumer in filing an appeal with the Marketplace or requesting a casework review because they cannot upload verification documents. Adding pre-eligibility verification may jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the FFM such that only the sickest and costliest consumers pursue SEPs. At the same time, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

As the NPRM preamble notes, some commenters to the 2018 Payment Notice suggested that additional steps to determine SEP eligibility worsen the problem by creating new barriers to enrollment. Yet based on issuer feedback, HHS is proposing to increase the scope of the pre-enrollment verification. We believe this should not be done unless and until the prior pilot analysis adequately identifies what cause and effect pre-eligibility verification may have on individuals and the marketplace as a whole.
Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to follow through.[6] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will take the steps necessary to complete the process.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. We work with populations that have variable employment and income; this proposed requirement is aimed at the most vulnerable working populations who are trying to move themselves out of poverty. They are mainly getting part time or variable seasonal employment and attempting to move up to full employment. During the interim, they are most likely to cycle on and off of coverage and not be able to get into the Marketplace. These are also generally young healthy consumers who we want to encourage to stay covered and balance the risk pool. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

a. *Electronic Verification*

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[6] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

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We do appreciate that HHS recognizes it will make every effort to verify eligibility through automated electronic means. It is not at all clear that the FFM would be technically or operationally capable of implementing an SEP verification process consistent with the Affordable Care Act's vision of a real-time, streamlined eligibility and enrollment system. HHS has already acknowledged that eligible individuals sometimes forgo coverage because they encounter difficulty securing and providing the documents requested to verify their eligibility when they have a data matching issue.[7] We cannot afford this result to duplicate with SEP verification. Our state Medicaid system has already experienced significant problems and delays in implementing a real time benefits eligibility application system. Illinois is still revising their application and renewal systems and needs time to get to full implementation. The extra burden of verifying Medicaid eligibility or more likely Medicaid denials and terminations to meet the strict SEP requirements in the Marketplace will be a logistical burden. In our experience, it is already very difficult for our clients to prove Medicaid termination or denials in time to enroll in the Marketplace and stay continuously covered.

As an example, consumers who are eligible for the permanent move SEP who have been enrolled in a QHP should not have to provide documentation of their "original" address. Yet this was required as part of the post-eligibility verification. Consumers provide this information during enrollment and burdens should not be added to submit documentation merely because HHS is unable to access this information. Before implementing a pilot, HHS should establish systems for an automatic check with issuers and public programs (Medicaid, CHIP, Medicare) about whether a consumer lost creditable coverage. Consumers should not be responsible for tracking down documentation to show that coverage was lost when this information is readily available from issuers. Only if electronic verification is inconclusive, or if a consumer disputes the result, should documentation be required.

b. Timeframes for document verification

We appreciate that HHS will provide consumers 30 days to provide documentation. We do ask that HHS also provide consumers with the opportunity to request an extension of that time period if they have difficulty obtaining certain documentation within that timeframe. This could allow the consumer to continue with an SEP application without losing eligibility merely due to difficulties obtaining documentation. If the consumer's SEP application is instead denied, the consumer may not be eligible at a later date due to the length of time from the qualifying event even if the consumer truly is eligible. We also strongly urge HHS to establish specific timeframes for evaluating documents as part of a pre-eligibility verification pilot. Without specific timeframes, consumers would not have necessary information to ascertain when a decision will be made, when to follow-up if they have not received a decision, and how to proceed if a decision is adverse. We also recommend that if a consumer submits documents, and the review by the FFM is not completed within 15 days, that the SEP must be granted so that consumers are not suffering without health insurance for lengthy periods of time. This could be done conditionally to give the FFM additional time for document review but it would balance the needs of the consumer for health insurance by preventing significant delays in enrollment. Under this situation, the process would continue similar to post-eligibility verification.

[7] *Strengthening the Marketplace – Actions to Improve the Risk Pool* (June 8, 2016), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending.

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As we have previously stated, we strongly believe that HHS should implement a model of verification more closely aligned with the IRS and should evaluate this as part of a pilot. Consumers already attest under penalties of perjury to the information provided in their applications. Rather than require pre-eligibility verification submission, HHS should only request documents from the specific consumers who will be audited (and this subset of consumers must be randomly selected and not based on any personally identifiable characteristics or claims data). Requiring 100% pre-eligibility verification seems unnecessary, burdensome for consumers, and adds additional processing and storage burdens for the FFM to receive, review, classify and store the documents.

c. Study of Pre-Enrollment Verification

HHS asked for comment whether a small percentage of individuals should be exempt from the pre-enrollment verification process to conduct a study. We strongly support this suggestion. The excluded population must be statistically significant so that an appropriate and legitimate comparison may be made between the two groups.

Further, HHS asked for comment about strategies HHS should take to increase the chances that healthier individuals complete the pre-eligibility verification. We strongly recommend that HHS eliminate the need for verifying any SEPs based on birth/adoption/foster care placement and marriage. Given the nature of the circumstances under which these SEPs arise, it is hard to imagine that many consumers will be seeking an SEP for these categories if not truly eligible. At a minimum, HHS should consider excluding from a pre-eligibility verification pilot unless and until the process for verifying loss of MEC and permanent move SEPs is implemented effectively and efficiently.

d. Changing Plan Levels

We believe HHS' proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1) While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We thus oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

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For example, adding a dependent or getting married likely alters the amount of APTC and possibly cost-sharing reductions (CSR) which can impact what plan enrollees wish to enroll in. As another example, a pregnant woman may have enrolled in a silver plan but if she gives birth to a child with special needs or complex medical conditions, she may want to change coverage to a gold or platinum plan to obtain a higher level of coverage. Or a woman may enroll in a platinum plan concerned she may have a high risk pregnancy but after the pregnancy, may want to move back to a silver plan. As another example, an individual may gain a dependent who has a disability and the plan selection should not be limited to merely adding the dependent to the enrollee's same plan or same level plan.

HHS seeks comment on whether an individual gaining an SEP due to new eligibility for cost-sharing reductions should be limited to only enroll in a silver QHP. While we recognize that most individuals newly eligible for cost-sharing reductions would benefit from enrolling in a silver plan to gain the benefits of the cost-sharing reductions, some consumers may have valid reasons for wanting to enroll in other metal plans and should not be restricted just because they have enrolled through an SEP since if they enrolled during open enrollment, they would be able to forego the silver plan and cost-sharing assistance if they so wished. That said, we do recognize the benefits of enrolling in a silver plan and thus believe consumers should receive sufficient information about the potential downsides of enrolling in a different metal plan to make an informed choice. But ultimately, consumers should have the choice.

We recognize HHS may have concerns about individuals using an SEP to "simply switch levels of coverage during the coverage year." But with the limitations of the eligibility verification and that switching plans comes with other potential problems for consumers – resetting deductibles and out-of-pocket costs – we believe consumers should have the choice and opportunity to do what is right for themselves and their families rather than be limited by regulation to continuing enrollment in the same plan.

We also believe HHS should provide SBMs the option to utilize these limitations rather than be forced to adopt them. As mentioned above, SBMs know their states and their markets and may have valid reasons not to adopt similar restrictions.

e. Payment of Past Premiums

We are concerned that HHS proposes allowing an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe this is discriminatory, in particular, against low-income consumers who may not have had the ability to pay premiums if they incurred significant medical costs before meeting a deductible or out-of-pocket maximum.

Other reasons may exist why an issuer believes a consumer has not paid premiums when the consumer actually has or attempted to. We have worked with a number of consumers who received erroneous bills and attempted to work with their insurer to determine the correct amounts to pay. Sometimes insurers did not accurately credit the amount of a tax credit or cost-sharing reduction, sometimes insurers did not match consumer's payments with the consumer's account, sometimes insurers cancelled a consumer's coverage despite a consumer paying. Due to the potential for insurer error, we believe that if HHS is going to permit insurers to reject enrollment, two preconditions must be met:

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1. The insurer must provide verification to HHS and the consumer of the non-payment;
2. The insurer must allow the consumer a reasonable opportunity to dispute the insurer's information and provide documentation of payment.

Secondly, even if an insurer does verify that a consumer did not pay premiums, we believe HHS should provide a waiver of this requirement for consumers who can document paying significant out-of-pocket costs for care or other relevant circumstances during the time premiums were not paid. For example, if a consumer incurred health care bills that exceeded the premium amounts, we believe the consumer should not have to repay the premiums since meeting the deductible may have been out-of-reach for the consumer. Or if the consumer can document a job loss or having suffered a serious medical incident that prevented paying the premiums, this should also be accepted for a waiver of paying past premiums. While we recognize insurers need to receive timely premiums, we also recognize that there must be a balance when consumers are unable to pay their bills due to exceptional circumstances and that other avenues exist for helping insurers compensate for consumers such as these.

We are also concerned about this proposal from a geographical perspective. That is, this proposal can discriminate against consumers merely due to where they live. If the consumer lives in a geographical area with only one issuer (which is the case in a number of counties across the country), these consumers will have no alternative but to enroll in a plan where they must first pay back premiums or be rejected. Consumers in geographic areas with a choice of plans may be able to enroll in a different plan and thus not be subject to the back payment requirement. We do not believe that a policy that likely will be implemented to the detriment of consumer merely based on geography should be adopted by HHS. As mentioned previously, in Illinois, consumers in rural and ex-urban areas are most likely to now have only one plan available to them.

HHS also stated that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and thus HHS should ensure that any verification must provide consumers with an opportunity to provide additional or contrary information that may negate information from an insurer.

f. Marriage SEP

HHS proposes that if a consumer is newly enrolling through the Exchange pursuant to an SEP obtained for marriage that at least one spouse demonstrate having had minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage. We are concerned about this limitation for a number of reasons.

First, some individuals who marry may have been ineligible for Exchange coverage during the 60 days prior. This is especially likely in Medicaid non-expansion states. Both individuals may have been below 100% FPL in an non-expansion state and thus in the coverage gap. A marriage could increase their joint income to over 100% FPL and make them both newly eligible for coverage yet the proposed rule would not allow them to enroll. This also has a geographical bias since many of the states that did not expand Medicaid are in the southern part of the country which also has the higher uninsured rates and higher rates of poverty.

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We do appreciate the recognition of an exception for individuals living abroad or in a U.S. territory. We strongly urge HHS to maintain this exception and not to require an onerous burden of proof to document a foreign or territorial residence.

g. Permanent Move SEP

We have similar concerns about the requirement for prior coverage as a predicate for obtaining a permanent move SEP. Some individuals may not have been eligible for coverage in the area they moved from (e.g. a Medicaid non-expansion state) and thus should not be penalized and made ineligible for an SEP.

Further, individuals who are survivors of domestic violence may have been prevented by their abuser from obtaining coverage. If these individuals permanently move away from their abusers, they should not be prevented from newly enrolling in coverage because they did not have prior coverage.

IV. § 156.140 – Levels of Coverage (Actuarial Value)

We oppose the proposed expansion of the de minimus actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

We believe this policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[8]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy

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[8] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

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Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[9]

Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to “account for differences in actuarial estimates.” (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is “to help issuers design new plans for future plan years, thereby promoting competition in the market.” The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation “to account for differences in actuarial estimates.” The proposed expansion exceeds the Secretary’s authority and undermines the plain meaning of the statute.

Contrary to the proposed rule’s assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee’s income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of $25,000. This individual’s expected contribution towards premiums is 6.8% of income or $1,700. If the person selects the benchmark plan, his/her net premium will be $1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial

[9] Aviva Aron-Dine and Edwin Park, *Trump Administration’s New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

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value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with HIV, hepatitis C, and other chronic conditions who depend on access to plans with a higher actuarial value to defray high cost sharing. Consider three possible silver benchmark plans:[10]

Benchmark Plan Costs, 2018						
Actuarial Value	Gross Premium	Deductible	Maximum Out-of-Pocket	Co-Insurance	Advance Premium Tax Credit	Net Enrollee Premium*
70	$4,138	$1,600	$7,200	30%	$2,438	$1,700
68	$4,020	$2,100	$7,200	30%	$2,320	$1,700
66	$3,902	$2,750	$7,200	30%	$2,202	$1,700

* *Examples assume consumer enrolls in the benchmark second lowest cost sliver level plan; net premium amount would increase if consumer enrolled in a higher AV plan*

While reductions in actuarial value reduce gross premiums, they do not reduce the net enrollee premium when selecting the benchmark plan resulting in less purchasing power for the consumer. Deductible increases allowed by the actuarial value reductions, however, will discourage enrollment, leading to a death spiral.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with “benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.” (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Under the plans above, using the 70 percent actuarial value plan as the benchmark would result in a 15 percent net enrollee premium reduction for enrollment in the 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease will likely spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium

[10] Actuarial values were calculated using the 2018 Actuarial Value Calculator for silver plans. Premiums assume 85 percent of costs are medical and 15 percent are administrative. Advance premium tax credit is based on a $25,000 income for a single 35 year-old enrollee, resulting in a $1,700 expected annual contribution from the enrollee and a $2,438 tax credit on average nationwide. This example assumes enrollment in the benchmark second lowest-cost sliver level plan. The applicable income percentage and gross premium for the 70 percent actuarial value plan were calculated using the Kaiser Family Foundation’s 2017 Health Insurance Marketplace Calculator.

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costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan.

Impact of Requiring 70 Percent Actuarial Value (AV) Benchmark Plan					
Actuarial Value	Gross Premium	Advance Premium Tax Credit (70 AV benchmark)	Net Enrollee Premium ($)	Net Enrollee Premium Reduction (%, compared to benchmark contribution of $1,700)	Increased Deductible (compared to $1,600 under 70 AV benchmark)
68	$4,020	$2,438	$1,582	7.0%	$500
66	$3,902	$2,438	$1,464	13.9%	$1,150

While we do not support expanding the de minimis actuarial value threshold to -4/+2 percent, if the Secretary finalizes this proposal, calculating the advance premium tax credit from plans with a true 70 percent actuarial value will reduce net enrollee premiums and encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

The Secretary must require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. The Secretary is given authority, however, to modify the out-of-pocket reduction only if it would “result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan” above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that the Secretary establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. The Secretary, then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We support the February 24, 2012 Actuarial Value and Cost-Sharing Reductions Bulletin’s explanation for not establishing cost-sharing reduction plans with a 70 percent actuarial value for these enrollees, but this explanation depended on the availability of 70 percent actuarial value plans for these enrollees. We encourage the Secretary to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and the Secretary should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

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Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

V. § 156.230 – Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. We have commended HHS for these steps, which are crucial to making the promise of care in the Affordable Care Act real. NHeLP has written extensively about the importance of network adequacy for low-income consumers, in particular.[11] Over time, HHS has made significant improvements to the regulations at sections 155.1050 and 156.230, in defining the network adequacy standards to which QHPs will be held. As a result, we have seen fewer lawsuits and consumer complaints regarding network adequacy issues in QHPs with each year the Exchanges operate. Even still, we have urged HHS to adopt more stringent regulations in this area, as the current regulations do not fully ensure that consumers who enroll in QHPs will have access to adequate networks.[12]

Thus, the proposals set forth in the preamble to this regulation would represent a step backward for guaranteeing network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

In Illinois, we saw this issue heightened in 2016 when none of the larger teaching hospitals in the Chicagoland area were included in Marketplace plans. This was incredibly disruptive to patients in the midst of treatments for chronic diseases.

a. HHS should not rely on state reviews for network adequacy

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires the Secretary of HHS to

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[11] *See, e.g.,* ABBI COURSOLLE, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE REGULATIONS: NETWORK ADEQUACY & ACCESS (2016), http://www.healthlaw.org/publications//Brief-3-MMC-Final-Reg; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to J.P. Wieske, Nat'l Assn. Ins. Comm'nrs (Jan. 12, 2015), http://www.healthlaw.org/publications/search-publications/NAICS-Comment; NHELP, NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), *available at* http://www.healthlaw.org/issues/medicaid/network-adequacy-in-medicaid-managed-care.

[12] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. 13-18 (Oct. 6, 2016), http://www.healthlaw.org/issues/medicaid/services/Comments-ACA-Benefit-Payment-Parameters.

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establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated the Secretary of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged the Secretary with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

We appreciate that HHS's current proposal will require issuers (save MSP issuers) in the FFE to meet HHS's "reasonable access standard," or state standards approved by HHS. While we support HHS's leaving the states and OPM with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, HHS must establish a clear national floor for network adequacy in these regulations, and monitor compliance with those national standards itself. The Secretary should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. Leaving network adequacy standards to the discretion of states has resulted in consumer protections varying widely across state lines. The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

b. HHS's "reasonable access" standard is not a sufficient measure of network adequacy.

HHS has never explained how its "reasonable access" standard is measured or monitored. Thus we have little information to assess whether the "reasonable access" standard has been successful in ensuring access in the past. We are therefore disappointed that HHS is proposing to revert to this standard, rather than adopting precise quantitative standards that would help insurance regulators, consumers, providers, and advocates to evaluate what constitutes "reasonable access." We recommend that HHS instead move forward with its prior proposal of establishing a national baseline for time and distance standards.

c. *HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.*

We disagree with HHS's proposed approach of replacing time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their

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accreditation does not replace the existence of such standards.[13] Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We have previously urged HHS to adopt more stringent standards, including specific time and distance standards.[14] In 2015, we commended HHS for taking the step to establish specific time and distance standards for QHPs, and urged HHS to adopt these standards in regulation, rather than its Letter to Issuers.[15] We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

VI. § 156.235 – Essential Community Providers

We urge HHS not to reduce the percentage requirement for ECPs. In the past, we have expressed our appreciation for HHS's continuing efforts to ensure that QHP networks include essential community providers (ECPs), including by requiring issuers to enter contracts with at least 30% of available ECPs in the service area.[16] We encouraged HHS to consider increasing the percentage required in future years.[17] Instead, HHS is proposing to go backward, and reduce the percentage to only 20%. This reduction represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

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[13] For a discussion of the role that accrediting agencies can play in this regard, see Letter from Emily Spitzer, Nat'l Health Law Prog., to CMS Desk Officer 11-14 (June 18, 2012), http://www.healthlaw.org/publications/search-publications/nhelp-comments-on-ffe-and-state-and-state-partnership-exchanges.
[14] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 59-61 (Dec. 21, 2015), http://www.healthlaw.org/issues/health-care-reform/2017-Parameters.
[15] *Id.*
[16] Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. & Andy Slavitt, Ctrs. Medicare & Medicaid Servs. 10 (Jan. 15, 2016), http://www.healthlaw.org/issues/health-care-reform/exchanges/Comments-Draft-2017-Letter.
[17] *Id.*

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We also urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

VII. Applicability of Executive Order 13771

We do not support the goals of Executive Order 13771 that requires repeal of two regulations for any new regulation. That said, the NPRM includes a finding that this proposal does not trigger the requirements of EO 13771 and we believe this decision should also apply to the rule once finalized. Making a change between a NPRM and a final rule would prevent public comment on the reasons for a change in the decision.

VIII. Conclusion

Thank you for consideration of our comments. If you have any questions, please contact Stephani Becker, stephanibecker@povertylaw.org or Stephanie Altman, stephaniealtman@povertylaw.org.

Comment separator page. Next comment follows.

In response to the four proposed steps "[t]o improve the risk pool and promote stability in the individuals insurance market," I would like to voice my concerns over unaccounted for costs to the proposed changes:

1)Change of dates for open enrollment period. This change impacts those without strong monthly cash flow. As you know, December is high-time for the holidays and many Americans use year-end bonuses and savings to purchase goods for their loved ones. According to a 2013 study conducted by Bankrate and reported by CNN, 76% of Americans live paycheck-to-paycheck and cannot incur the additional expense of a health insurance premium on top of their holiday expenses. Forcing Americans to choose between showing affection to their loved ones and paying for their health insurance is not a viable solution to the health insurance marketplace's issues (more on that at the end). Furthermore, investors in the stock market would agree that Q4 results tend to bear the most weight for the retail industry. Redirecting consumption elsewhere is harmful to that industry and risks potential downstream cost-cutting measures, including personnel layoffs. This would then, in turn, qualify a great deal of Americans for special enrollment periods in the very exchange the government is trying to fix!

2)Increasing pre-enrollment verification from 50% to 100%. I agree that this change needs to be put into place as it is common practice amongst insurers to go through this process. My concern lies in the difficulty many Americans will have in securing proper documentation and the costs associated with those materials. Pre-enrollment verification should be a cost that the consumer does not bear. Rather, the companies in the lucrative health insurance market should bear the cost of verifying whether consumers applying to special period enrollment are eligible for insurance. Perhaps reducing the cost of the first monthly premium payment for those Americans who have difficulty in obtaining documentation would help offset some of the consumer burden in this transaction. The difficulties of low-income Americans must

be considered at a top priority for any changes to existing policy.

3)Enforcing indebted premium payments from insured Americans. This makes sense from the perspective of the insurance company - we need to mitigate risk by encouraging more people to enroll in the insurance market. The method by which individuals should be held responsible, however, remains unknown. Will insurance companies expect upfront payment prior to receiving medical services? Will a cancer patient seeking chemotherapy be denied coverage for services rendered by the hospital? How does that impact the hospital's revenue and downstream operations? Will they be able to afford to provide quality care if they are not receiving payment for upwards of 10% of their patient base? Additioanlly, this also places a greater financial burden onto the patient as they are now balancing past due payments, high deductibles, future monthly premiums, co-pays, and all other health-related costs. Per my first comment, the 76% of Americans living paycheck-to-paycheck will find no reprieve from high healthcare costs with this rule if there is not oversight on how past due premiums are collected.

4)Increasing de minimis variation in AVs. This sounds like a ploy to allow insurers to offer plans that cover less than they already do. Americans will only accept plans that are broader in coverage and cheaper than their existing plans. Silver plans in the state of MO for a 26 year old, non-smoking male begin at $193 per month. If there is a way to reduce that cost without reducing the benefits coverage, then increasing the de minimis variation will be useful. Otherwise it is simply another way to thwart access to quality healthcare for Americans.

For what it is worth, the rules proposed are a good starting point. But the real issue is that there is little incentive for healthy individuals to enter the market in the first place. With annual out-of-pocket expenditures exceeding $5,000, paying the $695 individual mandate is a no-brainer alternative for those with weak cash flow. Economic theory would suggest that increasing the mandate to a much higher figure

while doing more to expand the tax credits would be a greater incentive to encourage healthy individuals to purchase plans on the exchange. This provides two-way pressure onto the consumer - a disincentive to forego coverage and an incentive to purchase coverage.

Thank you for your consideration of my comments.

Shaun Vaid
St. Louis, MO
No documents available.

Comment separator page. Next comment follows.

SOUTH CAROLINA appleseed LEGAL JUSTICE CENTER

March 3, 2017

Patrick Conway
Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Acting Administrator Conway,

Thank you for the opportunity to comment on HHS' proposed market stabilization rule. SC Appleseed Legal Justice Center advocates on behalf of low and moderate income consumers in our state. For over 30 years we have provided advocacy on access to quality, affordable healthcare for the people of South Carolina.

We have included our comments on specific sections below. But before providing specific comments, we want to raise significant concerns about the proposed rule's overall effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces.

The proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides. If implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;

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- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks; and
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals do not provide the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are strongly dismayed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Guaranteed Availability of Coverage

HHS seeks comments about its proposed premium payment policy, which would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy,

particularly for lower income individuals. We are putting a burden on individuals and most likely taking away their only ability to receive coverage.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and HHS does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

And beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, and other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with an issuer but faced numerous administrative and bureaucratic hurdles to do so.

It may also be due to issuer or marketplace error that leads to an assumed non-payment. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage

since they could lose their employment and need to come back for marketplace coverage but should not be subject to repayment.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring.

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.

- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

And if HHS were to proceed with this policy, we also recommend that this policy be limited to annual renewals and that consumers enrolling during a Special Enrollment Period (SEP) should not be subject to this policy. The mere fact that a consumer is eligible for an SEP means the consumer is facing a change in circumstance. For example, if a consumer stopped paying premiums in September of one year and gets an SEP to re-enroll in the middle of the next year, the consumer should not have to pay back premiums when there has been a significant time lapse between the events.

Further, we provide additional suggestions to provide additional protections for consumers. We suggest that HHS implement a "hardship exemption" to this policy such that consumers who can demonstrate significant financial hardship that caused the consumer to stop paying premiums, the issuer would not be permitted to apply new premium payments to past unpaid premiums. Consumers could document such a hardship by providing a narrative explanation as to why he stopped paying premiums. Since the NPRM would already allow consumers to enroll in another plan and thus issuers would not always recoup past premiums from these consumers, it seems that allowing a consume the option to stay with the same plan – which may be important to the consumer because of the network or particular providers – is a second option that would provide a compromise for the consumer and issuer.

Also, information about repayment should be clearly noted on the Plan Compare tool so that consumers would have that information before they enroll. Second, it should be noted in the Eligibility Determination Notice since consumers could change plans if open enrollment or a special enrollment period remains open.

Initial and Annual Open Enrollment Periods

We are concerned about the shortening of the annual open enrollment period. While we recognize a shorter enrollment period was planned for 2018, given all the potential

changes that consumers have to digest this year, we believe that keeping a longer open enrollment period would be beneficial to consumers as well as issuers. We believe the benefits – enrolling more consumers – outweigh the perceived costs of having consumers enroll for less than a full year (if they enroll after December 15).
HHS notes that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance. Thus the policy change could just as easily lead to a sicker pool, at least in the short term, if young, healthy people end up missing the new deadline for signing up. HHS acknowledges this uncertainty but it does not sufficiently explain why a positive result (decreased adverse selection, improved stability of the exchanges) is more likely than a negative result (increased adverse selection, reduced stability of the exchanges) with a shorter enrollment period.

We are also concerned about the proposed shortened enrollment period due to the added burdens it will put on navigators and assisters. Many navigators and assisters already work long hours and weekends throughout the current open enrollment period to meet the demand. Shortening the period will make it even more difficult to reach and serve all consumers. It will also make it difficult for brokers and agents to fully participate in the process as they will be engaged in both Medicare and non-Exchange open enrollment at that time. Ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment. We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help. Understanding how access to insurance is confusing at best and paralyzing for those who have not had the benefit of being educated to understand the intricacies of insurance coverage, we must do all we can to help consumer's make their choice.

Special Enrollment Periods

We have strong concerns about the proposed pre-enrolment verification process, particularly since it will include 100% of SEP applicants and because HHS has not released a full evaluation and analysis of the post-enrollment verification pilot operated in 2016. First, before requiring all applicants to verify their eligibility, it is important to identify any real or perceived limitations of verification that need to be addressed. Second, if the post-enrollment analysis finds that many eligible consumers are deterred or unable to complete verification, HHS should ensure these issues are fixed in a pilot of pre-enrollment verification. Overall, any required verification – whether for enrollment, data matching, or an SEP – needs to be easy and simple or eligible individuals will be deterred from enrolling. If the process is not easy, it is likely that those in more dire need of health insurance, rather than individuals who may be healthier and want coverage to avoid paying a tax penalty, will likely complete the process. For SEPs, we recognize that a disproportionate number of sicker individuals obtaining coverage through SEPs could disrupt the risk pool and lead to unanticipated higher costs. If a major concern for issuers is the higher costs associated with those coming in through SEPs, however, other interventions exist that would not burden consumers or presume fraudulent applications. For example, HHS' changes to the risk adjustment costs in 2018 and beyond to address higher than expected costs of those not enrolled for the full year would address this problem without assuming that those obtaining mid-year coverage through an SEP are ineligible and need to prove eligibility pre-enrollment.

To keep consumer engagement and trust high – an essential component to the success of the marketplaces – while preserving affordability, any SEP eligibility verification should be narrowly targeted only to instances of suspected ineligibility or fraud and should use electronic verification rather than requiring paper documentation. While we understand the balance the FFM must strike between plans and consumers to achieve affordability, we believe that mandatory SEP pre-eligibility verification will have a chilling effect on many eligible individuals. Excessive documentation requests may be a deterrent to potentially eligible applicants who would help spread the risk and HHS should take care not to discourage participation. Problems and consumer frustration with other verification processes already exist – such as lengthy times between document submission and review, trouble uploading verifications, incorrect eligibility results, confusing notices, long call center wait times, and difficulty resolving issues because consumers cannot directly reach those conducting the reviews. Adding pre-eligibility verification may jeopardize the integrity of the market mix by increasing consumer distrust and decreasing engagement with the FFM such that only the sickest

and costliest consumers pursue SEPs. At the same time, mandatory SEP eligibility verification will be time consuming and costly for both consumers and FFM administration.

As the NPRM preamble notes, some commenters to the 2018 Payment Notice suggested that additional steps to determine SEP eligibility worsen the problem by creating new barriers to enrollment. Yet based on issuer feedback, HHS is proposing to increase the scope of the pre-enrollment verification. We believe this should not be done unless and until the prior pilot analysis adequately identifies what cause and effect pre-eligibility verification may have on individuals and the marketplace as a whole. Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

a. *Electronic Verification*

We do appreciate that HHS recognizes it will make every effort to verify eligibility through automated electronic means. It is not at all clear that the FFM would be technically or operationally capable of implementing an SEP verification process consistent with the Affordable Care Act's vision of a real-time, streamlined eligibility and enrollment system. Some low-income consumers that are eligible sometimes forgo coverage because they encounter difficulty securing and providing the documents requested to verify their eligibility when they have a data matching issue. We cannot afford this result to duplicate with SEP verification.

As an example, consumers who are eligible for the permanent move SEP who have been enrolled in a QHP should not have to provide documentation of their "original" address. Yet this was required as part of the post-eligibility verification. Consumers provide this information during enrollment and burdens should not be added to submit documentation merely because HHS is unable to access this information.

Before implementing a pilot, HHS should establish systems for an automatic check with issuers and public programs (Medicaid, CHIP, Medicare) about whether a consumer lost creditable coverage. Consumers should not be responsible for tracking down documentation to show that coverage was lost when this information is readily available from issuers. Only if electronic verification is inconclusive, or if a consumer disputes the result, should documentation be required.

b. Timeframes for document verification

We appreciate that HHS will provide consumers 30 days to provide documentation. We do ask that HHS also provide consumers with the opportunity to request an extension of that time period if they have difficulty obtaining certain documentation within that timeframe. This could allow the consumer to continue with an SEP application without losing eligibility merely due to difficulties obtaining documentation, which may be of no fault of their own. If the consumer's SEP application is instead denied, the consumer may not be eligible at a later date due to the length of time from the qualifying event even if the consumer truly is eligible.

c. Payment of Past Premiums

We are concerned that HHS proposes allowing an issuer to reject an enrollment for which an issuer has a record of termination due to non-payment of premiums unless the consumer fulfills obligations for premiums due for past coverage. We believe this is discriminatory, in particular, against low-income consumers who may not have had the ability to pay premiums if they incurred significant medical costs before meeting a deductible or out-of-pocket maximum.

Other reasons may exist why an issuer believes a consumer has not paid premiums when the consumer actually has or attempted to. We have worked with a number of consumers who received erroneous bills and attempted to work with their insurer to determine the correct amounts to pay. Sometimes insurers did not accurately credit the amount of a tax credit or cost-sharing reduction, sometimes insurers did not match consumer's payments with the consumer's account, sometimes insurers cancelled a consumer's coverage despite a consumer paying. Due to the potential for insurer error, we believe that if HHS is going to permit insurers to reject enrollment, two preconditions must be met:

1. The insurer must provide verification to HHS and the consumer of the non-payment;

2. The insurer must allow the consumer a reasonable opportunity to dispute the insurer's information and provide documentation of payment.

Secondly, even if an insurer does verify that a consumer did not pay premiums, we believe HHS should provide a waiver of this requirement for consumers who can document paying significant out-of-pocket costs for care or other relevant circumstances during the time premiums were not paid. For example, if a consumer incurred health care bills that exceeded the premium amounts, we believe the consumer should not have to repay the premiums since meeting the deductible may have been out-of-reach for the consumer. Or if the consumer can document a job loss or having suffered a serious medical incident that prevented paying the premiums, this should also be accepted for a waiver of paying past premiums. While we recognize insurers need to receive timely premiums, we also recognize that there must be a balance when consumers are unable to pay their bills due to exceptional circumstances and that other avenues exist for helping insurers compensate for consumers such as these.
We are also concerned about this proposal from a geographical perspective. That is, this proposal can discriminate against consumers merely due to where they live. If the consumer lives in a geographical area with only one issuer (which is the case in a number of counties across the country), these consumers will have no alternative but to enroll in a plan where they must first pay back premiums or be rejected. Consumers in geographic areas with a choice of plans may be able to enroll in a different plan and thus not be subject to the back payment requirement. We do not believe that a policy that likely will be implemented to the detriment of consumer merely based on geography should be adopted by HHS.

HHS also stated that it intends to explore options for verifying a consumer was not terminated for non-payment of premiums for coverage as a precursor for being eligible for the loss of coverage SEP. We believe the same issues arise in this situation and thus HHS should ensure that any verification must provide consumers with an opportunity to provide additional or contrary information that may negate information from an insurer.

Network Adequacy

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. This is especially important in states like South Carolina where we have many people living in rural areas with limited transportation available outside of their towns or counties. SC Appleseed commends HHS for these efforts, which are crucial to making the promise of care in the Affordable Care Act real.

The proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. South Carolina does very little to protect consumers in our insurance market and we do not anticipate that our regulators would step in to ensure network adequacy if this rule is implemented. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

Essential Community Providers

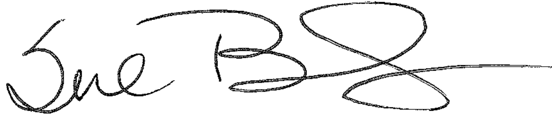
We urge HHS not to reduce the percentage requirement for ECPs. Instead, HHS is proposing to go backward, and reduce the percentage to only 20%. This reduction represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

We also urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

Thank you for consideration of our comments. If you have any questions, please contact Sue Berkowitz, sberk@scjustice.org. Thank you for your consideration,



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Comment separator page. Next comment follows.

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Empowered Families: Educated, Engaged, Effective!

SPAN & Family Voices-New Jersey comments to the Department of Health and Human Services on the Patient Protection and Affordable Care Act; Market Stabilization

March 7, 2017

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act; Market Stabilization. Family Voices is a national network that works to "*keep families at the center of children's healthcare*." The NJ State Affiliate Organization for Family Voices is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, Parent to Parent USA affiliate, and chapter of the Federation of Families for Children's Mental Health.

While SPAN provides information, training, technical assistance, parent to parent support, advocacy, and leadership development for all NJ families of children ages birth to 21, our priority is on children at greatest risk due to disability, special health care or emotional needs, poverty, discrimination based on race, culture, language, immigrant status, or economic status, or involvement in the child welfare or juvenile justice systems. Thus, we are particularly concerned with ensuring that the needs of children with special healthcare needs and their families are adequately addressed in federal, state and local policies and practices.

SUMMARY:

I. Executive Summary

We understand that there are concerns with issuer exit and increasing rates, and special enrollment periods as a potential source of adverse selection. To address this, we understand that the proposal is to shorten open enrollment to "a range of November 1, to December 15." Another proposal to prevent adverse selection in special enrollment is to increase "preenrollment verification of eligibility". A third proposal is to "allow issuers to apply a premium payment to an individual's past debt owed for coverage from the same issuer enrolled in within the prior 12 months". The last proposal is to "increase the de minimis variation in the actuarial values (AVs) used to determine metal levels of coverage for the 2018 plan year."

II. Background

A. Legislative and Regulatory Overview

1. Market Rules
2. Exchanges
3. Special Enrollment Periods
4. Actuarial Value

B. Stakeholder Consultation and Input

We appreciated the historical summary of market rules, exchanges, special enrollment periods, actuarial value, and description of stakeholder input.

III. Provisions of the Proposed Rule

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability of Coverage (§ 147.104)

We understand that there were ”concerns about the potential for individuals with histories of non-payment to take advantage of guaranteed availability by declining to make premium payments for coverage at the end of a benefit year.” We acknowledge that there is a proposal to modify “the guaranteed availability rules with respect to nonpayment of premiums.” We appreciate that the “proposal would not prevent the individual or employer from enrolling in coverage with a different issuer, or affect the ability of any individual other than the person contractually responsible for the payment of premium to purchase coverage, whether from the same or different issuer.” We understand that states are encouraged but not required “to adopt a similar approach, with respect to any State laws that might otherwise prohibit this practice.” We understand that due to “grace periods and termination of coverage, individuals with past due premium would generally owe no more than 3 months of premiums.”

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Initial and Annual Open Enrollment Periods (§ 155.410)

We understand that “beginning on January 1, 2018 would begin on November 1, 2017 and extend through January 31, 2018; and that the open enrollment period for benefit years beginning on January 1, 2019 and beyond would begin on November 1 and extend through December 15 of the calendar year preceding the benefit year.” We are concerned that the shorter enrollment may affect the number of individuals having access to care. We disagree that “this shorter open enrollment period may have a positive impact on the risk pool because it will reduce opportunities for adverse selection by those who learn they will need services in late December or January” as individuals can’t predict when health issues will arise.

2. Special Enrollment Periods (§ 155.420)

We understand that there are concerns that special enrollment “undermines the incentive for enrolling in a full year of coverage through the annual open enrollment period and increases the risk of adverse selection from individuals who wait to enroll until they are sick.” But we disagree with this concern as again individuals cannot predict life events which will necessitate special enrollment. We understand that there were “added warnings on *HealthCare.gov* regarding inappropriate use of special enrollment periods. We also eliminated several special enrollment periods and tightened certain eligibility rules.” We understand that there is a proposal to “increase the scope of preenrollment verification of special enrollment periods.” During this time “consumers’ enrollment would be ‘pended’ until verification of special enrollment period eligibility is completed.” We understand that consumers would have “30 days

to provide documentation, and would be able to upload documents into their account on *HealthCare.gov* or send their documents in the mail." We understand that self-attestation was insufficient however we would suggest retroactive coverage to the effective date as well as exceptions for certain circumstances such as domestic violence in which a safety issue would override the need for documentation. We understand that "State-based Exchanges that do not currently conduct pre-enrollment verification of special enrollment period eligibility consider following this approach as well."

Although we understand that the proposal is the "address concerns about potential adverse selection" we are concerned about timely health care access. We also understand that there are concerns that "Exchange enrollees are utilizing special enrollment periods to change plan metal levels based on ongoing health needs during the coverage year, and that this is having a negative impact on the risk pool." We would like data on the percentage of the population in the Exchange in which this occurs.

As a result, we comprehend that there is a proposal to "limit the ability of existing Exchange enrollees to change plan metal levels during the coverage year." This would "apply in the individual market outside the Exchanges, but would not apply in the group market." We are concerned that for "special enrollment periods administered on the Exchange, the Exchange would limit the plan selection choices." We strongly disagree with this determination as again individuals cannot predict life events requiring special enrollment and should have the same choices as all enrollees.

We further understand that "if the QHP's business rules do not allow the new dependent to enroll, the Exchange may allow the enrollee and his or her new dependent to enroll in another QHP within the same level of coverage (or an ''adjacent'' level of coverage, if no such plans are available)" but we question under which circumstances this is not allowed. We understand that "if an enrollee or his or her dependent is not enrolled in a silver level QHP and becomes newly eligible for cost-sharing reductions and qualifies for the special enrollment periods…the Exchange may allow the enrollee and dependent to enroll in only a QHP at the silver level." Again we strongly disagree with this as there should still be consumer choice but would suggest a reminder to enrollees that they would be eligible for cost-sharing if they chose a silver plan. We acknowledge that for an "enrollee who qualifies for the remaining special enrollment periods… the Exchange must only allow the enrollee and his or her dependents to make changes to their enrollment in the same QHP or to change to another QHP within the same level of coverage." We understand that "This proposal ensures that enrollees who qualify for a special enrollment period or are on an application where an applicant qualifies for a special enrollment period to newly enroll in coverage are not using this special enrollment period to simply switch levels of coverage during the coverage year." Again, we don't' think consumers can use life events in this manner if there is pre-enrollment verification this adds unnecessary restrictions. Lastly we are deeply concerned with the proposal to "exclude the special enrollment period in paragraph (d) (8) for Indians and their dependents" and would like clarification the rationale for this.

We understand that there is a proposal to "allow consumers to request a later coverage effective date than originally assigned if his or her enrollment was delayed due to an eligibility

verification and the consumer would be required to pay 2 or more months of retroactive premium in order to effectuate coverage or avoid termination of coverage due to nonpayment of premiums." We understand that this would allow "consumers to start their coverage 1 month later than their effective date would ordinarily have been." However, we strongly think that consumers should have the choice of retroactive coverage as well, as delays were due to no fault of their own.

We also comprehend that "in order to ensure that a special enrollment period for loss of minimum essential coverage in paragraph (d) (1) is not granted in cases where an individual was terminated for nonpayment…permit the issuer to reject an enrollment." We understand that there are concerns that "consumers are opting not to enroll in QHP coverage during the annual open enrollment period and are instead newly enrolling in coverage during the coverage year through the special enrollment period for marriage." We disagree with this in principle as we don't believe consumers plan marriage around health coverage. There is a proposal that "at least one spouse must demonstrate having had minimum essential coverage…for 1 or more days during the 60 days preceding the date of marriage." We appreciate the recognition that "individuals who were previously living abroad or in a U.S. territory may not have had access to coverage that is considered minimum essential coverage." To address this, we understand that the proposal is "at least one spouse must either demonstrate that they had minimum essential coverage or that they lived outside of the U.S. or in a U.S. territory for 1 or more days during the 60 days preceding the date of the marriage. This proposed change would only apply in the individual market."

We acknowledge that "HHS acknowledges that this rule proposes changes for special enrollment periods in the individual market that differ from the rules regarding special enrollment periods in the group market." We again disagree with the proposal to "limit plan selection to the same plan or level of coverage when an enrollee qualifies for a special enrollment period." We seek data to clarify why "Employer-sponsored coverage is generally a more stable risk pool." We do not understand why this necessitates "tighter restrictions on special enrollments and the ability to change plans for current enrollees better addresses the unique challenges faced in the individual market."

We understand that there is a proposal to "expand the verification requirements related to the special enrollment period for a permanent move." We also understand that "This special enrollment period is only available to a qualified individual or enrollee who has gained access to new QHPs as a result of a permanent move *and* had coverage for 1 or more days in the 60 days preceding the move, unless he or she is moving to the U.S. from abroad or a U.S. territory." The requirement is "to prove both their previous and new addresses." Again here we are concerned about domestic violence situations.

It is understood that there is a proposal to "significantly limit the use of the exceptional circumstances special enrollment period." The proposal is to discontinue special enrollment for:

- "Consumers who enrolled with advance payments of the premium tax credit that are too large because of a redundant or duplicate policy;

- Consumers who were affected by a temporary error in the treatment of Social Security Income for tax dependents;
- Lawfully present non-citizens that were affected by a temporary error in the determination of their eligibility for advance payments of the premium tax credit
- Lawfully present non-citizens with incomes below 100% FPL who experienced certain processing delays; and
- Consumers who were eligible for or enrolled in COBRA and not sufficiently informed about their coverage options."

We disagree with discontinuing special enrollment for "temporary errors," "processing delays," and consumers who were "not sufficiently informed about their coverage options." None of these circumstances were due to consumer error.

3. Continuous Coverage

We understand that there is a proposal of "a longer 'look back' period." This could include "prior coverage for 6 to 12 months, except that we might consider an individual to have had prior coverage, even if there was a small gap in coverage (for example, up to 60 days). " We disagree with this as many families with fluctuating incomes can go off and on insurance so when they have no coverage they should be eligible. Another proposal would be that "individuals who are not able to provide evidence of prior coverage… exception could allow them to enroll in coverage if they otherwise qualify for a special enrollment period, but impose a waiting period of at least 90 days before effectuating enrollment." Again we would ask this to be waived in exceptional circumstance such as domestic violence.

We understand that while HIPAA (Health Insurance Portability and Accountability Act) of 1996 didn't require maintenance of coverage, it did require "continuous, creditable coverage without a 63-day break in the group market if individuals wished to avoid the pre-existing condition exclusions." We strongly disagree with this proposal as it will slowly erode on of the main protections consumers have today regarding guaranteed issue and not allowing rescission of policies.

4. Enrollment Periods Under SHOP

We understand that these changes apply to "special enrollment periods in the individual market only' and that they "do not apply to special enrollment periods under the Small Business Health Options Program (SHOP). "

5. Exchange Functions: Certification of Qualified Health Plans (Part 155, Subpart K)

We understand that the Department will "issue separate guidance to update the QHP certification and look forward to this with great interest.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Levels of Coverage (Actuarial Value) (§ 156.140)

We acknowledge that a plan's "coverage level, or actuarial value (AV), is determined based on its coverage of the EHB for a standard population" Currently the ACA requires "a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent; a gold plan to have an AV of 80 percent; and a platinum plan to have an AV of 90 percent." In addition under the ACA the Secretary is authorized "to develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." We understand that "HHS established that the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is +/-2 percentage points." This includes the exception "if a bronze health plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan… the allowable variation in AV for such plan is -2 percentage points and +5 percentage points." We understand that this was to "ensure that a variety of bronze plans can be offered, including high deductible health plans, while ensuring that bronze plans can remain at least as generous as catastrophic plans." However we disagree with this as then the bronze plan becomes a catastrophic or "bare bones" policy, not a true bronze plan. We understand this was done "to give issuers the flexibility to set cost-sharing rates that are simple and competitive while ensuring consumers can easily compare plans of similar generosity" but we see this as higher rates for less care.

We understand that there is a proposal to change "the AV de minimis range for metal levels to help issuers design new plans for future plan years." It is postulated that "changing the de minimis range will allow more plans to keep their cost sharing the same from year to year…changing the de minimis range could also put downward pressure on premiums." We strongly disagree with this as premiums historically continue to rise. We comprehend that the proposal is "amending the definition of de minimis…to a variation of -4/+2 percentage points, rather than +/- 2 percentage points for all nongrandfathered individual and small group market plans that are required to comply with AV." This means that "a silver plan could have an AV between 66 and 72 percent." We strongly disagree with changing this amount as our experience has been that the minimum becomes the new maximum so it's the "ceiling not the floor."

We note that "For the 2018 AV Calculator, we made several key updates…including updating the claims data underlying the continuance tables that represent the standard population to reflect more current claims data." We understand that "all previous versions of the AV Calculator had been using 2010 (pre-Affordable Care Act) claims data and the 2018 AV Calculator is using 2015 (post- Affordable Care Act) claims data." We disagree that the "proposed flexibility in the de minimis range is also intended to help provide some stability to those plans that are being impacted by the updates to the AV Calculator."

We understand that the proposal is "to provide the increased flexibility in the *de minimis* range starting with the 2018 AV Calculator. We seek comment on whether making the change effective for the 2019 plan year would be preferable…" As stated above we disagree with the changes in the de minimis range.

We understand that there is not a proposal to "modify the *de minimis* range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent.)" We understand that there is consideration "whether the ability for an issuer to offer a standard silver level plan at an AV of

66 would require a plan variation to be offered at an AV of 70 or some other mechanism to provide for cost-sharing reductions for eligible individuals with household incomes that are more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved" which makes sense but again disagree in general with changing the de minimis level.

2. Network Adequacy (§ 156.230)

We understand that there is a proposal to "rely on State reviews for network adequacy in States in which an FFE is operating, provided the State has a sufficient network adequacy review process, rather than performing a time and distance evaluation." Although our state currently has no federal oversight on network adequacy, this proposal is deeply concerning as a recent report from the Office of the State Auditor demonstrated that 4 out of 5 NJ HMOs had inadequate networks.[i] We understand that there is also a proposal for "States that do not have the authority and means to conduct sufficient network adequacy reviews." In this case HHS would "rely on an issuer's accreditation (commercial or Medicaid) from an HHS recognized accrediting entity. HHS has previously recognized 3 accrediting entities for the accreditation of QHPs: the National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care." We strongly agree with the proposal to "further coordinate with States to monitor network adequacy, for example, through complaint tracking." We are interested in the intention to "release a proposed timeline."

3. Essential Community Providers (§ 156.235)

We understand that Essential Community Providers (ECP) "serve predominantly low-income and medically underserved individuals." We understand that there are two proposals regarding the stipulation "that a plan has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that the network includes as participating practitioners at least a minimum percentage, as specified by HHS." Originally this was set as a minimum percentage of 20 percent but was increased on 2015 to 30 percent. The proposal, with which we disagree, is to return to the 20 percent. The rationale is that it will "substantially lessen the regulatory burden on issuers…this proposal would result in fewer issuers needing to submit a justification to prove that they include in their provider networks a sufficient number and geographic distribution of ECPs to meet the standard." There must have been good cause to raise the minimum to 30 percent and we strongly oppose regressing to previous levels for administrative convenience which will have a negative impact on consumers.

We also understand that "for plan year 2018, we propose that an issuer's ECP write-ins would count toward the satisfaction of the ECP standard only for the issuer that wrote in the ECP on its ECP template, provided that the issuer arranges that the written-in provider has submitted an ECP petition to HHS by no later than the deadline for issuer submission." We also acknowledge that "if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider networks in future years."

IV. Collection of Information Requirements

We understand that comment is sought on the need for information collection; accuracy of estimates; quality, utility, and clarity of information, and minimizing the information collection burden. Our comments on each of these fall under the sections pertaining to ICRs below.

A. ICRs Regarding Verification of Eligibility for Special Enrollment Periods (§ 155.420)

We understand that the "pre-enrollment verification of eligibility for all categories of special enrollment" would affect "an additional 650,000 individuals." It is estimated that this would increase the annual burden in the amount of "130,000 hours with an equivalent cost of $5,306,600. We question if this cost is justifiable for the small amount in individuals affected.

B. ICRs Regarding Network Adequacy Reviews and Essential Community Providers (§ 156.230, § 156.235)

We acknowledge that this proposal would "reduce the burden related to the time and distance evaluation for issuers…by 15 hours per issuer on average. It is noted that this is the "equivalent reduction in cost of $192,500." However we have expressed our concerns regarding state monitoring of network adequacy above. We also understand that stand-alone dental issuers would have to submit plans at "an annual equivalent cost of $9,625."

V. Response to Comments

We understand the HHS is unable to acknowledge or respond to comments due to the large volume of comments received.

VI. Regulatory Impact Analysis

A. Statement of Need

Although we understand the rationale is regarding the "decrease in the number of participating issuers and… increases in premiums" we do not believe this approach will address this concern for the reasons stated above.

B. Overall Impact

We understand that this proposal "meets the definition of 'significant rule ' under Executive Order 12866. Therefore, HHS has provided an assessment of the potential costs, benefits, and transfers associated with this proposed rule." As stated in our comments we do not believe that consumers are "gaming" the system or can predict life events so this will not affect "adverse selection and incentivize consumers to maintain continuous coverage." We question whether the expense on special enrollment reviews is worthwhile and are concerned that less health care access due to delays will actually increase costs as conditions will be more severe and less treatable. Most importantly we are concerned with the potential human cost due to delays of

increased morbidity and mortality. Issuers would experience a reduction in costs related to network adequacy reviews.

C. Impact Estimates and Accounting Table

We appreciated Table 2 regarding "HHS's assessment of the benefits, costs, and transfers." Under *benefits*, we strongly disagree that this will result in "improved health and protection from the risk of catastrophic medical expenditures" due to delays as well is decreasing the de minimis standard. We also strongly disagree that this will result in "cost savings due to reduction in medical service provision" as ultimately this will increase costs due to lack of health care access for prevention and treatment. We also strongly disagree that there will be "Cost savings to issuers from not having to process claims while enrollment is 'pended' during pre-enrollment verification of eligibility" and if consumers have to pay retroactively, coverage should have a corresponding retroactive effective date. We understand that there will be cost savings due to the shortened enrollment period but question whether this will increase special enrollment requests.

Regarding *costs*, we again disagree with less "harms to health and reduced protection form the risk of catastrophic medical expenditures" for the reasons stated above. A single serious health even could bankrupt an uninsured family while they wait for coverage. We do agree that there could be increased costs if enrollment increases but again health expenditures overall are less for the insured due to access to preventive care and early treatment. We strongly agree that there will be "Decreased quality of medical services (for example, reductions in continuity of care due to lower ECP threshold)." We also agree that there will be increased costs regarding special enrollment verification, costs to issuers for plan redesign, and costs regarding outreach on the shortened enrollment period.

With regard to *transfers*, we strongly disagree that there will be "Transfers, via premium reductions, from special enrollment period abusers to all other enrollees" as we believe there is a small percentage of "abusers" and that premiums will rise in any case. We agree that there will be "Transfers related to changes in actuarial value from enrollees to issuers and, via possible reductions in subsidies" which means consumers will get less benefits and lower subsidies.

1. Guaranteed Availability of Coverage

We understand that the proposal will "require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past due premium owed to that issuer after the applicable due date for coverage in the prior 12- month period in order to resume coverage from that same issuer." We acknowledge that of the "21 percent of consumers stopped premium payments in 2015…. Approximately 87 percent of those individuals repurchased plans in 2016, while 49 percent of these consumers purchased the same plan they had previously stopped payment on." We understand that overall "one in ten enrollees had their coverage terminated due to non-payment of premiums in 2016."

2. Open Enrollment Periods

We agree that a “shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period” which would not mitigate adverse selection.

3. Special Enrollment Periods

We understand that the proposal “would increase the scope of pre-enrollment verification, strengthen and streamline the parameters of several existing special enrollment periods, and limit several other special enrollment periods” However we do not regard this as streamlining special enrollment but rather as an additional obstacle resulting in delays. We that “an additional 650,000 individuals having their enrollment delayed or ‘pended’ annually until eligibility verification is completed” which again will result in coverage delays. We do not agree that there is the possibility of pre-enrollment verification causing “premiums to fall and all individuals hat inappropriately enrolled via special enrollment periods continue to be covered, there would be a transfer from such individuals to other consumers” as premiums will rise regardless. We do agree that “if some individuals are no longer able to enroll via special enrollment period, they would experience reduced access to health care” resulting ultimate in higher costs, and increased morbidity/mortality.

4. Levels of Coverage (Actuarial Value)

We strongly disagree with “amending the de minimis range…to a variation of -4/+2 percentage points, rather than +/-2 percentage points for all non-grandfathered individual and small group market plans.” We also strongly disagree with changing “the de minimis range for the expanded bronze plans from +5/-2 percentage points to +5/-4 percentage points.” We understand that there will be no change to “the de minimis range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent.)” We strongly agree that this would “reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs.” We do not agree that providing “issuers with additional flexibility could help stabilize premiums.” Insurers already use “loopholes” to avoid their responsibility in providing care at the expense of consumers.

5. Network Adequacy

As stated previously, we strong disagree with HHS deferring to “State’s reviews in States with authority and means to assess issuer network adequacy” as network inadequacy is already existent and affects consumer health particularly in the areas of specialty care, pediatrics, and mental health.

6. Essential Community Providers

Again, as stated above we strongly oppose the proposal to reduce ECPs back down to 20 percent as this will adversely affect access to care to already vulnerable and underserved populations.

7. Uncertainty

We strongly disagree that “premiums would tend to fall if more young and healthy individuals obtain coverage” as historically they continue to rise. We agree that “shortened open enrollment period, pre-enrollment verification for special enrollment periods, reduced actuarial value of plans, less expansive provider networks result in lower enrollment, especially for younger, healthier adults, it would tend to increase premiums.”

C. Regulatory Alternatives Considered

We were disappointed as this section merely offered the option of maintaining the status quo for all areas with the only alternatives being the proposals offered. That being the case, we would prefer no changes at all.

E. Regulatory Flexibility Act

We understand that it was calculated that “entities with average annual receipts of $38.5 million or less would be considered small entities for these North American Industry Classification System codes.” We further understand that “approximately 97 out of 528 issuers of health insurance coverage nationwide had total premium revenue of $38.5 million or less.” We agree that this is an overstatement as “almost 74 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that would result in their revenues exceeding $38.5 million.”

F. Unfunded Mandates

We understand that while HHS has been unable to quantify all costs, it is expected that “the combined impact on State, local, or Tribal governments and the private sector to be below the threshold.”

G. Federalism

We agree that "this proposed regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets.” We also understand that some of these effects are mitigated as “States have choices regarding the structure, governance, and operations of their Exchanges.” In addition there is no requirement that “State-based Exchanges engage in pre-enrollment verification” or for states to conduct network adequacy reviews.

H. Congressional Review Act

We agree that “This proposed rule is subject to the Congressional Review Act provisions” and understand that “the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller for review.”

I. Reducing Regulation and Controlling Regulatory Costs

We acknowledge that it has been determined that “this proposed rule is not a ‘significant regulatory action that imposes costs’ and thus does not trigger the above requirements of Executive Order 13771.’’

Thank you again for the opportunity to comment to HHS on the Patient Protection and Affordable Care Act; Market Stabilization.

Sincerely,

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[i] https://www.healthmanagement.com/wp-content/uploads/012517-HMA-Roundup.pdf#nameddest=hma-roundup

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I oppose the proposed requirements that narrow special enrollment periods for the ACA. People who need to purchase insurance during a special enrollment period are often facing major life transitions, such as the birth of a baby or the loss of a job. The proposed requirement that proof be submitted prior to gaining coverage places an undue burden on people who may already be facing significant stress. The old rule, which allowed people to sign up and submit evidence of the life change and their qualification for the special enrollment period later is a better option because it ensures that Americans who are facing difficult life transitions will not become uninsured. Imagine having a baby born pre-maturely and having to be cared for in the NICU. Most people would want to add that baby to their insurance immediately and later, when their baby was out of danger, provide the documentation.

I am also concerned that the proposed rules would lead to subsidies decreasing. The proposal to increase the margin of error on coverage from 2% to 4% sounds like a minor change, but it means that the second cheapest silver plan could drop to 66% of coverage. This would mean that while subsidies would not increase, the cost of plans would increase. As somebody who is currently using the ACA (my husband owns a small business and I work in a full-time temp job that does not provide benefits) and receiving a subsidy, this would be a severe hardship for us. I am a cancer survivor and my husband has type 1 diabetes, which requires regular medical care and insulin. We cannot afford to choose a high deductible plan because we know that we would end up paying thousands of dollars in medical costs out of pocket. We need good coverage that is affordable. In the future, I hope that we will not need a subsidy, but while we do it does not make sense to penalize us with either premiums we cannot afford or a plan that does not provide full coverage. Under those conditions, my husband would need to close his small business and get a job with benefits so we could purchase the insurance that provides the coverage we need.

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Comments on CMS-9929-P

(155.410 (e)) With regard to the proposed change in the Enrollment period for 2018, I am concerned that State markets such as New York State of Health be required to accept enrollments for the full period: November 1, 2017 to December 15, 2017. In New York State for 2017 Enrollment, enrollments were not accepted until November 15, 2016. If that occurred again for 2018 Enrollment, the ending date of December 15 would only allow one month, during a holiday period. The enrollment periods for every state need to be at least one and one-half months.

(155.420) With regard to changes in the Special Enrollment Periods, this rule is premature. You are conducting two pilot projects to both retrospectively and prospectively audit or verify eligibility. But before you have the results, you are preemptively requiring eligibility checks for everyone. As you note, creating new barriers to enrollment will more likely deter healthier, less-motivated individuals. In addition, without knowing whether this increased verification will be useful, you are imposing $5,306,600 in additional costs. I would urge you to get and analyze the data from your current pilot projects before moving forward on these verification requirements. I will note that my own experience in providing information when my income declined was frustrating. Although I was projecting my 2017 income, New York State required irrelevant information about my previous income despite the fact that I had discussed why circumstances had changed. They used this irrelevant information to decrease my subsidy. While this will all come "out in the wash" when I file my 2017 income tax, it deprives me of current income in a time of reduced overall income. To assert, as you do in your Collection of Information Requirements, that the proposed provisions would not impose any additional burden on consumers is nonsensical. Clearly imposing more verification requirements will impose considerably greater burdens on consumers.

(156.140) I strongly oppose the proposed increase in the AV de minimis range for metal levels for either 2018 or 2019. Consumers are already faced with myriad choices. The metal ranges AV percentages give them some indication of what they are buying and its implications for their total health care spending. Allowing plans to provide more than 2% less than those stated levels

is destructive to consumer's ability to make sensible choices.

(156.230) I also strongly oppose dropping the time and distance criteria for establishing network adequacy. Network adequacy is already among the most problematic decision for consumers. Eliminating quantifiable measurements for vague state or accreditation criteria is anti-consumer.

(156.235) The proposed lessening of standards for ECPs and for the inclusion of ECPs in QHPs are similarly anti-consumer. These changes will decrease access for predominantly low-income and medically underserved individuals. I strongly oppose these proposed changes.

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March 7, 2017

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Acting Administrator
Centers for Medicare & Medicaid Services
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RE: Patient Protection and Affordable Care Act; Market Stabilization (CMS-9929-P)

Dear Acting Administrator Conway:

Thank you for the opportunity to comment on the proposed Market Stabilization rule. These comments are jointly submitted by the Office of the Health Care Advocate and the Vermont Low-Income Taxpayer Clinic, both of which are projects of Vermont Legal Aid.

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. The HCA handles over 4,000 cases per year. The HCA also engages in a wide variety of consumer protection activities on behalf of the public, including before Vermont Health Connect, other state agencies, and the Vermont legislature.

The Vermont Low-Income Taxpayer Clinic is a low-income taxpayer clinic funded under section 7526 of the Internal Revenue Code. The Clinic educates, represents, and advocates for low-income individuals on federal tax matters.

General Comments

In general, we are concerned that the proposed rule will negatively impact consumers' ability to enroll in good-quality, comprehensive, and affordable health coverage. The proposed rule would add enrollment restrictions and make coverage less comprehensive and more expensive for consumers. The enrollment restrictions are unlikely to further their stated purpose of stabilizing the health insurance marketplaces, and instead will likely reduce enrollment by healthy young adults. HHS's assessment of the benefits, costs, and transfers associated with this proposed regulation is inadequate and does not support the need for this proposed rule.

We are also disappointed by the unusually short comment period for this proposed rule. In light of the multiple significant changes being proposed, 20 days is not sufficient for stakeholders to thoroughly analyze and comment on this proposed rule.

HHS should open a new comment period to allow stakeholders to analyze how pending budget reconciliation legislation unveiled on March 6, 2017,[1] affects the proposed rule.

Guaranteed Availability of Coverage - § 147.104

The Department of Health and Human Services (HHS) proposes to allow issuers to refuse to enroll a consumer in any insurance product, if the consumer has an unpaid premium bill from the past 12 months' enrollment with that issuer. Also, issuers who allow enrollments in that situation would be able to attribute premium payments to the prior year's unpaid bill. In contrast, current HHS guidance distinguishes between the sale of a new insurance product (which is subject to the statutory guaranteed issue requirement) and the renewal of a consumer's existing plan (which is not).[2]

The proposed change would violate the Affordable Care Act's guarantee of coverage availability. The proposed reinterpretation of the guaranteed availability provision is unlawful and beyond HHS's statutory authority. An issuer "must accept every employer and individual in the State that applies for such coverage."[3] Enrollment may only be restricted to open or special enrollment periods. HHS does not have authority to add a new restriction for prior non-payment of premiums.

CMS Marketplace enrollment statistics do not support some issuers' speculation that consumers might be deliberately failing to pay premiums at the end of the year.[4] No evidence of significant gaming has been presented by issuers. Instead, only anecdotes have been cited. This is consistent with our experience interacting with thousands of healthcare consumers per year. We do not see our clients gaming the system; they do not understand the system well enough. In Vermont, the enrollment system has also been too dysfunctional for anyone to game.

<u>Operational Concerns</u>: If the proposed reinterpretation is adopted, we predict that it will lead to consumers who have paid their bills being wrongfully denied enrollment and losing needed medical care.

Vermont's exchange, Vermont Health Connect (VHC), has suffered from widespread billing and other operational problems.[5] (In Vermont, exchange enrollees must pay their premiums through the exchange rather than directly to the issuer.) Consumers frequently complain of being billed the

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[1] *Ways and Means Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://waysandmeans.house.gov/american-health-care-act/; *Energy and Commerce Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://energycommerce.house.gov/news-center/press-releases/energy-and-commerce-republicans-release-legislation-repeal-and-replace.

[2] *Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual, Section 6.3 Terminations for Non-Payment of Premiums, available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf.

[3] 42 U.S.C. § 300gg–1(a).

[4] See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016. See particularly Figure 1, *Enrollees Leave Marketplace Health Plans Gradually Throughout the Year.*

[5] *See*, Strategic Solutions Group LLC, *Recommendations for the Future of the Vermont Health Benefit Exchange* (Dec. 21, 2016), pp. 12-27, available at http://www.leg.state.vt.us/jfo/Future_of_VHC_Exchange.aspx.

wrong amount, having their payments rejected or not applied correctly, and other problems. The HCA routinely represents consumers attempting to resolve billing problems that are not their fault. The access to care problems that this causes would be compounded if issuers could deny enrollment altogether or attribute current-year premiums to a prior year's debt. This currently happens to renewed consumers, and would happen more widely if it also affected consumers who changed plans with the same issuer.

> Case example: Mr. H called us when he found out that his family plan had been cancelled. He had discovered the cancellation when he took his children to the doctor and was told that they had no coverage. We looked into the issue and found that he had been terminated for non-payment. When Mr. H's payment record was reviewed, though, it showed that he had paid all his premiums. The family had dropped their dental coverage, which had created an error in the billing system that ultimately caused him to be terminated, even though he was up-to-date with his payments. Because there was no basis for a non-payment termination, we got the family's coverage reinstated.

The Vermont exchange also has a history of failing to terminate coverage promptly upon request. This can lead to issuer records showing several months of unpaid premiums. In 2014 and 2015, the exchange had serious trouble processing terminations and was unable to do so within 15 days of a consumer request. This problem was compounded by incorrect tax reporting and failure to enforce the grace period regulations. During the 2016 tax season, we saw many examples of Forms 1095-A incorrectly showing more than one month of unpaid premiums due. Initially the exchange said this was because the grace period termination rules were permissive, not mandatory.

While the Vermont exchange has improved its processing times greatly in the past year, and now says it is enforcing the HHS grace period rules, nonpayment records are not always accurate. If the proposed reinterpretation is adopted, consumers must be given an opportunity to dispute the amount and existence of the debt.

Most low-income consumers do not have the ability to pay their premium twice in one month. If a premium payment is attributed to a prior year's debt, the consumer may not be able to pay the current premium. This may lead to nonpayment terminations and long periods of consumers going without insurance until the next open enrollment period.

If the proposed reinterpretation of guaranteed issue is adopted, we believe at a minimum the following safeguards should be adopted:

1. Notice. The issuer's repayment policy should be clearly noted on the exchange website so that consumers have that information when comparing plans. Second, it should be noted in the eligibility determination notice since consumers could change plans if open enrollment or a special enrollment period remains open. Third, the issuer should be required to provide notice of the policy on its website, to new enrollees, and in all dunning notices.
2. Premium payment thresholds should be permitted. See comment below. Issuer flexibility in this area benefits both issuers and consumers.
3. Hardship exceptions. Exceptions should be required for hardship situations, including but not limited to domestic violence, falling victim to a crime, being unable to pay due to a medical emergency, incarceration, and financial hardships.

4. Reiterate the maximum debt following a nonpayment termination. HHS should reiterate that when a subsidized enrollee's coverage is terminated at the conclusion of the 90-day grace period, the person would normally owe no more than their share of the premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers and state-based exchanges that the grace period termination rules at section 155.430(d)(4) are mandatory.

We do not believe the reinterpretation, if adopted, should apply to special enrollment periods.

Premium Payment Threshold: Comments were requested on whether issuers should be permitted to enact a premium payment threshold policy, whereby a consumer would be considered in good standing upon payment of a threshold percentage or amount of past due premiums. We strongly support flexibility for issuers to set a reasonable tolerance for premium payments, both in general and if the proposed reinterpretation of guaranteed availability is adopted.

Open Enrollment Dates - § 155.410

The open enrollment period should continue through the month of January 2018, or at least until January 15. We believe the window of time after January 1 is critical to capturing consumers who forgot to enroll on time or misunderstood the enrollment process. For example, there may be consumers who *thought* they were enrolled or renewed, and it will not be until January when they seek medical care that they figure out they were not enrolled, or that they were enrolled in the wrong plan. In our experience, consumers with enrollment problems usually discover them when they attempt to fill a prescription or visit a medical provider. Consumers also regularly discover problems when they receive their January premium bill, which is often received after December 15.

We do not believe Vermont consumers are ready for a much shorter enrollment period in 2017. The HCA heard from many consumers with enrollment questions and problems after December 15, 2016. In addition, there are many fewer navigators than there were in 2014, and shortening the enrollment period would make it more difficult for them to reach and serve all consumers requesting help. For example, there is only one navigator left in Windham County, Vermont, and she also serves part of Windsor county. With further navigator grant cuts proposed, it is even less likely that consumers will get the help they need during a shortened enrollment period.

HHS explains that it proposes shortening the open enrollment period to limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are generally the most diligent about signing up for insurance. We believe the policy change could just as easily lead to a sicker pool, if young, healthy people end up missing the new deadline.

Further, ending the open enrollment period in mid-December is problematic because it is when many consumers face financial pressures and distractions due to the holiday season.[6] Many of our clients worry about "how to pay for Christmas" for their children. As Blue Cross Blue Shield of Florida noted, ending open enrollment in December "forces consumers to make financial decisions

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[6] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

when their debt is at its highest levels and their interest in their health is at the lowest."[7] We agree with this assessment based on our experience assisting Vermont consumers.

Special Enrollment Periods - § 155.420

We are seriously concerned that the proposed verification requirements will deter eligible consumers from accessing health insurance, to the detriment of the market and to the goals of the Affordable Care Act (ACA). We disagree with the proposed changes to special enrollment period verification, because they are not based on solid evidence. Rather than strengthening the risk pool, they will more likely weaken it by discouraging mid-year enrollment by younger, healthier people. HHS should not take that risk without evidence-based analysis.

Significant changes in enrollment verification should not be adopted prior to a full evaluation and analysis of the post-enrollment verification pilot and the random sampling audits conducted by HHS in 2016. HHS should continue its previous plan to conduct a pre-enrollment verification pilot in 2017. Then, HHS can take appropriate steps against fraudulent enrollments, informed by actual data.

The fact that mid-year enrollees have higher health costs on average is not proof that special enrollment period (SEP) enrollments are fraudulent or erroneous. Consumers who lose health insurance mid-year will compare the cost of a Marketplace plan with the tax penalty for remaining uninsured, and some choose not to sign up. It is contrary to the aims of the ACA to address this by establishing barriers that discourage *eligible* consumers from enrolling. Aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that were put into place in 2016: twenty percent fewer consumers enrolled using in SEPs, and younger consumers were less likely than older ones to follow through.[8] These young consumers tend to be healthier and are the very people we need to encourage to enroll in coverage. These new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will take the steps necessary to complete the process.

Given the dramatic effects of the 2016 SEP changes, it is inaccurate to say that the proposed changes will have no increased burden on consumers. On the contrary, they will increase consumer burden significantly. Not only will verification requirements be expanded, but enrollment will be pended while verification is conducted. We doubt that exchanges (at least Vermont's) will have the capacity to electronically verify many (if any) SEPs in realtime; therefore many consumers will experience a delay in access to medical care while paper verification is submitted and processed. This is extremely concerning.

HHS's cost analysis must include the impact on consumers and providers of pended enrollments, including missed medical appointments, delayed medical care, and the need to pay out of pocket while enrollment is pending. We anticipate these will be significant costs to consumers subject to pre-enrollment verification, particularly if it involves submission and review of paper documents.

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[7] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492.

[8] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

Also, HHS's cost analysis should include the individual and systemic costs of *eligible* consumers going uninsured due to an inability or unwillingness to complete the verification process.

We disagree with HHS's statement that pre-enrollment verification would reduce costs for issuers. In Vermont, issuers regularly complain about having to process retroactive claims and retroactively effective enrollments. At best, issuers' costs under pre-enrollment verification would be neutral. HHS's cost analysis should also include the increased time spent by medical providers having to re-bill claims after the fact, and time that consumers will have to spend requesting that their claims be re-billed.

HHS justifies the proposed changes by "strong issuer feedback and the potential to help stabilize" the marketplace. Since SEP enrollees have higher-than-average costs, issuers have an incentive to request restrictions on SEP enrollments regardless of consumer eligibility; issuer interests are not aligned in this area with the public health goals of the ACA. It seems highly unlikely that restricting enrollment is the missing piece needed to stabilize the market, given the uncertainty in Congress around the future of the ACA, and given the pending lawsuit challenging cost-sharing reduction payments to issuers.

In our experience, most consumers are confused by the exchange regulations, and do not understand the system well enough to try to game it. In Vermont, we have not seen SEPs being abused by consumers. There is a lot of confusion about how long SEPs last, and some consumers have called HCA after missing the deadline.

Erroneous enrollments do sometimes result from exchange or assistor error. We support HHS's efforts to conduct pilots and studies to better understand enrollment dynamics, the composition of the SEP enrollee population and the causes thereof, and the effects of pre-and post-enrollment verification requirements. If the proposed changes are implemented, we support the exclusion of a statistically significant population for study purposes.

We believe pre-enrollment verification would result in fewer enrollments, especially among consumers who do not expect to need much health care. In our experience, enrollment barriers have a significant deterrent effect on consumers who are on the fence regarding getting coverage. We have seen this with consumers abandoning the application process after not being able to complete it in one session. Consumers who know that they will need medical care, on the other hand, will gather the necessary documents and complete the SEP enrollment process.

If HHS finalizes its proposed changes to SEPs, it should permit state-based marketplaces to establish their own verification rules or pilot programs. We disagree with HHS's proposal to encourage state-based marketplaces to adopt pre-enrollment verification.

<u>Implementation Suggestions</u>: If the proposed verification changes are adopted, we have several concerns and suggestions for implementation.

- Verification should only be required in suspicious individual cases or for situations with a higher likelihood of erroneous enrollment. We believe that the birth/adoption/foster care placement SEP should be excluded from blanket verification requirements.

- HHS should not adopt pre-enrollment verification requirements until the exchanges are operationally capable of electronically verifying at least prior public coverage (including Medicaid, CHIP, Medicare) and prior QHP coverage nationwide.
- A statistically significant population should be excluded for study purposes.
- State-Based Marketplaces should be permitted to establish their own verification rules including verification pilot programs. They should not be required to conduct pre-enrollment verification.
- Consumers should continue to have flexibility to request later coverage effective dates if their enrollment is delayed by the verification process. We object to the proposal to limit this choice to one month maximum, when there is no time limit placed on the exchanges to process verification documents. Consumers should be able to request a coverage effective date as late as necessary to limit their retroactive premiums to one month. This will tie the limit to the promptness of the exchange's verification process.
- Any additional SEP changes made by HHS (including those discussed below) should be optional for State-Based Marketplaces.

Changing Plan Levels: We oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event. Life changes such as birth and marriage may significantly alter the amount of cost-sharing reductions and advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs.

An individual who gains a new dependent should be permitted to take that dependent's medical needs into account when deciding which insurance plan to choose, as well as the family's financial situation. In some cases it would be simply cruel to restrict a new parent of a special needs child to the metal level they chose during open enrollment, at which time they may not have expected to have a baby at all.[9] An unexpected dependent also has a significant financial impact on a family. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs.

The potential for adverse selection is already adequately addressed by the requirement to qualify for an SEP (based on non-medical criteria) in the first place. We support the use of studies and pilot projects to investigate issuer claims of malfeasance. The ACA provides for special enrollment periods, and issuers simply need market experience and data to price their plans accordingly.

The proposal to limit plan metal level changes during SEPs is prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage."[10] While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage." HHS does not have the statutory authority to limit which plans an SEP enrollee can choose.

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[9] In 2006, 49% of pregnancies were unintended. See, Centers for Disease Control and Prevention, at https://www.cdc.gov/reproductivehealth/unintendedpregnancy/.

[10] 42 U.S.C. § 300gg–1.

Payment of Past-due Premiums: Consumers do not qualify to enroll in an SEP for loss of minimum essential coverage if that loss was due to nonpayment of premiums. It is reasonable to require exchanges to develop electronic verification systems for this factor. However, if issuers are permitted to reject enrollments on this basis, the exchange should be required to notify the consumer of this and give the consumer the opportunity to contest the issuer's records as part of an appeal of the SEP denial. In addition to notice and the opportunity to appeal, hardship exceptions should be adopted, including but not limited to domestic violence, falling victim to a crime, being unable to pay due to a medical emergency, incarceration, and financial hardships.

As explained above, we object to HHS's proposal to allow issuers to reject SEP enrollees who have an unpaid premium bill from coverage in the prior 12 months. This is prohibited by the ACA's guaranteed issue requirement.

Marriage and Permanent Move SEPs: Requiring evidence of continuous coverage for marriage and permanent move SEPs is prohibited by statute.[11] The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage."[12] While issuers "may restrict enrollment … to open or special enrollment periods," this does not allow any continuous coverage requirement.

The proposed continuous coverage requirement will lead to hardship and an increase in the uninsured population. Individuals may not have been eligible for affordable coverage prior to marriage or prior to their move. This is particularly likely in Medicaid non-expansion states.

If this proposal is adopted, we support an exception for individuals living abroad or in a U.S. territory. HHS should not impose expensive and time-consuming proof to document a foreign or territorial residence.

Continuous Coverage

HHS requests comments on policies in the individual market that would promote continuous coverage, and also on whether continuous coverage requirements are needed. We strongly object to requiring continuous coverage as a condition of enrollment in the individual market. This would move health insurance in the U.S. backwards rather than forwards. HIPAA's continuous creditable coverage requirement caused great hardship for low-income individuals who for various reasons had not been able to maintain health insurance coverage.

HHS can and should promote continuous coverage by funding consumer education, outreach and adequate enrollment assistance, and by reaching out to under-enrolled populations.

The ACA already contains a punitive mechanism for promoting continuous coverage: the individual shared responsibility provision.[13] The Internal Revenue Service recently signaled to the public that it is not serious about enforcing this provision, by backtracking on plans to reject so-called "silent" tax

[11] The requirement of prior coverage was added to the permanent move SEP in an interim final rule published May 11, 2016. 81 Fed. Reg. 29,146. It is not currently part of the marriage SEP.
[12] 42 U.S.C. § 300gg–1.
[13] 26 U.S.C. § 5000A.

returns that fail to address the individual shared responsibility provision.[14] This suggests that continuous coverage requirements are not needed and purported concerns may not be real. Even if the concerns are real, the federal government cannot intentionally create a problem by refusing to enforce the main continuous coverage mechanism in the ACA, and then use that problem as an excuse to create a different mechanism through regulation.

Proposed budget reconciliation legislation was unveiled on March 6, 2017 that would replace the individual shared responsibility provision with a premium penalty for people who lack of continuous coverage.[15] We do not believe this is good policy, but that is a decision that Congress can make. HHS does not have the ability to write a different continuous coverage penalty into the ACA's health insurance eligibility and enrollment provisions.

Actuarial Value - § 156.140

We oppose the proposed expansion of the de minimis actuarial value (AV) variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces.

The proposed reduction in the minimum AV of silver level plans is particularly bad, because it would reduce the amount of premium tax credits *for all consumers* by reducing the "second-lowest-cost silver plan" upon which the subsidy is based.[16] This would reduce the buying power of consumers who receive advance payments of the premium tax credit. This is a significant issue for the marketplace, since 84 percent of enrollees receive APTC.[17]

A Families USA analysis recently found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[18] In addition, a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[19] Consumers already complain to us that it's hardly

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[14] *See* IRS.gov, Individual Shared Responsibility Provision, at https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision (last updated Feb. 15, 2017) ("the IRS has decided to make changes that would continue to allow electronic and paper returns to be accepted for processing in instances where a taxpayer doesn't indicate their coverage status.") *See also* Michael Hiltzik, *Trump's IRS stages a stealth attack on Obamacare*, Los Angeles Times, Feb. 15, 2017, *available at* http://www.latimes.com/business/hiltzik/la-fi-hiltzik-irs-obamacare-20170215-story.html; Dan Mangan, *IRS won't reject tax returns if they do not include Obamacare disclosures*, CNBC, Feb. 15, 2017, *available at* http://www.cnbc.com/2017/02/15/irs-wont-reject-tax-returns-if-they-do-not-include-obamacare-disclosures.html.

[15] *Ways and Means Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://waysandmeans.house.gov/american-health-care-act/; *Energy and Commerce Republicans Release Legislation to Repeal and Replace Obamacare* (Mar. 6, 2017), at https://energycommerce.house.gov/news-center/press-releases/energy-and-commerce-republicans-release-legislation-repeal-and-replace.

[16] *See* 26 U.S.C. § 36B.

[17] CMS, First Half of 2016 Effectuated Enrollment Snapshot (Oct. 19, 2016), available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html.

[18] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

[19] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Center on Budget and Policy Priorities, Feb 2017), available at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

worth paying premiums when they are unlikely to meet their deductible or maximum out-of-cost limit. The proposed slide in AV standards would exacerbate this perception of unaffordability and reduce enrollment by healthy adults. These costs must be included in HHS's cost-benefit analysis of the regulation.

The proposed expansion of the de minimis actuarial value variations is unlawful. The allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates."[20] However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds the Secretary's authority and violates the plain meaning of the statute.

While we do not support expanding the de minimis actuarial value threshold, if HHS finalizes this proposal, the benchmark premiums for the premium tax credit should still be based on plans with a true 70 percent actuarial value, or on a minimum variation such as 68% that meets the statutory requirement of only accounting for differences in actuarial estimates.

We appreciate HHS raising the question of whether its proposed change to AV standards implicates the ACA's requirement to reduce cost-sharing for all enrollees with income up to 400 percent of the poverty line, up to specified actuarial values. The ACA requires the Secretary to establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent.[21] Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. Therefore, HHS should require issuers to offer 70 percent actuarial value cost-sharing reduction plans for eligible enrollees, unless the issuer offers a plan with a 70 percent actuarial value. This would maximize issuer flexibility in benefit design, allowing issuers to respond to consumer preferences and increase competition in the marketplace.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans with an AV of 73, 87 and 94 percent. HHS should extend this requirement to 70 percent AV plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the poverty line.

Thank you for considering these comments.

Sincerely,

Christine Speidel
Staff Attorney, Office of the Health Care Advocate
Director, Vermont Low-Income Taxpayer Clinic

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[20] 42 U.S.C. § 18022(d)(3).
[21] 42 U.S.C. § 18071.

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President Trump promised a better health program that covers more people for less cost, and the proposed new rules would break that promise and the trust of the people who voted for President Trump. The authors of this rule are well aware they are breaking the promise to the American People including listing some of the costs as follows:

Harms to health and reduced protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical conditions (if health insurance enrollment decreases)
Cost due to increases in medical service provision (if health insurance enrollment increases)
Decreased quality of medical services (for example, reductions in continuity of care due to lower ECP threshold)
Administrative costs incurred by the federal government and by States that start conducting verification of special enrollment period eligibility

These rules jeopardize health coverage for those who depend on it and break President Trump's promises, which will erode the voting public's trust in this President and the US government.
No documents available.

Comment separator page. Next comment follows.

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, NY 10007

March 7, 2017

VIA ONLINE SUBMISSION
Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Ref: CMS-9929-P: Patient Protection and Affordable Care Act; Market Stabilization

Dear Dr. Conway,

The City of New York (NYC), on behalf of the NYC Human Resources Administration (HRA), NYC Health and Hospitals Corporation (HHC), and the NYC Department of Health and Mental Hygiene (DOHMH), respectfully submit the following comments in response to the Proposed Rule on the Affordable Care Act (ACA); Market Stabilization as published in the Federal Register on February 17th, 2017 ("Proposed Rule").

Expanding access to health insurance has been a central principle of the ACA and continues to be a critical goal for NYC. As such, we hope to emphasize the importance of easy health insurance enrollment and maintenance of coverage, and we respectfully oppose the imposition of any additional barriers related to affordability, ease of enrollment and availability of providers. We welcome any steps CMS can take towards supporting those objectives.

Introduction:

Since the enactment of the ACA in 2010, the uninsured rate in NYC has dropped from 14.8% to 9.3%. Moreover, the uninsured rate among children in NYC has been cut in half from 4.6% to 2.3%. Much of our recent success in reducing the number of uninsured New Yorkers has been

built on the longstanding partnerships with agencies, community organizations and assistors that have allowed us to reach NYC's most vulnerable populations and connect them to coverage, as well as the establishment of our state-based exchange, the New York State of Health, which has made enrollment in coverage more accessible and affordable.

We are concerned that the Proposed Rule makes the healthcare enrollment process more difficult for vulnerable populations whose conditions require continuous access to affordable high quality care. Overall, this Proposed Rule would result in poorer outcomes and higher long-term costs for our nation's health system.

Accordingly, our comments present arguments in favor of maintaining current:

- Enrollment Period Timelines
- Special Enrollment Processes
- Levels of Coverage and Actuarial Values
- Network Adequacy Criteria
- Requirements for Contracting with Essential Community Providers

Open Enrollment Periods

Recommendation #1: *NYC recommends that the Department of Health and Human Services (HHS) not shorten the annual open enrollment period and keep the open enrollment period as is from November 1 through January 31.*

The Proposed Rule intends to shorten the duration of open enrollment periods for benefit years 2018 and beyond from a three-month period beginning November 1, 2017 through January 31, 2018 to a six week period beginning November 1, 2017 through December 15, 2017.

NYC again urges that all rules be crafted with an eye toward insuring as many individuals as possible, as we believe that having health insurance increases access to health care. Increasing access to health care leads to greater use of preventive care, and eventually decreased use of avoidable emergency and inpatient visits, thereby saving money for the entire health care system.

NYC understands the stated goal of stabilizing the insurance market and assuring a healthy risk pool as part of that general goal. One concern expressed in the preamble of the Proposed Rule is that the extent open enrollment period can encourage greater adverse selection among consumers who learn they have health conditions later in the enrollment period and pursue enrollment because they are motivated by health care concerns. However, there is no clear evidence noted in the preamble to support this conclusion.

Shortening the forthcoming open enrollment period for the 2018 benefit year will severely limit the time needed to prepare for this significant change and make enrollment more difficult for consumers. Our marketplace, the New York State of Health, depends on a host of navigator organizations, certified application assistors, community organizations and other partners in NYC and across the state to educate, support and motivate those who are uninsured and eligible

for coverage pursuant to the ACA to complete enrollment. It is already difficult to assist many of our fellow New Yorkers who work as consultants, freelancers or in other part-time and non-traditional jobs to obtain the necessary information and documentation needed to affirm their employment and income amidst the steady volume of inquiries and general enrollment demand that occurs during the open enrollment period.

Further, as reflected in this Proposed Rule, this change would likely be but one of several that these agencies and entities would need to first digest and then explain to consumers to help them adapt to the new enrollment and eligibility processes. Although the Proposed Rule notes that CMS intends to conduct extensive outreach to educate consumers of this change, we are concerned that this task may be more difficult than anticipated, particularly for vulnerable populations in NYC, such as those with limited literacy skills and those with critical health needs. Shortening the forthcoming open enrollment period will disproportionately impact these populations, and for whom successful outreach requires well-developed, targeted, and more labor intensive efforts.

Recommendation #2: *NYC urges CMS to maintain its commitment to providing funding and support for insurance enrollment assistors and navigators.*

As of January 31, 2016, almost 74 percent of individuals enrolled in the New York State of Health received help from insurance assistors when they first enrolled.[1] This affirms the importance of having this ready assistance to guide consumers through the sometimes complex processes connected to the health insurance enrollment in the federal and state-based marketplaces.

Assistors play a vital role on the front lines in many communities helping consumers to understand their coverage options and select and enroll in a plan that best suits their needs. As CMS considers any move toward changes to the length of open enrollment period, it is critical to note that agents, brokers, navigators, and assistors in NYC will also have to surmount the unique demands of serving the diverse literacy capacities of our residents.

Special Enrollment Periods (SEPs)

Recommendation #3: *NYC recommends no change to the current verification process and level of documentation needed for plan enrollment during special enrollment periods.*

This Proposed Rule intends to expand pre-enrollment verification for all categories of special enrollment periods (SEP) for all new consumers in all states served by a marketplace using the HealthCare.gov platform. CMS has requested comments regarding the impact of this verification on consumers, whether State-based Exchanges (SBEs) should be required to conduct pre-

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[1] 2016 NY State of Health Open Enrollment Report, available at https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202016%20Open%20Enrollment%20Report%282%29.pdf

enrollment verification, and how long the transition period should be to implement such a process.

Making the SEP's more cumbersome by requiring pre-enrollment verification for all categories of SEP's for all new consumers and applying more rigorous testing of the exceptional circumstances during the SEP will make it more difficult for people to enroll in a qualified health insurance plan (QHP) and receive much needed healthcare.

SEPs provide an avenue for individuals and their families to obtain or adjust their health insurance coverage to address major changes in life circumstances. While in the midst of these qualifying life events, such as losing a job, changing professions or making a major move, individuals can face challenges which often hinder their ability enroll in coverage quickly. These challenges are particularly stark for many populations, such as those working in small businesses or non-traditional and part-time work settings where obtaining documentation on short notice is difficult. As this rule proposes to expand pre-enrollment verification and implement a 30-day limit for individuals to supply documentation, it will present an additional obstacle to overcome to enroll in health insurance. Although this Proposed Rule intends to promote continuous coverage, providing this additional obstacle to enrollment may negatively impact that goal.

In the CMS guidance document entitled "Pre-Enrollment Verification for Special Enrollment Periods," which shared results from a 2016 SEP confirmation process review that explored the impact of documentation submission, the agency noted that younger consumers are disproportionately less likely to complete the verification process for SEPs. In a preliminary snapshot of customers selected for review, only 55% of consumers aged 18-24 submitted documents after initial outreach, compared to 73% of those aged 55-64.[2] Although this proposed rule seeks to achieve healthier risk pools in the individual market, this report suggests that additional paperwork burden may further discourage enrollment among younger, healthier adults and effectually reduce market stability.

Finally, this Proposed Rule change is not based on documented evidence of ineligible people enrolling during SEPs, but rather a 2016 report from the Government Accountability Office that such enrollments are theoretically possible.[3] Notably, the report states that its findings were "not generalizable to the population of applicants or marketplaces." As such, this report does not justify a move to substantially increase the administrative burden on federal and state exchanges.

Recommendation #4: *NYC recommends eliminating the addition of (4)(i) and (4)(iii) to §155.420.*

[2]This brief can be found at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf

[3] U.S. GOV'T ACCOUNTABILITY OFF., PATIENT PROTECTION AND AFFORDABLE CARE ACT: RESULTS OF UNDERCOVER ENROLLMENT TESTING FOR THE FEDERAL MARKETPLACE AND A SELECTED STATE MARKETPLACE FOR THE 2016 COVERAGE YEAR (GAO-16-784) (Sep. 12, 2016), *available at* http://www.gao.gov/assets/680/679671.pdf.

This Proposed Rule intends to, through various mechanisms, restrict consumers from changing metal levels during special enrollment periods. CMS has requested comments on these proposals, and whether SEPs other than the following described in §155.420 should be excluded from these restrictions: (d)(4) unintentional or erroneous enrollment into the Exchange, (d)(8) enrollment based on Indian status , (d)(9) exceptional circumstances, and (d)(10) if the individual or dependent is a victim of domestic abuse or spousal abandonment. Our comments pertain to the rule's proposal to add sections (4) (i) and (4)(iii) to §155.420(a). These new sections would place restrictions on a consumers' ability to change metal levels at the time they experience the remaining qualifying events noted in paragraph (d), including but not limited to gaining or becoming a dependent, loss of pregnancy-related coverage, and a permanent move.

The choice among bronze, silver, gold and platinum metal levels available through the federal and state marketplaces are designed to afford consumers an array of benefit designs as well as pricing choices that can serve their health care needs and financial capacities. The qualifying events that trigger SEPs listed in this section create circumstances that drastically impact the lives of consumers and their dependents. As mentioned earlier, SEPs offer consumers and their families the opportunity to gain and/or adjust their health insurance coverage to accommodate life changes. Placing restrictions on metal-level changes in these instances prohibits consumers making insurance coverage choices based on their unique financial capacity and health care needs.

Requirement for State-Based Exchanges (SBE's)

Recommendation #5: *NYC recommends that SBEs should not be required to implement expanded pre-enrollment verification prior to a comprehensive review of its potential impact on the market and consideration of best practices to mitigate adverse impacts.*

In 2016, CMS announced a pilot program to begin in June 2017 that would require a randomly selected 50% of consumers on Federally-facilitated Exchanges to submit pre-enrollment verification documents. The presentation of the pilot included plans for an evaluation. This Proposed Rule intends to expand the pilot to 100% of consumers on this platform with little discussion of its plan to analyze the processes and challenges in this new verification framework. As noted above, implementing this rule could present unforeseen risks to market stability.

SBEs should be given flexibility and deference regarding the extent to which they conduct pre-enrollment verification. In addition to the arguments articulated above, NYC comes to this conclusion because SBEs were established to create systems and processes that would best cater to their specific populations. These exchanges face a unique set of circumstances that create operational differences from FFEs and SBE-FPs.

Levels of Coverage: Actuarial Value (AV)

Recommendation #6: *NYC recommends that the de minimis range for all metal level plans remain unchanged*

The Proposed Rule intends to expand allowable de minimis variation in actuarial values used to determine metal levels of coverage for the 2018 plan year from +2/-2 to +2/-4 for general metal plans and from +5/-2 to +5/-4 for certain bronze plans.

A plan with a lower actuarial value will have lower premiums than one with a higher actuarial value. By allowing greater leniency on the lower end of the actuarial spectrum for each metal level, particularly as it relates to silver plans, issuers would be permitted to offer coverage with lower premiums and a higher percentage of cost-sharing. Since the premium tax credits adjust dollar for dollar based on the premium of the second lowest cost silver plan, decreases in the premium for this plan would likely result in lower premium tax credits overall.

Receiving lower tax credits can dramatically change the purchasing equation for consumers in the marketplace. The consumer will face the choice of having less financial support from the tax credit and may have to spend more money on premiums to get plans with better actuarial values or incur higher deductibles and other out of pocket costs to maintain more affordable premium levels. Accordingly, this change in actuarial valuation can have the effect of increasing premiums and/or out of pocket costs for many consumers and families in the marketplace contrary to our common goal to maximize choice and affordability.

NYC understands the benefits of affording issuers greater flexibility in plan design as a means to expand plan choices for consumers, minimize issuers' need to redesign plan offerings annually and thus stabilize the market. However, we are concerned that this adjustment may adversely affect consumers who rely on advanced premium tax credits to help them afford the cost of coverage. These tax credits, designed to help qualifying individuals and families pay for health insurance, are calculated based on the difference between the premium for the second-lowest cost silver plan, or 'benchmark" plan, and the percentage of income they are expected to pay for coverage under the ACA. As of January 31, 2016, approximately 54% of those enrolled in Quality Health Plan (QHP) coverage through the New York State of Health received tax credits.[4]

Essential Community Providers (ECPs) (§156.235)

Recommendation #7: *NYC recommends that plans continue to be required to contract with at least 30% of ECPs.*

[4] 2016 NY State of Health Open Enrollment Report, available at https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202016%20Open%20Enrollment%20Report%282%29.pdf

NYC is concerned that the interpretative proposal to reduce the requirement to contract with essential community providers (ECPs) from 30% to 20% of available essential community providers in a plan's service area may impact access to care among low-income and medically underserved populations.

Recommendation #8: *NYC recommends that CMS should amend the ECP standard to require QHP issuers to offer contracts, in good faith, to every willing ECP hospital in each county of a plan's service area.*

Currently, QHPs must include at least 30 percent of all available ECPs in its service area to meet network adequacy requirements. CMS notes decreasing this percentage to 20 percent for 2018 would lessen the burden on issuers, while preserving access to care provided by ECPs. However, decreasing the ECP inclusion standard leaves room for QHPs to exclude the essential hospitals, such as NYC Health + Hospitals, which provide low-income and medically underserved populations the full continuum of quality care. Essential hospitals fulfill such a unique role in their communities that specific guidance on including such providers in QHP networks is warranted.

To this end, if essential hospitals are excluded from QHP networks, patients will lose access to these vital health services. CMS should require QHP issuers to offer contracts, in good faith, to all willing ECP hospital providers—especially essential hospitals—to guarantee that low-income and medically underserved patients have reasonable and timely access to vital health services.

Network Adequacy (§156.230)

Recommendation #9: *NYC recommends that Health and Human Services (HHS) maintain the current minimum criteria for health plans to be certified as QHPs, so that they maintain a network that is sufficient in number and types of providers, including mental health and substance abuse service providers.*

The proposal to rely on state reviews for network adequacy may result in too much variation between states and a reduction in the availability of mental health and substance abuse services in some states. Additionally, state-level reviews often do not adequately measure service capacity and need at the local level.

Conclusion

NYC would like to applaud efforts to stabilize the individual insurance market. NYC believes that ensuring the payment of the cost sharing reduction payments and enforcing the individual responsibility provision of the ACA, would help contribute to the success of the individual marketplace.

In addition, NYC would have expected that CMS would have provided more than 20 days to comment on this proposed rule particularly in light of (i) the minimal consultations with hospital-providers, and (ii) the impact on public health and patient care that each change to healthcare can

have. Indeed, we urge CMS to reopen or extend the comment period to allow for additional commentary.

In closing, it will always be a top priority for NYC to optimize the ability for individuals and families to access affordable, high-quality health insurance coverage. We thank you for your consideration of our comments and we appreciate the opportunity to contribute our perspective to shaping the proposed regulations. Please do not hesitate to contact Walter Bishop at 202-624-5915 with any questions.

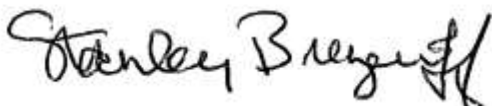
Sincerely,

Mary T. Bassett, Commissioner

New York City Department of Health and Mental Hygiene

Steve Banks, Commissioner

New York City Human Resources Administration



Stanley Brezenoff, President and Chief Executive Officer

New York City Health and Hospitals Corporation

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Comments to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, CMS-9929-P

RE: Patient Protection and Affordable Care Act; Market Stabilization
by Consumers for Affordable Health Care, Maine

March 7, 2017

Consumers for Affordable Health Care (CAHC) is a Maine-based advocacy organization and Maine's designated Consumer Assistance Program. CAHC was founded in 1988, and our mission is to advocate the right to quality, affordable health care for every person in our state. We operate a statewide HelpLine which consumers can call with questions about getting, keeping, using, or fixing problems with health coverage; this HelpLine receives thousands of calls a year from consumers across the spectrum of our health coverage system. We are also a Certified Application Counselor (CAC) organization that directly assists consumers in enrolling in health coverage through Maine's Federally Facilitated Marketplace (FFM).

Given this expertise, we have significant concerns about the proposed rule's effect on Maine consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces. If finalized as written, the proposed rule would add unnecessarily burdensome enrollment restrictions and make coverage less comprehensive and more expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides, upon which Mainers rely to keep themselves and their families physically and financially healthy.

Analysis by our national partners at Families USA (FUSA) and the Center on Budget and Policy Priorities (CBPP) shows that, if implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks;
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the rule itself also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals are far from the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Guaranteed Availability of Coverage (§147.104)

The NPRM proposes allowing issuers in the individual or group market to refuse coverage to an individual (or employer) who owes the issuers premiums from the prior 12 months, unless and until the individual (or employer) pays the premium debt in full. This change should not be adopted. This conflicts with the statute, which says that issuers generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. This change would bar people, many of them with limited incomes, from accessing coverage and the financial assistance for which they are eligible as a result of premium shortfalls during the prior year.

Under this proposed rule, only those who can rapidly come up with a possibly significant sum of money by a given deadline can be guaranteed access to health coverage. This policy would likely deter healthier people who get behind in their premiums from enrolling, since often-healthy younger people are more likely to miss bill payments in general – an odd outcome from a proposed rule aimed at providing greater stability in the insurance market. This could weaken the overall health of the coverage pool in a similar way as the proposed changes to SEPs.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[1]

[1] [1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrollment declines gradually throughout the year, a sign that enrollees leave the market over time for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

1. Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.

2. In addition, the issuer should be required to provide notice within a week of the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice. HHS should further mandate strict time limits within which an issuer is required to submit this notice to the affected consumers, and require that insurers verify correct contact information with a consumer if an initial notice is not responded to within two weeks of it being sent. We have worked with callers to our HelpLine who have not received such notifications within a timely fashion, missed payments without realizing it, and consequently suffered a loss of coverage. This is of particular concern for consumers who have their payments set to withdraw from bank accounts automatically, who may not notice a problem until it is too late to do anything about it.

3. It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.

4. The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

Open Enrollment Periods (§155.410)

We strongly urge CMS to keep the length of open enrollment periods to three months, as was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about and enroll in coverage within the given timeframe. If the rule is finalized, there will limited time for affected consumers to learn about the changed length. We know that consumers continue to have gaps in knowledge about the coverage options available to them. We also know that even within the available enrollment timeframe, there are circumstances beyond consumers' control that can impact their ability to enroll within the current timeframes, let alone a halved window. We believe a three-month open enrollment period should continue in order to ensure eligible consumers enroll.

We also have concerns about consumers' ability to access in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer plans. We appreciate that CMS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand.[2] On our HelpLine, we see this clearly during current Open Enrollment periods: within two weeks of the major deadlines (December 15th, January 15th, and January 31st), assisters and Navigators book up. Some Navigators have reported that their schedules are filled in the first weeks of Open Enrollment before the enrollment period even begins. We run out of local options to refer consumers to for in-person enrollment assistance, and those consumers who may prefer or, for various reasons, require in-person help are forced to navigate the process alone. Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[3] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[4] On our HelpLine, we commonly receive calls in late December or mid-January from consumers who are upfront about the fact that they knew the enrollment period had been open since November, but were only just finding the time or the available finances to enroll.

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a

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[2] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[3] Stan Dorn, Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015), available online at: http://www.urban.org/sites/default/files/publication/41616/2000104- Enrollment-Periods-in-2015-and-Beyond.pdf.

[4] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

profound and positive impact on enrollment.[5] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[6]

Special Enrollment Periods (SEPs) (§155.420)

Overall, we are very disappointed about the proposed changes to SEPs and urge you not to finalize them. In order to ensure that healthy people enroll in coverage, thus bringing down the cost of coverage overall, enrollment rules and procedures should strive to make it easier, not harder, to enroll in coverage. Estimates show that less than 5 percent of eligible consumers enrolled in coverage through SEPs in 2015,[7] and we are concerned that these new requirements will likely result in even fewer eligible consumers accessing coverage using an SEP.

Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that ineligible people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to follow through.[8] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this harmful trend, because it will be those consumers most in need of coverage who will take the steps necessary to complete the process.

We are very disappointed in the proposal to expand pre-enrollment verification. No evaluation or analysis of the impact of the numerous changes – specifically increased verification requirements – that have already been implemented for the FFM has been conducted. We do, however, appreciate that the preamble requests comment on whether a small percentage of enrollees should be retained outside of the pre-enrollment verification process in order to evaluate the impact of these processes and we strongly urge CMS to do so.

We are also strongly opposed to requiring prior coverage for the marriage SEP and rules that limit the ability of currently enrolled consumers to change plans. Currently, enrolled consumers who are newly eligible for premium tax credits (PTCs) may select a plan from any available metal level. This is important so that individuals and families experiencing life changes can gain access to financial assistance or can adjust to loss of subsidies and still afford coverage. For example, someone who experiences an increase in income may receive a reduced premium credit

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[5] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[6] Zach Baron, In Person Assistance Maximizes Enrollment Success (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[7] Stan Dorn, Helping Special Enrollment Periods Work under the Affordable Care Act (Washington: Urban Institute, June 2016), available online at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[8] Centers for Medicare and Medicaid Services, Pre-Enrollment Verification for Special Enrollment Periods (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

and/or lose access to cost-sharing reductions during the course of the year. This warrants the chance to change metal levels if they choose.

It is critical that eligible consumers successfully finish the SEP verification process with minimal burden. We have seen cases on our HelpLine where a frustrating inability to have documentation verified by the FFM has led to ongoing, months-long hassle for consumers who play by the rules, submit requested verification documentation, but then see the processing center either request further documentation without clarity or guidance on what exactly is necessary in order to be verified, or lose the submitted documentation entirely, requiring multiple resubmissions.

The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the bar be higher, consistent with the streamlined eligibility and enrollment process envisioned by current law. For example, in cases such as birth, denial of Medicaid or CHIP, or loss of Medicaid or CHIP eligibility, SEP applicants' coverage should not be pended. Instead, their attestation should be accepted with eligibility verified afterward in order to ensure continuity of their health care and coverage. Further, we seek clarification about the timeline for building effective electronic verification systems and recommend that there are strong manual systems in place should electronic verification not be ready by June 2017 or should electronic verification not work for all consumers. It is also critical that marketplaces, not issuers, should continue conducting SEP verification, consistent with the law.

We also appreciate the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process. One strategy the Administration should use is to conduct robust outreach through email and calls to consumers who have not yet completed the process. The federal government should also again require issuers and health plans to automatically provide individuals with certificates of creditable coverage when coverage ends and upon request.[9] Loss of prior coverage is the main reason individuals apply for a marketplace SEP, but documenting this can be challenging. It would be unfair to require people to submit proof of past coverage in order to access an SEP – and delay their coverage in the meantime – without providing them a way to easily obtain that proof.

Continuous Coverage

According to the preamble, the Administration is considering various proposals that could be established that would "promote continuous enrollment in health coverage" without gaps and discourage people from "waiting until illness occurs to enroll in coverage."

One idea discussed would require individuals applying for a special enrollment period to show they have had health coverage for significant period of time (perhaps six to 12 months) without a gap of more than 60 days and then to be denied access to coverage through an SEP if they can't show they have had "continuous coverage." Another example discussed is a requirement that individuals who are not able to provide evidence of prior "continuous coverage" without a gap could face insurer practices – such as a waiting period before benefits begin or a late enrollment penalty—that have not been allowed in the individual market since enactment of the ACA. These ideas would serve as impediments to people getting coverage, overburden consumers, and would conflict with current law.

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[9] This federal requirement was ended by regulation in 2014.

Unless legislation changes the guaranteed availability requirements of the ACA, issuers still generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. There is no basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty (through the ACA's individual mandate). It is unfair to create another penalty that would withhold future coverage because a person has been uninsured. Imposing a waiting period on some consumers' benefits or making them wait "at least 90 days" for their coverage to be effectuated is completely inconsistent with guaranteed availability. Late enrollment penalties or surcharges conflict both with guaranteed availability and the requirement that premiums vary only based on certain specified factors; whether a person has been uninsured in the past is not an allowable rating factor, for example.

The ideas suggested in the preamble would also inflict serious harm on many consumers. Breaks in coverage are fairly common today, a fact that has been borne out by numerous studies.[10] [11] Imposing late fees, waiting periods before benefits begin, or other barriers to accessing coverage mean that some people will not get the coverage or the health care services that they need. Current law already has restrictions that protect against adverse selection: limiting enrollment to specified periods and the individual mandate penalty are two examples. In addition, the proposals floated in the preamble would likely reduce overall enrollment in coverage, particularly among healthier people. Therefore, the ideas floated here actually raise the risk of making the risk pool worse and health coverage less affordable overall. To truly promote continuous coverage, an open and accessible system – not a closed and onerous one – is needed to ensure that people successfully obtain coverage when they are first eligible and maintain it over time. The process for changing coverage should be as smooth and as swift as possible, and the government should avoid placing harmful restrictions on people's ability to make these transitions successfully – particularly in ways that conflict with the law.

Levels of Coverage (Actuarial Value) (§156.140)

We strongly oppose the proposal to broaden the allowed de minimis variation in actuarial value (AV) for each plan metal level to -4/+2 percent. This policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

[10] Some 36 percent of Americans ages 4 to 64 (89 million people) went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once, according to a study by the Commonwealth Fund: http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance

[11] Nearly one-quarter of people with pre-existing health conditions (31 million people) experienced at least one month without health coverage during 2014, according to data from the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[12]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[13]

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today or purchase coverage with hundreds to thousands of dollars in higher cost-sharing- either way they will have to pay much more for coverage and care.

The preamble of the proposed rule even acknowledges the harm that many consumers will experience, stating: "*A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government,"* and *"The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risk associated with high medical costs.*"

The administration should not proceed with a policy that will knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current de minimis actuarial value requirement of -2/+2 percent be maintained for all metal levels. We note that a broader level of variation is no longer de minimis and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare different plan options and also to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

If the administration is insistent on pursuing a policy to allow for lower value plans, however, we strongly urge that such change be limited to bronze level coverage. We strongly disagree with the assumption that the remaining uninsured are only looking for coverage with lower premiums,

[12] Lydia Mitts, Caitlin Morris, and Liz Hagan, President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense, (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.
[13] Aviva Aron-Dine and Edwin Park, Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

as many people, including young adults, report being just as concerned about high cost-sharing.[14] Our HelpLine has received calls from many consumers who initially select a plan based on lower premiums, only to later regret the choice when they face unexpected costs as a result of the higher cost-sharing levels of the plan they selected versus an alternative. As such, we are skeptical that reducing the floor of bronze coverage offered in the marketplace will attract a large number of new enrollees. However, if the premise of this proposed policy change is to expand marketplace offerings to include more barebones coverage than is currently available on the marketplace, lowering the minimum actuarial value for only bronze level coverage achieves that and does so without undercutting vital financial assistance.

Network Adequacy (§156.230)

Since our founding in 1988, CAHC has advocated for adequate provider networks that allow coverage enrollees to get the care they need, when they need it. A common complaint of both Democratic and Republican officials, including in Speaker Ryan's 2016 health care plan "A Better Way," is that provider networks are sometimes too narrow to meet consumers' needs.[15] If the Administration aims to promote adequate provider networks,[16] implementing the proposed rule will not achieve that goal, but will result in narrower networks.

Instead of HHS continuing to do its job to protect consumers from bait and switch products that can't fulfill guarantees to deliver access to care, under this rule the agency shirks its responsibilities and claims state oversight can ensure network adequacy. But currently, nearly half of states have no metrics in place to assess whether marketplace plans provide adequate networks.[17] This rule will gut the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allow states that have no adequacy metrics to maintain authority for provider network review.

This rule would take the health care system backwards in time to 2014, before HHS implemented critical network adequacy reviews that currently protect patients. The rule fails to describe how consumers' access to providers will be impacted by the removal of federal network adequacy review. We are interested in understanding how HHS will ensure consumers have the same or better access to providers in all states if this proposal is implemented.

We urge HHS to maintain the implementation of §156.230 as it stands now, as proposed changes to defer to state oversight will result in insurers selling health plans that do not include sufficient numbers and types of providers to serve enrollees. The proposed changes to network adequacy would jeopardize the health and financial security of consumers and we urge HHS to reject them.

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[14] Liz Hamel, Jamie Firth, Larry Levitt, Gary Claxton and Mollyann Brodie, Survey of Non-Group Health Insurance Enrollees, Wave 3 (Washington, DC: Kaiser Family Foundation, May 20, 2016), available online at http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/ and Kara Brandeisky, Why Millennials Hate Their Least Expensive Health Care Option, Time Magazine (Dec 8, 2014), available online at http://time.com/money/3614626/millennials-health-insurance-high-deductible/.

[15] Speaker Paul Ryan, A Better Way (Washington, DC: U.S. House of Representatives, June 2016), available online at: https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

[16] Claire McAndrew, Network Adequacy 101 (Washington, DC: Families USA, October 2014), available online at: http://familiesusa.org/product/network-adequacy-101-explainer.

[17] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

Essential Community Providers (§156.235)

Like section 156.230, section 156.235 will narrow networks for consumers. This section decreases FFE insurers' accountability to include in their networks Essential Community Providers (ECPs) — those that serve predominately low-income, medically underserved individuals. This section is a giveaway to insurance companies, which under the proposed rule will be allowed to travel back in time to 2014 and only contract with a measly 20 percent of ECPs in their service area.

Page 10996 of the proposed rule describes the impact of this section directly, showing that consumers will bear burdens so that insurers can cut corners:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

While Maine has met the federal standard, some states such as Connecticut and Montana, and their participating issuers, have achieved far higher ECP inclusion benchmarks.[18] This proposed modification for ECP inclusion in FFE networks signals that HHS and the Administration overall lack commitment to vulnerable marketplace enrollees and to network adequacy. We urge rejection of a change in the ECP standard to 20 percent and instead recommend increasing the threshold over the next 3 years until it reaches 75 percent.

Finally, we are appalled by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30,60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations; many affected parties will likely be unable to weigh in with comments.

Submitted by:

Consumers for Affordable Health Care, Maine

March 7, 2017

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[18] Cristina Jade Peña, Laurie Sobel, and Alina Salganicoff, Federal and State Standards for "Essential Community Providers" under the ACA and Implications for Women's Health (Washington, DC: Kaiser Family Foundation, 2015), available online at: http://kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca- and-implications-for-womens-health/.

Comment separator page. Next comment follows.

POLICY & ACTION FROM CONSUMER REPORTS

March 7, 2017

Tom Price, Secretary
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attn: CMS-9929-P
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-9929-P: Patient Protection and Affordable Care Act; Market Stabilization

Dear Secretary Price,

Consumers Union, the policy and mobilization arm of Consumer Reports,[1] has long advocated for access to high quality, affordable, healthcare and health coverage. Over the past seven years alone, Consumers Union provided feedback to HHS on the many of the proposed rules associated with the Patient Protection and Affordable Care Act (ACA).

The Congressional Budget Office estimates that for 2017, 31 million people under 65 will have obtained coverage under the ACA: 12 million through the Medicaid expansion, 10 million through non-group coverage from Marketplaces, 8 million through non-group coverage off the Marketplaces, and 1 million through the Basic Health Plan.[2] Thus, a large proportion of those who obtained coverage did so by accessing comprehensive benefits through the individual market -- making it a true lifeline. This lifeline depends upon stability in the insurance marketplace. Yet we believe that the current assertions of instability in the non-group market arise in large part from the uncertainty created by the current efforts to repeal the ACA. Furthermore, as explained below, we have concerns that many aspects of this proposed rule -- rather than enhancing stability -- will further deteriorate it.

We believe the NPRM will not achieve its stated purpose, which is as follows:

> *The provisions in this proposed rule aim to improve the health and stability of the Exchanges. They provide additional flexibility to issuers for plan designs, reduce regulatory burden, seek to improve the risk pool and lower premiums by reducing gaming and adverse selection and incentivize consumers to maintain continuous coverage. Issuers would experience a reduction in costs related to network adequacy reviews. Through the*

[1] Founded in 1936, Consumer Reports is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. Using more than 50 labs, its auto test center, and survey research center, the non-profit organization rates thousands of products and services annually. Consumer Reports has over 7 million subscribers to its magazine, website, and other publications. Its policy and advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and the marketplace. This division employs a dedicated staff of policy analysts, lobbyists, grassroots organizers, and outreach specialists who work with the organization's more than 1 million online activists to change legislation and the marketplace in favor of the consumer interest.

[2] The Congressional Budget Office, *Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage*, Jan. 2017, available at https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf.

> *reduction in financial uncertainty for issuers and increased affordability for consumers, these proposed provisions are expected to increase access to affordable health coverage. Although there is some uncertainty regarding the net effect on enrollment, premiums and total premium tax credit payments by the government, we anticipate that the provisions of this proposed rule would help further HHS's goal of ensuring that all consumers have quality, affordable health care and that markets are stable and that Exchanges operate smoothly.*

In fact, we believe the rule will have the contrary effect. The cost reductions and regulatory simplifications set forth in this proposed rule accrue mainly to the benefit of issuers, while the bulk of the costs and impediments to access will be borne by consumers. The stated purpose acknowledges "some uncertainty regarding the net effect on enrollment, but all signs in fact point to reduced enrollment in the Exchanges due to additional hurdles for consumers, including both healthy ones and those who know they need care. We detail our concerns below.

Initial and Annual Open Enrollment Periods (45 CFR §155.410(e))

In its prior rulemaking, HHS established an open enrollment period for 2018 that mirrors the current 2017 open enrollment period of 92 days (November 1 through January 31). In this proposed rule, HHS suggests cutting that period in half, shortening it to just 45 days, for open enrollment for the 2018 benefit year (November 1 to December 15, 2017). Consumers Union respectfully opposes this change, as described below, due to its likely harm to consumers and reduction in the number of people enrolling; the harm it will do to the quality of the risk mix, and thus to premiums; and the damage it would do to the operational functions of exchanges and insurers in this time of uncertainty for both consumers and the individual market.

As changes to the ACA are debated, we urge HHS to maintain the current open enrollment time frame of November 1 through January 31 for the 2018 benefit year. Moreover, due to the current dynamic policy environment, Consumers Union also urges HHS to revisit its prior decision to shorten the open enrollment period beginning with the 2019 plan year. Careful analysis should be performed to better understand the potential impact for individual market enrollment and risk mix of any transition to a shorter open enrollment period, and to balance it against any perceived benefits to shortening the enrollment period.

The proposal does damage to the risk mix, enrollment levels, and premiums: There is substantial evidence that shortening the enrollment period would negatively impact consumers' ability to enroll; overall enrollment numbers; the health of the risk mix; and premiums.

A healthy risk mix is essential to the stability of the individual market and to minimizing premium increases. A shorter open enrollment period would have an especially strong, adverse impact on enrollment of the most sought-after healthy cohort of consumers, including young adults, as illustrated below. Reducing their enrollment numbers would create a less healthy risk mix in the individual market and higher premiums for all enrollees. In many exchanges, a significant share of total open enrollment sign-ups occur in the *last month* of open enrollment.

The experience in California, a state in which Consumers Union has a strong presence and history working on behalf of consumers, is instructive. At that state's Exchange Covered California during open

enrollment for plan year 2017, **39 percent of new enrollments came in January 2017**. The share of **young adults increased as a percent of total plan selections from 35 percent in the first week to 41 percent in the final week**. Moreover, younger enrollees (ages 18-34), who constitute a critical demographic for ensuring a healthy risk mix, tend to have risk scores well below the average. The data from Covered California's 2016 open enrollment period (11/1/2015-2/6/2016) indicate that there was a steady **increase in the health status of enrollees throughout the open enrollment period**. For example, during the first three weeks of the 2016 open enrollment period, the average risk score was 1.02 and **in the final three weeks of the 2016 open enrollment period, the average risk score fell to .93**. Those with lower risk scores have a lower propensity to use medical care.

Thus, continuing the longer enrollment period through January 31 would help ensure a healthier risk mix and lower medical costs, which would tend to suppress premiums for 2018. Conversely, shortening the period to December 15, would damage the risk mix and lead to increased premiums for all.

The proposal would add to both consumer confusion and financial burden: While the preamble states HHS' belief that issuers and exchanges are ready for a transition to a shorter open enrollment period, we believe that consumers are not. Consumers still tend to be confused about open enrollment as a concept and about the precise timing.[3] Thus, the longer current time period is important to allow time for intensive outreach and education.

Moreover, Consumers Union believes that shortening open enrollment to end it on December 15 would put an intensive financial burden on consumers. Affordability is the number one concern of potential enrollees. End of year and holiday expenses will mean that new enrollees may have trouble making their first premium payment in December for January coverage during the season when family finances are tightest. This could lead to lower enrollment by forcing potential enrollees to decide between immediate, family needs and a health insurance premium for the coming year. Many consumers will likely opt for the former.

The experience at Covered California, for example, shows that enrollment tends to slow down in December, with many consumers preoccupied with holiday planning, travel and family gatherings. In contrast, as noted above, Covered California has experienced a *surge* in enrollment in the final days of open enrollment in January.

The operational implications of abbreviating the enrollment period are problematic: While there may be some operational benefits for issuers in shortening the open enrollment prior to the beginning of the plan year, Consumers Union believes those benefits are far outweighed by the operational risks of the very abbreviated proposed 45-day period. This shortened period will seriously destabilize the market as enrollees are confused by the process and fail to obtain coverage by the deadline. In addition, operational complications for consumers, as well as exchanges and agencies on the federal and state levels, will likely result if the open enrollment period is shortened, such as:

[3] Bianca DiJulio, Jamie Firth, Ashley Kirzinger, and Mollyann Brodie, *Kaiser Health Tracking Poll: January* 2016, The Henry J. Kaiser Family Foundation, Jan. 28, 2016, available at http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-january-2016/ (according to the January 2016 poll, just 15 percent of the uninsured could state the correct open enrollment deadline. The majority (57 percent) of the uninsured said they don't know the deadline and small shares incorrectly believed the deadline was some other time in 2016 than it actually was (16 percent)).

- Longer wait times at call centers as consumers struggle to get information; this will compound the drop-off of healthier individuals, who are the least motivated to persevere in seeking coverage since they lack the urgency of felt medical needs.
- Slowdowns in eligibility and data verification capacity in such a condensed time period.
- Enrollment assistance shortages as community-based assisters and agents alike will be busy with Medicare open-enrollment during this same timeframe, as well as with small businesses that have short year-end open-enrollment periods.

There should be additional flexibility for States: If HHS does finalize the abbreviated proposed rule on the open enrollment period, Consumers Union strongly urges HHS to provide state-based Marketplaces the flexibility to set their own open enrollment periods as long as they span, at minimum, the federal open enrollment period. Covered California, for example, has successfully operationalized the current November 1-January 31 open enrollment period. Changes to it would cause confusion for California consumers and assisters, and administrative burden for all stakeholders. We thus urge you to allow states that wish to establish longer enrollment periods than any federal floor to do so.

Special Enrollment Periods (45 CFR §155.420)

As the preamble notes, Section 1311(c)(6)(C) of the Affordable Care Act states that the Secretary is to provide for special enrollment periods (SEPs) specified in section 9801 of the Code and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Act. Section 2702(b)(3) of the PHS Act also directs the Secretary to provide for market-wide special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. Special enrollment periods are also a longstanding feature of employer-based coverage. Specified qualifying events under the ACA for enrollment in Marketplace plans, and changes of plan, outside of the annual Open Enrollment Period include significant life events such as divorce or marriage; birth or adoption of a child; permanent moves to a new region; and loss of minimum coverage, including loss of Medicaid eligibility.

Pre-enrollment verification requirements: The preamble notes that the proposed regulation would impose new pre-enrollment verification requirements of special enrollment qualifying events starting in June 2017, in response to strong issuer requests. HHS estimates that this rule would result in pre-enrollment verification for an additional 650,000 individuals. For some time, insurers have claimed that consumers are abusing current SEPs, but they have provided no evidence to support their claims. Insurers allege that many people using SEPs are either ineligible for Marketplace coverage, or that they use SEPs to enroll only when they know they need costly medical care, then obtain expensive care and drop coverage once the care is received.

While it is important to guard against adverse enrollment--people enrolling only when they are sick--it is also crucial to remember that the individual market is a residual one, the place people go when they have gaps in coverage, whether from job loss, becoming ineligible for Medicaid, or through other changes in life circumstance, such as divorce. The individual market, thus, has always been subject to short-term,

churning enrollment.[4] It is, and has always been, "gap coverage" for people transitioning into and out of other sources of coverage, such as job-based plans and Medicaid.[5] Since life changes that result in loss of coverage are often unpredictable, it makes sense that they often occur outside the narrow window of open enrollment.

There is reason to believe that the real problem regarding SEPs is not over-use, but under-use. According to Urban Institute estimates, fewer than *15 percent of those eligible* for SEPs enroll using them.[6] That means the people using SEPs are likely those most motivated to get coverage — those with medical conditions or who know they'll need medical services in the near future. This explains the higher claims costs among SEP enrollees, not misuse of the system or gaming the documentation rules. Therefore, for a robust risk mix, rather than narrowing the number of people attaining coverage during SEPs, a wiser goal would be broadening the number of people accessing coverage to bring in healthier consumers less motivated to scale documentation hurdles.

Moreover, there is also no validated evidence that SEP enrollees are dropping coverage inappropriately after receiving care. Nor is there data proving that the SEP enrollees who drop their plans soon after enrolling were originally ineligible or have the highest health claims and then become uninsured, as opposed to their simply obtaining other coverage.

CMS' pilot in 2016 tightening documentation requirements for 50% of consumers enrolling in the federal Marketplace during SEPs resulted in a drop in enrollment of 20% over 2015. Notably, younger, presumably healthier, consumers were disproportionately less likely to complete the verification process than older applicants: 73% of applicants age 55-64 completed the process, but only 55% of those 18 to 24.[7] The approach proposed here, further tightening that used in the pilot and applying it to all SEP applicants, thus risks deterring eligible people from enrolling. If, for example, they can't readily obtain needed documentation, they will be left uninsured and without needed health care. Those sturdy enough to overcome the more onerous documentation hurdles and verification process are likely to be even sicker and higher-cost—the most highly motivated to get coverage—contributing to a less healthy pool of enrollees.

The preamble states that HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We strongly support that effort. Due to the low probability of ineligibility in these cases—as validated by insurers—we urge that these applicants be given immediate coverage, and not have their applications pended as proposed. Instead, their self-attestation should continue to be accepted to ensure prompt, continuous access to health care and coverage. Furthermore, any SEP verification should continue to be done by

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[4] Miranda Dietz, Dave Graham-Squire, and Ken Jacobs, *The Ongoing Importance of Enrollment: Churn in Covered California and Medi-Cal*, The UC Berkeley Labor Center, April 2, 2014, available at http://laborcenter.berkeley.edu/the-ongoing-importance-of-enrollment-churn-in-covered-california-and-medi-cal/.

[5] Laurel Lucia, *How Do We Make Special Enrollment Periods Work?*, Health Affairs Blog, Feb. 16, 2016, available at http://healthaffairs.org/blog/2016/02/16/how-do-we-make-special-enrollment-periods-work/.

[6] Matthew Buettgens, Stan Dorn, and Hannah Recht, *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods*, The Urban Institute, Nov. 2015, available at http://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf.

[7] Timothy Jost, *Unpacking The Trump Administration's Market Stabilization Proposed Rule*, Health Affairs Blog, Feb. 16, 2017, available at http://healthaffairs.org/blog/2017/02/16/unpacking-the-trump-administrations-market-stabilization-proposed-rule/.

Marketplaces, not issuers, consistent with the ACA statute. As noted below (under "State flexibility urged"), some states are further along in using or establishing electronic verification systems; they should not be impaired in their ability to do so, for the benefit of their residents.

We appreciate that the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process and urge explicitly prioritizing that goal. One strategy is to proactively reach out via emails and phone calls to consumers who start, but not complete, the process. Another strategy would be for the federal government to again require certificates of creditable coverage from employers (which used to be required under HIPAA) so there is a reasonable way for people to obtain the proof of eligibility. Currently, there is no assurance that individuals will be able to documentary proof of such coverage, much less in the time frame suggested; in some cases, particularly for low-wage workers, applicants' former employers have not provided it upon request. Yet, under the proposed rule, coverage would be delayed and possibly denied for failure to submit such proof.

In summary, the preamble notes that, "it is possible that the additional steps required to verify eligibility might discourage some eligible individuals from obtaining coverage, and reduce access to health care for those individuals, increasing their exposure to financial risk. If it deters younger and healthier individuals from obtaining coverage, it could also worsen the risk pool." Consumers Union believes the evidence strongly points to those as likely outcomes of the intensive documentation proposed for an HHS --estimated 650,000 consumers-- and, therefore, urge HHS not to move forward with this proposal. Rather, we urge you to closely examine the results of your pilot and consult with state Marketplaces about their efforts to glean how to craft a more tailored policy going forward.

Metal tier coverage changes limitations: The proposed rule also suggests limitations on consumers who already have Marketplace coverage from switching metal levels during SEPs. When an enrollee marries or has a child, for example, the enrollee and new spouse or child qualify for an SEP. Under the proposed rule, the enrollee would have to add the new dependent to the enrollee's QHP, or, if that was not possible, to another QHP in the same metal level (or in an adjacent metal level, if no QHP in the same metal level was available). If an enrollee was not enrolled in a silver-level plan, however, and adding the dependent would make the family eligible for cost-sharing reductions, the enrollee could move to a silver-level plan. The complexity imposed by this proposal will make for enormous confusion for enrollees. Moreover, there are circumstances, such as a consumer having an increase in income simultaneous to qualifying for an SEP, in which he may receive a reduced premium credit or lose access to cost-sharing reductions. This warrants the chance to change metal levels if the enrollee chooses. The very triggers that qualify an individual for an SEP—such as marriage or birth of a child—by definition signal major life changes that carry financial as well as medical implications that warrant allowing metal level changes.

Eligibility limitations: The proposed rule also would impose several new limitations on eligibility for SEPs, limitations we believe are unwarranted and would harm consumers. The preamble suggests, for example, allowing issuers to reject SEP enrollments for loss of minimum essential coverage where the applicant *earlier* lost coverage for non-payment of premiums. The consumers who seek coverage in Exchanges are primarily at the lower end of the income scale, with little disposable income. A slip-up in a month's premium payment resulting in loss of coverage does not necessarily foretell behavior on future payments, but may simply be due to an unexpectedly high utility bill. We oppose excluding such individuals from obtaining coverage through an SEP.

The rule also proposes to require that those seeking an SEP based on a marriage prove that one of the partners previously had minimum essential coverage for one or more of the prior 60 days. This is more onerous than the employer market and creates a catch-22, where only those with insurance would be qualified to buy insurance. This proposal may also exceed the statutory requirements.

The rule also proposes a much more rigorous test for future uses of the "exceptional circumstances" SEP, including requiring supporting documentation. There may be situations that cannot be anticipated and for which a remedy allowing consumers an SEP opportunity is justified. The exceptional circumstance category allows State Marketplaces leeway on a case-by-case basis to allow for medical coverage if warranted by unusual facts that do not fit any pre-determined category. We believe the Marketplaces have already shown proper restraint in approving exceptional circumstances cases, and any further tightening of the standard would be inappropriately excessive.

State flexibility urged: At the least, states should be permitted the flexibility to devise their own solutions for verifying SEP eligibility. Some states, such as California, have spent several years intensively meeting with stakeholders, probing the evidence on issuers' assertions about SEP abuses, and developing new protocols and solutions for verifying eligibility. For example, Covered California is conducting a random, statistically significant sampling of the SEP categories issuers claim to be most subject to abuse: loss of minimum essential coverage and permanent moves. And it is making solid progress on electronic verification measures to simplify the verification process. As discussed above, using electronic sources to verify special enrollment qualifying events can streamline the process and avoid the need to rely on outmoded, cumbersome, and prolonged paper document retrieval. Local resources for electronic or other forms of verification may vary greatly; it makes sense to push down to the states the option to use the verification resources at their disposal in order to ensure timely coverage for their residents.

Continuous coverage: The preamble notes that HHS is actively exploring additional policies in the individual market that would promote continuous coverage and seeks input on which policies would effectively do so consistent with existing legal authorities. Policies mentioned include, with respect to SEPs that require evidence of prior coverage, policies for the individual market that would require that individuals show evidence of prior coverage for a longer "look back" period, such as 6 to 12 months. Also mentioned for consideration are HIPAA policies requiring maintenance of continuous, creditable coverage without a 63-day break on penalty of pre-existing condition exclusions and waiting periods. Consumers Union urges HHS not to pursue such policies as they would impede people from getting needed coverage, overburden consumers, and conflict with current law.

Under the ACA, issuers generally "must accept every employer and individual in the State that applies for coverage" during open enrollment and SEPs-- the "guaranteed availability" provision. There is no legal basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty through the ACA's individual mandate. Imposing additional penalties on consumers would be both unfair and contrary to law.

Of course, it is in consumers' interest to maintain coverage. But the reality is that gaps in coverage commonly occur. According to the Commonwealth Fund, more than one-a third of American ages 4-64 went without insurance coverage for at least a month between 2004 and 2007, and about one-quarter lost

coverage more than once.[8] This has lead researchers to counsel that "the uninsured" should not be considered a static cohort, but rather that we should think of uninsurance as a fluid state in which gaps occur for many.[9] The ACA recognizes this by aiming to create a system for continuous coverage with an accessible, residual individual market, while protecting against adverse selection through various steps including open and special enrollment periods and the individual mandate penalty. The best way to foster continuous coverage is not by placing further financial and other penalties and complex rules on consumers, steps that impose greater hardships on consumers, but to create as seamless a process as possible that will allow for smooth transitions to avoid gaps.

Levels of Coverage (Actuarial Value) (45 CFR §156.140)

Consumers Union opposes the proposed changes to the actuarial value (AV) of the metal levels, which would be harmful to consumers. De minimis variations permitted to date have been defined as +/- 2 percent--leeway aimed at recognizing that with a wide variety of plans and underlying cost variability, it is difficult to hit precise actuarial numbers for each of the metal tiers. The stated aim of the proposed re-definition of de minimis variation as -4/+2 percentage points (for all metal level plans except for bronze plans which could vary from -4/+5), is to lower premiums. Our concern is that it would result in products with a lower premium, but higher cost-sharing. Moreover, it would result in more variation amongst products in a given metal tier, making it difficult for consumers to compare plans within the same metal level.

This adjustment in de minimis variations could also adversely affect advanced premium tax credits (APTCs), creating a "race to the bottom" if silver plans adopt a 66%, rather than 70%, AV. Since the APTC is calculated using the difference between the second lowest cost silver plan premium and the applicable percentage of the enrollee's income, allowing issuers to offer a less generous silver plan would reduce the value of the APTCs. Almost 90% of enrollees rely on APTC's to afford their coverage. Consumers would be forced to choose between a plan with lower premiums but higher out-of-pocket costs, such as a Bronze plan, or a plan with higher premiums and lower out-of-pocket costs. Either way, the consumer would pay more out-of-pocket (either through premiums or cost-sharing). For example, the Center on Budget and Policy Priorities found that a family of four with an income of $65,000 would either pay $327 more a year in premiums or face a $550 increase in their deductible if they chose a 66 percent AV plan.[10]

The preamble of the proposed rule plainly acknowledges the harm that many consumers will experience under this rule,stating: "A reduction in premiums would likely reduce the benchmark premium for

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[8] Pamela Farley Short, Deborah R. Graefe, Katherine Swartz, and Namrata Uberoi, *New Estimates of Gaps and Transitions in Health Insurance*, The Commonwealth Fund, Aug. 3, 2012, available at http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance; *see also*, Joseph Sudano and David Baker, "Intermittent Lack of Health Insurance Coverage and Use of Preventive Services," *American Journal of Public Health*, Volume 93, Number 1 (2003).

[9] Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Volume 22, Number 6 (2003).

[10] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions Of Moderate-Income Families*, The Center for Budget and Policy Priorities, Feb. 15, 2017, available at http://www.cbpp.org/sites/default/files/atoms/files/2-15-17health.pdf.

purposes of the premium tax credit, leading to a transfer from credit recipients to the government, " and "The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of- pocket expenses, thus increasing their exposure to financial risk associated with high medical costs."

The Administration must not adopt such a policy that would increase out-of- pocket costs and erode financial assistance for lower- and moderate-income consumers. We strongly recommend that the current de minimis actuarial value requirement of -2/+2 percent be maintained for all metal levels. We believe that a broader level of variation is no longer de minimis and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare plan options and also to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

Consumers already have access to plans at a wide variety of price points in the exchanges. Therefore, there are no gains for consumers to counteract the consumer harm from reducing the certainty associated with metal tier coverage and the threat to their critical tax credit subsidies.

Network Adequacy (45 CFR §156.230)

Consumers Union opposes the proposal to revert to the pre-2014 standard of reliance on state oversight. The standard currently set forth in Section 156.230(a)(2) provides a simple but sound floor for provider networks: it requires a QHP issuer to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all covered services will be accessible without unreasonable delay. The current federal standard was created largely to respond to persistent concerns about narrow network plans. To regress to the earlier standard would be to purposefully backtrack on advances in consumers' access to healthcare providers.

Currently, nearly half the states have no network adequacy standards and state network adequacy requirements often only apply to certain types of network designs, such as HMOs but not PPOs..[11] This rule would diminish the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allows states without sufficient metrics to maintain authority for provider network review. Relying on an issuer's accreditation by an external entity - typically self-attestation that networks are adequate -- is not comparable to government oversight. To wit, study after study has found error rates in provider directories of up to 50%[12]; in some health plans in Texas, up to 50% of in-network hospitals are not served by *any* in-network emergency room doctors (thus guaranteeing a surprise out-of-network bill).[13]

By weakening federal network adequacy standards, particularly in the majority of states lacking either the authority or capacity to conduct sufficient network adequacy reviews, we are concerned that the proposed

[11] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks*, The Commonwealth Fund, May 2015, available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

[12] Consumers Union Healthcare Value Hub, *Network Adequacy: Resources for Advocates*, available at http://www.healthcarevaluehub.org/events/network-adequacy-webinar-resources/#ProviderDirectory (last visited Mar. 7, 2017) (contains a list of studies detailing problems in current Provider Directories).

[13] Stacey Pogue, *A Texas-Sized Problem: How to Limit Out-of-Control Surprise Medical Billing*, The Center for Public Policy Priorities, Feb. 2017, available at http://forabettertexas.org/surprisebills/img/2017_HW_SurpriseMedBill.pdf.

rule will ultimately limit consumer access to providers and prevent consumers from meaningfully distinguishing among plan networks at the point of plan shopping.

The preamble recognizes the uncertainty for consumers created by this rule stating, "Issuers could potentially use network designs to encourage enrollment into certain plans, exacerbating selection pressures. The net effect on consumers is uncertain." We believe the effect is certain given our nation's significant experience with often inadequate state oversight of plan networks. Consumers Union urges HHS to maintain the implementation of §156.230 as it stands now in order to provide a strong floor of protection for consumers and to ensure timely access to providers so as to receive covered benefits.. The ongoing gaps in standards at the state level and prior experience, relying on accreditors would jeopardize the health care and financial security of consumers. We urge HHS to reject this proposed change in oversight.

Essential Community Providers (45 CFR §156.235)

Consumers Union urges HHS to maintain the current requirement that a plan's provider network contain at least 30% of available essential community providers (ECPs), rather than the proposed reduction to 20%. Reducing the minimum ECP requirement from 30% to 20% will result in decreased consumer access to ECPs, which include providers who serve predominantly low-income, medically underserved individuals and those who predominantly provide specialty services (such as children's hospitals). Even under the existing 30% standard, consumers struggle to access ECPs; reducing the ECP requirement will exacerbate this problem.

The preamble acknowledges that consumers' access to care will suffer under this rule, so that insurers can avoid contracting with ECPs:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

It further states that the rule would result in "decreased quality of medical services (for example, reductions in continuity of care due to lower ECP threshold)." In addition to the negative impact on consumers' care, the proposed change appears to be unnecessary. In the preamble, HHS notes that only six percent of issuers failed to meet the 30% ECP threshold for the 2017 plan year and, of these, all were able to justify why they failed to meet this threshold. Lowering the threshold would encourage the 94% who currently meet the standard to lower their inclusiveness. Since the vast majority of issuers—94%—were able to meet the current ECP standard for 2017, this change is unnecessary and unjustified. We urge that current 30 percent standard be maintained.

On behalf of Consumers Union, I appreciate this opportunity to provide input on this proposed regulation. We look forward to working with the Administration to develop steps that will truly create a health risk pool, stabilize the market, and ensure full access to affordable coverage and care for all Americans.

Sincerely,

Elizabeth M. Imholz

Director of Special Projects

Consumers Union

Comment separator page. Next comment follows.

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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March 7, 2017

The Honorable Tom Price
Secretary
Department of Health and Human Services
Attention: CMS–9929-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Patrick Conway
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; Market Stabilization (45 CFR Parts 147, 155, and 156; CMS-9929-P)

Submitted Electronically

Dear Secretary Price and Acting Administrator Conway:

On behalf of the Council for Affordable Health Coverage (CAHC), I would like to thank you for the opportunity to submit comments on the Market Stabilization Proposed Rule (Proposed Rule), published by the Centers for Medicare & Medicaid Services (CMS) on February 17, 2017, which proposes various policies meant to stabilize the individual and small group markets.

CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests – organizations representing small and large employers, manufacturers, retailers, insurers, patient groups, and physician organizations.
Our full membership list is available on our website at www.cahc.net.

CAHC generally supports many provisions in the Proposed Rule, particularly the various areas seeking to shore up markets by curtailing system gaming and creating greater plan flexibility. The proposed policies strike the proper balance between preserving needed consumer protections and access while helping foster risk pool health and permitting greater choice and flexibility in benefit design.

While we appreciate many of the policies presented in the Proposed Rule, there are still numerous additional policies that impose unnecessary and costly restrictions on plans and harm markets. Rather than benefiting consumers, these policies pose serious harm to consumer access by undermining market stability, increasing premiums, and limiting choice and access. We urge you to consider adopting additional policies that could promote similar goals for market stability and consistent consumer access in the Final Rule as well as any other regulations that affect future plan years.

Our comments and recommendations for overall market stabilization policies and specific areas of the Proposed Rule are below. The following comments reflect the positions of the Coalition, but may not necessarily reflect the individual views of our members.

Grace Periods

CAHC supports monitoring and limiting the use of grace periods to prevent system gaming. Under current law, enrollees using subsidies to obtain coverage have a 90-day grace period where coverage cannot be rescinded for failure to pay premiums as long as coverage was initially effectuated. Evidence has shown that a disproportionate number of enrollees are halting premium payments toward the end of the year, yet a majority of individuals who cease to pay premiums enroll in coverage during the new open enrollment period.[1] Current policy merely serves to undermine the integrity of the marketplace and drive up costs for enrollees who pay their fair share.

In a similar vein, CAHC supports the proposed policies that allow issuers to collect outstanding premium balances from enrollees for previous plan years before effectuating cover for the current plan year. We also support providing issuer flexibility to determine whether to institute an owed premium threshold policy before effectuating coverage, so long as the threshold is applied uniformly. We do not believe a threshold below the full outstanding balance should be imposed on issuers, however.

We are also in favor of proposed policies that reject special enrollment periods (SEPs) for consumers who have a record of termination of coverage due to non-payment of premiums. There is no logical reason for an individual to qualify for an SEP due to loss of minimal essential coverage because of non-payment of premiums. Such a qualification would clearly run counter to the congressional intent of the purpose of instituting SEPs.

Special Enrollment Periods

We are pleased that CMS has recognized the need to refine the special enrollment process and definitively verify eligibility for SEPs by implementing universal prospective eligibility determination. SEPs serve a valuable role in helping individuals who lose health coverage during the year or who experience major life changes to maintain continuous coverage – but it is equally important for the stability of exchange plan risk pools and premiums to ensure that SEPs are not misused or abused.

Under current law, determination of eligibility for an SEP is retroactive since individuals can obtain coverage through an SEP before they have proven their eligibility. As a result, ineligible individuals have been able to generate significant claims costs before CMS completes the verification process to determine whether coverage was appropriately obtained through the SEP. There is concern that the policy may be widespread as claims costs for SEP enrollees are higher, on average, than individuals who enroll in open

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[1] Center for U.S. Health System Reform. (2016, May), 2016 OEP: Reflection on enrollment. McKinsey&Company. Retrieved from: http://healthcare.mckinsey.com/sites/default/files/McK%202016%20OEP%20Consumer%20Survey%20Infographic_vF.pdf?mc_cid=15afa5ee8f&mc_eid=8eecfe3a1a

enrollment periods.[2] In their first month of coverage alone, SEP enrollees were much more likely to generate large claims in 2015 than traditional enrollees.[3] As a result, plans can be exposed to millions of dollars in inappropriate claims. Once claims are paid for an individual, it is both unlikely and costly to recoup those funds, even if consumer ineligibility or fraud is determined later.

We, therefore, applaud CMS' efforts to institute a prospective enrollment policy and do not believe the policy should cause a significant burden or delay in access to care for enrollees, as long as coverage is retroactive to the enrollment eligibility date and processes for obtaining in-network care and filing claims are clearly presented to consumers.

CAHC generally supports measures that ensure that potential enrollees are not gaming the system and that special enrollment periods are used as policy makers intended – as means to access coverage under special, limited circumstances, not avenues for enrollment that undermine individual responsibility for obtaining coverage and the marketplaces generally. This includes using a "more rigorous test for future uses of the special circumstances special enrollment period," limiting the ability to change to a plan with a higher metal tier when switching exchange plan coverage through an SEP, and instituting proof of continuous coverage for some SEPs.

Actuarial Value and Network Adequacy

CAHC is broadly supportive of enhanced flexibility in benefit design. Both statute and regulation have dictated coverage levels and benefit and network design with broad secretarial discretion for how these provisions should be implemented. The previous Administration adopted narrow bands for AV variation and had relatively strict standards for benefit designs and network adequacy requirements. We support efforts to provide additional plan flexibility, which can help lower costs and increase plan choice for consumers. We suggest adding additional flexibility in the essential health benefit benchmark and approval process, however. We also suggest diverting more regulatory authority and reducing regulatory duplication by deferring review to states for all aspects of benefit and rate review, not just network adequacy as is proposed. Additional comments on these policies are discussed below.

Additional Suggestions

While CAHC values CMS' various proposed market stabilization measures, we are concerned that many of these policies will not be sufficient to improve plan participation and access to affordable health choices in 2018. We strongly believe congressional action will be necessary to achieve these goals, but we also recommend enacting additional changes that can help to improve markets and inject greater competition, choice, and value into the marketplace. These changes include:

- *Creating additional pathways for consumer enrollment.* Consumers face numerous decisions and complexities when determining coverage needs and evaluating available options. Consumers who use agent, broker, or issuer assistance to learn about options and help with coverage decisions in

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[2] Pear. R. (2016, January 9). Insurers say costs are climbing as more enroll past health act deadline. *The New York Times.* Retrieved from: http://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=_

[3] Pear. R. (2016, January 9). Insurers say costs are climbing as more enroll past health act deadline. *The New York Times.* Retrieved from: http://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=_

an online format – also known as web-based entities (WBEs) – are currently required to leave the WBE site, complete an eligibility determination on HealthCare.gov, and then return to the WBE's site to complete the enrollment process. This so-called "double redirect" serves no consumer-focused purpose and results in significant enrollment attrition. The convoluted process may also lead many consumers to believe they have completed enrollment even if they have not. Case studies have estimated that 69 percent of consumers facing the double redirect fail to complete eligibility determination and enrollment.[4]

Prior to March 2016, WBEs were able to utilize a more streamlined process that shielded consumers from the confusing double redirect. With this process, WBEs could enroll consumers in coverage on their websites using the Direct Enrollment Agent Pathway (DEAP) where consumers could complete the standard, uniform federal eligibility application directly on the WBE's site. A live agent or broker could then connect with the consumer and transmit the information from the application onto HealthCare.gov where they would receive the eligibility determination and then assist the consumer in finalizing enrollment. This method was effective for enrollment in 2015 and 2016, but language included in the final Notice of Benefit and Payment Parameters (NBPP) for 2017 effectively eliminated the DEAP as an online enrollment option by prohibiting WBEs from utilizing eligibility applications directly on their websites and transmitting the information to HealthCare.gov.[5]

The next plan year would be positively impacted by the reinstatement of the DEAP as enrollment rates through these avenues would likely considerably increase – as much as 78 percent.[6] Evidence also indicates that younger enrollees are more likely to use these alternative platforms.[7] Therefore, regulations prohibiting the DEAP should be reversed immediately, and WBEs should be allowed to enroll consumers and host eligibility applications on their websites without the forced double redirect. The increased enrollment likely to result from this change can help to shore up risk pools with significantly less cost to taxpayers.

We also urge the Administration to focus efforts on instituting Enhanced Direct Enrollment where consumers could complete the entire plan selection and subsidy application process on a WBE site while eligibility information is communicated with government servers entirely on the back-end. A similar process has been proposed for the past three NBPPs, but never implemented. Current policies are hand cuffing the private sector and consumers are unable to access their full benefits

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[4] Linked Health. (2015). Direct enrollment: Not as simple as it sounds. Retrieved from: http://www.linkedhealth.com/DE_casestudy.pdf

[5] CMS–9937–F; 45 CFR Part 155; 155.220(c)(1): "Web-brokers must continue to comply with the current direct enrollment process, through which a consumer is directed to HealthCare.gov to complete the eligibility application, and all associated guidance. This means direct enrollment entities are not permitted at this time to use non- Exchange Web sites to complete the Exchange eligibility application or automatically populate data collected from consumers into HealthCare.gov through any non-Exchange Web site. Completion of the Exchange eligibility application on a non-Exchange Web site, or collection of data through a non- Exchange Web site that is then used to complete the eligibility application, will be considered a violation of the direct enrollment entity's agreement with the FFEs."

[6] Tsao, T. (2017, February 16). Leveraging private marketplaces like eHealth to innovate consumer ecommerce experiences for health insurance. eHealth. Retrieved from: http://cahc.net/wp-content/uploads/2017/02/01_CAHC-Briefing_Tom-Tsao_2-16-17.pdf

[7] Tsao, T. (2017, February 16). Leveraging private marketplaces like eHealth to innovate consumer ecommerce experiences for health insurance. eHealth. Retrieved from: http://cahc.net/wp-content/uploads/2017/02/01_CAHC-Briefing_Tom-Tsao_2-16-17.pdf

when it comes to plan selection. The Administration should act to reverse this trend as soon as possible.

- *Reducing unnecessary regulatory burdens and uncertainty.* The current regulatory certification process for health plans is cumbersome, complex, and expensive. Prior to enactment of the Affordable Care Act (ACA), health plans were primarily regulated on the state level. Today, plans sold in the individual market are regulated at both the state and federal level, with some state-based exchanges requiring additional requirements and oversight. Duplicative information must often be approved by multiple regulatory bodies – which frequently provide conflicting guidance or requested changes – over the course of several months. Such a system is highly inefficient and costly with almost no benefit to consumers. Rising administrative costs lead to premium increases, particularly since the percentage of premiums that can go toward administrative expenses is capped. CAHC urges CMS to immediately shift more regulatory power to states by deferring benefit, rate, and network adequacy review to them.

  Uncertainty in the regulatory environment has also contributed to higher costs and instability in the market. Regulatory uncertainty has been a constant of ACA implementation with both final rule-making and subregulatory guidance changing the rules of the game after market decisions and rate determinations have already been made. This seriously undermines stability and makes it difficult to accurately evaluate markets.

  CAHC urges the new Administration to release rules in a timely manner with adequate notice and opportunities for comment and stakeholder engagement. Duplicative regulation should also be reduced or eliminated whenever possible.

- *Prohibiting third-party payments by providers or other entities to help consumers enroll in coverage.* Hospitals and other healthcare providers as well as additional commercial entities frequently support premium payments for consumers receiving their care. Many enrollees receiving this assistance have high health care needs. There are significant concerns (even from CMS) that this could skew risk pools and further contribute to unbalanced marketplaces. Insurers have cited third-party payments as a reason for losses on exchanges, which has contributed to market exits.

  CMS has long recognized this as a problem. Former CMS Administrator, Andy Slavitt, has said, "These actions can limit benefits for those who need them, potentially resulting in greater costs to patients, and ultimately increase the cost of marketplace coverage for everyone."[8] While CMS has asked for requests for comment on the practice, discouraged its use, and considered curtailing the practice, it has not prohibited it. CAHC encourages them to do so immediately.

- *Eliminating the promotion of standardized plan designs*. Standardized designs can lead to reduced plan offerings, higher premiums and cost-sharing for certain consumers, and may influence suboptimal plan selection. Beginning in 2016, CMS designed plan offerings where a significant number of benefits were not subject to a deductible. CMS promoted these plans above others on HealthCare.gov, even though they may not have been the most appropriate plan designs for many

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[8] Muchmore, S. (2016, August 18). CMS may crack down on third-party groups that subsidize ACA premiums. *Modern Healthcare*. Retrieved from: http://www.modernhealthcare.com/article/20160818/NEWS/160819912

enrollees. Such designs may unduly influence consumer behavior, further limit the number of tools available to insurers to hold down premiums, and force dramatic increases in cost-sharing for some services to meet AV thresholds. These designs can lead to higher premiums and reductions in access to services for some enrollees.

For the 2018 plan year, the Administration should eliminate standard plans on HealthCare.gov as an anti-consumer, cost increasing regulatory measure. CMS should also change current regulations to prohibit state-based exchanges from either requiring plans to offer standardized plans or prohibiting plans that deviate from standard designs. Such policies not only lead to higher costs but also inhibit consumer choice.

- *Aligning requirements in individual market plans with those for consumer-driven health products.* ACA implementation has restricted access to and undermined the usage of consumer-driven health products. Most exchange plans are not coupled with Health Savings Accounts (HSAs), including most standardized plans being offered this year, even when their deductibles are higher than those in HSA-eligible high deductible health plans (HDHPs). Additionally, ACA regulations have imposed new requirements in the market that are undermining HSA utilization.

  The Internal Revenue Service (IRS) sets upper and lower out-of-pocket limits on HDHPs. Any health plan that has out-of-pocket limits outside this range cannot be coupled with an HSA. These requirements are not aligned with other ACA plan requirements, however, so the number of plans eligible for HSAs is dwindling. For example, out-of-pocket limits for standard individual Bronze and Silver plans for 2017 are $7,150, which is $600 above the $6,550 upper maximum out-of-pocket limit for HSA qualification.[9] [10] For 2017, average annual out-of-pocket maximums for Bronze plans were $6,940 with average deductibles of $6,092.[11] Because of the misalignment in thresholds, individuals enrolled in these polices do not have access to tax-preferred mechanisms that can help cover these high out-of-pocket costs. CAHC firmly believes that consumers should be allowed to avail themselves of current tax-preferred mechanisms to help them maintain access to coverage in plans with high cost-sharing. CMS should work with IRS to align any requirements for individual market policies with those in consumer-driven health products to facilitate their use.

- *Encouraging creativity in network design.* Networks have grown increasingly narrow as a key measure to contain costs. This is particularly true in areas where there is an imbalance in market share between insurers and providers. This has become progressively more common as provider networks consolidate and drive up rates. Rural areas are particularly impacted as they contain fewer providers, making it difficult to both meet network adequacy standards and to negotiate competitive rates. This results in higher premiums and fewer options for everyone, but particularly for rural consumers.

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[9] HealthCare.gov. (Accessed on 2016, January 8). Out-of-pocket maximum/limit. U.S. Department of Health and Human Services. Retrieved from: https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

[10] Miller, S. (2016, May 2). IRS sets 2017 HSA contribution limits: Health savings account annual limit for individuals rises by $50. Retrieved from: https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/irs-sets-2017-hsa-contribution-limits.aspx

[11] InfoStat. (2016, October 26). Aging consumers without subsidies hit hardest by 2017 Obamacare premiums and deductibles. HealthPocket. Retrieved from: https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles#.WHRZrvkrI2x

Over the last several years, state and federal regulators have held insurers to quantitative network design standards (such as time and distance). HealthCare.gov has even explored rating plans based on network breadth alone. This is highly problematic and contradictory to CMS' goal of moving from volume-based reimbursement to a value-based system. Such a rating would provide consumers with no information about the quality of networks and providers, implying that broad networks are better even if the network's providers are lower quality. This creates powerful incentives against innovative network designs such as medical homes or accountable care organizations. The Administration should abandon the network breadth rating and develop a method that would inform consumers about network quality not just breadth.

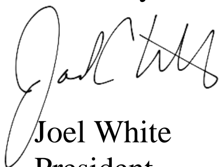
More flexibility should also be granted to plans in designing networks to meet consumer needs. For instance, we believe the Administration should create standards to include telemedicine services for appropriate provider types (such as behavioral health) as part of network adequacy qualifications. Such a policy could improve patient access, serve as a solution to current provider shortages, help patients stay adherent to treatment, and save costs.

Conclusion

CAHC appreciates your careful consideration of our comments and applauds your efforts to stabilize the individual and small group markets. We believe that additional policies should be considered, however. While the additional policy recommendations presented here by no means represent a comprehensive set of solutions, we believe they will help to stabilize and improve markets.

CAHC stands ready and willing as to serve you as you seek to improve the 2018 marketplace and beyond.

Sincerely,



Joel White
President
Council for Affordable Health Coverage

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I do not believe these new rules are necessary and will not help United States citizens access healthcare and medical services. I believe these new rules will impede access to needed services and will cause delays in service provision. The open enrollment period as it stands from November 1, 2017, through January 31, 2018, is adequate and does not need to be limited to 6 weeks. The three-month window allows consumers the time needed to compare plans and decide the appropriate coverage for their health needs. Also, I do not agree with requiring pre-enrollment verification of eligibility for consumers who need to enroll during a special enrollment period. A qualifying event for special enrollment is the loss of a job, the death of a spouse, the birth of a child, or the termination of a student health plan. I do not believe a person should be forced to fill out extensive paperwork to fulfill this requirement or be denied coverage. I believe this paperwork will lead to delays in service and would be detrimental to health and well-being. The requirements as they stand today are sufficient and no additional paperwork should be required. This will burden people who are already under duress, due to a loss of a job, student coverage, or a death of a spouse. Please do not implement this rule, for I believe this requirement will cause harm to those in need of care.

No documents available.

Comment separator page. Next comment follows.

Comments to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, CMS-9929-P

RE: Patient Protection and Affordable Care Act; Market Stabilization

by **Doctors For Change**
Houston, Texas
http://www.doctorsforchange.org/hope/

[3-7-17]

The ACA has greatly improved insurance coverage and access for individuals throughout the nation. The impact was notable in those states with Medicaid expansion. Additionally, funding for public health initiatives was included in the ACA. According to a Commonwealth Fund report released in February 2017, data shows evidence of an economic stimulus from the ACA due to releasing funds from private and public resources for investment directed into jobs and production (Commonwealth Fund 2017). In particular, these reforms also show a significant decrease in health spending growth (Commonwealth Fund 2017).

We agree that improving market stability of the individual market is key as for many the premiums and cost-sharing is unaffordable. We are concerned that the proposed rule is likely to worsen rather than improve the current market. These proposed rule are likely to set up more barriers for the person who is seeking to avail the individual market. By enacting barriers to enroll for these services, we are concerned that these attempts at addressing enrollment may further destabilize the insurance markets rather than make them more viable. In addition, we feel that these proposed rule could result in an increase in health spending growth.

We oppose the 18 day comment period. Not only is this very brief review period a violation of standard practices under the Administrative Procedure Act and Executive Order 13563, but also given the nature of our group (healthcare providers with busy working schedules), this shortened comment period did not allow for a thorough review and investigation of evidence related to the proposed rule changes. Shortening the period for review and comment to such a major proposal is unacceptable and prevents public inclusion in this civic process. In the least, the review period should be the standard 30 to 45 days but given the gravity of the proposed changes to the Affordable Care Act, a review period of 90 days would be appreciated.

Open enrollment periods (§155.410)

The NPRM proposes changing the Open Enrollment Period Dates from November 1, 2017- January 31, 2018 to November 1, 2017- December 15, 2017. The point discussed in the NPRM is that "this shorter open enrollment period may have a positive impact on the risk pool because it will reduce opportunities for adverse selection by those who learn they will need services in late December or January."

In the 2016-2017 period, according to CMS data there were a total of 9.2 million people who enrolled with a plan during the open enrollment time period (CMS 2017). Particularly of note, between November 1- December 19, 2016 there were a total of 6.3 million people enrolled in a ACA FFE plan(CMS 2016). The difference between the total number enrolled and the Nov 1- Dec 19, 2017 show that about 3 million people enrolled during the period that is to be shortened. This is roughly 1/3 of the total number that are enrolled.

The statement that this will reduce the opportunities for adverse selection by cutting down the time for open enrollment could result in those without access to coverage. 23.25% of Texas's population are uninsured, which results in Texas being the highest uninsured state in the country (US News). Due to lack of health care access, there is decreased access to preventative care. This in turn can cause for the increase in emergency services which can be costly. In Texas during the CMS enrollment period, a total of 1.2 million people enrolled with about 400,000 people enrolling between December 19 and January 31 (CMS 2016, CMS 2017). In the Texas context, by shortening the enrollment period, potentially there is an increase for the very adverse selection that is sought to be avoided as there is concern for increased resource utilization by those without coverage.

This increased resource utilization is what is being seen in the city of Houston. Houston, Texas located in Harris County has one of the largest public health systems. Without adequate

References:

1) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-03.html#
2) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-21.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending
3) https://www.usnews.com/news/best-states/articles/2017-02-21/health-care-outcomes-in-states-influenced-by-coverage-disparities

Special Enrollment Period:

The proposed changes to the Special Enrollment Period in particular related to the pre-enrollment verification is a cause of concern as this will make it harder for people to seek health insurance and could potentially lower the number seeking health insurance. For those that undergo loss of employment or similarly stressful situation requiring change of insurance, adding a pre-enrollment period to that can make it harder for those who are seeking health care. This specifically also relates to maternal care.

Harris County has a rate of mothers dying from childbirth and pregnancy –related complications greater than 56 other countries. The rate of 31.3 per 100,000 live births is more than double the US rate of 15.1 and four times greater than Canada's.

Nearly 20 percent of Harris County's 249 ZIP codes has infant mortality rates above the national average of 6.69 deaths per 1,000 live births. Additionally, 13 of these ZIP codes have infant death rates 2.5 to 3 times higher than the healthy community goals established in Healthy People 2010 by the U.S. Health

and Human Services Department. Much of these at-risk areas are concentrated to the north and east of Interstate 45 and south and east of State Highway 288.

In 2016 two reports showed that the rate of maternal mortality in Texas had more than doubled over the past two years. African-American women were identified as being at the greatest risk of death (accounting for 11.4% of births but 28.8% of maternal deaths).

Early and ongoing prenatal care is vital to ensure pregnant women receive important preventive care, such as vaccines and nutritional counseling. Prenatal care also helps detect and manage behaviors and illnesses that may negatively impact the health of the mother and baby, including smoking, high blood pressure, substance abuse, and diabetes (all of which contribute to poor birth outcomes). Prenatal care also helps ensure that babies are born at term. Babies born prematurely cost ~18 times more than a full-term baby. Over the first year of life, HHSC estimates a premature baby will cost Texas Medicaid an average of $100,000, while a full term baby just costs $572.

We believe the Department of Health and Human Services has a responsibility to support efforts to decrease maternal morbidity in Texas. The proposed rules changes such as limiting the enrollment period make it more not less difficult for the non-insured women of pregnancy –age to obtain insurance enrollment. Creating more barriers for low income young women to obtain health insurance coverage will result in less good pregnancy care and continue the startling maternal and infant death rates particularly in areas of Harris County.

Continuous Coverage

One attempt to fulfill the promise of abolishing the individual mandate without destabilizing coverage for individuals at higher risk of health care utilization (i.e. those with pre-existing conditions) is to financially incentivize the payment of premiums by lower risk individuals via the Continuous Coverage proposal. [1] During the enrollment period (notably shortened from Nov 1- Jan 31 to Nov 1- Dec 15), those found with gaps in coverage (60 days or more) on pre-enrollment verification would be penalized with delayed coverage (90 day waiting period), late enrollment fees, or even exclusion from enrollment entirely. Although intended to stabilize the market for insurance issuers with consistent participation of healthy individuals, the Continuous Coverage proposal would penalize those currently uninsured or without year-round coverage, especially when breaks in coverage are fairly common (36% of Americans age 4-64, or 89 million people, went without coverage for at least 1 month between 2004 and 2005, with about 25% of this group losing coverage more than once).[2]

This rule would disproportionately impact young, healthy adults and people with pre-existing conditions. Young adults are likely to have gaps in coverage secondary to a more transient lifestyle (college graduation, aging out of parents' plans, more frequent employment changes). From 2008-2010, young adults were more than twice as likely as older adults to have a gap in coverage over a two year span.[3] Their incomes are also likely to be lower, making any financial penalty for re-enrollment a greater disincentive. However, the entry of these low-risk patients into the market is necessary for market stability. In addition, those with pre-existing conditions are also at higher risk for having a gap in coverage, with nearly 25% (36million) experiencing at least one month without health coverage during 2014.[4] Beyond the financial burden of a monetary penalty serving as an unfair hindrance to re-

enrollment for those who most need it, denying them enrollment during an SEP or forcing them to wait 90 days would leave many patients at high risk of requiring health services without coverage for a significant period of time.

In Texas, the effect would be particularly damaging. Being uninsured in Texas is a chronic issue, with 53% of uninsured adults not having had coverage in 5 years and 31% never having had coverage.[5] In addition, out of poor, uninsured Texans (<100% FPL), 44% have never had coverage and 60% have not had coverage for at least 5 years.[5] If these patients attempt to obtain coverage once they are able to afford it, they may be denied coverage, forced to wait for coverage, or have to pay a penalty. Even among those who are currently insured, 8% reported a gap in coverage in the past year and another 11% reported a transition in coverage.[5] These coverage changes are often due to circumstances such as change in employment or changes in eligibility for public programs. The lack of Medicaid expansion also adds another hurdle. Low and moderate-income Texans are more likely to have seasonal/part-time work that temporarily moves them into or out of the coverage gap.[5] A financial penalty, denial of coverage during an SEP, or waiting period would prevent a seasonal employee from obtaining coverage.

The rule proposed by HHS, rather than incentivizing people to maintain coverage, will disincentivize people from gaining coverage when they, inevitably, have gaps in coverage. It will lead to lack of coverage for people who are most needed for the financial solvency of the market (young, healthy individuals) and for the most vulnerable (people without financial stability, those with pre-existing conditions). The best way to ensure continuous coverage is to minimize roadblocks to obtaining coverage in the first place.

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3) Schwartz, K and Sommers, B. "Young Adults are Particularly Likely To Gain Stable Health Insurance Coverage as a Result of the Affordable Care Act." ASPE Research Brief. Department of Health and Human Services. March 21, 2012. https://aspe.hhs.gov/system/files/pdf/76421/rb.pdf
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C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. LEVELS OF COVERAGE (ACTUARIAL VALUE) (§ 156.140)

We oppose the proposed rule to increase the *de minimis* variation in the actuarial values (AVs) used to determine metal levels of coverage for the upcoming plan years. The proposal expand the allowable minimum variation in the actuarial value (AV) for each plan level to -4%/2% of the current plan AVs. It is apparent that the proposed change will shift cost sharing toward the consumer and as usual the consumer with the least ability to absorb the impact will be most negatively impacted. These proposed rule changes would allow cost sharing in all but the Silver variant levels. This is an attempt to push higher cost sharing burden to the consumer. While the amount may seem trivial to lawmakers who have incomes in the upper 3%, for the vast majority the cost can be crippling. For arguments sake, in 2017 the individual average deductible is estimated at $6,092 (1). which would increase the deductible by approximately $245. This will likely impact people who can least afford even a slight increase in cost sharing. Keep in mind, most individuals are paying upwards of $280 per month for the pleasure of having insurance, so the total cost per year, in a year where a person meets their out of pocket maximum in a bronze level plan (and make 250% of FPL) would be upwards of $17000 in most cases. (2) Only the very secure financially could absorb such a hit. This change is not the fix to ACA that would yield comprehensive reform and rather sets up a situation where the consumer is absorbing issues with the insurance pool, rather than the issuer. A better solution would be to limit the profits an insurance company can make from Exchange policies, or reform charging practices in healthcare and pharmaceutical industries.

1. **Coleman, Kev.** Health Pocket Healthcare research. *Health Pocket.* [Online] InfoStat, 10 26, 2016. [Cited: March 5, 2017.] https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles#.WL3NtU3ruUn.

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3. Matthew Rae, Larry Levitt, Gary Claxton, Cynthia Cox, Michelle Long, and Anthony Damico. Patient Cost-Sharing in Marketplace Plans, 2016. *The Kaiser Family Foundation.* [Online] November 13, 2015. [Cited: March 6, 2017.] http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/.

Essential Community Providers (156.235)

Community provides are a part of the public health system. The CDC could potentially lose over 10% of its budget with the repeal of ACA. State and Local Health agencies also could lose funding as well. With emerging diseases like Zika and rises in vaccine preventable diseases like measles, mumps and pertussis, it is critical that we continue to support funding for public health.

Recommendations identified in this rulemaking for the ACA and specifically for Essential Community Providers would require higher costs for a population that is already facing challenges accessing access to health care. Further, funding shifts would necessitate higher costs to the states, local governments, and ultimately, local taxpayers.

Currently, local Federally Qualified Health Centers (FQHCs) see our neighbors who are children, disabled adults, pregnant women, and the elderly. The proposed changes will put the entire Texas health care system at risk. We strongly believe that essential community providers should be expanded as these providers are located in our communities and provide excellent care for our neighbors. We believe that FQHCs should be expanded to all parts of our community as they are unique in their role as one-stop shops for the medical, dental and behavioral healthcare needs of all Texans, including Medicaid and Medicare recipients, the uninsured and privately insured individuals and families. Health centers are an integral part of the healthcare infrastructure in our community

Reducing the enrollment period is especially problematic for targeted populations who generally have less access to the internet. The proposed changes would have an adverse impact by reducing the number of people in the risk pool, and promote a break in coverage resulting in uncovered individuals seeking care in our Emergency rooms at the highest cost for municipalities and taxpayers.

The proposed changes are directly provided to benefit issuers on the backs of the people they are supposed to be covering.

In Closing:

While the title of the bill calls for "market stabilization" we have significant concerns about the proposed rule's effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces. Overall, the proposed rule, if finalized, would add enrollment restrictions and make coverage less comprehensive and more expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides.

Under the Affordable Care Act the city of Houston has seen historic reductions in the uninsured and any administrative change that moves us backward instead of forward is unacceptable. Over 360,000 Houston area residents signed up for health coverage through the federal marketplace in 2017 and we care deeply that the coverage for these individuals be maintained and not be made more expensive or less adequate.

During his confirmation process Secretary Price said, "Nobody's interested in pulling the rug out from under anybody. We believe that it's absolutely imperative that individuals that have health care be able to keep health coverage and move hopefully to greater choices and opportunities for them to gain the kind of coverage that they want for themselves and their families." In that vein, we are submitting our comments to ensure that our community is able to easily enroll in health insurance thereby accessing preventative care services leading to a happy healthier state.

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We have significant concerns about the proposed rule's effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces. Overall, the proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides.

If implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium credits many people receive;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks;
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals are far from the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are appalled by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations; many affected parties will likely be unable to weigh in with comments.

Guaranteed Availability of Coverage (§147.104)

The NPRM proposes allowing issuers in the individual or group market to refuse coverage to an individual (or employer) who owes the issuers premiums from the prior 12 months, unless and until the individual (or employer) pays the premium debt in full. This change should not be adopted. This conflicts with the statute, which says that issuers generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. This change would bar people, many of them with limited incomes, from accessing coverage and the financial assistance for which they are eligible as a result of premium shortfalls during the prior year. Under this proposed rule, only those

who can rapidly come up with a possibly significant sum of money by a given deadline can be guaranteed access to health coverage. In some parts of the country, people who owe back premiums to one issuer could then seek coverage with a different issuer, but that would not be possible in areas with only one issuer offering individual coverage. Strangely, in a proposed rule aimed at providing greater stability in the insurance market, this policy would likely deter *healthier* people who get behind in their premiums from enrolling, since often-healthy younger people are more likely to miss bill payments in general. This could weaken the overall health of the coverage pool in a similar way as the proposed changes to SEPs.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[1]

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

Open Enrollment Periods (§155.410)

We strongly urge CMS to keep the length of open enrollment periods to three months, as is was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed,

[1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrollment declines gradually throughout the year, a sign that enrollees leave the market over time for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

significantly reduces people's ability to learn about *and* enroll in coverage within the given timeframe. If the rule is finalized, there will limited time for affected consumers to learn about the changed length. We know that consumers continue to have gaps in knowledge about the coverage options available to them and we believe a three-month open enrollment period should continue in order to ensure eligible consumers enroll.

We also have concerns about consumers' ability to access in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer pans. We appreciate that CMS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand.[2] Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[3] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[4]

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[5] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[6]

<u>Special Enrollment Periods (SEPs) (§155.420)</u>

Overall, we are very disappointed about the proposed changes to SEPs and urge you not to finalize them. In order to ensure that healthy people enroll in coverage, thus bringing down the cost of coverage overall, enrollment rules and procedures should strive to make it *easier*, not *harder*, to enroll in coverage. Estimates show that less than 5 percent of eligible consumers enrolled in coverage through SEPs in 2015,[7]

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[2] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (*Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[3] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[4] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

[5] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[6] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[7] Stan Dorn, *Helping Special Enrollment Periods Work under the Affordable Care Act* (Washington: Urban Institute, June 2016), available online at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

and we are concerned that these new requirements will likely result in even fewer eligible consumers accessing coverage using an SEP.

Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to follow through.[8] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will take the steps necessary to complete the process.

We are very disappointed in the proposal to expand pre-enrollment verification. No evaluation or analysis of the impact of the numerous changes – specifically increased verification requirements – that have already been implemented for the FFM has been conducted. We do, however, appreciate that the preamble requests comment on whether a small percentage of enrollees should be retained outside of the pre-enrollment verification process in order to evaluate the impact of these processes and we strongly urge CMS to do so.

We are also strongly opposed to requiring prior coverage for the marriage SEP and rules that limit the ability of currently enrolled consumers to change plans. Currently, enrolled consumers who are newly eligible for premium tax credits (PTCs) may select a plan from any available metal level. This is important so that individuals and families experiencing life changes can gain access to financial assistance or can adjust to loss of subsidies and still afford coverage. For example, someone who experiences an increase in income may receive a reduced premium credit and/or lose access to cost-sharing reductions during the course of the year. This warrants the chance to change metal levels if they choose.

It is critical that eligible consumers successfully finish the SEP verification process with minimal burden. The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the bar be higher, consistent with the streamlined eligibility and enrollment process envisioned by current law. For example, in cases such as birth, denial of Medicaid or CHIP, or loss of Medicaid or CHIP eligibility, SEP applicants' coverage should *not* be pended. Instead, their attestation should be accepted with eligibility verified afterward in order to ensure continuity of their health care and coverage. Further, we seek clarification about the timeline for building effective electronic verification systems and recommend that there are strong manual systems in place should electronic verification not be ready by June 2017 or should electronic verification not work for all consumers. It is also critical that marketplaces, not issuers, should continue conducting SEP verification, consistent with the law.

We also appreciate the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process. One strategy the Administration should use is to conduct robust outreach through email and calls to consumers who have not yet completed the process. The federal government should also again require issuers and health plans to automatically provide individuals with certificates of creditable coverage when coverage ends and upon request.[9] Loss of prior coverage is the main reason individuals apply for a marketplace SEP, but documenting this can be challenging. It would be unfair to require people to submit proof of past coverage in order to access an SEP – and delay their coverage in the meantime – without providing them a way to easily obtain that proof.

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[8] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

[9] This federal requirement was ended by regulation in 2014.

The proposed rule also requests comments about changes to SEPs for state-based marketplaces (SBMs). We urge the Administration to not require SBMs to align with the federal process for pre-enrollment verification, nor with the other SEP changes proposed in this regulation. States should have the flexibility to create policies and processes that work for them. Because the federal government is proposing to rush ahead with policies that risk reducing enrollment of eligible people, including those who are healthy, it is critical to allow states to take other approaches that fit their specific needs. This serves the dual purposes of ensuring that more eligible people are able to access coverage without undue hassles in SBMs and allows the federal government to benefit from the information that states find as they adopt their own policies. We also note that SEPs largely apply on a marketwide basis, and states continue to have authority over their individual and small-group insurance markets and can implement issuer standards and other rules that are more protective of consumers and that do not impede the application of federal law.

Continuous Coverage

According to the preamble, the Administration is considering various proposals that could be established that would "promote continuous enrollment in health coverage" without gaps and discourage people from "waiting until illness occurs to enroll in coverage."

One idea discussed would require individuals applying for a special enrollment period to show they have had health coverage for significant period of time (perhaps six to 12 months) without a gap of more than 60 days and then to be denied access to coverage through an SEP if they can't show they have had "continuous coverage." Another example discussed is a requirement that individuals who are not able to provide evidence of prior "continuous coverage" without a gap could face insurer practices – such as a waiting period before benefits begin or a late enrollment penalty—that have not been allowed in the individual market since enactment of the ACA. These ideas would serve as impediments to people getting coverage, overburden consumers, and would conflict with current law.

Unless legislation changes the guaranteed availability requirements of the ACA, issuers still generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. There is no basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty (through the ACA's individual mandate). It is unfair to create another penalty that would withhold future coverage because a person has been uninsured. Imposing a waiting period on some consumers' benefits or making them wait "at least 90 days" for their coverage to be effectuated is completely inconsistent with guaranteed availability. Late enrollment penalties or surcharges conflict both with guaranteed availability and the requirement that premiums vary only based on certain specified factors; whether a person has been uninsured in the past is not an allowable rating factor, for example.

The ideas suggested in the preamble would also inflict serious harm on many consumers. Breaks in coverage are fairly common today, a fact that has been borne out by numerous studies.[10,11] Imposing late fees, waiting periods before benefits begin, or other barriers to accessing coverage mean that some people will not get the coverage or the health care services that they need. Current law already has restrictions that protect against adverse selection: limiting enrollment to specified periods and the individual mandate penalty are two examples. In addition, the proposals floated in the preamble would likely reduce overall enrollment in coverage, particularly among healthier people. Therefore, the ideas floated here actually

[10] Some 36 percent of Americans ages 4 to 64 (89 million people) went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once, according to a study by the Commonwealth Fund: http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance

[11] Nearly one-quarter of people with pre-existing health conditions (31 million people) experienced at least one month without health coverage during 2014, according to data from the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

raise the risk of making the risk pool worse and health coverage less affordable overall. To truly promote continuous coverage, an open and accessible system – not a closed and onerous one – is needed to ensure that people successfully obtain coverage when they are first eligible and maintain it over time. The process for changing coverage should be as smooth and as swift as possible, and the government should avoid placing harmful restrictions on people's ability to make these transitions successfully – particularly in ways that conflict with the law.

Levels of Coverage (Actuarial Value) (§156.140)

We strongly oppose the proposal to broaden the allowed *de minimis* variation in actuarial value (AV) for each plan metal level to -4/+2 percent. This policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[12]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[13]

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today *or* purchase coverage with hundreds to thousands of dollars in higher cost-sharing- either way they will have to pay much more for coverage and care.

The preamble of the proposed rule even acknowledges the harm that many consumers will experience, stating: "*A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government*, " and "*The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risk associated with high medical costs.*"

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[12] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

[13] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

The administration should not proceed with a policy that will knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current *de minimis* actuarial value requirement of -2/+2 percent be maintained for all metal levels. We note that a broader level of variation is no longer *de minimis* and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare different plan options and also to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

If the administration is insistent on pursuing a policy to allow for lower value plans, however, we strongly urge that such change be limited to bronze level coverage. We strongly disagree with the assumption that the remaining uninsured are only looking for coverage with lower premiums, as many people, including young adults, report being just as concerned about high cost-sharing.[14] As such, we are skeptical that reducing the floor of bronze coverage offered in the marketplace will attract a large number of new enrollees. However, if the premise of this proposed policy change is to expand marketplace offerings to include more barebones coverage than is currently available on the marketplace, lowering the minimum actuarial value for *only* bronze level coverage achieves that and does so without undercutting vital financial assistance.

Network Adequacy (§156.230)

We have long advocated for adequate provider networks that allow coverage enrollees to get the care they need, when they need it. A common complaint of both Democratic and Republican officials, including in Speaker Ryan's 2016 health care plan "A Better Way," is that provider networks are sometimes too narrow to meet consumers' needs.[15] If the Administration aims to promote adequate provider networks,[16] implementing the proposed rule will not achieve that goal, but will result in narrower networks.

Instead of HHS continuing to do its job to protect consumers from bait and switch products that can't fulfill guarantees to deliver access to care, under this rule the agency shirks its responsibilities and claims state oversight can ensure network adequacy. But currently, nearly half of states have no metrics in place to assess whether marketplace plans provide adequate networks.[17] This rule will gut the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allow states that have no adequacy metrics to maintain authority for provider network review.

This rule would take the health care system backwards in time to 2014, before HHS implemented critical network adequacy reviews that currently protect patients. The rule fails to describe how consumers' access to providers will be impacted by the removal of federal network adequacy review. We are interested in understanding how HHS will ensure consumers have the same or better access to providers in all states if this proposal is implemented.

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[14] Liz Hamel, Jamie Firth, Larry Levitt, Gary Claxton and Mollyann Brodie, *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Washington, DC: Kaiser Family Foundation, May 20, 2016), available online at http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/ and Kara Brandeisky, *Why Millennials Hate Their Least Expensive Health Care Option,* Time Magazine (Dec 8, 2014), available online at http://time.com/money/3614626/millennials-health-insurance-high-deductible/.

[15] Speaker Paul Ryan, *A Better Way* (Washington, DC: U.S. House of Representatives, June 2016), available online at: https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf

[16] Claire McAndrew, *Network Adequacy 101* (Washington, DC: Families USA, October 2014), available online at: http://familiesusa.org/product/network-adequacy-101-explainer

[17] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

We urge HHS to maintain the implementation of §156.230 as it stands now, as proposed changes to defer to state oversight will result in insurers selling health plans that do not include sufficient numbers and types of providers to serve enrollees. The proposed changes to network adequacy would jeopardize the health and financial security of consumers and we urge HHS to reject them.

Essential Community Providers (§156.235)

Like section 156.230, section 156.235 will narrow networks for consumers. This section decreases FFE insurers' accountability to include in their networks Essential Community Providers (ECPs) — those that serve predominately low-income, medically underserved individuals. This section is a giveaway to insurance companies, which under the proposed rule will be allowed to travel back in time to 2014 and only contract with a measly 20 percent of ECPs in their service area.

Page 10996 of the proposed rule describes the impact of this section directly, showing that consumers will bear burdens so that insurers can cut corners:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

States around the country like Connecticut and Montana, and their participating issuers, have achieved far higher ECP inclusion benchmarks.[18] This proposed modification for ECP inclusion in FFE networks signals that HHS and the Administration overall lack commitment to vulnerable marketplace enrollees and to network adequacy. We urge rejection of a change in the ECP standard to 20 percent and instead recommend increasing the threshold over the next 3 years until it reaches 75 percent.

[18]Cristina Jade Peña, Laurie Sobel, and Alina Salganicoff, *Federal and State Standards for "Essential Community Providers" under the ACA and Implications for Women's Health* (Washignton, DC: Kaiser Family Foundation, 2015), available online at: http://kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/

Comment separator page. Next comment follows.

Dear Health and Human Services,

I am writing to comment on CMS-9929-P . There are several proposed rule changes to the Affordable Care Act that are of concern.

1. Reducing the Enrollment Period from 3 months to 6 weeks will cause more Americans to remain uninsured. The reason cited is to 'improve the risk pool because it would reduce opportunities for adverse selection by those who learn they will need services' which shows the purpose is to reduce the number that are insured. While there may indeed be issues with people 'gaming the system' the resolution of that issue does not like in reducing the enrollment period; it lies in increasing the incentive for all people to sign up for health insurance.

2. Increasing the enrollment verification from 50% to 100% for those using special enrollment periods will increase costs of running the Health Exchange. Many companies use sampling for quality control, and it would be a much less expensive option to use sampling, rather than using 100% verification. Is this rule change designed to protect Americans who need insurance, or to protect insurance companies?

3. Allowing insurers to apply a premium payment to past debt for those people who enroll with the same insurer makes insurance more expensive and hurts people who need insurance. This rule does not seem to be about 'gaming' but rather about getting more money into the coffers of insurance companies. Those people who have subsidized premiums are generally living on the edge, paycheck to paycheck, and if they are unable to pay the premiums, I venture there is a reason other than trying to game the system.

4. Increasing the de minimis variation in the actuarial values allows insurance companies to change the value of the plans. It has been a benefit of the Health Care Exchange to have plans with minimum coverage requirements and easily comparable.

Please take my comments into account. Medicare for all would be cheaper, provide better coverage and eliminate many of these issues.

Emma Jones

Comment separator page. Next comment follows.

American Cancer Society/ Cancer Action Network ∞ Actors Fund ∞ Children's Defense Fund-New York
Community Service Society of New York ∞ Consumers Union ∞ Empire Justice Center
Make the Road New York ∞ Medicare Rights Center ∞ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ∞ New York Immigration Coalition ∞ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ∞ Schuyler Center for Analysis and Advocacy ∞ Small Business Majority
Young Invincibles

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: NPRM (RIN 0938-AT14) – Patient Protection and Affordable Care Act; Market Stabilization

Dear Sir/Madam:

Health Care For All New York (HCFANY) respectfully submits the following comments to the Department of Health and Human Services (HHS) in response to the Notice of Proposed Rulemaking released on February 15, 2017.

HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that the concerns of real New Yorkers are heard and reflected. For more information on HCFANY, visit us on the web at **www.hcfany.org**.

HCFANY greatly appreciates the opportunity to provide comments on the proposed rule. Many of the proposed changes would make it more difficult or costly for consumers to get health insurance without improving the risk pool or lowering premiums. HCFANY recommends leaving existing rules and interpretations in place. This includes those for guaranteed availability, open enrollment, special enrollment periods, actuarial value, network adequacy, and essential community providers. In the event that the Department of Health and Human Services (HHS) moves forward with the proposed regulation, HCFANY strongly urges HHS to guarantee state flexibility in these matters. States with State-based Exchanges (SBEs) or state regulatory guidance in these areas should be permitted to continue to operate in a manner consistent with the best interests of consumers in their local regulatory environment.

We address each of these proposed regulatory changes in turn below.

Health Care For All New York
c/o Elisabeth Ryden Benjamin, Community Service Society of New York
633 Third Ave., 10th Floor, New York, New York 10017
(212) 614-5461

Guaranteed Availability of Coverage (§ 147.104)

This section proposes to modify the interpretation of § 147.104 to allow insurers to attribute premium payments for coverage under the same or a different product from the same insurer during the previous 12 months and refuse to effectuate new coverage for failure to pay premiums.

HCFANY strongly urges the Secretary to maintain the current interpretation of the ACA's guaranteed availability provision. The proposed reinterpretation would allow insurance companies to apply payments meant for a new plan year to outstanding debt, instead of using them to cover the first month of a new policy. Those customers would then be left without coverage for the new plan year due to a failure to pay the first month's premium. In New York, as elsewhere, there are areas where people have only one plan available. Under the proposed rule, they would have no other options if locked out with one company. The stated goal of this change is protecting insurance companies from beneficiaries who only pay premiums when experiencing a health problem. However, it is likely that this method for enforcing premium payments will simply lead to fewer people overall in the risk pool, a result certain to raise premiums in the future. Insurers should use other tools to collect overdue premiums that will not push people with overdue payments out of the market altogether.

Recommendation: HCFANY recommends the following: (1) HHS should maintain the present interpretation of § 147.104. (2) If HHS decides to move forward with the proposed modification to the interpretation of § 147.104, HCFANY implementation should be optional for states. (3) HHS should make an exception to this provision for insurer or Marketplace administrative error. (4) HHS should require insurers to extensively disclose this new rule on all relevant notices to consumers.

Initial and annual open enrollment periods (§ 155.410 (e))

HCFANY opposes shortening the open enrollment period. The proposed rule would allow consumers six weeks to purchase plans instead of three months. The stated goal of shortening the open enrollment period is to discourage customers from waiting until they have a health problem to start paying premiums, and to limit the administrative burdens of signing people up after the plan year has started.

However, the most likely result of a shorter open enrollment period that falls over a major holiday season (Thanksgiving, Christmas, Chanukah) is reduced enrollment overall, rather than reduced enrollment of unhealthy people. A shortened open enrollment period would greatly increase the burden on health plans, providers, navigators, and other assistors who help people enroll. It is not clear that it would reduce administrative burdens on plans overall, given that in the best case scenario, they would be asked to complete enrollments for the same number of people in a very compressed timeline. Moreover, the Secretary provides no data to support the idea that a large number of people come down with serious health conditions at the end of December and in January and thus decide to purchase health plans when they otherwise would not.

A better way to alleviate the burden of enrolling people for partial plan years would be to shift open enrollment to October 1 through December 15 so that all new coverage starts on January 1. This would give everyone ample time to shop and select a plan, while giving insurance companies a smoother enrollment process.

Recommendation: HCFANY recommends that HHS maintain the existing open enrollment period for the 2018 plan year. Alternatively, HCFANY recommends that open enrollment for the 2018 plan year begin on October 1, 2017 and end on December 15, 2017. If HHS decides to move forward with a shortened open enrollment period, HCFANY strongly recommends that states be able to choose whether or not to implement this change.

Special Enrollment Periods (§ 155.420)

This section proposes: (1) to increase the scope of pre-enrollment verification of special enrollment periods (SEPs) to all applicable SEPs beginning in June 2017 for Federally-facilitated exchanges and State-based exchanges on the Federal platform; (2) to prevent consumers from changing metal levels when they enroll in new plan through SEPs; and (3) to make continuous coverage a pre-condition of SEP availability under certain circumstances.

HCFANY opposes the modifications proposed for special enrollment periods, including pre-verification, a prohibition on changing metal levels, and continuous coverage requirements. The stated purpose of these rules is to stop consumers from using special enrollment periods to avoid paying for health insurance until they have a health problem. However, no evidence is provided that such abuse is occurring in numbers large enough to degrade the market's risk pool. The likely outcome of these changes will be to decrease enrollment altogether, rather than keep a balance between healthy and sick consumers. If these changes to special enrollment periods are pursued, HCFANY strongly urges HHS to make the implementation optional for State-based Exchanges.

Pre-Enrollment Verification

HHS proposes pending enrollment in a plan until insurers verify documentation after a qualifying life event. HCFANY opposes this because of the barrier it will create for consumers. HHS justifies many of the proposed changes as efforts to alleviate administrative burdens, but this proposal would only greatly increase administrative burdens on consumers and plans. Additionally, exceptions should be included for pregnant women, newborns, and people whose eligibility for Marketplace plans changes mid-year and are thus forced to enroll in a new plan. Access to health care is particularly critical for pregnant women and newborns. There should not be any additional barriers to enrollment in health coverage for these populations.

Prohibition on Changing Metal Levels

Consumers should be allowed to reevaluate their choice of plan when enrolling new dependents because of marriage, birth, or adoption. These life events may alter the amount of

advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their health and affordability needs. This is particularly true for people living with chronic conditions for whom appropriate plan choice is critical to affordable health care access. Consumer choice during SEPs is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

Continuous Coverage Requirements

Life circumstances will inevitably result in occasional gaps in health insurance coverage, particularly for lower income individuals. This should not preclude consumers from being able to enroll in coverage during an SEP when they meet all other criteria. The proposed documentation requirements would be burdensome for consumers and insurers, and will create an enrollment barrier for the general population, not just those who have waited until they have a health need to enroll. Moreover, healthy people are more likely to be dissuaded from enrolling when faced with a difficult enrollment process. A difficult enrollment process could therefore reduce the number of healthy people entering the risk pool.

Loss of Minimum Essential Coverage

HHS proposes to store information about consumers who have been dropped from coverage due to non-payment in order to prevent them from enrolling with a different carrier using a Loss of Minimal Coverage special enrollment period. As stated above, it is inappropriate and inconsistent with the goal of increasing enrollment to permanently lock consumers out of health coverage after missing premium payments. Past due premiums should be negotiated between consumers and their previous insurer, not used to prevent individuals and their dependents from getting insurance with other companies.

Recommendation: In summary, HCFANY has the following recommendations: (1) HHS should maintain the current scope of pre-enrollment verification for SEPs; (2) if HHS decides to move forward with increasing the scope of pre-enrollment verification for SEPs, implementation should be optional for State-based Exchanges that do not use the federal platform; (3) exceptions to the pre-enrollment verification provision should be made for pregnant women, newborns, and consumers who experience mid-year changes in Marketplace eligibility; (4) consumers should continue to be allowed to change plan metal levels during an SEP; and (5) consumers who have experienced gaps in coverage should continue to be allowed to enroll in coverage through an SEP for which they otherwise qualify.

Levels of coverage (actuarial value) (§ 156.40 (c))

HCFANY opposes reducing the actuarial value to consumers of health insurance plans. Any changes should be optional for states. HHS proposes to allow de minimis variation in actuarial value (AV) from -4 to +2 percentage points for QHPs (except certain bronze plans, which could vary from -4 to +5 percentage points) instead of the current +/-2 percentage points. The stated purpose of this change is to reduce premiums. However, the effect would be to

substantially decrease the tax credits received by most Marketplace consumers, which would coverage less affordable.

The amount of advanced premium tax credits (APTCs) is calculated based on the second-lowest cost silver plan. An expansion of the de minimis variation in AV from -4 to +2 percentage points would mean that a silver plan could have an AV ranging from 66 percent to 72 percent. If a silver plan with a low AV (e.g. 66 percent) becomes the second-lowest cost silver plan, APTCs for moderate income consumers would be reduced.

Most consumers would thus experience increased premiums, the exact opposite of what the rule is meant to achieve. As HHS explains, higher premiums lead to reduced enrollment overall and hurt the risk pool. Affordability is already the largest issue consumers face when purchasing health coverage.[1] Many consumers would no longer be able to afford coverage that meets their needs with reduced tax credits.[2]

HCFANY supports maintaining the existing de minimis variation of +/- 1 percentage point for the silver plan variations with AVs of 73, 87, and 94 percent.

Recommendation: HCFANY urges HHS to maintain the current de minimus variation in AV for all QHPs. If HHS decides to move forward with the proposed change in de minimis variation, HCFANY strongly recommends that implementation of this change be optional for states. HCFANY supports maintaining the de minimus variation of +/- 1 percentage point for silver plan variations.

Network adequacy (§156.230)

The proposed rule indicates several departures from HHS's previous enforcement of provider network adequacy requirements. HHS proposes to: (1) rely on state reviews for network adequacy in states with a Federally Facilitated Exchange (FFE), provided the State has a sufficient network adequacy review process, rather than performing a time and distance evaluation; (2) defer to the states' reviews in states with the authority that is at least equal to the "reasonable access standard" defined in §156.230 and means to assess issuer network adequacy, regardless of whether the Exchange is a SBE or FFE, and regardless of whether the state performs plan management functions; and (3) rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity in states that do not have the authority and means to conduct sufficient network adequacy reviews.

HCFANY opposes the proposed rule, as it removes federal oversight of issuer compliance with federal network adequacy requirements and abandons the time and distance criteria for assessing reasonable access. Network adequacy remains a concern for consumers,

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[1] Robin Osborn, David Squires, Michelle M. Doty, Dana O. Sarnak, and Eric C. Schneider. "In New Survey of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care." *Health Affairs*. November 2016. DOI: 10.1377/hlthaff.2016.1088.

[2] Aviva Aron-Dine and Edwin Park. "Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs For Millions of Moderate Income Families." *Center on Budget and Policy Priorities*. 15 February 2017. http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for

particularly as issuers continue to utilize narrow networks for exchange-based products. The trend towards narrow networks continues into 2017, and narrow networks can impacts consumers' ability to access medical services, particularly specialists, mental health and substance abuse providers.

First, HHS would no longer review issuer provider networks under the time and distance criteria in States with an FFE, but would rely on states with a sufficient network adequacy review process. HCFANY opposes this approach, as it delegates the crucial role of enforcing compliance with federal network adequacy requirements to states without federal oversight or review, and without requiring states perform the easily applied and quantified time and distance criteria. Even states with authority to perform network adequacy reviews should be subject to federal oversight to ensure compliance with federal network adequacy requirements, particularly if states choose to implement less stringent methodology than the established time and distance criteria.

Second, HHS would "defer to state reviews of network adequacy in states with the authority that is at least equal to the "reasonable access standard" defined in §156.230 and means to assess issuer network adequacy, regardless of whether the Exchange is a State-based Exchange (SBE) or FFE, and regardless of whether the State performs plan management functions." HCFANY opposes this approach as it removes federal oversight of issuer compliance with federal network adequacy standards, and permits states that meet a relatively open-ended and vague standard perform the sole review of issuer provider networks. This is particularly concerning for states that lack the means to perform plan management, as it is likely that such states lack sufficient capacity to ensure compliance with federal network adequacy requirements.

Third, HHS, would rely on issuer accreditation in lieu of federal oversight of issuer provider networks in states without the authority or means to conduct sufficient network adequacy reviews. HCFANY opposes this approach as HHS will accept issuer accreditation for either Medicaid or commercial products, with no guarantee that all products offered by the issuer comply with federal network adequacy standards. It is likely that under this approach, issuers' provider networks will not be sufficiently reviewed across all products to ensure that issuers are compliant with federal network adequacy standards.

Under the proposed changes, HHS would no longer review issuer provider networks but would merely rely on state assessments or issuer accreditations. Both state assessments and issuer accreditations require additional federal oversight to ensure that consumers have access to sufficiently robust provider networks. Time and distance criteria for network adequacy is an appropriate metric for determining provider network adequacy. Time and distance criteria provide an easily applied and verifiable means to assess issuer provider networks against the open-ended "reasonable access" standard. Without time and distance criteria, there is a risk that state assessments and issuer accreditations will employ a weaker methodology and fail to ensure that provider networks are sufficiently robust to protect consumer access to medical services. Federal oversight, and time and distance criteria, are therefore critical to ensure that issuer provider networks ensure reasonable access to care.

Recommendation: HCFANY recommends that HHS continue to review issuer provider networks under the “reasonable access” standard, using the time and distance criteria, for all States. If HHS decides to move forward with the proposed changes, HCFANY recommends that implementation be optional for states.

Essential community providers (§156.235)

The proposed rule modifies inclusion requirements of Essential Community Providers (ECPs) in two ways: (1) it reduces the required minimum percentage standard of ECPs in a provider network from 30 percent to 20; and (2) it permits issuers to count write-in ECP providers towards the percentage standard, on the condition that the ECP files an ECP petition and the issuer includes the ECP on its ECP template.

HCFANY opposes the reduction of the required minimum percentage standard of ECPs in provider networks. HHS notes that only 6 percent of issuers were required to provide justification for failing to meet the ECP standard, and that all of these justifications were deemed sufficient. The other 94 percent of issuers were able to meet the current minimum standard of 30 percent. A reduction in the ECP standard would permit all issuers to reduce ECP participation in their networks, which would further reduce consumer access to ECPs. Given how critical ECPs are for medically underserved areas and populations, any potential reduction in availability of ECPs to consumers must be critically weighed against the potential benefit. HCFANY opposes a potential reduction in the availability of ECPs for the benefit of reducing the administrative burden on only 6 percent of issuers.

HCFANY supports the limitation of issuers’ ability to count write-in ECPs towards the percentage standard, on the condition that the ECP files an ECP petition and the issuer includes the ECP on its ECP template. HCFANY recognizes that not all ECPs are currently on the HHS ECP list, and supports the inclusion of ECPs with appropriate measures to ensure that the ECPs join the HHS list.

Recommendation: HCFANY opposes any reduction of the required minimum percentage standard of ECPs in a provider network. HCFANY supports the conditional inclusion of write-in ECPs towards an issuers’ ECP percentage standard.

Public comment period

HCFANY recommends that future proposed regulations include a much longer comment period. Insurance markets are highly complex and rushed policy changes could have enormous impacts on consumers. Consumers do not have as much access to government as industry stakeholders do while such policies are being developed. They therefore need more time after policy changes are publically released to understand the proposed changes and to inform HHS of how those changes could affect their ability to access health care.

Recommendation: HCFANY recommends that future proposed regulations include a public comment period of at least 30 days.

Thank you for the opportunity to provide comments on the Patient Protection and Affordable Care Act; Market Stabilization proposed rule. If you have any questions about our comments, please contact Taylor Frazier at tfrazier@cssny.org or at (212) 614-5541.

Very truly yours,

Taylor Lauren Frazier, MPH
Health Policy Associate
Community Service Society of New York

Comment separator page. Next comment follows.

March 7, 2017

Submitted via the Federal e Rulemaking Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: RIN 0938-AT14 Patient Protection and Affordable Care Act; Market Stabilization

To Whom It May Concern:

At Howard Brown Health, we work to eliminate health disparities experienced by lesbian, gay, bisexual and transgender people, and we provide our community primary medical care, behavioral health, research, HIV/STI prevention, youth services, elder services, and community initiatives. Every day, we observe first-hand the importance of having meaningful access to the Qualified Health Plans available on the Marketplaces. We see the impact access to health plans has on our community, including people living with HIV who used to be denied coverage due to pre-existing health conditions, and LGBT individuals who previously experienced discrimination by health insurance companies. We appreciate the opportunity to provide comments to the Department of Health and Human Services (HHS) on the proposed rule regarding market stabilization for the individual and small group markets.

We understand that the uncertainty caused by the current health policy debate in Congress may have implications for the stability of the individual health insurance market in many states. We support federal and state efforts to allay uncertainty among both issuers and consumers and to increase robust competition in the Marketplaces for the 2018 plan year. However, we believe that curbing vital consumer protections with regard to affordability and access is not the way to address stability, and that in fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

If implemented, the proposed rule would:

- Make coverage more expensive by weakening cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many, while also reducing the premium tax credits many people receive;
- Disrupt the balance of the risk pool by restricting special enrollment periods and increasing paperwork and red tape for consumers, which is likely to depress enrollment, particularly among younger people;
- Limit access to enrollment by cutting the next open enrollment period in half, which is especially concerning as this is a confusing time for consumers;
- Unfairly deny coverage to individuals by allowing insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;

- Decrease the availability of healthcare services by eliminating requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks;
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that in reality would disrupt people's access to coverage and conflict with current law.

Guaranteed Availability of Coverage (§147.104)
The NPRM proposes allowing issuers in the individual or group market to refuse coverage to an individual (or employer) who owes the issuers premiums from the prior 12 months, unless and until the individual (or employer) pays the premium debt in full. This change should not be adopted. This conflicts with the statute, which says that issuers generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. This change would bar people, many of them with limited incomes, from accessing coverage and the financial assistance for which they are eligible as a result of premium shortfalls during the prior year. Under this proposed rule, only those who can rapidly come up with a potentially significant sum of money by a given deadline can be guaranteed access to health coverage. This would also create a patchwork of uneven accessibility where in some parts of the country, people who owe back premiums to one issuer could then seek coverage with a different issuer, but that would not be possible in areas with only one issuer offering individual coverage. Strangely, in a proposed rule aimed at providing greater stability in the insurance market, this policy would likely deter *healthier* people who get behind in their premiums from enrolling, since healthy people would have less motivation to pay back premiums if they fall behind. This could weaken the overall health of the coverage pool.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment[1].

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the requirements are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the

[1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrollment declines gradually throughout the year, a sign that enrollees leave the market over time for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.

- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Without more clarification, issuers can use the threat of withholding future coverage to try to do this.

Open Enrollment Periods (§155.410)

We strongly urge CMS to keep the length of open enrollment periods to three months, as was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about *and* enroll in coverage within the given timeframe. If the rule is finalized, there will be limited time for affected consumers to learn about the change.. Consumers continue to have gaps in knowledge about the coverage options available to them and a three-month open enrollment period should remain in order to ensure eligible consumers enroll.

We also have doubts about consumers' ability to access in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer plans. We appreciate that CMS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. During existing enrollment periods, some longer than three months, our team of certified application counselors were stretched to capacity and had to turn consumers away during times of high demand, an experience shared by enrollment assisters and brokers across the country[2].

Further, ending the open enrollment period in December places consumers at a disadvantage because it is often when consumers have heightened financial constraints and are distracted by the holiday season[3]. As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[4]

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[2] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (*Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[3] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[4] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[5] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[6]

Special Enrollment Periods (SEPs) (§155.420)

Overall, we are very disappointed about the proposed changes to SEPs and urge you not to finalize them. In order to ensure that healthy people enroll in coverage, thus bringing down the cost of coverage overall, enrollment rules and procedures should strive to make it *easier*, not *harder*, to enroll in coverage. Estimates show that less than 5 percent of eligible consumers enrolled in coverage through SEPs in 2015,[7] and we are concerned that these new requirements will likely result in even fewer eligible consumers accessing coverage using an SEP.

Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, there is still no evidence that *ineligible* people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using SEPs and younger consumers were less likely than older ones to follow through and complete the enrollment process.[8] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because those most in need of coverage are the ones who are most likely to take the extra steps necessary to complete the process.

We are opposed to expanding pre-enrollment verification. No evaluation or analysis of the impact of the numerous changes – specifically increased verification requirements – that have already been implemented for the FFM has been conducted. We do, however, appreciate that the preamble requests comment on whether a small percentage of enrollees should be retained outside of the pre-enrollment verification process in order to evaluate the impact of these processes and we strongly urge CMS to do so.

We are also strongly opposed to requiring prior coverage for the marriage SEP and to the proposed rules to limit the ability of currently enrolled consumers to change plan metal levels during the coverage year. Currently, enrolled consumers who are eligible for a special enrollment due to a change in household

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[5] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage

[6] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[7] Stan Dorn, *Helping Special Enrollment Periods Work under the Affordable Care Act* (Washington: Urban Institute, June 2016), available online at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[8] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

income and consequently a change in financial assistance are able to choose a new plan from any available metal level. This is important so that individuals and families experiencing life changes can gain access to financial assistance or can adjust to loss of subsidies and still afford coverage. For example, someone who experiences an increase in income may receive a reduced premium credit and/or lose access to cost-sharing reductions during the course of the year. This warrants the chance to change metal levels if they choose.

It is critical that eligible consumers successfully finish the SEP verification process with minimal burden. The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the bar be higher, consistent with the streamlined eligibility and enrollment process envisioned by current law. For example, in cases such as birth, denial of Medicaid or CHIP, or loss of Medicaid or CHIP eligibility, SEP applicants' coverage should *not* be pended. Instead, their attestation should be accepted with eligibility verified afterward in order to ensure continuity of their health care and coverage.

Further, we seek clarification about the timeline for building effective electronic verification systems and recommend that there are strong manual systems in place should electronic verification not be ready by June 2017 or should electronic verification not work for all consumers. It is also critical that marketplaces, not issuers, should continue conducting SEP verification, consistent with the law.

We also appreciate the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process. One strategy the Administration should use is to conduct robust outreach through email and calls to consumers who have not yet completed the process. The federal government should also again require issuers and health plans to automatically provide individuals with certificates of creditable coverage when coverage ends and upon request.[9] Loss of prior coverage is the main reason individuals apply for a marketplace SEP, but documenting this can be challenging. It would be unfair to require people to submit proof of past coverage in order to access an SEP – and delay their coverage in the meantime – without providing them a way to easily obtain that proof.

The proposed rule also requests comments about changes to SEPs for state-based marketplaces (SBMs). We urge the Administration to not require SBMs to align with the federal process for pre-enrollment verification, nor with the other SEP changes proposed in this regulation. States should have the flexibility to create policies and processes that work for them. Because the federal government is proposing to rush ahead with policies that risk reducing enrollment of eligible people, including those who are healthy, it is critical to allow states to take other approaches that fit their specific needs. This serves the dual purposes of ensuring that more eligible people are able to access coverage without undue hassles in SBMs and allowing the federal government to benefit from the information that states find as they adopt their own policies. WE also note that SEPs largely apply on a marketwide bases, and states continue to have authority over their individual and small-group insurance markets and can implement issuer standards and other rules that are more protective of consumer and that do not impede the application of federal law.

Continuous Coverage

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[9] This federal requirement was ended by regulation in 2014.

According to the preamble, the Administration is considering various proposals that could be established that would “promote continuous enrollment in health coverage” without gaps and discourage people from “waiting until illness occurs to enroll in coverage.”

One idea discussed would require individuals applying for a special enrollment period to show they have had health coverage for significant period of time (perhaps six to 12 months) without a gap of more than 60 days. Another example discussed is a requirement that individuals who are not able to provide evidence of prior “continuous coverage” without a gap could face insurer practices – such as a waiting period before benefits begin or a late enrollment penalty—that have not been allowed in the individual market since enactment of the ACA. These ideas would serve as impediments to people getting coverage, overburden consumers, and would conflict with current law.
Unless legislation changes the guaranteed availability requirements of the ACA, issuers still generally “must accept every employer and individual in the State that applies for coverage” during open and special enrollment periods. There is no basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty (through the ACA’s individual mandate). It is unfair to create another penalty that would withhold future coverage because a person has been uninsured. Imposing a waiting period on some consumers’ benefits or making them wait “at least 90 days” for their coverage to be effectuated is completely inconsistent with guaranteed availability. Late enrollment penalties or surcharges conflict both with guaranteed availability and the requirement that premiums vary only based on certain specified factors; whether a person has been uninsured in the past is not an allowable rating factor, for example.

The ideas suggested in the preamble would also inflict serious harm on many consumers. Gaps in coverage are fairly common today, a fact that has been borne out by numerous studies.[10][11] Imposing late fees, waiting periods before benefits begin, or other barriers to accessing coverage mean that some people will not get the coverage or the health care services that they need. Current law already has restrictions that protect against adverse selection: limiting enrollment to specified periods and the individual mandate penalty are two examples. In addition, the proposals floated in the preamble would likely reduce overall enrollment in coverage, particularly among healthier people. Therefore, new continuous coverage restrictions would actually raise the risk of making the risk pool worse and health coverage less affordable overall. To truly promote continuous coverage, an open and accessible system – not a closed and onerous one – is needed to ensure that people successfully obtain coverage when they are first eligible and maintain it over time. The process for changing coverage should be as smooth and as swift as possible, and the government should avoid placing harmful restrictions on people’s ability to make these transitions successfully – particularly in ways that conflict with the law.

Levels of Coverage (Actuarial Value) (§156.140)
We strongly oppose the proposal to broaden the allowed *de minimis* variation in actuarial value (AV) for each plan metal level to -4/+2 percent. This policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance

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[10] Some 36 percent of Americans ages 4 to 64 (89 million people) went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once, according to a study by the Commonwealth Fund: http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance

[11] Nearly one-quarter of people with pre-existing health conditions (31 million people) experienced at least one month without health coverage during 2014, according to data from the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[12]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Premium tax credits are calculated based on the second lowest-cost silver level plan, which under the proposed rule is likely to have a lower actuarial value and lower premium relative to the rest of the silver level plans. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[13]

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today *or* purchase coverage with hundreds to thousands of dollars in higher cost-sharing- either way they will have to pay much more for coverage and care. As a health center that cares for many people with chronic health conditions, including HIV, we believe that this will disproportionately hurt those who do not have the ability to choose a plan with lower coverage.

The preamble of the proposed rule even acknowledges the harm that many consumers will experience, stating: "*A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government*, " and "*The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risk associated with high medical costs.*"

The administration should not proceed with a policy that will knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current *de minimis* actuarial value requirement of -2/+2 percent be maintained for all metal levels. We note that a broader level of variation is no longer *de minimis* and conflicts with the purpose of the

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[12] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

[13] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

metal levels, which is to make it easier for consumers to compare different plan options and also to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

If the administration is insistent on pursuing a policy to allow for lower value plans, however, we strongly urge that such change be limited to bronze level coverage. We strongly disagree with the assumption that the remaining uninsured are only looking for coverage with lower premiums, as many people, including young adults, report being just as concerned about high cost-sharing.[14] Our certified application assisters already see many healthy, young adults who choose to go without coverage rather than pay for a plan they believe they will never use due to high out of pocket costs. As such, we are skeptical that reducing the floor of bronze coverage offered in the marketplace will attract a large number of new enrollees. However, if the premise of this proposed policy change is to expand marketplace offerings to include more barebones coverage than is currently available on the marketplace, lowering the minimum actuarial value for *only* bronze level coverage achieves that and does so without undercutting vital financial assistance.

Network Adequacy (§156.230)

We have long advocated for adequate provider networks that allow coverage enrollees to get the care they need, when they need it. A common complaint of both Democratic and Republican officials, including in Speaker Ryan's 2016 health care plan "A Better Way," is that provider networks are sometimes too narrow to meet consumers' needs.[15] If the Administration aims to promote adequate provider networks,[16] implementing the proposed rule will not achieve that goal, but will result in narrower networks.

Instead of HHS continuing to do its job to protect consumers from bait and switch products that cannot fulfill guarantees to deliver access to care, under this rule the agency shirks its responsibilities and claims state oversight can ensure network adequacy. But currently, nearly half of states have no metrics in place to assess whether marketplace plans provide adequate networks.[17] This rule will gut the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allow states that have no adequacy metrics to maintain authority for provider network review.

This rule would take the health care system backwards in time to 2014, before HHS implemented critical network adequacy reviews that currently protect patients. The rule fails to describe how consumers' access to providers will be impacted by the removal of federal network adequacy review. We are

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[14] Liz Hamel, Jamie Firth, Larry Levitt, Gary Claxton and Mollyann Brodie, *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Washington, DC: Kaiser Family Foundation, May 20, 2016), available online at http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/ and Kara Brandeisky, *Why Millennials Hate Their Least Expensive Health Care Option,* Time Magazine (Dec 8, 2014), available online at http://time.com/money/3614626/millennials-health-insurance-high-deductible/.

[15] Speaker Paul Ryan, *A Better Way* (Washington, DC: U.S. House of Representatives, June 2016), available online at: https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf

[16] Claire McAndrew, *Network Adequacy 101* (Washington, DC: Families USA, October 2014), available online at: http://familiesusa.org/product/network-adequacy-101-explainer

[17] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

interested in understanding how HHS will ensure consumers have the same or better access to providers in all states if this proposal is implemented.

We urge HHS to maintain the implementation of §156.230 as it stands now, as proposed changes to defer to state oversight will result in insurers selling health plans that do not include sufficient numbers and types of providers to serve enrollees. The proposed changes to network adequacy would jeopardize the health and financial security of consumers and we urge HHS to reject them.

Essential Community Providers §156.235

Like section 156.230, section 156.235 will narrow networks for consumers. This section decreases FFE insurers' accountability to include in their networks Essential Community Providers (ECPs) — those that serve predominately low-income, medically underserved individuals. This section is a giveaway to insurance companies, which under the proposed rule will be allowed to travel back in time to 2014 and only contract with a measly 20 percent of ECPs in their service area.

Page 10996 of the proposed rule describes the impact of this section directly, showing that consumers will bear burdens so that insurers can cut corners:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

States around the country like Connecticut and Montana, and their participating issuers, have achieved far higher ECP inclusion benchmarks.[18] This proposed modification for ECP inclusion in FFE networks signals that HHS and the Administration overall lack commitment to vulnerable marketplace enrollees and to network adequacy. We urge rejection of a change in the ECP standard to 20 percent and instead recommend increasing the threshold over the next 3 years until it reaches 75 percent.

Compressed Public Comment Period

Lastly, we would like to express concern at the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30-, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations; many affected parties will likely be unable to weigh in with comments.

Thank you, again, for the opportunity to comment on Market Stabilization Proposed Rule. We urge HHS to continue its commitment to ensuring that the ACA is implemented in ways that ensure that people have the best possible access to care. Please contact us if we can be of further assistance.

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[18] Cristina Jade Peña, Laurie Sobel, and Alina Salganicoff, *Federal and State Standards for "Essential Community Providers" under the ACA and Implications for Women's Health* (Washington, DC: Kaiser Family Foundation, 2015), available online at: http://kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/

Sincerely,

Howard Brown Health
Chicago, IL

Comment separator page. Next comment follows.

Regarding CMS-9929-P, Patient Protection and Affordable Care Act; Market Stabilization

The HHS states that "we propose taking several steps to increase the incentives for individuals to maintain enrollment in health coverage and decrease the incentives for individuals to enroll only after they discover they require services." A stated aim of the proposed changes is "to adopt policies that promote continuous enrollment in health coverage and to discourage individuals from waiting until illness occurs to enroll in coverage." This comment addresses the likelihood that changes in enrollment periods will assist with these aims.

One of the most significant changes in this 70+ page document is the change in enrollment dates and enrollment opportunities. The proposed changes include cutting the number of days available for regular enrollment in half (from three months to one and a half months). The proposed changes further encumber enrollment during Special Enrollment Periods (SEP) which are provided to allow for life changes including job loss, death of or divorce by a family member who provided employer-based insurance, birth or adoption of a child).

Effect of Limiting the Enrollment Period

The regulation language suggests that these changes — in particular limiting the enrollment period — will limit use of the system by persons who don't enroll until and unless they have an illness requiring costly intervention. However, available data on ACA insurance use does **not** support the contention that people are incentivized to enroll by becoming ill. Rather, incentives seem to be tied to accessibility of the exchanges, as promoted by:

- affordability of available plans
- awareness of financial assistance available (which compounds the problem above)[1]
- limited paperwork burden

The Market Stabilization Plan, rather than providing more of these incentives to access by all persons (including those in good health), will discourage enrollment by:

- Lessening the time during enrollment, thus limiting access assistance with the process
- Burdening organizations available to assist people with the enrollment process limiting the available time to get through the process[2]
- Increasing the paperwork burden during special enrollment periods

Given what's known about current enrollment behavior, these changes are likely to **decrease** enrollment by young, healthy people, particularly because assistance with completing the process will be harder to access[3]. Nothing in enrollment data in ACA suggests that moving the annual enrollment deadline to an earlier date and reducing the time available for enrollment will encourage more healthy persons to enroll. In fact, reduced time available for enrollment

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[1] http://kff.org/health-reform/issue-brief/assessing-aca-marketplace-enrollment/
[2] https://www.enrollamerica.org/soe_report_2015/#Messages
[3]https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf

may compromise the ability for adequate outreach about enrollment (including information about subsidies and other assistance), which correlates with enrollment[4].

Special Enrollment Periods

An alternative means of increasing the number of health persons enrolling would be to increase options for re-enrollment when unintended lapses in coverage occur (e.g. job loss, death of or divorce by insurance-carrying spouse)[5]. Job loss is a particular problem among younger individuals (those between 24 and 54 years of age). These proposed changes will make it likely that potential participants will use of SEPs, by increasing the paperwork burden. In addition, reducing ease of access during SEPs may also hamper enrollment by uninsured young persons when they turn 26[6].

The use of ACA exchanges by healthy individuals provides financial support to the system, thus providing coverage for those with greater health care needs. The ability to enroll when one has a pre-existing illness is a key feature of the ACA and one of which the majority of Americans (69%) approve.[7] Restricting enrollment through the methods above would, in essence, undermine the ability of patients who have pre-existing conditions to seek insurance through the exchanges, thus *de facto* removing one of the facets of the ACA that the American people want to keep. Furthermore, these changes are unlikely to increase the enrollment of healthy individuals needed to maintain the ACA system. Loss of still more of the small pool of healthy persons in the exchange because of unnecessary changes to enrollment periods will not assist in maintaining the system financially.

In summary, the *stated* aims of changes in enrollment are unlikely to be achieved by these changes, nor will they assist in keeping intact one of the facets of the ACA of which the majority of Americans approve. In fact, the proposed regulations will discourage persons who need insurance most from seeking it through the exchange and will keep from enrolling people who can pay into the system now and take advantage of it as they age.

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[4] http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-october-2015/

[5] http://www.rand.org/blog/2017/01/can-a-continuous-coverage-requirement-produce-a-healthy.html

[6] http://www.nejm.org/doi/full/10.1056/NEJMhpr1503614#t=article

[7] http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2016; https://www.usnews.com/news/data-mine/articles/2016-12-01/poll-americans-want-to-see-changes-to-obamacare

Comment separator page. Next comment follows.

I have comments on several sections of this proposed rule change:

Shortening the enrollment period - This will work against stabilizing the market by discouraging healthier people from signing up. The enrollment period should stay at the current length. We are against this change.

Requiring pre-verification for special enrollment periods - This will substantially increase the burden on the consumer and discourage healthier people from signing up. There should at least be a pilot period involving only a small percentage of the pre-enrollment consumers to help ensure a smooth roll out. We are against this change.

Allowing the consumer to choose a later date to start their enrollment. If the verification process takes long, this seems well thought-out and consumer-friendly and we support it.

Applying premium payments to debt first and premiums second will penalize consumers who are trying to catch up on bills and comply with the insurance mandate. The rule proposal cites concerns about consumers potentially "gaming" the system as the need for this change, but does not cite any evidence that this is actually happening. At the very least, insurers should be required
to inform consumers when they have adopted this type of policy, should the rule go into effect. We are against this change.

Reducing the ECP requirement will likely encourage issuers to drop their ECP percentages to a level where they truly can't provide adequate coverage to low-income consumers.
Lowering the ECP minimum will also decrease consumer choice, and will almost certainly lead to a disruption in continuity
of care for some consumers who will need to change providers once theirs is no longer covered. We are against this change.

Comment separator page. Next comment follows.

March 7, 2017

Patrick Conway

Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization NPRM (CMS-9929-P)

Dear Dr. Conway,

Thank you for the opportunity to comment on Department of Health and Human Services (HHS)'s proposed market stabilization rule. We wish to raise concerns about the proposed rule impact on low-income families' ability to enroll in affordable, high-quality, comprehensive, and affordable health care coverage through the marketplace. We disagree with the proposed rule actions, but if the rule must be implemented, we provide suggested modification to remedy concerns.

The National Center for Law and Economic Justice provides legal representation, policy advocacy, impact litigation, and grassroots organizing support for low-income families, individuals, communities, and organizations to advance economic justice and preserve fundamental rights.

This proposed rule, if finalized, will cause health care enrollment to drop, make insurance less comprehensive and more expensive for consumers, and will particularly burden low-income and limited English proficient (LEP) communities. This proposed rule must take an approach that is consistent with the Title VI of the Civil Rights Act, Consumer Protection Act, section 1557 of the Affordable Care Act, and Federal and State Constitutional requirements for Due Process. If implemented, this proposed rule would:

- Restrict special enrollment and increase paperwork and other barriers for consumers, likely reducing the enrollment of healthier populations.
- Weaken cost-sharing requirements for marketplace plans, increasing health insurance deductibles, but reducing premium credits.
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage.
- Eliminate requirements for insurers to maintain adequate networks and to include sufficient numbers of essential community providers in their networks;

- Open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but in reality would disrupt people's access to coverage and conflict with current law.

If implemented, this proposal could cause instability in the Marketplace and create barriers to enrolling in coverage. These barriers are particularly significant for low-income and LEP populations who require more time to understand coverage and properly enroll.

Furthermore, we strongly object to HHS's decision to provide a 20-day comment period for this proposed rule. This is a drastic departure from past opportunities to comment, which typically offer 30-, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. We urge HHS to consider all issues raised by advocates working directly with impacted communities. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

I. Introduction

The Patient Protection and Affordable Care Act was enacted to make coverage more accessible to all Americans seeking health care coverage. It created new Health Exchanges for individuals who generally did not have access to affordable employer coverage and small businesses, to purchase coverage. Health insurance makes a difference in whether or not people get their care, when people get their care, where they get their care, and ultimately, how healthy they are. In 2016, 73 percent of nonelderly uninsured workers worked at a firm that did not offer health benefits to the worker.[1] Uninsured adults are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.[2]

The Affordable Care Act has successfully improved access to healthcare and decreased the uninsured rate in the United States. Data on 2016 Open Enrollment showed that 12.7 million Americans selected affordable, quality health plans, with 4 million new consumers signing up for coverage.[3] According to the US Census Bureau, before the ACA in 2009 about 48.6 million or 15.7 percent of the population was uninsured.[4] A 2015 study by the CDC using Census data showed the total uninsured rate as 9.2 percent and the uninsured rate for

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[1] Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS, http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

[2] *Id.*

[3] Center for Medicare & Medicaid Services, Health Insurance Marketplaces 2017 Open Enrollment Period: January Enrollment Report, January 10, 2017, pg. 5. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html#

[4] U.S. Census, Number Uninsured and Uninsured Rate: 1987 to 2011, http://www2.census.gov/programs-surveys/demo/visualizations/p60/243/figure8.pdf

individuals aged 18 – 64 demographic as 13 percent.[5] Thus, according to the CDC and census the uninsured rate has fell from 15.7 percent to 9.2 percent under the Affordable Care Act, the lowest uninsured rate in 50 years.

II. Revising the Guaranteed Coverage Provision.

HHS seeks comments about its proposal to revise the guaranteed availability requirement to allow issuers to apply a premium payment to an individual's past debt owed for coverage from the same issuer enrolled in within the prior 12 months. The proposal, which allows issuers to apply new premium payments to past premiums owed, harms low-income consumers and lacks critical protections. We oppose the proposal to change the guaranteed coverage rule because it would allow issuers to reject enrollees seeking coverage if they have past due premiums. We are very concerned about the harmful impact this provision would have on low-income and LEP communities.

Pursuant to 42 U.S.C.A. § 300gg-1, "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." The statute is intended to protect enrollees and ensure that all families are able to access health insurance without unfair restrictions, which is why the statute explicitly forbids rejecting people on the basis of pre-existing conditions and applying lifetime caps. Under current law, issuers must accept any enrollee who makes an application for coverage during an open or special enrollment period, regardless of past due premium payments.

More than one quarter of people who stop paying their premiums do so simply because they cannot afford them.[6] By forcing people to repay all of their arrears before they can qualify for coverage again, the proposal would create an insurmountable barrier to coverage for many low-income enrollees. In a state where only one or two health plans are available in the exchange, this provision could permanently block people from getting healthcare coverage.

Furthermore, allowing insurers to apply payments to past-due premiums without prior notice raises serious due process concerns. Issuers must comply with federal law and accept all families who apply for coverage, regardless of past due premiums. At a minimum, any proposal must contain the following basic consumer and due process protections.

[5] Cohen and Martinez, National Health Interview Survey Early Release Program, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January- March 2015, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf.

[6] Another 36% do so because they obtained other health coverage and therefore do not owe anything. McKinsey & Company, Center for U.S. Health System Reform, 2016 OEP: Reflection on Enrollment, May 2016, http://healthcare.mckinsey.com/sites/default/files/McK%202016%20OEP%20Consumer%20Survey%20Infographic_vF.pdf; KFF.org, Key Facts about the Uninsured Population, Sep. 29, 2016, http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

A. The proposal should require issuers to maintain accurate payment and account records.

Many consumers experience problems with data matching where consumers have actually paid their premiums or encountered other accounting errors that were not their fault. Consumers who attempt to address these data problems often encounter administrative and language access hurdles. Navigators frequently report problems communicating with health insurance companies because the automated phone systems are difficult to use and do not provide translation services for most languages.

Consumers experience a change in circumstances that was reported to the issuer, but not properly recorded. For example, many consumers drop marketplace coverage after getting a new job and enrolling in employer-based insurance. Consumers in this situation often experience difficulties cancelling a plan or the cancellation may not be properly recorded, causing the consumer to accrue unpaid premiums without their knowledge. When this occurs, consumers must be permitted to show they obtained alternative coverage and did not pay premiums because they had other coverage, and they may not be barred from enrolling in the marketplace if they require coverage again after losing their job.

B. The proposal should require issuers to notify enrollees when applying new premium payments to past debt.

First, any notice provided to enrollees regarding arrears and the application of premium payments must satisfy Title VI of the Civil Rights Act and ensure meaningful access to programs and activities by Limited English Proficient (LEP) persons.[7] Currently when a consumer enrolls in health insurance through the National or State exchange, she submits her information first and then completes the enrollment by paying the premium directly to the insurance company. Under this system, a consumer in arrears would not find out until too late that her payment did not in fact effectuate new insurance coverage.

If HHS implements this proposed change, it must require the issuer to first notify the applicant that her enrollment is not complete and that a premium payment is due. The issuer must also notify the consumer that if she has unpaid past premiums, the issuer will apply the payment first to arrears and it will not provide new coverage until all arrears are paid. This notice must occur prior to the consumer paying the premium payment. The information about

[7] The United States Department of Justice has issued a Policy Guidance, "Enforcement of Title VI of the Civil Rights Act of 1964- National Origin Discrimination Against Persons with Limited English Proficiency." These guidelines require Department staff to make reasonable efforts to provide timely language assistance services to ensure that LEP individuals have substantially equal and meaningfully effective access to Department programs or services. These guidelines are designed to be consistent with the standards set forth in the Department's initial LEP Guidance, Enforcement of Title VI of the Civil Rights Act of 1964— National Origin Discrimination Against Persons With Limited English Proficiency, 65 Fed. Reg. 50,123 (Aug. 16, 2000), the Department's later LEP Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455 (June 18, 2002) and the Attorney General's memorandum to the heads of Department components, Language Access Obligations Under Executive Order 13166 (June 28, 2010).

repayment should appear in the Plan Compare tools prior to enrollment and in the Eligibility Determination notice when consumers change plans during open enrollment or with special enrollment.

The notice should explain the amount owed, the grace period that the issuer will include the unpaid charges for insurance coverage in future bills, and that the issuer will deny coverage in the future unless the consumer pays the arrears. These notices should also comply with language access requirements to ensure consumers understand their rights and can get meaningful access to these services.

C. The proposal should direct issuers to permit deferred payment plans.

Issuers should allow for partial payment and payment plans to ensure they do not block consumers from health coverage as a result of errors or underpayments. The rule should ensure that the consumer has extended time to pay the past due amount, which makes the payments more affordable, and that the issuer provides coverage during this extended payment period. The issuer should provide the consumers a deferred payment plan that permits continued coverage during repayment. For example, issuer should amortize past due bills over a 12 month period and each monthly bill should include the charge for the next month, plus 1/12 of the amount owed for previous coverage.

This practice would align with the utilities and mortgage payment context, where the 12 month period for a 1 year contract is a standard payment plan. Many state utility commissions offer deferred payment agreements for delinquent utility bill payments by low-income customers.[8]

Additionally, consumers should be able to report any income changes or changes in household or hardships, in order to adjust their premium tax credit and payment plan. In the utility context, there is no legal impediment to attempted renegotiation of a deferred payment agreement in the face of changed circumstances. Some states even require utility companies to amend a deferred payment agreement after the consumer's circumstances change.[9] This practice recognizes the hardships low-income households face when seeking health care coverage for their families. In the utility context, companies must offer payment plans during the first instance where a consumer is unable to pay in full a delinquent bill. For consumers who are still connected or who have been disconnected for less than 120 days, companies must offer a payment plan that extends over at least 12 months. Companies must also offer a second

[8] Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia (winter only), Wisconsin, and Wyoming. *See* National Ass'n of Regulatory Utility Comm'ns, 1994–1995 Compilation of Utility Regulatory Policy in the U.S. and Canada 464, 465, tbl. 211.

[9] *See* N.Y. Comp. Codes R. & Regs. tit. 16, § 11.10(a)(5) (N.Y. Pub. Serv. Comm'n) (N.Y. Pub. Serv. Comm'n). See also In re Rules & Regulations for Tel. Utils., 151 Pub. Util. Rep. 4th 64 (W. Va. Pub. Serv. Comm'n 1994) (renegotiable only if significant changes in financial circumstances).

payment agreement if the consumer made at least two payments required under the first agreement, for the same term as or longer than the term of the first payment plan.

Issuers should implement a similar payment policy in the marketplace insurance context. Consumers who make incomplete payments are not trying to game the system. Consumers often cannot afford these payment amounts or their financial situations have changed, and they may need a new longer payment plan.[10] Consumers should be provided a payment plan, and if the consumer is unable to make that payment plan, issuers should offer a second payment plan as long as the consumer has made at least two payments. All payments made on a consumer's behalf, including those made with the assistance of the Premium tax credit, would count as a continuous payment under the second payment rules.

Lastly, HHS must implement a "hardship exemption" for consumers who are unable to make premium payments due to demonstrable significant financial hardship that caused the consumer to be unable to make premium payments. If issuers can use new premium payments to satisfy prior payment, they should be forbidden from charging late fees, interest or collection charges.[11] This policy should only apply for the policy holder of the individual policy and should not impact the enrollment of a family member and vice versa. For example, if a married couple is enrolled in care, and one spouse is behind on their premium payment, the issuers should be prohibited from refusing health care services to the other spouse.

III. Special Enrollment Periods

HHS proposes increasing pre-enrollment verification of eligibility for all categories of individual market special enrollment periods (SEP) for all States served by the HealthCare.gov platform to 100 percent of applicants. Requiring all special enrollment period applicants to provide pre-enrollment verification will dramatically decrease the number of enrollees, negatively impact the economic viability of the ACA, and possibly violate current federal laws regarding language access and guaranteed coverage.

We oppose the requirement that 100 percent of special enrollment period applicants undergo pre-enrollment verification as this will significantly burden low-income and LEP proficient populations and cause enrollment to drop.

A. CMS Data demonstrates the importance of SEP on overall enrollment

2016 Special Enrollment data shows that 1.6 million individuals enrolled through the SEP.[12] Sixty percent were granted access because they had lost minimum essential coverage. Eighteen percent of the SEP plan selections were made by consumers who initially applied for coverage during open enrollment but needed to receive an eligibility determination from their

[10] *See* Access to Utility Service (5th ed. 2011), 6.3.3.3.5 Renegotiation of plan based on changed circumstances updated at www.nclc.org/library.
[11] *See* note 14.
[12] Center for Medicare & Medicaid Services, March 31, 2016 Effectuated Enrollment Snapshot, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html.

state Medicaid agency before they could be determined eligible for Marketplace coverage and/or financial assistance. Efficient enrollment is essential to ensure continuous coverage, particularly those who lost coverage because of a loss of employment or death of a primary insurance holder.

The SEP increases overall enrollment numbers. For example, approximately 33.5 million Americans lose coverage each year between Open Enrollment periods for reasons that qualify for SEP such as job lost and divorce.[13] This number is necessary to supplement drops in enrollment during the year. The proposed rule to require SEP pre-verification relies on the GAO report on Special enrollment to suggest that consumers are misusing the system to enroll in coverage only if they become sick.[14] However, the report based this argument on a twelve person sample size, which is too small a sample size to be conclusive.

B. Special Enrollment Pre-verification will deter healthy enrollees

Adding additional barriers for consumers going through periods of adjustment in their lives, such as experiencing a change in family size, creates a disincentive to enroll in health insurance. Behavioral economics support that even small obstacles to enrollment can substantially reduce consumer enrollment.[15] For example, when CMS implemented the Deficit Reduction Act of 2005, which required Medicaid applicants to document citizenship, participation of eligible persons dropped precipitously.[16] Conversely, the Congressional Budget Office estimated that when the Children's Health Insurance Program Reauthorization Act of 2009 repealed its citizenship documentation requirements, an additional 500,000 eligible people would receive coverage.[17].[18]

CMS's implementation of the Special Enrollment Period in June 2016 shows that pre-verification would deter younger enrollees. CMS reported that 45 percent of SEP enrollees ages 18-24 who were selected for a post-enrollment review under the existing process failed to

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[13] Dorn, Research Report: Helping Special Enrollment Periods Work under the Affordable Care Act, page 2, June 2016. http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[14] United States Government Accountability Office, Report to Congressional Requesters, Patient Protection and Affordable Care Act, Results of Enrollment Testing for the 2016 Special Enrollment Period, page 7, Nov. 2016, http://www.gao.gov/assets/690/681094.pdf.

[15] Baicker et al. "Health Insurance Coverage and Take-up: Lessons from Behavioral Economics," V 90, I 1 The Milbank Quarterly, Mar. 19, 2012, http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00656.x/full

[16] Donna Cohen Ross, "New Medicaid Citizenship Documentation Requirement Is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up," Center on Budget and Policy Priorities, revised March 13, 2007, http://www.cbpp.org/archiveSite/2-2-07health.pdf.

[17] P. R. Orszag, Congressional Budget Office, letter to Speaker Nancy Pelosi, Oct. 25, 2007, https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/pelosicitdocletter10-25-07.pdf.

[18] *Hackmann, Martin B, Jonathan T. Kolstad and Amanda E. Kowalski.* "Adverse Selection and an Individual Mandate: When Theory Meets Practice." American Economic Review, 2015, 105(3): 1030-66, https://www.aeaweb.org/articles?id=10.1257/aer.20130758.

submit satisfactory documentation after an initial round of outreach.[19] By contrast, among individuals ages 55-64, the failure rate was much lower: 27 percent. Age is only a proxy for health status, but this data strongly suggests that the discouraged SEP enrollees would be comparatively healthy. The data showed that since implementing the pre-verification confirmation process in June, there was a 20 percent reduction in the number of consumers enrolling through special enrollment process between June 2016 and December 2016.

C. Pre-verification will overwhelming burden disadvantaged communities.

HHS should avoid higher documentation burden for enrollees during this period of time.[20] Considering the difficulties that immigrant and LEP consumers already face to verify identity and citizenship processes, it appears these populations would also be disproportionately less likely to enroll. Additionally, many LEP and low-income families will struggle to gather the necessary income and identification information because they work in non-traditional jobs, do not receive regular paychecks, are self-employed, or have limited income verification information. Low-income consumers who are eligible may abandon the enrollment process if they encounter difficulty obtaining documents or costs to reproduce documentation.

Requiring pre-verification completion before enrollment for special enrollment would also significantly impact families in crisis. For example, it is generally recognized that families fleeing domestic violence, particularly immigrant victims, would have difficulty producing the paperwork.[21] Requiring 100 percent of special enrollment applicants to produce pre-verification paper prior to enrollment would result in harsh results for many in crisis who need healthcare. The rule would create a barrier for survivors seeking healthcare, or cause significant delays during times of crisis where health care is essential.

D. Recommendations

If HHS implements the pre-enrollment verification process, it must identify the process for data matching, troubleshooting problems, and ensuring errors are corrected immediately. The pre-verification needs to be explained to consumers and the process must be simple and low cost to prevent enrollment deterrents.

As HHS indicated, electronic verification and data matching would make the verification process the most efficient. However, it is unclear whether current technology and information

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[19] Center for Medicare & Medicaid Services, Pre-Enrollment Verification for Special Enrollment Periods. https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf; see also http://pnhp.org/blog/2016/12/20/ethics-of-cms-experiment-on-special-enrollment/.

[20] *See supra* Section II B. Actions may violate Title VI of the Civil Rights Act by denying full enjoyment of the privileges, the Marketplace, based on national origin by proxy of language.

[21] U.S.C.I.S. Information on the Legal Rights Available to Immigrant Victims of Domestic Violence in the United States and Facts about Immigrating on a Marriage Based Visa Factsheet, https://www.uscis.gov/news/fact-sheets/information-legal-rights-available-immigrant-victims-domestic-violence-united-states-and-facts-about-immigrating-marriage-based-visa-fact-sheet.

sharing programs available will be able to support a real-time, streamlined eligibility and enrollment system. HHS must also provide a deadline for agents verifying the documents to prevent a delay in services and ensure needy families will be able to gain access to the health care services they need.

IV. Initial and Annual Open Enrollment Periods

HHS proposes to change the dates for open enrollment in the individual market for the benefit year starting January 1, 2018 from November 1, 2017 to January 31, 2018, to November 1, to December 15, 2017.

We are concerned about the impact cutting the enrollment period in half will have on low-income and LEP populations. Shortened enrollment period from 90 days to 45 days will dramatically decrease the number of enrollees, negatively impact the economic viability of the ACA, and may violate federal law.[22]

A. Enrollment data highlights need for longer open enrollment period.

ASFE enrollment data for Open Enrollment 2014, 2015, and 2016 support that a longer enrollment period would improve plan selection.[23] In 2014, 22 percent or around 1.2 million, of plan selections occurred during the beginning from October 1, 2013 until December 28, 2013; this percentage improved to 73 percent or 6.5 million enrollment occurring between November 15, 2014 and December 26, 2014. For 2016 Open Enrollment 86 percent, or 8.25 million enrollees, of plan selection occurred between November 1, 2015 and December 19, 2015. Although the data shows an increase with timely enrollment for 2016 Open enrollment, a closer look at the enrollment numbers show that approximately 39 percent of enrollment were new consumers and 61 percent were consumers renewing their coverage.[24] Renewals do not occur until December 15, meaning the numbers are concentrated in the period between December 15 and December 19th. CMS reported that December 15, 2016 was the biggest day of any Open Enrollment ever, with 670,000 plan selections.[25]

B. Longer Enrollment Periods will improve risk pools.

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[22] *See supra* IIB. These guidelines are designed to be consistent with the standards set forth in the Department's initial LEP Guidance, Enforcement of Title VI of the Civil Rights Act of 1964— National Origin Discrimination Against Persons With Limited English Proficiency, 65 Fed. Reg. 50,123 (Aug. 16, 2000), the Department's later LEP Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455 (June 18, 2002) and the Attorney General's memorandum to the heads of Department components, Language Access Obligations Under Executive Order 13166 (June 28, 2010).

[23] ASPE Issue Brief: Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report. March 11, 2016. https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.

[24] Center for Medicare & Medicaid Services, Special Edition Open Enrollment Snapshot: November 1 through December Deadline for January 1 Coverage, Dec. 21, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-21.html.

[25] *Id.*

Enrollment of young adults is important to produce a surplus in premium revenues to cover the cost of higher-risk older populations. Historically, younger and healthier people tend to wait until the end of open enrollment to buy coverage.[26] For 2017 Open Enrollment, 2.29 million 18-34 year olds got coverage through the Marketplace.[27] A majority of the younger population that enrolled occurred in the final weeks of enrollment.

The higher enrollment numbers after week 6 can be explained by consumer behavior. The November and December holiday season are busiest for individuals working in the service industry. Most families with school-age children would take holiday and vacations during the time period of December 24 through January 3. Students and younger, oftentimes healthier populations, are more likely to wait until the end of the year to submit documentation. During this time frame, the highest concentration of enrollment occurs because of time and resources available to dedicate to enrollment. Instead, the shortened enrollment period would likely result in a smaller, sicker pool. Those who are sick or have chronic conditions are more motivated to enroll regardless of the hurdles.

B. Impact on disadvantaged communities

Shortening the enrollment period from 90 days to 45 days would drastically reduce enrollment for the neediest populations. In particular, the consumers who require the most outreach, younger and LEP populations, would be less likely to enroll. Many families enroll at the end of the enrollment period for various reasons. Families who work service jobs are often the ones least likely to have employer based insurance, and usually only have one day during the weekday where they are free to physically go to the office to enroll. The enrollment process is particularly cumbersome for individuals with limited English ability and require immigration status verification. These families open need to seek assistance from navigators and in-person assisters.

The shortened enrollment period will also be a significant strain on navigators and assisters. Even with the current 90 day enrollment period, navigators and in-person assisters, especially language specific advocates, struggle to enroll all individuals who need help and often will need to turn people away. Many navigators and assisters already work long hours and weekends during the open enrollment period. Several holidays fall in this period of time, during which navigators are not available to assist. Many LEP and low-income families will need months to gather the necessary income documentation because they work in non-traditional jobs, do not receive regular paychecks, are self-employed, or have limited income verification information.

A shortened open enrollment period would also limit the time that organizations have to educate and conduct outreach to consumers about healthcare enrollment. This would in turn

[26] ASPE Issue Brief: Health Insurance Marketplace Enrollment Projections for 2017, Oct. 19, 2016, https://aspe.hhs.gov/system/files/pdf/211056/EnrollmentProjections.pdf.

[27] Center for Medicare & Medicaid Services, Health Insurance Marketplaces 2017 Open Enrollment Period: January Enrollment Report, Jan. 10, 2017, page 8, https://downloads.cms.gov/files/final-marketplace-mid-year-2017-enrollment-report-1-10-2017.pdf.

lead to lower enrollment. Populations that require more outreach, particularly younger, poorer, and LEP populations would be less likely to enroll.

C. Additional Rule Clarifications, Recommendations, and Considerations

One glaring omission to the rule is when and how plan renewals will occur, since historically, renewals begin December 15. Most renewals are not automatic, thus enrollees will need to proactively renew their coverage. Many LEP individuals will need to rely on navigator assistance to renew since they do not have access to the account portal information.

If this change is made, HHS and issuers must provide proper notice to all individuals impacted by this rule change. The failure to issue proper notice to public benefits recipients routinely results in the granting of preliminary injunctive relief.[28] HHS should give notice to all current ACA and past ACA enrollees, in an array of languages to ensure individuals enroll.

Since the passage of the Affordable Care Act, States and community advocates have worked tirelessly to promote the existence of the exchange and spent time and money promoting the timeline for enrollment. Drastically shortening the enrollment period to 45 days will not only cause many families to miss the deadline, but also cost states significant additional cost to properly notify and inform consumers of the changes. CMS should not decrease the enrollment period by 50 percent without giving all affected parties notice. Any attempts to reduce outreach and education will result in decreased enrollment. This is evidenced by the current administration's decision to reduce outreach and advertisements in the final two weeks of the 2017 enrollment period, which caused a drop in enrollment.

Thus, HHS should create an outreach plan to ensure consumers are aware of the change. They should continue to provide funding and support to Navigators and in-person assisters. Families with assisters are nearly twice as likely to successfully enroll as those enrolling online without help. These advocates are critical to educating communities in need and ensuring that consumers successfully enroll.

Lastly, the proposed rule hopes to design open enrollment to mirror private employer insurance coverage. This analogy is not applicable because the market considerations are different. Employer coverage, by default, automatically verifies income. Employers often have on-site human resource personnel available during work hours to provide assistance with enrollment and plan selection. For this model to be applicable, more navigators and in-person assister would needed to be funded and hired to streamline the process. Unlike in the traditional employer based insurance coverage, many new ACA enrollees are first time insurance buyers. New consumers have difficulty understanding the complexity of health insurance and plan coverage and require significant time to evaluate options and understand

[28] *See, e.g., Reynolds v. Giuliani*, 35 F. Supp. 2d at 331, 347-48 (S.D.N.Y. 1999).

coverage.[29] Younger populations, low-income communities, LEP people, and first time insurance buyers need time to process and understand coverage options.

V. Essential Community Providers

HHS proposes allowing issuers to use a write-in process to identify Essential Community Providers (ECPs) who are not on the HHS list of available ECPs for the 2018 plan year; and lowering the ECP standard to 20 percent, rather than 30 percent.

HHS should not reduce the percentage requirement for ECPs. HHS increased the ECP from 20 percent to 30 percent last open enrollment because it recognized the importance of ECP to provide for communities in need. ECPs represent a critical resource for low-income and vulnerable populations and those in medically underserved areas. A reduction in ECP coverage would particularly impact consumers by restricting access to specialty care, dangerous and costly treatment interruptions, and poor access to culturally appropriate care provides. Oftentimes the ECPs are institutions that have provided long-term care for communities and have strong relationships that are essential to management of chronic health conditions and disabilities. QHPs should be expected to do the work of ensuring all of their enrollees can access the type of providers best suited to their needs. The proposed reduction would not provide any meaningful reduction in issuer costs, but instead harms consumers. Allowing issuers to remove these providers from their network will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider that has no experience caring for historically disadvantaged populations.

VI. Levels of Coverage

HHS proposed increasing the de minimis variation in the actuarial values used to determine metal levels of coverage for the 2018 plan year. Increasing the de-minimus variation AV will shift costs onto the enrollees, with higher deductibles and copayments, allowing insurance companies to sell cheaper, but deceptively less comprehensive, insurance plans.

Consumers rely on the metal tiers to differentiate between the value and cost-sharing required among different products. Increasing the variation, particularly to allow lower value plans, blurs the lines between metal tiers, and may lead to consumers unwittingly enrolling in a plan that does not meet their needs.

VII. Conclusion

Overall, this proposed rule places significant burdens and barriers on consumers who seek to enroll in health insurance and reduces the quality of insurance products. The ACA was passed to expand access to affordable health insurance. This rule would effectively dismantle the progress the act has made toward increased access to healthcare and improved health outcomes. It most likely would reduce the quality of risk pools by discouraging enrollment

[29] *See* Loewenstein and Bhargava, The Simple Case Against Health Insurance Complexity, Aug. 23, 2016, http://catalyst.nejm.org/simple-case-health-insurance-complexity/.

among healthier people while erecting barriers that would likely disproportionately impact minority, immigrant, and low-income communities. HHS should not adopt the proposed rule, but if it is finalized, we hope HHS will consider the suggested modifications.

Thank you for your consideration of our comments.

Comment separator page. Next comment follows.

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Submitted March 7, 2017 via www.regulations.gov

Re: CMS-9929-P: Patient Protection and Affordable Care Act; Market Stabilization

Dear Sir or Madam:

The Virginia Poverty Law Center (VPLC) appreciates the opportunity to comment on the proposed rule, "Patient Protection and Affordable Care Act; Market Stabilization" (CMS-9929-P), published in the *Federal Register* on February 17, 2017.

Founded in 1978, VPLC is a nonpartisan, nonprofit organization that coordinates and leads efforts to seek justice in civil legal matters for lower income Virginians. Since the launch of the Health Insurance Marketplace (Marketplace) in 2013, VPLC and its community-based partners have provided more than 110,000 Virginians with free, unbiased assistance with the health insurance application and enrollment process.

Today, Virginia enjoys a stable and competitive Marketplace[1]. Eleven insurance carriers currently offer plans on the Marketplace in Virginia and this is the same number of carriers as last year. Robust competition has resulted in a wide variety of comprehensive health plan options for consumers, and during the most recent open enrollment period more than 400,000 Virginians selected a health plan. Since the passage of the Patient Protection and Affordable Care Act (ACA), Virginia has seen a 20% reduction in the number of uninsured Virginians, and the current uninsured rate is at a historical low.

While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, the proposed rule, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people

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[1] Martz, Michael. (2016, October 27). Virginia, Richmond region fare relatively well in health insurance analysis. *Richmond Times-Dispatch*. ("The availability of insurance options will remain relatively robust and increases in premiums relatively low").

will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Under the Affordable Care Act (ACA) we have made unprecedented coverage gains and continuing this success should be the priority moving forward. Providing meaningful access to coverage as well as strong consumer protections that ensure coverage is high quality and affordable will not only preserve the impressive coverage gains the ACA has made, but will also contribute to a robust and stable Marketplace.

Lastly, we are strongly dismayed by the decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Detailed comments on the proposed rule follow below. If you have any questions or concerns regarding VPLC's comments, contact Deepak Madala (deepak@vplc.org) or Sara Cariano (sara@vplc.org) at (804) 432-0199.

<u>Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets</u>

Guaranteed Availability of Coverage (§ 147.104)

The proposed rule would allow issuers to require consumers to pay past due premiums before resuming coverage with the same issuer in a subsequent year. We are very concerned about this policy, particularly for lower income individuals.

We believe the proposed reinterpretation of the guaranteed availability provision is unlawful and outside the HHS's authority. We encourage HHS to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through ordinary collection procedures.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and <u>HHS does not have authority to expand these restrictions to include prior non-payment of premiums</u>. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and HHS must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments.

And beyond the legality of the proposal, we have significant concerns regarding its potential implementation. We have encountered numerous situations where consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, or had other accounting irregularities that were of no fault to the consumers. Consumers often attempted to fix these issues with a plan but faced numerous administrative and bureaucratic hurdles to do so.

It may also be an issuer or marketplace error that leads to an assumed non-payment. For example, if a consumer enrolled in a marketplace plan gets a new job and obtains employer-based insurance, the consumer may have tried to cancel a plan but the marketplace or issuer may not have received the information or accurately acted upon it. To the issuer, it may look like a consumer stopped paying premiums while the consumer actually had obtained alternative coverage and no longer needed marketplace coverage. In this situation, consumers must be able to show they obtained alternate coverage and thus did not pay premiums because they had other coverage. In the future, if they need to come back for marketplace, they should not be subject to any repayment.

The proposal also raises concerns regarding significant hardship for consumers living in areas where only one issuer may participate in the marketplace. In these situations, these consumers would be forced to repay past premiums while consumers living in areas with multiple issuers could enroll in a different plan and not be subject to repayment.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.

Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

Initial and Annual Open Enrollment Periods (§ 155.410)

We strongly urge HHS to keep the length of open enrollment periods to three months, as it was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about and enroll in coverage within the given timeframe. If the rule is finalized, there will be limited time for affected consumers to learn about the changed length. The most motivated, often sickest, consumers will diligently enroll, but healthier and younger consumers are less likely to be aware of the change and miss the new deadline. We know that consumers continue to have gaps in knowledge about the coverage options available to them and we believe a longer open enrollment period should continue in order to ensure that all eligible consumers enroll.

We also have concerns about consumers' ability to gain in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer plans. We appreciate that HHS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand.[2] Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[3] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[4]

We support HHS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements

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[2] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (*Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[3] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[4] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[5] We urge HHS to provide more detail about what these activities will include. We also urge HHS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[6]

If HHS determines it necessary to end open enrollment on December 15, we propose that open enrollment begin on October 1, as the first open enrollment did. An earlier start date would provide enough time to consumers to learn about any Marketplace or plan changes before enrolling, limit adverse selection that may occur as the result of a shortened open enrollment period, and allow for Navigators, in-person assisters, certified application counselors, brokers and agents to provide assistance to more consumers; yet all plans would begin on January 1. It will provide stability by both allowing more people to enroll, creating a larger risk pool, and avoiding shortened plan years and churn that occurs from people changing plans after December 15.

Special Enrollment Periods (§ 155.420)

We've served consumers throughout Virginia and have yet to see evidence of consumer abuse of special enrollment periods (SEPs). We do, however, regularly see significant gaps in knowledge about the Marketplace and enrollment processes among eligible consumers. Very few people who are eligible for SEPs know that they are eligible and even less are able to navigate the enrollment process without in-person assistance.

A recent study from the Urban Institute confirms our experience and puts the SEP-enrolled population at just five percent of those who are eligible.[7] Given these facts, we do not believe consumers are gaming a system they know little about. HHS should work to support a balanced risk pool by increasing enrollment in SEPs. This can be accomplished by:

- Supporting public education and marketing campaigns that increase awareness of and enrollment in SEPs – especially among young adults. Nearly all of the past and current marketing efforts by the Marketplace and QHP issuers have occurred during open enrollment periods. More of these efforts need to occur between open enrollment periods to promote SEP enrollment opportunities.

[5] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[6] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[7] Dorn, Stan, "Helping Special Enrollment Periods Work under the Affordable Care Act," June 2016.

- Increasing funding for Navigators and other enrollment assistance professionals. Based on our experience, consumers who are eligible for SEPs often require a navigator, agent/broker, CAC, or other enrollment professional to help them apply for and enroll in coverage.
- HHS should work with federal and state agencies that serve the unemployed to increase awareness of SEPs among consumers who lose employment-based coverage. We have worked extensively with displaced workers through Virginia's Workforce Centers and Rapid Response program. We have found awareness of SEPs very limited when people are losing employment-based coverage. Employers provide lots of information about Cobra, but little to nothing on more affordable FFM options.

SEPs are important mechanisms to ensure that individuals maintain coverage year-round without any gaps and should be marketed widely and be easy for consumers to access. People's life circumstances change throughout the year and SEPs are needed to assure families are insured when those changes occur. Through our work we regularly see the importance of SEPs and the protections they offer. Any changes that serve to delay enrollment jeopardize one of the ACA's most important and popular protections – an individual's ability to gain coverage "right away" following a life event and maintain continuous coverage. If additional burdens are going to be placed on the consumer there should be additional protections provided for them as well.

Pre-enrollment verification requirements will further limit access to SEPs and they may jeopardize the integrity of the market mix by ensuring that only the sickest and costliest consumers pursue SEPs. If pre-enrollment verification requirements are implemented, then a number of protections are needed to ensure that consumers understand what is happening and are able to avoid gaps in coverage.

- The Marketplace should provide clear and accurate notices that inform people about their rights and responsibilities and information about any additional actions they need to take to secure coverage using an SEP.
- A timeframe for the Marketplace to review documentation should be set. If the documents are not reviewed within this timeframe, the consumer should be allowed to enroll.
- If an enrollment is delayed due to the verification processes, retroactive coverage and/or a hardship exemption should be available to enrollees who are later verified.
- There should be a smooth confirmation process in place before the pre-enrollment verification process is launched that relies on external data sources to verify eligibility before requesting additional information from the consumer.
- We strongly recommend that any pre-enrollment verification processes still allow someone to select a plan, even if they cannot fully enroll in the plan before verified. We assist many consumers who live in rural areas or have mobility or transportation difficulties. Consumers are less likely to finish the process of

enrolling when we require more than one appointment. Only the most motivated and in need of medical care will do this, while those who do not have an urgent need for coverage will not finish the enrollment process.

- We have concerns about the capacity for the Marketplace to quickly verify documents that are submitted. Under the current SEP verification process, only a small percentage of documents are reviewed. We regularly work with consumers who have data matching issues that take a very long time to resolve because documents are not reviewed. We recommend a special group of staff is used to review these documents and that consumers and assisters can communicate with this group to check on the status of documents after they have been submitted or get clarification if a document is not accepted.

We have also found that it is difficult for consumers to get proof of prior coverage from their former insurer or employer. As such, we recommend that HHS require insurers to provide notices when individuals lose coverage or agree to issue a standard proof of coverage document upon request to the Marketplace.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

<u>Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges</u>

Levels of Coverage (Actuarial Value) (§ 156.140)

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe this policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing. It will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage by shifting significant costs to families and, as a result, will likely reduce enrollment. Not only would the proposed hurt consumers and increase deterioration of Marketplaces, it is unlawful.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, a Families USA analysis found that

reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[8]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size of the premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[9]

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee's income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. While reductions in actuarial value may reduce gross premiums, they do not reduce the net enrollee premium. Potential enrollees will, however, face higher deductibles and other out-of-pocket expenses for the same cost if de minimis variation is expanded. The impact statement of the proposed rule even states that "*The proposed change in AV could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks with high medical costs."*

As a result, and contrary to the proposed rule's assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by increasing cost-sharing expenses and thus discouraging enrollment of younger and healthier consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment nor offset the increases in cost-sharing.

Further, the proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility

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[8] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense.

[9] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The proposed expansion exceeds the Secretary's authority and undermines the plain meaning of the statute.

If the Secretary finalizes this proposal, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Using a 70 percent actuarial value plan as the benchmark would result in a significant enrollee premium reduction for enrollment in a 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease would likely spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan. Using this methodology will encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

The Secretary must also require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. The Secretary is given authority, however, to modify the out-of-pocket reduction only if it would "result in an increase in the plan's share of the total allowed costs of benefits provided under the plan" above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that the Secretary establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. The Secretary, then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We encourage the Secretary to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow

issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and the Secretary should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

Network Adequacy (§ 156.230)

Over the last several years, HHS has taken significant steps to strengthen network adequacy protections in the Exchange. We commend HHS for these steps, which are crucial to making the promise of care in the Affordable Care Act real. Over time, HHS has made significant improvements to the regulations at sections 155.1050 and 156.230, in defining the network adequacy standards to which QHPs will be held. Even still, we urge HHS to adopt more stringent regulations in this area, as the current regulations do not fully ensure that consumers who enroll in QHPs will have access to adequate networks.[10]

Thus, the proposals set forth in the preamble to this regulation would represent a step backward in the area of network adequacy. HHS proposes to take a more hands off approach to monitoring this area, and cede authority to states and accrediting agencies. We urge HHS not to implement these proposals, but instead to continue on the path of taking steps to monitor network adequacy in Exchange plans more closely. Without access to the providers that deliver the services they need, consumers' access to coverage in Exchange plans is an empty promise. HHS must ensure that these plans contain sufficient provider networks to afford consumers access to the services and treatment they need without delay. Without these assurances, consumers will be unable to access care, and some will experience complications, worsening of symptoms, or even death, as a result.

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[10] *See, e.g.,* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Dep't Health & Human Servs. 13-18 (Oct. 6, 2016), http://www.healthlaw.org/issues/medicaid/services/Comments-ACA-Benefit-Payment-Parameters.

a. HHS should not rely on state reviews for network adequacy

HHS must establish and monitor a national network adequacy standard for QHP issuers, and the same standard should be applied to all QHP issuers. The Affordable Care Act requires the Secretary of HHS to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the states. In the ACA, Congress clearly mandated the Secretary of HHS to "by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum . . . . ensure a sufficient choice of providers." ACA § 1311(c)(1). If Congress had wanted each state to set and review its own network adequacy standards, it would have said so. It did not, but instead charged the Secretary with establishing minimum standards applicable to all Exchanges, and ensuring compliance with those standards. ACA § 1311(c)(1).

We appreciate that HHS's current proposal will require issuers (save MSP issuers) in the Marketplace to meet HHS's "reasonable access standard," or state standards approved by HHS. While we support HHS's leaving the states and OPM with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, HHS must establish a clear national floor for network adequacy in these regulations, and monitor compliance with those national standards itself. The Secretary should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country.

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. Leaving network adequacy standards to the discretion of states has resulted in consumer protections varying widely across state lines. The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges, and monitoring compliance with that standard itself.

b. HHS's "reasonable access" standard is not a sufficient measure of network adequacy.

HHS has never explained how its "reasonable access" standard is measured or monitored. Thus we have little information to assess whether the "reasonable access" standard has been successful in ensuring access in the past. We are therefore disappointed that HHS is proposing to revert to this standard, rather than adopting precise quantitative standards that would help insurance regulators, consumers, providers, and advocates to evaluate what constitutes "reasonable access." We

recommend that HHS instead move forward with its prior proposal of establishing a national baseline for time and distance standards.

c. *HHS should not allow states to rely on accreditation agencies to supersede time and distance standards.*

We disagree with HHS's proposed approach of replacing time and distance standards with accreditation. While we agree that accrediting bodies can play an important role in the area of network adequacy by measuring QHPs against the network adequacy standards set out in the federal regulations, their accreditation does not replace the existence of such standards. Rather, the Exchanges themselves must hold QHPs to rigorous network adequacy standards. We urge HHS to reconsider the approach set forth in the preamble, and instead move forward with its previous plan of establishing specific geographic access standards.

Essential Community Providers (§ 156.235)

We urge HHS not to reduce the percentage requirement for ECPs. HHS is proposing to go backward, and reduce the percentage from 30 percent to only 20 percent. This reduction represents a significant step backward, that will reduce the availability of essential community providers to consumers, denying them access to these critical providers who have experience serving their communities.

The proposed reduction would not provide any meaningful reduction in issuer costs. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. Any reduction in ECPs could, however, harm beneficiaries by restricting access to the appropriate specialty care, creating dangerous and costly treatment interruptions, and limiting access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities.

Instead, we urge HHS to strengthen the requirements for ECN providers to be included in all QHP networks by:

- instituting an "any willing provider" requirement for QHPs to contract with ECPs.
- stating explicitly that QHPs may not contract directly with individual providers working within an ECP, but must contract with the ECP as an entity.
- at a minimum, require QHPs to offer legally-compliant, good-faith contracts to all FQHCs in their service area.

If the proposed reduction is finalized, we urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers could attempt to shed high-cost enrollees by eliminating their ECP from the provider network.

This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

Thank you for considering these comments.

Sincerely,

Deepak Madala

Sara Cariano

Comment separator page. Next comment follows.

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COMMENTS to the Department of Health and Human Services Centers for Medicare & Medicaid Services

RE: Patient Protection and Affordable Care Act; Market Stabilization

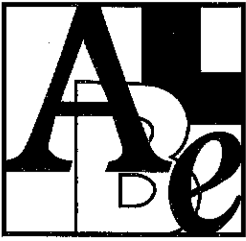
Re: CMS-9929-P

By Advocates for Basic Legal Equality

March 7, 2017

Advocates for Basic Legal Equality(ABLE) respectfully submits the following comments to the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) in response to the CMS-9929-P proposed rule changes (hereafter "the proposed rule") affecting the Patient Protection and Affordable Care Act (ACA). ABLE is a regional nonprofit law firm that provides a full range of free, high quality legal assistance to low-income groups and individuals to help them achieve self-reliance, and equal justice and economic opportunity. ABLE represents quite a large number of individuals who have greatly benefitted from the medical coverage provided through the ACA. Previous to the passage of the ACA, many of these individuals had no access to affordable medical coverage and were at risk for serious illnesses and even death. Understandably, these individuals are extremely concerned about losing their current access to the healthcare which is assisting them with paying for medications, medical treatments, physician visits, durable medical equipment and surgeries.

ABLE is submitting these comments to the proposed rule altering implementation of the ACA because ABLE is deeply concerned by provisions that will make it harder for consumers to obtain and maintain health insurance coverage. The consumer protections of the ACA have given low and moderate-income Ohioans access to affordable health care providers who have



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treated their chronic and acute illnesses. This treatment has enabled Ohioans to live better, fuller lives.

In observing the ACA's effect in Ohio over the past few years, the healthcare law's impact is unquestionable. The overall uninsured rate decreased from 11% to 6.5% from 2013-2015.[1] Furthermore, Ohio managed to enroll almost 500,000 citizens in the first few years following the approval of the state Medicaid expansion, through the ACA.[2] Despite the enormous benefits brought to Ohio from the ACA, surveys within the population struggling to access healthcare insurance reveal both the high cost of health insurance and Medicaid ineligibility as ongoing detriments towards reliable insurance access.[3]

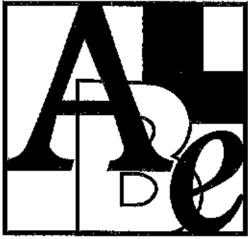
ABLE has significant concerns about the proposed rule's effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces. Overall, the proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides. In particular, if implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;

[1] Jessica C. Barnett and Marina S. Vornovitsky, *Health Insurance Coverage in the United States: 2015* (Washington, DC: U.S. Department of Commerce, Sep 2016), available online at: https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf

[2] Nelson A. Rockefeller Institute of Government, *Ohio: Individual State Report* (September, 2015), available online at: http://www.healthpolicyohio.org/wp-content/uploads/2015/10/2015-09-Ohio_Individual_Report.pdf.

[3] Health Policy Institute of Ohio, *HPIO Webinar on Private Health Insurance* (November 30, 2016), available online at: http://www.healthpolicyohio.org/wp-content/uploads/2016/11/InsuranceBasics_Webinar_slides.FINAL_.pdf.



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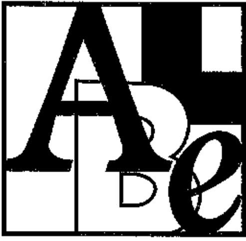
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks; and
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that would actually disrupt people's access to coverage and conflict with current law.

The new set of proposals will make it far more difficult for the lower-income population of Ohio that purchase health care insurance plans directly from the marketplace. In accordance with ABLE's goals, the purpose of these comments is to outline how the proposals will negatively impact individuals' ability to access and afford healthcare insurance.

The preamble of the proposed rule states, "continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited," but the *rule itself* also mentions seven times that the effect of certain provisions of the rule is "uncertain" or "ambiguous." While we agree that there is a need to promote market stability and ensure that issuers continue to offer coverage for the 2018 plan year, these proposals are far from the correct or appropriate solutions to the problem. Further, these changes would do nothing to address the biggest threat to the market: the instability and uncertainty created by the continued threat of repeal from the President and Congress.

In fact, the Administration's proposals, if implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers virtually guarantee that fewer people will enroll, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable



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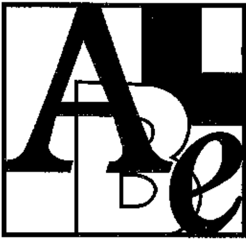
market. Those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

Lastly, we are appalled by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is drastic departure from past opportunities to comment, which typically offer 30, 60, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations; many affected parties will likely be unable to weigh in with comments.

Guaranteed Availability of Coverage (§147.104)

The NPRM proposes allowing issuers in the individual or group market to refuse coverage to an individual (or employer) who owes the issuers premiums from the prior 12 months, unless and until the individual (or employer) pays the premium debt in full. This change should not be adopted. This conflicts with the statute, which says that issuers generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. This change would bar people, many of them with limited incomes, from accessing coverage and the financial assistance for which they are eligible as a result of premium shortfalls during the prior year. Under this proposed rule, only those who can rapidly come up with a possibly significant sum of money by a given deadline can be guaranteed access to health coverage. In some parts of the country, people who owe back premiums to one issuer could then seek coverage with a different issuer, but that would not be possible in areas with only one issuer offering individual coverage. For example, within Ohio, Anthem is the sole carrier offering ACA Marketplace healthcare insurance in 19 counties, and in 28 other counties only Anthem plus one additional insurance carrier offer plans on their insurance marketplaces.



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Therefore, out of the 88 counties in Ohio, more than 50% have no more than 2 coverage options for individual enrollees.[4]

Strangely, in a proposed rule aimed at providing greater stability in the insurance market, this policy would likely deter *healthier* people who get behind in their premiums from enrolling, since often-healthy younger people are more likely to miss bill payments in general. This could weaken the overall health of the coverage pool in a similar way as the proposed changes to SEPs.

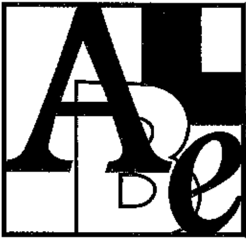
Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment[5].

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment

[4] Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Plan Selections by County* (March, 2016), available online at: https://aspe.hhs.gov/sites/default/files/aspe-files/187796/mar2016marketplacezipcode_1.xlsx.

[5] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrolment declines gradually throughout the year, a sign that enrollees leave the market during the year for many reasons, including obtaining other coverage. See: http://www.cbpp.org/research/health/marketplace-grace-periods-working-as-intended



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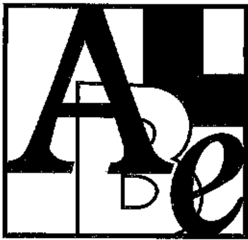
schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.

- The issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers in the notice recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

- <u>Open Enrollment Periods (§155.410)</u>

  We strongly urge CMS to keep the length of open enrollment periods at three months, as is was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about *and* enroll in coverage within the given timeframe. If the rule is finalized, there will limited time for affected consumers to learn about the changed length. We know that consumers continue to have gaps in knowledge about the coverage options available to them and we believe a three-month open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enrollment period should continue in order to ensure eligible consumers enroll.

We also have concerns about consumers' ability to gain in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with open enrollment in Medicare and many employer plans. We appreciate that CMS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand[6]. Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Furthermore, the proposal advocating for a changed 2018 enrollment deadline running from Nov. 1 to Dec 2017 is problematic because that time period is when consumers often have heightened financial constraints and are distracted by the holiday season[7]. As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[8] Altering the enrollment period to only consist of the few weeks at the end of the year will dramatically affect insurance purchasing patterns.

- Requiring individuals who live at 138% of the federal poverty level to make a purchasing decision regarding healthcare insurance amidst the other payments due at the end of the year is likely to impact the perceived value associated with healthcare insurance in the moment. Combined with a reduction in time for individuals to learn about coverage in their local area, the efficacy of healthcare insurance purchasing patterns by consumers, especially given the fact that insurance companies price plans based on these patterns, will alter the risk pool while also influencing consumers' ability to maintain sustained coverage. Combining the shorter open enrollment period with

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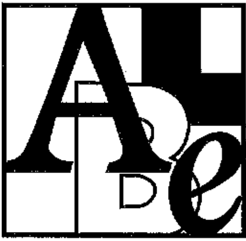
[6] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (*Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[7] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[8] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492



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the presence of potential continuous coverage requirements and increases in cost-sharing through changes in the insurance plan actuarial value boundaries (discussed below), consumers will be required to make quicker decisions regarding their preferred healthcare insurance plan on the marketplace while also having to consider the implications of being unable to sustain continuous coverage coupled with complex changes in the prices associated with each plan's coverage.

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[9] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[10]

Special Enrollment Periods (SEPs) (§155.420)

Overall, we are very disappointed about the proposed changes to SEPs and urge you not to finalize them. In order to ensure that healthy people enroll in coverage, thus bringing down the cost of coverage overall, enrollment rules and procedures should strive to make it *easier*, not *harder*, to enroll in coverage. Estimates show that less than 5 percent of eligible consumers enrolled in coverage through SEPs in 2015,[11] and we are concerned that these

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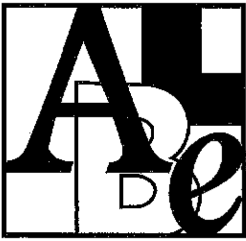
[9] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[10] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[11] Stan Dorn, *Helping Special Enrollment Periods Work under the Affordable Care Act* (Washington: Urban Institute, June 2016), available online at:



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new requirements will likely result in even fewer eligible consumers accessing coverage using an SEP.

Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, we *still* have not been provided with any evidence that ineligible people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to follow through.[12] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will complete the process.

We are very disappointed in the proposal to expand pre-enrollment verification. No evaluation or analysis of the impact of the numerous changes – specifically increased verification requirements – that have already been implemented for the FFM has been conducted. We do, however, appreciate that the preamble requests comment on whether a small percentage of enrollees should be retained outside of the pre-enrollment verification process in order to evaluate the impact of these processes and we strongly urge CMS to do so.

We are also strongly opposed to rules requiring prior coverage for the marriage SEP and rules limiting the ability of currently enrolled consumers to change plans. Currently, enrolled consumers who are newly eligible for premium tax credits (PTCs) may select a plan from any available metal level. This is important so that individuals and families experiencing life changes can gain access to financial assistance or can adjust to loss of subsidies and still afford coverage. For example, someone who experiences an increase in income may receive a reduced premium credit and/or lose access to cost-sharing reductions

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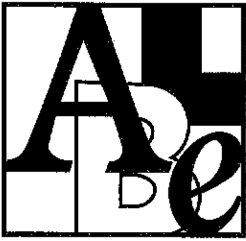
http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[12] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.



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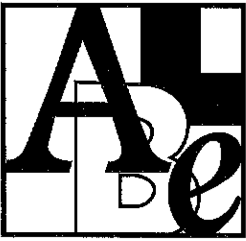
during the course of the year. This warrants the chance to change metal levels if they choose.

It is critical that eligible consumers successfully finish the SEP verification process with minimal burden. The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the bar be higher, consistent with the streamlined eligibility and enrollment process envisioned by current law. For example, in cases such as birth, denial of Medicaid or CHIP, or loss of Medicaid or CHIP eligibility, SEP applicants' coverage should *not* be pended. When considering patient population who benefitted from Medicaid expansion programs, like in Ohio, individuals who transition in and out of the expanded Medicaid status will be subject to these new more stringent purchasing restrictions as a result of the increase in SEP verification processes. These individuals are also likely to fall into the category of being those that require medical insurance assistance the most. As such, altering or restricting the ability of these individuals to gain access to insurance through SEPs may even pose the danger of restricting access to much-needed insurance coverage for unhealthier patient population groups. The extensive requirements for past coverage may also harm these patient populations, given the fact that uninsured individuals who transitioned to Medicaid via the expansion, and may be now seeking private insurance may have difficulties in procuring the relevant documentation to pass the stringent SEP requirements.

Instead, their attestation should be accepted with eligibility verified afterward in order to ensure continuity of their health care and coverage. Further, we seek clarification about the timeline for building effective electronic verification systems and recommend that there are strong manual systems in place should electronic verification not be ready by June 2017 or should electronic verification not work for all consumers. We also want to emphasize that



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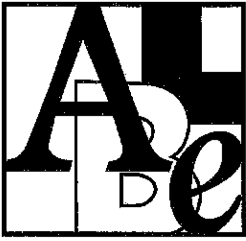
marketplaces, not issuers, should continue conducting SEP verification, consistent with the law.

We also appreciate the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process. One strategy the Administration should use is to conduct robust outreach through email and calls to consumers who have not yet completed the process. Another strategy would be for the federal government to again require insurers or employers to issue certificates of creditable coverage (which used to be required under HIPAA) so there is a reasonable way for people to obtain the proof of eligibility. Currently, there is no assurance that individuals will be able to obtain such proof of coverage, much less in the time frame suggested, and we are aware of cases when people's former employers have not provided it upon request. Yet, under the proposed rule, people's coverage would be held up and possibly denied for failure to submit such proof.

The proposed rule also requests comments about changes to SEPs for state-based marketplaces (SBMs). We urge the Administration to not require SBMs to align with the federal process for pre-enrollment verification, nor with the other SEP changes proposed in this regulation. States should have the flexibility to create policies and processes that work for them. Because the federal government is rushing ahead with policies that risk reducing enrollment of eligible people, including those who are healthy, it is critical to allow states to take other approaches that fit their specific needs. This serves the dual purposes of ensuring that more eligible people are able to access coverage without undue hassles in SBMs and allows the federal government to benefit from the information that states find as they adopt their own policies. We also note that SEPs largely apply on a marketwide basis, and states continue to have authority over their individual and small-group insurance markets and can implement issuer standards and other rules that are more protective of consumers and that do not impede the application of federal law.



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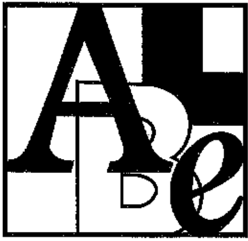
Continuous Coverage

According to the preamble, the Administration is considering various proposals that could be established that would "promote continuous enrollment in health coverage" without gaps and discourage people from "waiting until illness occurs to enroll in coverage."

One idea discussed would require individuals applying for a special enrollment period to show they have had health coverage for significant period of time (perhaps 6 to 12 months) without a gap of more than 60 days and then to be denied access to coverage through an SEP if they can't show they have had "continuous coverage." Another example discussed is a requirement that individuals who are not able to provide evidence of prior "continuous coverage" without a gap could face insurer practices – such as a waiting period before benefits begin or a late enrollment penalty—that have not been allowed in the individual market since enactment of the ACA. These ideas would serve as impediments to people getting coverage, overburden consumers, and conflict with current law. Individuals who are unable to maintain continuous health insurance coverage are likely to be patients within the population that will require health insurance the most. Imposing artificial waiting periods on these consumers due to the fact that they were unable to maintain continuous coverage leading up to marketplace enrollment will constitute a denial of coverage for patient populations who are most in need. In particular, the 90-day waiting period suggested in the proposed rule may exacerbate the health of individuals with chronic conditions requiring continuous monitoring. A delay in obtaining insurance due to a lack of continuous coverage will put them at an increased health risk not only for the 90-day waiting period, but in the time following the waiting period, when increased health care resources are needed to regain control of chronic illness. It could well be more costly to the health care system to resolve an entirely preventable acute condition brought on by the lack of needed health care during the waiting period.



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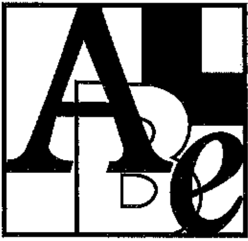
Unless legislation changes the guaranteed availability requirements of the ACA, issuers still generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. There is no basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty (through the ACA's individual mandate). It is unfair to create another penalty that would withhold future coverage because a person has been uninsured. Imposing a waiting period on some consumers' benefits or making them wait "at least 90 days" for their coverage to be effectuated is completely inconsistent with guaranteed availability. Late enrollment penalties or surcharges conflict both with guaranteed availability and the requirement that premiums vary only based on certain specified factors; whether a person has been uninsured in the past is not an allowable rating factor, for example.

The ideas suggested in the preamble would also inflict serious harm on many consumers. Breaks in coverage are fairly common today, a fact that has been borne out by numerous studies.[13], [14] Imposing late fees, waiting periods before benefits begin, or other barriers to accessing coverage mean that some people will not get the coverage or the health care services that they need. Current law already has restrictions that protect against adverse selection: limiting enrollment to specified periods and the individual mandate penalty are two examples. In addition, the proposals floated in the preamble would likely reduce overall enrollment in coverage, particularly among healthier people. Therefore, the ideas floated here actually raise the risk of making the risk pool worse and health coverage less affordable overall. To truly promote continuous

[13] Some 36 percent of Americans ages 4 to 64 (89 million people) went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once, according to a study by the Commonwealth Fund: http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance

[14] Nearly one-quarter of people with pre-existing health conditions (31 million people) experienced at least one month without health coverage during 2014, according to data from the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.



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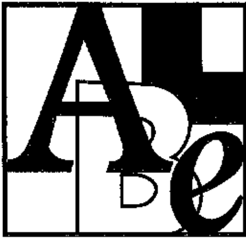
coverage, an open and accessible system – not a closed and onerous one – is needed to ensure that people successfully obtain coverage when they are first eligible and maintain it over time. The process for changing coverage should be as smooth and as swift as possible, and the government should avoid placing harmful restrictions on people's ability to make these transitions successfully – particularly in ways that conflict with the law.

Healthcare is a fundamental mechanism through which individuals can ensure a greater quality of life and well-being. The restriction of coverage due to a lack of continuous coverage is likely to have a disparate impact the portion of the population that gained health insurance as a result of the ACA, as those at the margins are more likely to churn off and on Medicaid and struggle with premium payments in the private marketplace. As such, it is imperative that the post-ACA status quo is not reverted back to the high rates of uninsured individuals before the enactment of the law. The proposals put forth regarding continuous coverage are dangerously close to pulling back the progress made on this front.

Levels of Coverage (Actuarial Value) (§156.140)

We strongly oppose the proposal to broaden the allowed *de minimis* variation in actuarial value (AV) for each plan metal level to -4/+2 percent. This policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.



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While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[15]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[16]

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today *or* purchase coverage with hundreds to thousands of dollars in higher cost-sharing- either way they will have to pay much more for coverage and care. When the proposed changes to AV values are added to the proposed restrictions surrounding the ability for families to

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[15] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

[16] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

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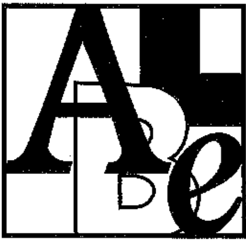
shift metal levels in their plan coverage, families who don't receive cost-sharing reduction subsidies when adding a dependent will face markedly increased deductibles and medical expenditures as a result of greater allowable variance in plan AV values.

The preamble of the proposed rule even acknowledges the harm that many consumers will experience, stating: "*A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government,* " and "*The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risk associated with high medical costs.*"

The administration should not proceed with a policy that will knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current *de minimis* actuarial value requirement of -2/+2 percent be maintained for all metal levels. We note that a broader level of variation is no longer *de minimis* and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare different plan options and also to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

If the administration is insistent on pursuing a policy to allow for lower value plans, however, we strongly urge that such change be limited to bronze level coverage. We strongly disagree with the assumption that the remaining uninsured are only looking for coverage with lower premiums, as many people, including young adults, report being just as concerned about high cost-sharing.[17] As such, we are skeptical that reducing the floor of bronze coverage

[17] Liz Hamel, Jamie Firth, Larry Levitt, Gary Claxton and Mollyann Brodie, *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Washington, DC: Kaiser Family Foundation, May 20, 2016), available online at http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/ and Kara Brandeisky, *Why Millennials Hate Their Least Expensive Health Care*



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offered in the marketplace will attract a large number of new enrollees. However, if the premise of this proposed policy change is to expand marketplace offerings to include more barebones coverage than is currently available on the marketplace, lowering the minimum actuarial value for *only* bronze level coverage achieves that and does so without undercutting vital financial assistance.

Network Adequacy (§156.230)

We have long advocated for adequate provider networks that allow coverage enrollees to get the care they need, when they need it. A common complaint of both Democratic and Republican officials, including in Speaker Ryan's 2016 health care plan "A Better Way," is that provider networks are sometimes too narrow to meet consumers' needs.[18] If the Administration aims to promote adequate provider networks,[19] implementing the proposed rule will not achieve that goal, but will result in narrower networks.

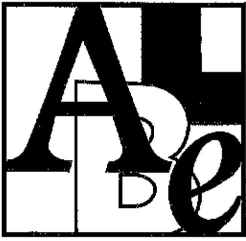
Instead of HHS continuing to do its job to protect consumers from bait and switch products that can't fulfill guarantees to deliver access to care, under this rule the agency shirks its responsibilities and claims state oversight can ensure network adequacy. But currently, nearly half of states have no metrics in place to assess whether marketplace plans provide adequate networks.[20] This rule will gut the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allow states that have no adequacy metrics to maintain authority for provider network review.

Option, Time Magazine (Dec 8, 2014), available online at http://time.com/money/3614626/millennials-health-insurance-high-deductible/.

[18] Speaker Paul Ryan, *A Better Way* (Washington, DC: U.S. House of Representatives, June 2016), available online at: https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf

[19] Claire McAndrew, *Network Adequacy 101* (Washington, DC: Families USA, October 2014), available online at: http://familiesusa.org/product/network-adequacy-101-explainer

[20] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf



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This rule would take the health care system backwards in time to 2014, before HHS implemented critical network adequacy reviews that currently protect patients. The rule fails to describe how consumers' access to providers will be impacted by the removal of federal network adequacy review. We are interested in understanding how HHS will ensure consumers have the same or better access to providers in all states if this proposal is implemented.

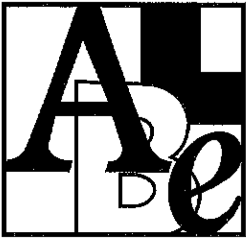
We urge HHS to maintain the implementation of §156.230 as it stands now, as proposed changes to defer to state oversight will result in insurers selling health plans that do not include sufficient numbers and types of providers to serve enrollees. The proposed changes to network adequacy would jeopardize the health and financial security of consumers and we urge HHS to reject them.

Essential Community Providers (§156.235)

Like section 156.230, section 156.235 will narrow networks for consumers. This section decreases FFE insurers' accountability to include in their networks Essential Community Providers (ECPs) — those that serve predominately low-income, medically underserved individuals. This section is a giveaway to insurance companies, which under the proposed rule will be allowed to travel back in time to 2014 and only contract with a measly 20 percent of ECPs in their service area.

Page 10996 of the proposed rule describes the impact of this section directly, showing that consumers will bear burdens so that insurers can cut corners:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging*



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> *contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

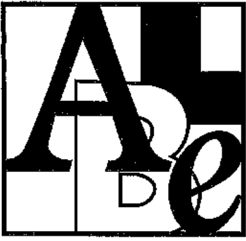
States around the country like Connecticut and Montana, and their participating issuers, have achieved far higher ECP inclusion benchmarks.[21] This proposed modification for ECP inclusion in FFE networks signals that HHS and the Administration overall lack commitment to vulnerable marketplace enrollees and to network adequacy. We urge rejection of a change in the ECP standard to 20 percent and instead recommend increasing the threshold over the next 3 years until it reaches 75 percent.

Conclusion

To conclude, the cumulative effects of the proposal brought forward will not result in better quality and access to care for all Ohioans. On the contrary, when analyzing the potential combined impact that the rules will have on individuals, it becomes easier to identify entire portions of the population that stand to lose should HHS succeed in pushing these changes forward.

Changes involving the SEP enrollment period restrictions (pre-verification, removal of most SEP conditions, and lack of ability to shift metal plans through SEPs), continuous coverage requirements, and even fluctuations in AV values will restrict access to insurance and increase the consumer's cost-sharing burden. Reductions in network adequacy requirements and essential community provider inclusion stand in polar opposite to the values ABLE holds. To the great benefit of 500,000 Ohioans, under the ACA, the insurance rate within Ohio dropped from 11% to 6.5% over the time period ranging from

[21] Cristina Jade Peña, Laurie Sobel, and Alina Salganicoff, *Federal and State Standards for "Essential Community Providers" under the ACA and Implications for Women's Health* (Washington, DC: Kaiser Family Foundation, 2015), available online at: http://kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/



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2013 to 2015. We are doubtful that this significant a reduction would have occurred had the proposed rules been in effect.

Thank you for the opportunity to submit these comments.

Respectfully submitted,
Advocates for Basic Legal Equality(ABLE)

By: Rebecca J. Steinhauser
Managing Attorney for Health and Public Benefits

Comment separator page. Next comment follows.

March 7, 2017

The Honorable Tom Price
Secretary
Department of Health and Human Services
Attention: CMS-9929-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Patient Protection and Affordable Care Act; Market Stabilization
82 Fed. Reg. 10980 (February 17, 2017)

Dear Secretary Price:

On behalf of the millions of patients, survivors, and their families who live with serious diseases and chronic illness, and the providers who care for them, we write to share our thoughts on the recent proposed rule issued by the U.S. Department of Health and Human Services (HHS) on market stabilization. As discussed in more detail below, our respective organizations are concerned about the potential impact on enrollees and the providers who treat them if the proposed rule is finalized in its current form.

COMPRESSED PUBLIC COMMENT PERIOD

We are deeply concerned about the abbreviated public comment period. A 20-day comment period for a proposed rule of this magnitude seriously hampers the ability of state regulators, advocates, consumers, providers, and other stakeholders to offer meaningful comments on the significant proposals included in the rule. We urge HHS to adopt a comment period of at least 30 days and to fully comply with notice-and-comment requirements under the Administrative Procedure Act.

INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS (45 CFR § 133.410)

We recognize that over time it may not be necessary to maintain an annual enrollment period that extends into a new plan year, and doing so will be administratively simpler. The proposed rule would restrict the annual enrollment period for 2018 so that it begins on November 1, 2017 and ends on December 15, 2017, with an effective date of coverage on January 1, 2018.

We are concerned that this enrollment change is too soon, particularly in light of the uncertainty regarding any potential future Congressional and/or Administrative action to make further changes to the future of the Affordable Care Act. Curtailing the open enrollment period at this point in time could have a chilling effect on enrollment and would depress the enrollment of young adults who tend to wait to enroll until the final deadline, which has been January 31st for the past two enrollment cycles. There is also no evidence of actual adverse selection caused by individuals who wait to enroll in coverage in January or towards the end of the open enrollment period.

Nevertheless, should HHS decide to proceed with this proposal, we caution against doing so without making a significant investment of resources to properly educate consumers about the proposed limited opportunity for consumers to enroll and/or change plans and the ramifications for failing to do so. We were pleased to see that the proposed rule recognized the need to "conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage

within this shorter time frame," and we urge HHS to prioritize outreach and enrollment funding and efforts for the 2018 open enrollment period.

SPECIAL ENROLLMENT PERIODS (45 CFR §155.420)

Special Enrollment Periods (SEPs) are critical to ensuring that consumers have access to health insurance following a significant life event, or an extenuating circumstance that prevented enrollment during the open enrollment period. In 2016, CMS announced[1] that in June 2017, it would implement a pilot program to test whether pre-enrollment verification would impact the risk pool. Given that this pilot program has yet to be implemented, and thus its impact has not been evaluated, we believe the pre-enrollment verification proposed rule is premature at best. Absent evidence of fraud or abuse, we do not support proposals that seek to limit the availability and accessibility of SEPs.

SEPs are a key part of the overall mission of the marketplace to help consumers navigate important life transitions with the peace of mind that they can still access affordable health coverage. Situations change over the course of a year, and many of these changes warrant allowing consumers to enroll in coverage or change plans. Getting married, having a baby, or moving can significantly affect people's decisions about whether to enroll in health coverage and the plan design that is most appropriate given a change in circumstances. This is particularly true for young adults, who are more likely than older adults to experience all but one of the major events that may trigger an SEP, but persistently underutilize SEPs.[2] Consumer choice during SEPs is also a common industry practice in the employer-sponsored coverage market upon which consumers in the non-group market should be able to equally depend.

We believe that having too few consumers enroll in coverage through SEPs is a greater threat to stability than having too many enroll. The individual market is now, as it has always been, subject to churn: people are constantly entering and leaving the market as they gain or lose other forms of coverage. But currently only a small percentage of those eligible for coverage under SEPs – an estimated five percent – are enrolling.[3] Moreover, the FFM's SEP "confirmation" process that began last summer to request extra documentation from most people seeking to access an SEP coincided with a 20 percent reduction in SEP enrollment.[4] We should be encouraging everyone who loses coverage, whether through an employer, Medicaid, or other form of coverage—most of them healthy—to enroll and avoid subjecting them to burdensome processes that are likely to further dampen enrollment and coverage delays that could impact their access to needed care.

Imposing ever-higher bureaucratic barriers to enrollment has already been shown to discourage healthy young people from enrolling and will ensure that only those most desperate for coverage will enroll, worsening the risk pool. Data from the FFM confirmation process show that younger consumers are disproportionately likely to fail to complete the verification process compared to older applicants: 73

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[1] Center for Consumer Information and Insurance Oversight, Pre-Enrollment Verification for Special Enrollment Periods Fact Sheet, available at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

[2] Young Invincibles, *Young Adults More Likely to Qualify for Special Enrollment*. Apr. 2014, available at: http://younginvincibles.org/wp-content/uploads/2014/04/Young-Adults-and-Special-Enrollment-FINAL.pdf.

[3] Stan Dorn. *Making Special Enrollment Periods Work under the Affordable Care Act*. Urban Institute, June 2016, available at http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[4] Center for Consumer Information and Insurance Oversight, *supra* note 1.

percent of applicants age 55-64 submitted verification documents compared to only 55 percent of those age 18 to 24.[5]

For these reasons, we urge HHS to maintain current SEP application and verification standards and to gather the data from ongoing FFMS verification efforts to inform an evidence-based path going forward. At the very least, some consumers should be kept outside of the pre-enrollment verification process as a control group that would help to inform future policy-making. Creating burdensome documentation requirements before someone may enroll in a plan, particularly absent evidence of consumers abusing SEPs, will only serve to limit SEP availability to individuals who have in fact had a qualifying life event. We believe that the current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, should be left in place.

We are concerned that some of the changes in the proposed rule—such as limiting plan metal level changes during SEPs or requiring evidence of continuous coverage—erode guaranteed issue protections in federal law, will be confusing to consumers, and could be challenging to implement. We are particularly concerned that the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP will harm consumers and is counter to prevailing industry practice in the employer-based market. We also oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably result in gaps in health insurance coverage, particularly for lower-income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria.

We urge HHS to commit to collecting balanced and actionable information to help shape future policy decisions about SEPs. For instance, HHS should examine the extent to which SEP verification deters enrollment of SEP-eligible people, particularly those who are healthier. HHS should also be capable of following up with consumers who began the application process but dropped out at some point to gather information about whether people who failed to complete enrollment might have actually been eligible. Any further changes to SEP rules should only be made if there is actual evidence that consumers are abusing the SEP process.

Finally, we urge HHS to grant continued flexibility to state-based marketplaces to decide whether to adopt pre-enrollment SEP verification requirements and any other changes to the SEP process. State-based marketplaces should retain discretion and not be required to adopt SEP changes if they do not wish to do so for policy or practical reasons. Already, some state-based marketplaces have taken different approaches that they have found to be far less burdensome for consumers, while also supporting a well-balanced risk pool and robust enrollment of eligible people.[6]

We understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities, further reduce barriers to enrollment, and ensure a strong risk adjustment program—not to restrict access to SEPs or penalize consumers.

[5] Center for Consumer Information and Insurance Oversight, *supra* note 1.
[6] See, for example, "Appendix IV: Comments from the DC Health Benefit Exchange Authority," in Results of Enrollment Testing for the 2016 Special Enrollment Period, GAO-17-78, U.S. Government Accountability Office, November 2016.

ACTUARIAL VALUE (45 CFR § 156.140)

We are concerned that the proposed changes to the actuarial value of the metal levels would be harmful to consumers—particularly consumers who are high utilizers of health care services. A de minimis variation of -4/+2 percentage points (for all metal level plans except for bronze plans which could vary from -4/+5), could result in the offering of products that have a lower premium but higher cost-sharing. This variation will make it difficult for consumers to compare plans within the same metal level.

We are also concerned about the potential impact of this adjustment on the advanced premium tax credits (APTCs). Under the ACA, the APTC is calculated using the difference between the second lowest cost silver plan premium and the applicable percentage of the enrollee's income. By allowing issuers to offer a less generous silver plan, the proposed rule would reduce the value of the APTCs, thereby forcing consumers to choose between a plan with lower premiums but higher out-of-pocket costs or a plan with higher premiums and lower out-of-pocket costs. Under either scenario the consumer would pay more out-of-pocket (either through premiums or cost-sharing). For example, the Center on Budget and Policy Priorities found that a family of four with an income of $65,000 would either pay $327 more a year in premiums or face a $550 increase in their deductible if they chose a 66 percent AV plan.[7]

NETWORK ADEQUACY (45 CFR § 156.230)

Although nearly all states have adopted some sort of regulatory framework for network adequacy, oversight is uneven across and within states, and state network adequacy requirements often only apply to certain types of network designs, such as HMOs but not PPOs.[8] The recently updated NAIC Health Benefit Plan Network Access and Adequacy Model Act serves as a solid base upon which states can adopt statutes and regulations to ensure that plan networks are adequate to meet the needs of diverse consumer population. However, to date, few states have moved forward with adopting all of the changes included in NAIC Model Act. Given ongoing gaps at the state level, we believe it is appropriate for federal regulators to defer to state oversight, but only while maintaining strong minimum federal network adequacy standards that are at least as protective as the current ACA standards.

While we support efforts to streamline monitoring and enforcement of insurance standards between federal and state regulators, we are concerned the proposed network adequacy standards fall short of the protections necessary to ensure that consumers across the country are provided an adequate plan network. Although we believe that state regulators should have flexibility to regulate their markets, we urge HHS to continue to move towards a minimum federal network adequacy standard that includes strong quantitative standards, such as time-and-distance measures. Such standards are critical for consumers and especially appropriate where state regulators lack the authority for comprehensive oversight of plan network adequacy.

We do not believe that relying on an issuer's accreditation from an external entity is sufficiently comparable to government oversight. Accreditation standards are not publicly available, and it can be

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[7] Center for Budget and Policy Priorities. *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions Of Moderate-Income Families*. Feb 15, 2017, available at http://www.cbpp.org/sites/default/files/atoms/files/2-15-17health.pdf.

[8] Justin Giovannelli et al., *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks*. May 2015, available at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

challenging for regulators to determine the extent to which these plans are complying with the ACA's network adequacy requirements. This policy change takes a significant step backwards by returning to a standard from 2014 that HHS has already rejected. HHS rejected this standard—sole reliance on an issuer's accreditation from an HHS-recognized accrediting entity—in response to concerns about narrow network plans that were featured prominently in the media and affected many of the consumers you serve. By weakening federal network adequacy standards, particularly in states without the authority or means to conduct sufficient network adequacy reviews, we are concerned that the proposed rule will reduce government oversight in this critical area and ultimately limit consumer access to providers.

ESSENTIAL COMMUNITY PROVIDERS (45 CFR § 156.235)

We are concerned with the proposal to require plans to contract with at least 20 percent of available essential community providers (ECPs) within a plan's provider network. Reducing the minimum ECP requirement from 30 percent to 20 percent will result in decreased access to ECPs, which include providers (such as children's hospitals) who predominantly provide specialty services and/or serve predominantly low-income, medically underserved areas. Even under the existing 30 percent standard, we note that consumers struggle to access ECPs and we fear that reducing the ECP requirement will exacerbate this problem, leaving consumers without access to the care they need. Further, this change appears to be unnecessary: HHS notes that only six percent of issuers failed to meet the 30 percent ECP threshold for the 2017 plan year and, of these, all were able to justify why they failed to meet this threshold. Given that the vast majority of issuers—94 percent—were able to meet the current ECP standard for 2017, this change is unjustified. We strongly urge that current 30 percent standard be maintained.

CONCLUSION

Thank you in advance for your consideration of our comments. We are happy to talk further if you have any questions about the content of this letter. Please contact Keysha Brooks-Coley (Keysha.Brooks-Coley@cancer.org).

Sincerely,

American Cancer Society Cancer Action Network
Academy of Integrative Pain Management
ADAP Advocacy Association (aaa+)
Adult Congenital Heart Association
AIDS Alliance for Women, Infants, Children, Youth & Families
Alliance for Aging Research
Alliance for the Adoption of Innovations in Medicine (Aimed Alliance)
Alpha-1 Foundation
American Association for the Study of Liver Diseases
American Association on Health and Disability
American Lung Association
American Medical Association
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Community Cancer Centers (ACCC)

Association of Nurses in AIDS Care
Association of Oncology Social Work (AOSW)
Asthma and Allergy Foundation of America
Bronx Lebanon Family Medicine
Cancer Support Community
CancerCare
Caregiver Action Network
Catholic Health Association
Center to Advance Palliative Care
Community Access National Network (CANN)
Community Catalyst
Disability Rights Education and Defense Fund
Dysautonomia International
Esophageal Cancer Action Network
Epilepsy Foundation
Fabry Support & Information Group
Fight Colorectal Cancer
Global Healthy Living Foundation
HealthyWomen
Hydrocephalus Association
Immune Deficiency Foundation
International Pain Foundation
Lakeshore Foundation
LUNGevity
Lupus and Allied Diseases Association, Inc.
Multiple Sclerosis Foundation
Nashville CARES
National Alliance on Mental Illness
National Black Women's HIV/AIDS, Inc.
National Center for Transgender Equality
National Consumers League
National Council for Behavioral Health
National Hemophilia Foundation
National Multiple Sclerosis Society
Oncology Nursing Society
Out2Enroll
PMG Awareness Organization
Susan G. Komen
The AIDS Institute
The National Viral Hepatitis Roundtable
The Veterans Health Council

Tuberous Sclerosis Alliance
U.S. Hereditary Angioedema Association
U.S. Pain Foundation
Vietnam Veterans of America
Virginia Organizing
Wellness and Education Community Action Health Network (WECAHN)
Association for Behavioral Healthcare - Massachusetts
Center for Independence of the Disabled, NY
Easter Seals Massachusetts
Epilepsy Foundation New England
Epilepsy Foundation of Alabama
Epilepsy Foundation of North/Central Illinois, Iowa, Nebraska
Lupus Foundation of Florida
Lupus LA
NC League of Women Voters Heath Care Advocacy Team
New Jersey Association of Mental Health and Addiction Agencies, Inc.
New Yorkers for Accessible Health Coverage
North Carolina Justice Center

Comment separator page. Next comment follows.

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National President and CEO
Harold P. Wimmer

March 7, 2017

The Honorable Tom Price, MD
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington DC, 20201

Re: CMS-9929-P

Dear Secretary Price:

The American Lung Association appreciates the opportunity to comment on the proposed rule, *Patient Protection and Affordable Care Act; Market Stabilization* (RIN 0938-AT14).

The Lung Association recognizes that a stable marketplace is essential for people with lung disease to have quality and affordable healthcare coverage. However, while this rule gives more flexibility to the insurance companies participating in the marketplace, there is concern that these stabilization provisions may also have the consequence of creating additional barriers to healthcare. Any market stabilization reforms should aim to create a more robust marketplace, increasing quality and affordable healthcare.

Shortened Comment Period:
The Lung Association understands the time constraints on any new regulations to be effective for plan year 2018. However, a twenty-one day comment period is not sufficient to solicit meaningful comments. A rule of this significance should be subject to a full comment period of at least 30 days for stakeholders, including the healthcare industry, state regulators, consumers and other interested parties to order to adequately respond to the request for comment. The Lung Association urges the Department of Health and Human Services (HHS) to allow for at the minimum a 30-day comment period moving forward.

Shortened Open Enrollment:
The Lung Association is concerned about the proposal to shorten the open enrollment to six weeks for plan year 2018. Consumers are just becoming familiar with the open enrollment period lasting from November 1 – January 31. Consistency for the enrollment period will ensure high enrollment. We urge HHS to maintain the twelve-week enrollment period.

Advocacy Office:
1331 Pennsylvania Avenue NW, Suite 1425 North
Washington, DC 20004-1710
Ph: 202-785-3355 F: 202-452-1805

Corporate Office:
55 West Wacker Drive, Suite 1150 | Chicago, IL 60601
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

1-800-LUNGUSA | LUNG.org

If HHS does move forward with this proposal, a strong and vigorous public outreach campaign must accompany the change. Without the public outreach campaign, the proposed change could reduce enrollment in marketplace plans.

Changes for Special Enrollment Periods (SEPs):
The Lung Association is concerned about the proposed changes for SEPs. Enrollment, including enrollment during an SEP should be as straight-forward as possible to encourage people to sign up, including young, healthy individuals. Unfortunately, the proposed rule creates barriers to access quality and affordable care.

The pre-verification process for everyone enrolling in a SEP is both onerous and arbitrary due to the lack of evidence of fraud and abuse within the system. Additionally, HHS has proposed ending the pre-verification pilot program that would show how burdensome the pre-verification process was for both HHS and enrollees, allowing appropriate steps to be taken to balance the need of pre-verification and build capacity for the extra work. The Lung Association urges HHS to keep the pre-verification pilot program, reserving the authority to impose the pre-verification program on all SEP enrollees until there are results from the pilot program.

The Lung Association is also concerned the pre-verification process will delay care. The proposal does not include a required deadline for HHS to verify eligibility. Recognizing the administrative burden the pre-verification process will impose on HHS, there is a need for more transparency from the agency regarding when a verification decision will be made, so patients do not have their applications pending indefinitely. This especially important to lung disease patients who need continuous treatment to manage their diseases, such as lung cancer, asthma and COPD.

The Lung Association is very concerned with the proposed changes for individuals who qualify for an SEP through a triggering life event. HHS proposes these new dependents can only be added to the current enrollee's plan rather than having the option to choose a new plan. These enrollees are spouses and children, who may have different health needs than the enrollee who originally chose a specific plan. For patients with lung disease who are reliant on medications and treatments to breathe, these proposed changes are incredibly precarious. This proposed change differs from the standard in the employer-sponsored marketplace, where when new dependents are added, a family has the option to change their health plan. Diverging from this prevailing standard creates unnecessary confusion and imposes barriers to care.

Changing the Actuarial Value of Metal Levels:

The proposed rule would expand the actuarial value of plans allowed in the various metal levels. If adopted, this proposal will increase the variation in the generosity of plan benefits offered with a metal level, making more difficult for consumers to identify the plan level they need.

In addition to adding more confusion to the marketplace, the proposed rule could also impact the Advance Premium Tax Credit (APTC) for lower income individuals and families. The APTC is based on the premium of the second lowest cost sliver plan. Allowing more variation for the actuarial value for silver plans, could result in silver plans with lower premiums due to the less generous coverage offered by the plan. Patients with pre-existing conditions, such as lung disease, who often need a more generous plan, could face a lower APTC and higher out of pocket costs.

While this change would directly impact lung disease patients on the exchange, hampering their access to quality and affordable care, it also could destabilize the marketplace. A lower APTC or higher premiums could discourage healthier individuals from signing up for insurance coverage in the first place. The Lung Association encourage HHS to not adopt changing the actuarial value of plans allowed in the various metal levels.

Continuous Coverage Requirements:

The Lung Association is discouraged to see HHS exploring policies promoting continuous coverage by imposing a waiting period for enrollment or assessing a late enrollment penalty. Both policies would create an excessive burden for individuals with pre-existing conditions, including those with lung disease.

Imposing a 90-day waiting period for individuals who are unable to prove continuous coverage will disrupt the marketplace. The proposed waiting period will delay needed care, creating the need for more expensive care once the waiting period has ended. The Affordable Care Act (ACA) has allowed people with pre-existing conditions to buy insurance that offers robust benefits in a timely manner.

Assessing a late enrollment penalty would create a financial hardship for families that may have lacked coverage because of unemployment or other hardship. The Lung Association strongly implores HHS to reject both of these policy proposals.

The Lung Association believes that the ACA guarantees issue of health insurance, regardless of previous health status or health insurance status; and that no price variations can be made based on either of these conditions. Without that standard, patients lack access to quality and affordable healthcare.

The Lung Association appreciates the opportunity to comment on the proposed Market Stabilization rule and encourages HHS to look at the implications to patients of the new market stabilization rules. Consumer transparency and patient protections are key to a stable marketplace and must not be forgotten in any effort to stabilize the marketplace. The Lung Association strongly urges HHS to ensure patients have access to quality and affordable care through the marketplace.

Sincerely,

Harold P. Wimmer
National President and CEO
American Lung Association

Comment separator page. Next comment follows.

Re CMS-9929-P.

Two comments

1.The comment period for the proposed regulations is inadequate. According to The office of the Federal Register, https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf, "In general, agencies will specify a comment period ranging from 30 to 60 days . . . Agencies may also use shorter comment periods when that can be justified."

The rule was published on 2/17/17 and comments are due on 3/7/17/, less than 30 days later. I see no justification for the shortened notice period in the proposal. The regulation should be re-noticed with a full 60-day comment period. It makes major changes that will impact individuals and small organizations (see comment 2) and they need adequate time to analyze it and comment. Any perceived need to hurry for the sake of insurers does not justify diminishing the ability of these affected parties to comment.

2. Regarding Regulatory Flexibility, I am president of the board of a small "not-for-profit organization that is not dominant in its field." We created 3.5 FTE jobs in the past 4-5 years. Our principles would have made it difficult or impossible to do this without the ACA, since we would allow not ourselves to have employees who lacked access to heath insurance, yet we cannot afford to offer it ourselves. Any weakening of the ACA, as proposed herein, will harm organizations like ours. This impact must be considered.

Comment separator page. Next comment follows.

March 3, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: New Mexico Health Insurance Exchange Comments filed on CMS–9929–P, "Patient Protection and Affordable Care Act; Market Stabilization"

Dear Secretary Price:

On behalf of beWellnm, New Mexico's Health Insurance Exchange, we appreciate the opportunity to submit these comments on the proposed rulemaking entitled, "Patient Protection and Affordable Care Act; Market Stabilization."

New Mexico is uniquely positioned to continue being the benchmark SBE-FP. Most notably, the beWellnm financial sustainability model is a cornerstone of our state exchange success, allowing us to mitigate the financial burden on New Mexicans while achieving our core mission of expanding access to health insurance at the lowest cost possible to New Mexicans.

We look forward to working with CMS to ensure that we continue to be the gold standard of this emerging model to successfully serve New Mexicans. Following are our comments on the proposed changes that directly impact our mission to enroll as many New Mexicans as possible in affordable health care:

Special Enrollment Period Pre-Enrollment Verification

BeWellnm understands and agrees that it is important to protect the integrity and fidelity of a Special Enrollment Period's (SEP) purpose. It is also important to support the true purpose of an SEP without creating an unnecessarily burdensome process for applicants.

The logistics of how pre-verification is handled are critically important. Forms of documentation must be easily obtainable. There is also the potential for a backlog within HHS in verifying SEP qualification. A backlog, and the resulting delay, could interrupt an individual's ability to obtain insurance or continuity of care.

Any verification handled exclusively via internet may negatively impact thousands of New Mexicans in rural areas who do not have access to broadband services. As such, verification services must be available independent of internet connectivity.

Guaranteed Availability

BeWellnm appreciates the importance of addressing challenges presented by individuals who exploit opportunities to obtain coverage. Consumer issues that may arise due to this change

are of concern to beWellnm. Our Exchange needs any data you have on these individuals and how they actually impact the risk mix of the total pool. Resolving errors and other concerns could delay enrollment and medical care for some of the most medically fragile that may, in fact, not owe any back-payments. Additional burdens, especially to healthy individuals, may cause them to become uninsured even after having obtained coverage at one point.

New Open Enrollment Timeframe

While the adjusted timeframe was originally intended for Open Enrollment (OE) 6, we believe it is reasonable to align it sooner with Medicare Advantage OE. It may be important to consider the positive or negative impact for those who have historically applied from December 16-January 31. BeWellnm will appreciate HHS' support in communicating this change as soon as possible so that outreach and marketing planning can begin. We also anticipate that minimizing the enrollment timeframe will put added pressure on our outreach efforts and enrollment assistance network.

Other Matters

As beWellnm has consistently communicated in the past, additional flexibility afforded state exchanges will greatly support exchange stability. Even when states work collaboratively with the federal government, such as the SBE-FP model, exchanges should be allowed significant regulatory independence. This facilitates local agencies and key stakeholders to work jointly in furthering exchange stability. BeWellnm is prepared to engage in conversations with HHS leadership moving forward on how to make this happen.

Initially, our recommendations are:

1. Continued discussions with CMS regarding the Federal platform agreement provisions, particularly those related to timely access to data need to occur. Over the past two years, beWellnm has submitted multiple requests for access to a number of data elements from CMS. Unfortunately, while CMS has provided some data, the data received is not detailed enough to add significant value to outreach efforts. Receipt of comprehensive data is critical for New Mexico to execute a successful and robust outreach strategy.

2. Pursuant to President Trump's Executive Order on January 20th to minimize the economic burden of the Affordable Care Act, consideration must be given to removing the 1.5% 2017 rate and proposed 2.0% 2018 rate for leasing Healthcare.gov. This shift would directly support state flexibility and market stability. Relieving states of this multi-million dollar economic burden will show that the Executive Order is a meaningful pathway to provide support for their exchanges.

3. Finally, allowing SBE-FPs to choose from a "menu of options" within the Healthcare.gov lease would greatly support state flexibility. BeWellnm operates its own Small Business Health Options Program (SHOP) Marketplace. Despite this, our Exchange is charged the same as those who do not run their own SHOP. It is important that HHS consider giving states the option to opt into particular services offered by Healthcare.gov while scaling the cost accordingly. This will empower exchanges to become more sustainable and be tailored to their populations' needs.

Thank you again for your consideration of our comments. We appreciate the opportunity to share our thoughts with you. As a State-Based Exchange with sound financial footing, we want to continue working with HHS to support state flexibility, exchange stability, and a low cost high value Exchange for New Mexicans.

Sincerely,

Cheryl Smith Gardner
Chief Executive Officer
beWellnm, New Mexico's Health Insurance Exchange

Comment separator page. Next comment follows.

925 L Street, Suite 350
Sacramento, CA 95814
p: 916.443.1749 | f: 916.443.3202
cwda.org

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016.

Re: File Code CMS-9929-P

To Whom It May Concern:

The County Welfare Directors Association of California (CWDA) is pleased to offer our comments on the Proposed Rule regarding the Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10).

CWDA is a statewide association that represents the directors of public human services departments in all 58 of California's counties, which provide public assistance services, child welfare services, and services to seniors and people with disabilities. In California, counties act on behalf of the state to determine eligibility and provide case management for Medi-Cal, the state's Medicaid program, as well as providing eligibility activities for Covered California, the state's exchange created pursuant to the Affordable Care Act.

CWDA's comments are focused on those areas of the proposed rule that may have overlap to the administrative activities that counties perform on behalf of the California Department of Health Care Services (the state Medicaid agency) and Covered California.

Below are specific comments to the proposed rule.

Shortened Open Enrollment Period (Section 155.410)

- The proposed shortened open enrollment period would significantly disadvantage customers, and we urge its reconsideration in the final rule. Over the past four open enrollment periods, we have found that our customers tend to enroll steadily throughout the period, with an increase in the waning days.

- Additionally, even though there is no open enrollment period deadline for Medicaid, customers applying during the open enrollment period are often found to be eligible for coverage for Medicaid, not just for Exchange-based coverage. Reducing the open enrollment period would therefore result in less opportunity for coverage under both programs, not just the Exchange-based programs, and could therefore reduce access to health coverage for many Americans.

Verification Requirements for Special Enrollment Periods (Section 155.420)

- The verification requirements for special enrollment periods under section 155.420 also place customers at a disadvantage, and should be reconsidered.

- Depending on the circumstances, it may be difficult for an applicant to immediately obtain verification. If coverage is delayed until all necessary verifications are obtained, there could potentially be gaps or complete lapses in coverage following a legitimate change of circumstance. This is unnecessary, as verifications can be collected in other ways – for example, collecting verifications after coverage is granted, or selecting random cases for follow up, could ensure that individuals enrolling due to a special circumstance are being truthful in their applications without delaying needed health care for those who are unable to immediately produce verifications.

Thank you for the opportunity to comment on the proposed regulation. If you need additional information, please contact me at (916) 443-1749.

Sincerely,

/s/

Cathy Senderling-McDonald
Deputy Executive Director

Comment separator page. Next comment follows.

I have comments of several sections of this proposed rule change.

- I disagree with shortening the enrollment period to end on December 15. A stated goal of this proposal is to stabilize the insurance market, and I agree with the assessment that encouraging healthier people to purchase insurance will do that. However, shortening the time available to sign up will likely lead to an overall decrease in people choosing to enroll. This will particularly impact low-resource or low-education populations who require assistance to sign up, since there will just be fewer hours of assistance available in the given period.
- Requiring pre-verification for special enrollment periods will substantially increase the burden on consumer, and will likely discourage some healthy people from enrolling, undermining the stated goal of market stabilization. At the very least, the initially proposed pilot project with only a small percentage of pre-enrollment verification, rather than full roll-out, is more likely to protect consumers and ensure a smooth transition before full implementation. There should also be retroactive benefits from the date of qualifying event of initial application, regardless of how long the verification process takes. The proposed rule to allow the consumer to choose a later date to start their enrollment, if the verification process takes long, seems well thought-out and consumer-friendly and thus I support it.
- The proposal to apply premium payments to debt first and premiums second is going to be a boon to insurers while penalizing consumers. People who are trying to start fresh, or get themselves out of a financial hole, will have that much farther to climb before they can find level ground. They will be better served without this change going into effect, so they can meet their premium requirements first and work on debt second. The rule proposal cites concerns about consumers potentially "gaming" the system but does not cite any evidence that this is actually happening. At the very least, insurers should be required to inform consumers when they have adopted this type of policy, should the rule go into effect.
- Regarding reduction in ECP requirement, the proposed rule cites evidence that some issuers who met < 30% ECP were able to otherwise demonstrate adequacy in their provider pools. Making a rule change based on what only 6% of issuers were able to prove seems dangerous, and may encourage other issuers to drop their ECP percentages to a level where they truly can't provide adequate coverage to low-income consumers. I would caution against this rule change, particularly since there is a demonstrably successful pathway for the issuers to qualify

with a lower percentage of the ECP. Lowering the required ECP minimum will lead to a decrease in consumer choice, and will almost

Comment separator page. Next comment follows.

CENTER *for* PUBLIC POLICY PRIORITIES

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016 Baltimore, MD
21244-8016

Re: Comments on Patient Protection and Affordable Care Act; Market Stabilization, CMS-9929-P

The Center for Public Policy Priorities (CPPP), appreciates the opportunity to comment on CMS-9929-P, "Patient Protection and Affordable Care Act; Market Stabilization" (hereinafter referred to as "the proposed rule"). CPPP is an independent public policy organization established in 1985 that uses data and analysis to advocate for solutions that enable Texans of all backgrounds to reach their full potential. Improving access to health care for Texans has been at the core of our mission and activities since our founding.

General Comments

We have significant concerns about the proposed rule's effect on consumers' ability to enroll in good-quality, comprehensive, affordable health coverage through the marketplaces. Overall, the proposed rule, if finalized, would add enrollment restrictions and make coverage *less* comprehensive and *more* expensive for consumers. These proposals chip away at some of the most popular and valued consumer protections the ACA provides.

If implemented, the proposed rule would:

- Weaken cost-sharing requirements for marketplace plans, effectively increasing health insurance deductibles for many;
- Restrict special enrollment periods and increase paperwork and red tape for consumers, which is likely to depress enrollment particularly among younger people;
- Cut the next open enrollment period in half, limiting the opportunity to enroll in coverage at a very confusing time for consumers;
- Allow insurance companies to reject people from coverage, and possibly render them uninsured, based on past premium shortfalls;
- Eliminate federal requirements for insurers to maintain adequate networks and include sufficient numbers of essential community providers in their networks;
- Potentially open the door to additional policy changes in the future that purport to ensure that people have "continuous coverage," but that would actually disrupt people's access to coverage and conflict with current law.

The rule purports to address instability, but implemented, could actually cause instability in the individual market by creating numerous additional barriers to enrolling in coverage. These barriers are like to result in fewer people enrolling in coverage, particularly younger and healthier individuals whose participation is critical to maintaining the balanced risk pool necessary to ensure a stable market. If enrollment becomesto burdensome, only people with high health care needs will be motivated enough to sign up. Futhermore, those that are able to enroll in coverage will be left with less comprehensive, more expensive plans.

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Guaranteed Availability of Coverage (§147.104)

The NPRM proposes allowing issuers in the individual or group market to refuse coverage to an individual (or employer) who owes premiums from the prior 12 months, unless and until the individual (or employer) pays the premium debt in full. This change should not be adopted. This conflicts with the statute, which says that issuers generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. This change would bar people, many of them with limited incomes, from accessing coverage and the financial assistance for which they are eligible as a result of premium shortfalls during the prior year. Under this proposed rule, only those who can rapidly come up with a possibly significant sum of money by a given deadline can be guaranteed access to health coverage. In some parts of the country, people who owe back premiums to one issuer could then seek coverage with a different issuer, but that would not be possible in areas with only one issuer offering individual coverage. This policy would likely deter *healthier* people who get behind in their premiums from enrolling, since often-healthy younger people are more likely to miss bill payments in general. This could weaken the overall health of the coverage pool in a similar way as the proposed changes to SEPs.

Currently, issuers can require people to pay back premiums before renewing coverage, but if the person is newly applying for coverage (including with the same issuer), then guaranteed availability applies and the coverage must be issued. This should not change, particularly when there is no evidence that the stated concern of the insurance industry is actually occurring. Individuals are not stopping their premium payments at the end of the year because they can re-enroll during open enrollment.[1]

If the Administration takes the ill-advised step of allowing issuers to hold people's coverage hostage to old premium shortfalls, then a number of protections are needed to ensure that consumers understand what is happening. These include, but are not limited to, the following:

- Any issuer that chooses to adopt this practice should be required to notify enrollees and applicants (at least prior to the premium-policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if the stakes are raised related to falling behind on premiums, greater efforts should be made to ensure consumers understand the new implications.
- The issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer will deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This should be included in the notice provided at the time of enrollment.
- The Administration should reiterate that when a subsidy-eligible individual's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers,

[1] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrolment declines gradually throughout the year, a sign that enrollees leave the market during the year for many reasons, including obtaining other coverage. See: http://www.cbpp.org/research/health/marketplace-grace-periods-working-as-intended

and issuers should be required to notify affected consumers in the notice recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.

- The administration should work to improve the process for automatic renewals so that individuals are not unwillingly renewed and charged premiums into a plan when they have actively attempted to switch to a different plan for the year. Enrollment assisters on the ground have reported many instances where consumers have past due on premium payments, not because they weren't paying their bills but because they had been automatically renewed into one plan for the year but at the same time they had actively enrolled in a different plan. They were paying the premiums for the coverage they actively chose but only find out much later that the Marketplace had re-enrolled them into their old plan as well. It can take some time to get dis-enrolled from the additional coverage and for the erroneous premium bills to be cancelled.

Open Enrollment Periods (§155.410)

We strongly urge CMS to keep the length of open enrollment periods to three months, as is was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about *and* enroll in coverage within the given timeframe. If the rule is finalized, there will limited time for affected consumers to learn about the changed length. We know that consumers continue to have gaps in knowledge about the coverage options available to them and we believe a three-month open enrollment period should continue in order to ensure eligible consumers enroll.

We also have concerns about consumers' ability to gain in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer pans. We appreciate that CMS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand.[2] Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Further, ending the open enrollment period in December is problematic because it is often when consumer have heightened financial constraints and are distracted by the holiday season.[3] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[4]

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the Administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is

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[2] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (*Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[3] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[4] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

abundantly clear that outreach and education have a profound and positive impact on enrollment.[5] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[6]

Special Enrollment Periods (SEPs) (§155.420)

Overall, we are very disappointed about the proposed changes to SEPs and urge you not to finalize them. In order to ensure that healthy people enroll in coverage, thus bringing down the cost of coverage overall, enrollment rules and procedures should strive to make it *easier*, not *harder*, to enroll in coverage. Estimates show that less than 5 percent of eligible consumers enrolled in coverage through SEPs in 2015,[7] and we are concerned that these new requirements will likely result in even fewer eligible consumers accessing coverage using an SEP.

Issuer claims of SEP "abuse" are far from new. However, aside from anecdotes from issuers, we *still* have not been provided with any evidence that ineligible people are accessing SEPs to any significant degree. We do, however, have some troubling data showing the effect of the SEP changes that CMS put into place in 2016: twenty percent fewer consumers enrolled using in SEPs and younger consumers were less likely than older ones to follow through.[8] These young consumers tend to be healthier and are the very people we want to encourage to enroll in coverage. We believe these new restrictions will only increase this troubling trend because only those most in need of coverage are the ones who will complete the process.

We are very disappointed in the proposal to expand pre-enrollment verification. No evaluation or analysis of the impact of the numerous changes – specifically increased verification requirements – that have already been implemented for the FFM has been conducted. We do, however, appreciate that the preamble requests comment on whether a small percentage of enrollees should be retained outside of the pre-enrollment verification process in order to evaluate the impact of these processes and we strongly urge CMS to do so.

We are also strongly opposed to requiring prior coverage for the marriage SEP and rules that limit the ability of currently enrolled consumers to change plans. Currently, enrolled consumers who are newly eligible for premium tax credits (PTCs) may select a plan from any available metal level. This is important so that individuals and families experiencing life changes can gain access to financial assistance or can adjust to loss of subsidies and still afford coverage. For example, someone who experiences an increase in income may receive a reduced premium credit and/or lose access to cost-sharing reductions during the course of the year. This warrants the chance to change metal levels if they choose.

It is critical that eligible consumers successfully finish the SEP verification process with minimal burden. The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the bar be higher, consistent with the streamlined eligibility and enrollment process envisioned by current

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[5] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through healthcare.gov than the last two weeks of the third open enrollment period. See: http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage.

[6] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[7] Stan Dorn, *Helping Special Enrollment Periods Work under the Affordable Care Act* (Washington: Urban Institute, June 2016), available online at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[8] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

law. For example, in cases such as birth, denial of Medicaid or CHIP, or loss of Medicaid or CHIP eligibility, SEP applicants' coverage should *not* be pended. Instead, their attestation should be accepted with eligibility verified afterward in order to ensure continuity of their health care and coverage. Further, we seek clarification about the timeline for building effective electronic verification systems and recommend that there are strong manual systems in place should electronic verification not be ready by June 2017 or should electronic verification not work for all consumers. We also want to emphasize that marketplaces, not issuers, should continue conducting SEP verification, consistent with the law.

We also appreciate the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process. One strategy the Administration should use is to conduct robust outreach through email and calls to consumers who have not yet completed the process. Another strategy would be for the federal government to again require certificates of creditable coverage (which used to be required under HIPAA) so there is a reasonable way for people to obtain the proof of eligibility. Currently, there is no assurance that individuals will be able to obtain such proof of coverage, much less in the time frame suggested, and we are aware of cases when people's former employers have not provided it upon request. Yet, under the proposed rule, people's coverage would be held up and possibly denied for failure to submit such proof.

Continuous Coverage

According to the preamble, the Administration is considering various proposals that could be established that would "promote continuous enrollment in health coverage" without gaps and discourage people from "waiting until illness occurs to enroll in coverage."

One idea discussed would require individuals applying for a special enrollment period to show they have had health coverage for significant period of time (perhaps six to 12 months) without a gap of more than 60 days and then to be denied access to coverage through an SEP if they can't show they have had "continuous coverage." Another example discussed is a requirement that individuals who are not able to provide evidence of prior "continuous coverage" without a gap could face insurer practices – such as a waiting period before benefits begin or a late enrollment penalty—that have not been allowed in the individual market since enactment of the ACA. These ideas would serve as impediments to people getting coverage, overburden consumers, and would conflict with current law.

Unless legislation changes the guaranteed availability requirements of the ACA, issuers still generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. There is no basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty (through the ACA's individual mandate). It is unfair to create another penalty that would withhold future coverage because a person has been uninsured. Imposing a waiting period on some consumers' benefits or making them wait "at least 90 days" for their coverage to be effectuated is completely inconsistent with guaranteed availability. Late enrollment penalties or surcharges conflict both with guaranteed availability and the requirement that premiums vary only based on certain specified factors; whether a person has been uninsured in the past is not an allowable rating factor, for example.

The ideas suggested in the preamble would also inflict serious harm on many consumers. Breaks in coverage are fairly common today, a fact that has been borne out by numerous studies.[9,10] Imposing late fees, waiting periods before benefits begin, or other barriers to accessing coverage mean that some people will not get the coverage or the health care services that they need. Current law already has restrictions that protect against adverse selection: limiting enrollment to specified periods and the individual mandate penalty are two examples. In addition, the proposals floated in the preamble would likely reduce overall enrollment in coverage, particularly among healthier people. Therefore, the ideas floated here actually raise the risk of making the risk pool worse and health coverage less affordable overall. To truly promote continuous coverage, an open and accessible system – not a closed and onerous one – is needed to ensure that people successfully obtain coverage when they are first eligible and maintain it over time. The process for changing coverage should be as smooth and as swift as possible, and the government should avoid placing harmful restrictions on people's ability to make these transitions successfully – particularly in ways that conflict with the law.

Levels of Coverage (Actuarial Value) (§156.140)

We strongly oppose the proposal to broaden the allowed *de minimis* variation in actuarial value (AV) for each plan metal level to -4/+2 percent. This policy will open the door for insurers to sell plans with even higher deductibles and other cost-sharing, and will effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. In total, this policy will shift significant costs to families, either through higher premiums or higher cost-sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will do nothing to boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[11]

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size premium tax credit these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[12]

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[9] Some 36 percent of Americans ages 4 to 64 (89 million people) went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once, according to a study by the Commonwealth Fund: http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance

[10] Nearly one-quarter of people with pre-existing health conditions (31 million people) experienced at least one month without health coverage during 2014, according to data from the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

[11] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

[12] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today *or* purchase coverage with hundreds to thousands of dollars in higher cost-sharing- either way they will have to pay much more for coverage and care.

The preamble of the proposed rule even acknowledges the harm that many consumers will experience, stating: "*A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government*, " and "*The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risk associated with high medical costs.*"

The administration should not proceed with a policy that will knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current *de minimis* actuarial value requirement of -2/+2 percent be maintained for all metal levels.

Essential Community Providers (§156.235)

Section 156.235 will narrow networks for consumers. This section decreases FFE insurers' accountability to include in their networks Essential Community Providers (ECPs) — those that serve predominately low-income, medically underserved individuals. This section is a giveaway to insurance companies, which under the proposed rule will be allowed to travel back in time to 2014 and only contract with a measly 20 percent of ECPs in their service area.

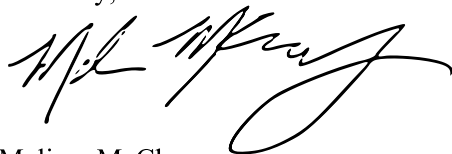
Page 10996 of the proposed rule describes the impact of this section directly, showing that consumers will bear burdens so that insurers can cut corners:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

As described in the preamble, this proposed modification for ECP inclusion in FFE networks creates a cost savings for insurers but at the expense of consumers. We urge rejection of a change in the ECP standard to 20 percent.

Thank you for consideration of our comments on this important rule. If you have any questions regarding these comments, please contact Melissa McChesney, independent contractor and policy analyst with the Center for Public Policy Priorities at mcchesney@cppp.org.

Sincerely,



Melissa McChesney

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March 7, 2016

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-9929-P

RE: "Patient Protection and Affordable Care Act; Market Stabilization," Proposed Rule

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes.

Our comments on the above rule follow this letter. Despite being characterized as changes to improve "market stabilization," the proposed rule, if finalized, actually raises the risk that eligible people will not enroll in coverage, including healthier consumers needed to ensure a balanced risk pool in the individual health insurance market. If finalized, the rule would weaken consumer protections while lowering premium tax credits, allow insurers to increase people's deductibles and other cost-sharing charges, further restrict special enrollment periods, allow insurance companies to deny or delay people's coverage if they fall behind on their premiums, and eliminate requirements for insurers to maintain adequate networks of health care providers. Our comments urge HHS not to finalize many of these proposals or, at the very least, to adopt other changes in order to protect consumers from the most severe harm.

In addition, we object to the Administration's decision to provide an unusually short, 20-day comment period for this proposed rule. This is drastic departure from usual public comment periods, which are at least 30 days or more often 60 days or 90 days. The short timeframe is especially inadequate for a rule of this significance and complexity. We, like other affected stakeholders, had insufficient time to fully analyze the rule and offer comprehensive recommendations. Many affected parties will likely be unable to weigh in with comments during the very short time period.

Sincerely,

Sarah Lueck	Judith Solomon	Edwin Park
Senior Policy Analyst	Vice President for Health Policy	Vice President for Health Policy

Guaranteed Availability of Coverage §147.104

Prior to 2014, when the ACA's major market reforms took effect, insurers in the individual market were able to deny coverage to people who wanted to re-enroll with them unless the person paid any outstanding premium charges they owed. But under the ACA's guaranteed availability requirement, this practice and many other previous industry practices are no longer permitted. Under current law, health insurance issuers that offer coverage in the individual or group markets in a state generally must accept every individual or employer that seeks to enroll in such coverage. The statute includes several specific limitations on this requirement, as follows[1]:

- Issuers can limit enrollment to open and special enrollment periods.
- Issuers of "network plans" can avoid enrolling people who do not live, work, or reside in the service area of the plan.
- Issuers that demonstrate to the applicable state authority that the plan lacks the capacity to adequately deliver services to employers and individuals may deny coverage to additional groups or individuals.
- Issuers that demonstrate to the applicable state authority that they lack the financial reserves necessary to underwrite additional coverage may deny coverage to additional individuals and employers.

There is no statutory exception to guaranteed availability that would permit issuers to delay or deny new coverage when a person has failed to pay premiums in the past. Nevertheless, in the NPRM, HHS proposes that it would no longer be considered a violation of the guaranteed availability requirements for an issuer to refuse to make a person's coverage effective if the person has premium debt with that issuer from the prior 12 months, in either the individual or group markets unless the person pays the back premiums.

This represents a significant shift in the federal government's interpretation of the guaranteed availability requirements. Previously, HHS has drawn a distinction between issuance of new coverage (which is subject to guaranteed availability) and renewals of coverage (which provide issuers with greater ability to apply premium payments to prior premium debt).[2] This has some basis in the statute: The ACA retained earlier statutory exceptions to the federal guaranteed renewability requirements, including a provision allowing an issuer to refuse to renew coverage in cases when an employer or individual has premium debt. As noted, there is no similar statutory provision that

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[1] Public Health Service Act, 42 U.S.C. 300gg-1

[2] For example, if someone is terminated for non-payment, "any new coverage with the same issuer would fall under the guaranteed availability requirements" and the issuer could not refuse to enroll the person. In addition, someone who was terminated for non-payment can select a plan (including from the same issuer) during a future SEP or annual OEP, and "under the guaranteed availability requirements" the issuer would not be able to refuse enrollment based on failure to pay premiums. But if someone is in a grace period for non-payment (and has not been terminated) and then becomes eligible for an SEP related to eligibility for APTC, the issuer may treat the enrollment as continuous and attribute forthcoming payments to prior debt. See *Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual*, Section 6.3, July 19, 2016.

would permit an issuer to deny or delay *new* coverage to a person based on a history of premium debt.

HHS has already grappled with the impact of the ACA's guaranteed availability requirement on pre-ACA insurer practices. In 2012, the department proposed a rule that would have continued to allow issuers in the small-group market to refuse to issue coverage to small employers if they could not meet minimum contribution or minimum participation requirements. [Requiring employers to pay a minimum portion of workers' premiums (a minimum contribution), or to commit to a minimum number of workers signing up for the plan (minimum participation) were common practices prior to the ACA. These requirements were meant to mitigate adverse selection but made it difficult for small firms to access coverage.] In the final rule, HHS said that "after further consideration," issuers would not be permitted to deny new coverage to small employers because they failed to meet minimum participation or contribution requirements during the annual open enrollment period created by the ACA because to do so would be a violation of the guaranteed availability provision.[3] Issuers could refuse to *renew* coverage if a small business failed to meet minimum participation or contribution requirements (because these remained as exceptions to the guaranteed renewability provision post-ACA). But they could not refuse to issue new coverage within the annual open enrollment period.[4] In other words, open enrollment is truly open, a chance to newly enroll in a plan regardless of prior premium debt. The legal right to guaranteed availability has not changed in either the individual or the group markets. HHS should therefore not finalize a new interpretation of this provision that conflicts with the law.

The proposed change would harm people with coverage in the individual market, who may miss premium payments for a variety of reasons. Some people intentionally stop paying their premiums because their eligibility changes—for example, they become eligible for Medicaid-- without understanding the need to terminate their old plan or how to terminate it. People may be unaware they have entered a grace period and built up premium debt, for example if an insurer fails to provide notice or the notice is unclear or never received. Others may be unable to pay in a particular month: 70 percent of marketplace enrollees had income below 250 percent of the federal poverty level in the most recent open enrollment period.[5] In one survey of individual-market enrollees, 67 percent of people reported they either could not meet their basic expenses, barely met their basic expenses, or met those expenses with little left over. One-third reported having difficulty paying for food, housing, or utilities.[6] Under the HHS proposal, people in difficult financial straits would face the prospect of losing access to health coverage unless they can come up with whatever amount of money the insurer says they owe before the opportunity to enroll has passed.

It is, of course, reasonable for insurers to expect people to pay their premiums (or their share of premiums) for those months that they provided coverage to an enrollee. But insurers already have

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[3] Federal Register, Vol. 78, No. 39, February 27, 2013, pp. 13416.

[4] The small-group market has rolling enrollment, allowing employers to seek coverage for their workers at any time during the year. Outside of the annual open enrollment period, issuers are permitted to apply minimum participation and contribution requirements to small employers.

[5] "Health Insurance Marketplaces 2017 Open Enrollment Period: January Enrollment Report," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, January 10, 2017.

[6] "Survey of Non-Group Health Insurance Enrollees, Wave 3," Kaiser Family Foundation, May 20, 2016.

recourse to collect back premiums from people who owe them by demanding payment and using debt collection processes. It is overly harsh to hold people's access to coverage hostage in the meantime. Insurers are also protected under current rules because they can terminate coverage (after the applicable grace period), which generally limits the premium shortfall for the company to no more than one month. In addition, for people enrolled in subsidized marketplace plans, insurers receive an average of 73 percent of the premium amount from the federal government. And there is no evidence that the stated concern of the insurance industry is actually warranted: Individuals are not stopping their premium payments at the end of the benefit year because they can re-enroll during open enrollment.[7]

The policy in the proposed rule would be harshest for people who live in areas with one insurance carrier in the marketplace, or worse yet, one carrier in the entire individual market. People who live in areas where there is more than one insurance carrier would still be able to purchase a plan during an open or special enrollment period, even if they had past premium debt, because they could obtain a plan from an insurer to whom they have no debt. But anyone who lives in an area where there is only one carrier in the individual market could potentially lose access to coverage altogether, unless they pay the past due amounts. People who live in areas where there is only one marketplace carrier would lose the ability to obtain federal premium tax credits and cost-sharing reductions to which they are entitled. Plus, they would be uninsured until the next enrollment period (assuming they could then pay what they owe). They would owe a penalty under the ACA's individual mandate and would also be on the hook for any medical expenses they might incur while they are uninsured.

If the Administration takes the ill-advised step of finalizing this proposal, protections should be adopted to restore some balance for consumers. These include, but are not limited to, the following:

- The Administration should not permit insurers to delay or deny coverage to subsidy-eligible people due to past premium shortfalls. This population has low or moderate incomes and may therefore have difficulty catching up on past debt. It would be unfair to punish them by rendering them uninsured or delaying their access to coverage, particularly when insurers receive a significant portion of their premiums from the federal government.
- If HHS permits this policy to hit subsidy-eligible individuals, then the agency should make very clear that when this population's coverage is terminated at the conclusion of the 90-day grace period, the person would owe no more than their share of premium for one month (i.e. the first month of the grace period). This is stated in a footnote in the preamble of the proposed rule, but it should be made abundantly clear to issuers, and issuers should be required to notify affected consumers as recommended above. We are concerned that issuers may have an incentive to attempt to collect a person's premium contribution in the second and third months of the grace period in order to be able to keep the federal tax credit payment for those months. Some may use the threat of withholding future coverage to try to do this.
- Any issuer that chooses to adopt this practice should be required to notify enrollees and future applicants (at least prior to the premium-payment policy taking effect, and at the time of enrollment) that coverage may be denied in the future unless the person stays current on

[7] CMS data show that, after an initial drop in enrollment as some people lose coverage due to unresolved data-matching issues, enrolment declines gradually throughout the year, a sign that enrollees leave the market during the year for many reasons, including obtaining other coverage. See Tara Straw, "Marketplace Grace Periods Working as Intended," Center on Budget and Policy Priorities, revised October 14, 2016.

their premiums, as well as about the applicable grace period, premium-payment schedule and other relevant information. Currently, consumers report confusion about many of these issues, and if they will now potentially have their coverage delayed or denied as a result of premium shortfalls, insurers should be required to ensure consumers understand the new implications. HHS should supply standard language for these notices.

- In addition, the issuer should be required to provide notice after the person misses all or part of one month's premium payment. The notice should explain clearly the amount the person owes, how the applicable grace period works, and the fact that the issuer may deny coverage in the future unless the person pays a given amount (and the applicable amount should be specified). HHS should supply standard language for this notice.
- It would make sense to allow issuers to consider less than 100 percent premium payment as full payment, to ensure that people are not blocked from health coverage as a result of insignificant errors or underpayments. But this should be fully transparent; issuers should be required to disclose to consumers whether they use this practice and what the threshold is that they will apply. This information should be included in the notice provided at the time of enrollment.
- If this proposal is finalized, HHS should ensure there is an appeal process available to consumers when an insurer refuses coverage because of an alleged pre-existing debt and should clarify what that process is. People are likely to face situations when an insurer claims there is a debt but a consumer disagrees, or when the insurer failed to cancel coverage in a timely manner leading to premium debt the consumer should not owe. It is essential to provide people with the ability to challenge insurer demands for payment that are in error or are unfounded so they can obtain coverage without delay.

Guaranteed Availability: Proposed Restrictions on Plan Choice

The NPRM, if finalized, would place new restrictions on the plan choice of anyone who is already enrolled in an individual market plan (through an exchange or in the outside market) and who experiences an event during the benefit year that triggers a special enrollment period. We oppose these changes, which also conflict with the guaranteed availability requirements and unnecessarily restrict the plan options of people who experience significant life events.

Currently, people who are eligible for an SEP generally are allowed to choose any available plan, just as they would be able to do during the annual open enrollment period. They can change metal levels, choose a new plan when an SEP involving their dependents is triggered – the same array of plan choices as would be available during the annual open enrollment period. This is consistent with the guaranteed availability requirement that requires issuers that "offer…coverage" to accept any applicant "for such coverage." This is an important consumer protection because it helps prevent insurers from selectively offering access to plans to some people and not others (which could lead to market segmentation), and it also permits individuals with the flexibility they need to evaluate their coverage and adjust it when they or their family members experience significant life changes.

The proposed rule includes a number of changes that conflict with the guaranteed availability requirements because they would restrict certain the plan options of people who are enrolled in an individual market plan, while allowing other people who come in during the year to freely choose the plan that best meets their needs. The proposed rule would generally prevent people enrolled in an individual-market plan from switching to a different metal level during the year. People who

trigger an SEP that involves adding a dependent would generally only be able to add that dependent to their plan and not to change plans themselves as is currently permitted.

The rule would permit a plan enrollee and any dependents to enroll in a silver plan if they are eligible for an SEP because they have become newly eligible for cost-sharing reductions. This is important because it ensures that people can access cost-sharing subsidies if they become newly eligible for them during the benefit year. But there are other instances where allowing people to change metal levels is important that the proposed rule fails to recognize. For example, someone who loses eligibility for cost-sharing reductions or premium tax credits due to an increase in income, or otherwise experiences a change in cost-sharing reduction eligibility, should have the chance to modify their plan choice, including by switching to a different metal level, such as bronze, if that is more affordable.

In addition to conflicting with guaranteed availability, these proposals also conflict with section 1312 of the ACA, which states that an individual eligible to enroll in exchange coverage may enroll in any qualified health plan that is available and for which the person is eligible.[8]

Insurers claim there is a problem with people "buying up" their coverage during the year, absent actual evidence that this is happening to a significant degree. Yet HHS is acting on these claims and proposing major changes to the enrollment rules that conflict with current law and would negatively impact consumers and. By this time, after four enrollment cycles, insurers should be able to adequately price for occasional shifts that current enrollees may make between metal levels or different plans during the year. The proposed rule seeks comment on whether these changes should be optional for state-based exchanges. We urge HHS to permit state-based marketplaces to maintain their current rules and processes and to avoid federal rule changes that require them to limit the plan choices of their enrollees – particularly because they may want to set a consistent, and more consumer-protective standard that applies across the individual market.

Initial and Annual Open Enrollment Periods §155.410

We strongly urge CMS to maintain a three-month open enrollment period for the 2018 benefit year, as finalized in earlier regulations. Cutting the enrollment period in half, as proposed, would likely cause enrollment to be lower than what it would otherwise be. Consumer awareness of open enrollment remains quite low, and a shorter period would hinder efforts by consumer assisters, navigators, brokers, marketplaces and others to ensure that people have the information they need and that they complete the enrollment process before the deadline.

While a shortened enrollment period is being justified as a way to positively impacting the risk pool, it is actually more likely to reduce the number of younger and healthier people who enroll. As noted in the proposed rule's impact estimates, younger and healthier people usually enroll late in the enrollment period. Without sufficient time, and with enrollment assisters and marketplace systems working more intensively for a shorter period, these younger and healthier people may simply not enroll. In addition, we note that the shorter open enrollment period would be especially problematic

[8] While this provision explicitly states that employers buying coverage through an exchange may select one coverage level to be made available to their workers, with the workers then choosing any plan in that coverage level, this is the only restriction on choice that the ACA included in the "consumer choice" requirement.

if HHS finalizes the proposal to allow insurers to refuse to cover people who have prior premium debt. A shorter enrollment period would give people – likely many younger and healthier people – far less time to come up with the money to pay any prior premiums owed.

We appreciate that CMS is seeking comment on the effect of the shortened open enrollment period on assisters and navigators. The effect would be substantial. In prior years when open enrollment was longer, these entities were stretched and had to turn consumers away during times of high demand.[9] The capacity of agents and brokers to help people enroll in coverage would also be sharply reduced. In addition, consumers are getting confusing messages in the news about the future of the ACA marketplaces, premium credits and cost-sharing subsidies, and their current coverage, as Congress and President Trump continue to push for repeal of the law. This is likely to present additional challenges for the next enrollment period that assisters and others working on outreach and enrollment will have to overcome. Providing sufficient time would make that task somewhat easier.

After four enrollment cycles, it has also become clear that there are important advantages to extending open enrollment past December, when consumer have heightened financial constraints and are distracted by the holiday season.[10] As Florida Blue Cross Blue Shield has noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[11]

We support CMS's plan "to conduct extensive outreach" if the next open enrollment period is shorter. This is critical regardless, even if the longer open enrollment period is retained. Either way, we urge CMS to provide more detail about its outreach plans for the 2018 benefit year as soon as possible. We also urge CMS to continue to provide navigator grant funding at levels that are at least comparable to prior years because this is a highly effective way to promote enrollment; consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[12]

Special Enrollment Periods (§155.420)

Based on "strong issuer feedback," HHS is proposing yet another round of restrictions to special enrollment rules and procedures. We strongly oppose these proposals, because they are very likely to reduce people's access to health coverage.

[9] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[10] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[11] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

[12] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

No data from industry or government sources has been produced to show whether and how often people who are ineligible for SEPs are using them to access coverage. Insurers have shown that people enrolling through SEPs have higher medical claims costs than people who enroll during the annual open enrollment period, but this is likely related to the fact that so few SEP-eligible people — five percent by one estimate[13] — are actually using SEPs to enroll. Consumers' level of knowledge about special enrollment periods is quite low.[14] So it is unsurprising that SEP enrollees would be somewhat costlier to cover than people signing up during the open enrollment period, as those who expect to need medical would be more likely to seek out coverage when they lose it from another source (such as a job) in order to avoid even a short stint without insurance. Moreover, the costs of SEP enrollees don't appear to be all that much higher when compared to people who come in during open enrollment. A report by Avalere showed that in 2015, SEP enrollees had healthcare costs that were five percent higher than those of OEP enrollees, down from a 16 percent differential in 2014.[15]

And yet, HHS is proposing that in a matter of months, most consumers seeking SEPs will start having their coverage delayed unless and until they provide documentation of the event that triggered the SEP for which they have claimed eligibility. No evaluation or analysis of the impact of prior increases in SEP documentation requirements have been made available. The little data we do have on the post-enrollment verification requirements that CMS put in place last summer are quite troubling: 20 percent fewer consumers enrolled using SEPs and younger consumers were less likely than older ones to follow through.[16] These young consumers tend to be healthier and are the very people needed to help balance the risk pool. Delaying coverage until verification is produced will only worsen this troubling trend because those most in need of coverage are the ones who are much more likely to take the steps necessary to complete the process.

If HHS continues with its plans for pre-enrollment verification, it is critical that eligible consumers successfully finish the SEP verification process with minimal burden. The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the bar be higher, consistent with the streamlined eligibility and enrollment process envisioned in the ACA and in current law. A number of other measures are needed to ensure that consumers are as protected as possible from delays, denials, and unnecessary red tape. For example:

- In cases such as birth, denial of Medicaid or CHIP, or loss of Medicaid or CHIP eligibility, SEP applicants' coverage should *not* be delayed pending verification. Instead, their attestation should be accepted with eligibility verified afterward in order to ensure continuity of their health care and coverage.

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[13] Stan Dorn, "Helping Special Enrollment Periods Work under the Affordable Care Act," The Urban Institute, June 2016.

[14] Jane Wishner, Sandy Ahn, Kevin Lucia and Sarah Gadsden, "Special Enrollment Periods in 2014: A Study of Select States," February 2015.

[15] "The State of Exchanges: A Review of Trends and Opportunities to Grow and Stabilize the Market," Avalere Health, October 2016.

[16] Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

- The federal government should reinstitute the requirement, that issuers and health plans to automatically provide individuals with certificates of creditable coverage when coverage ends and upon request.[17] This should be done, through regulations, before people seeking "loss of coverage" SEPs can be required, as a condition of obtaining coverage, to submit documentation of the coverage loss. Loss of prior coverage is the main reason individuals apply for a marketplace SEP, but documenting this can be challenging. It would be unfair to require people to submit proof of past coverage in order to access an SEP – and delay their coverage in the meantime – without providing them a way to easily obtain that proof.
- HHS should commit to providing a response to SEP applicants whose coverage is delayed within five days of an applicant submitting documentation. If HHS fails to respond in that timeframe (with an approval, denial, or request for additional information related to the SEP), then the person's coverage should be made effective.
- People who fail to submit documentation that proves one SEP but who submit documentation showing another SEP should be allowed to begin getting coverage. Alternatively, HHS should commit to calling those individuals to clarify any additional information that might be required. In any case, people who appear eligible for coverage should not be barred from having it once they have provided documentation that they are eligible for an SEP.
- It is critical that marketplaces, not issuers, should continue conducting SEP verification for exchange enrollees.
- We appreciate the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process. One strategy the Administration should use is to conduct robust outreach through email and calls to consumers who have not yet completed the process.
- We support the idea, suggested in the preamble, that a small percentage of enrollees would be retained outside of the pre-enrollment verification process in order to evaluate the impact of these processes. We have wanted an evidence-based approach to the FFM's SEP process since insurers first began complaining about SEPS more than a year ago. This small control group is the very least that is needed to glean information that could inform future decisions about enrollment rules and procedures.
- The new process shouldn't be launched until there is adequate training of navigators, brokers and agents, and other assisters. New consumer-facing materials should be tested and clearly explain the verification process, including information on how consumers can maintain the coverage effective date applicable to their situation.

We are also strongly opposed to requiring prior coverage for the marriage SEP and rules that limit the ability of currently enrolled consumers to change plans, as noted in the earlier comments on guaranteed availability. We further note that under the requirement in section 1311(c)(6)(c) of the Affordable Care Act, the Secretary is directed to require exchanges to establish SEPs as specified in section 9801 of the Code and under circumstances similar to such periods under Part D of title XVIII of the Act. That the statute references both HIPAA and Medicare Part D is significant; it recognizes that people's access to SEPs should take into account that they are accessing a private plan that is also, for many, the vehicle for receiving substantial federal help with their costs. We note that special enrollment rules are quite flexible in Medicare Part D, particularly for people who have lower incomes. Creating special enrollment rules that are *more* restrictive than both HIPAA

[17] This federal requirement was ended by regulation in 2014.

and Medicare Part D – as this proposed rule would do – is inconsistent with the statute, which requires the Secretary to implement a combination of both.

We also urge the Administration to not require state-based marketplaces (SBMs) to align with the federal process for pre-enrollment verification, nor with the other SEP changes proposed in this regulation. States should have the flexibility to create policies and processes that work for them. For example, the D.C. Health Benefit Exchange Authority has found that its SEP enrollees skew younger than the people who sign up during the open enrollment period. Finding no evidence that consumers are abusing SEPs, and wishing to reduce the risk of overburdening consumers and deterring enrollment, DCHBX opted to accept attestation (under penalty of perjury) from applicants rather than requiring documentation of a recent marriage, birth, or move to D.C. Other SEP-triggering events require additional verification, which may involve a review of information or documentation provided by the consumer, the insurance carrier, or DCHBX systems.[18]

The final rule should maintain states' flexibility to take the approaches that best fit their specific needs and the needs of their residents – particularly because the federal government is proposing to rush ahead with a verification process and other restrictions that risk reducing the enrollment of eligible people, including those who are healthier. We also note that SEPs largely apply on a market-wide basis, and states continue to have authority over their individual and small-group insurance markets. They can implement rules that are more protective of consumers and that do not impede the application of federal law. States with an SBM, in particular, should have the ability to align rules and processes across the market in ways that better protect consumers.

SEP Barriers in the FFM Eligibility Process

It has come to our attention that the FFM eligibility application contains system logic that fails to allow consumers who are eligible for certain SEPs to have the opportunity to apply for coverage using those SEPs. Specifically, it appears that the definition of dependents for SEP purposes is being implemented more narrowly than federal rules permit.

From what we understand about the logic of the marketplace eligibility application, if a household includes a child who appears eligible for Medicaid or the Children's Health Insurance Program (CHIP) based on the household's projected income, then an SEP for the family cannot be triggered for any qualifying event that involves that child. The most common example of this is if a couple has a child, the birth does not trigger a marketplace SEP for either parent if the newborn is eligible for Medicaid or CHIP. This conflicts with federal regulations, which do not condition SEP eligibility of family members on the type of coverage for which the person experiencing the triggering event is eligible. It also, in practice, applies what is effectively an income test for access to certain SEPs.

According to the SEP regulation at 45 CFR §155.420(d), "The Exchange must allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from

[18] Letter from Mila Kofman, DCHBX executive director, to Seto J. Bagdoyan, director of Forensic Audits for the Government Accountability Office (GAO), regarding GAO's report *Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period* (GAO-17-78). The letter also describes a number of flaws in the GAO report (which is cited by HHS in the proposed rule). For example, GAO investigators lied to get SEPs, attesting under penalty of perjury to facts they knew were false. This is not representative of real consumers' behavior. Self-attestation remains an important way to minimize burden in the eligibility process, including in other federal programs such as income-tax filing.

one QHP to another if one of the following triggering events occur…" The provision then goes on to list the various events that trigger an SEP. Under 45 CFR §155.20, a qualified individual is "an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market." Someone is eligible to enroll in a QHP through an Exchange if they are "lawfully present" in the U.S. and are not incarcerated. Eligibility to enroll in a QHP is distinct from eligibility for marketplace subsidies, which hinges on whether people have access to other coverage such as employer coverage, Medicaid or CHIP.

"Dependent" is defined for purposes of the SEP provisions as having "the same meaning as it does in 26 CFR 54.9801-2, referring to any individual who is *or who may become eligible* for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee." (Italics added.) Again, whether someone is a dependent of another person for SEP purposes doesn't hinge on what health coverage, if any, the person might enroll in or be eligible for. In practical terms, a person who is considered under the terms of an insurance plan to be a family member, is a dependent for SEP purposes.

In the birth example, the relevant SEP trigger is at (d)(2)(i): "The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order." In the example of a family who has a baby, both the mother and father are qualified individuals (because they are both lawfully present and not incarcerated), and both are gaining a dependent because their child has been born. That child clearly fits the definition of "dependent" established for the SEP regulations because the child is eligible (or may become eligible) to enroll in the QHP together with the parents. The parents should be able to access an SEP to enroll through the marketplace (or in the individual market more broadly) regardless of what coverage the baby might be eligible for.

This reading is consistent with our understanding of the SEP regulations during several years of commenting on their various permutations, discussing them with CMS officials in great depth, presenting examples on webinars about SEPs, and preparing written materials about how SEPs work.

The marketplace application system has been implementing the SEP in this situation in a manner that conflicts with the law. It appears to assume that if a baby is born and appears to be eligible for Medicaid or CHIP, then the birth of the child doesn't trigger an SEP in the marketplace for anyone in the household. This is highly inequitable. If the family has higher income, such that the child is not eligible for Medicaid or CHIP, then an SEP would be available to the parents. Lower-income families should not have less access to an SEP. That is inconsistent with the law.

An important group that we have already heard concerns about are those women who receive CHIP while pregnant under the "unborn child" option. Fifteen states define "child" under CHIP as including the period from conception to birth, in accordance with the definition of child in 42 CFR 457.10. This allows pregnant women who are not eligible for Medicaid usually because of their immigration status to get coverage related to their pregnancies, but the coverage is technically for the child. Therefore, the pregnant woman getting pregnancy-related care through this option is not considered to have minimum essential coverage. After giving birth, these women lose eligibility for CHIP. However, CHIP coverage is not a form of minimum essential coverage for these women, so losing it does not trigger an SEP. Nor do the current SEP regulations, which recognize losses of certain other types of non-MEC coverage as triggering an SEP, address the unborn child option.

The birth of the child should provide these women who are lawfully present but ineligible for Medicaid because of their immigration status or income access to an SEP so that they can get coverage once their children are born. This makes sense: They are qualified individuals gaining a dependent, and the fact that their babies are getting coverage other than through a QHP should have no bearing. But according to the way the application works, these women are not able to access an SEP.

We urge you to correct the application logic, which appears to be in serious conflict with the SEP requirements. HHS should review this issue as it relates to the "birth" SEP and as it may affect other SEP triggers. The agency should ensure the application treats dependents consistently, regardless of whether they will enroll in a QHP. A person's income level or other coverage options should not determine whether or not an SEP applies, particularly when the practical consequences of doing so end up applying an inadvertent income test on SEP eligibility. HHS should address this as soon as possible, and if it will take time to fully update the application, a workaround should be found so that SEP-eligible people can access coverage or change plans both online and over the phone.

Continuous Coverage

According to the preamble, HHS is considering various proposals that could be established that would "promote continuous enrollment in health coverage" without gaps and discourage people from "waiting until illness occurs to enroll in coverage." These proposals should not be implemented. They conflict with the law and would create unnecessary burdens for consumers that would leave them unable to access the coverage and benefits that they need.

One idea discussed would require individuals applying for a special enrollment period to show they have had "continuous coverage," defined here as having health coverage for period of time (perhaps six to 12 months) without a gap of more than 60 days. If a person fails to demonstrate they had "continuous coverage," they could then be denied the SEP, effectively barring them from gaining coverage and from accessing any federal subsidies they may be eligible for. Another idea discussed in the proposed rule would expose SEP applicants who do not provide evidence of prior "continuous coverage" to new penalties – such as a waiting period before their benefits begin or a late enrollment penalty -- that have been prohibited in the individual market since enactment of the ACA.

Under the guaranteed availability requirements of the ACA, issuers generally "must accept every employer and individual in the State that applies for coverage" during open and special enrollment periods. There is no basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. Imposing a waiting period on some consumers' benefits or making them wait "at least 90 days" for their coverage to be effectuated is completely inconsistent with guaranteed availability. Late enrollment penalties or surcharges conflict both with guaranteed availability and the requirement that premiums vary only based on certain specified factors; whether a person has been uninsured in the past is not an allowable rating factor, for example.

Even if these ideas were legal, they would be layered on top of an array of existing policies that already encourage people to obtain coverage and not to wait until they are sick. For example, people who go without coverage for longer than a two months are already subject to a financial penalty, in the form of the ACA's individual mandate – which unlike what HHS is suggesting, applies broadly, generally to anyone who goes without health insurance beyond a short gap and not only those

people who attempt to enter the individual market. In addition, current law allows insurers to deny coverage to people outside of the annual open enrollment period or a special enrollment period that is triggered by experiencing a life event (for example losing other coverage, having a baby, or making a permanent move). Insurers don't have to provide coverage whenever someone wants it, and becoming sick on its own doesn't trigger an SEP.

The ideas suggested in the preamble would harm many consumers. Breaks in coverage are fairly common, a fact that has been borne out by numerous studies.[19,20] Imposing late fees, waiting periods before benefits begin, or other barriers to accessing coverage would mean that some people would go without the coverage or the health care services that they need. In addition, the proposals floated in the preamble would fail to motivate healthier people to secure coverage. A young, healthy person who is leaving his job and losing his employer-sponsored health plan is unlikely to be motivated to buy coverage in the individual market by the threat that, if he does not, he would potentially face a financial penalty (or waiting period) at some point in the future *if* he attempts to purchase an individual-market plan after being uninsured for more than 63 days. Moreover, if there is a financial penalty for people who have been uninsured and then want to get a plan, it would fuel adverse selection. Someone who is healthy would opt to sit out, remaining uninsured until he gets some other source of coverage. People who have expensive medical conditions, in contrast, would be more willing to buy a plan even if they have to pay the penalty, since that could easily be cheaper than paying out of pocket for the health care services they expect to use.

Therefore, the ideas floated here actually raise the risk of making the risk pool worse and health coverage less affordable overall. To truly promote continuous coverage, an open and accessible system – not a closed and onerous one – is needed to ensure that people successfully obtain coverage when they are first eligible and maintain it over time. The process for changing coverage should be as smooth and as swift as possible, and the government should avoid placing harmful restrictions on people's ability to make these transitions successfully – particularly in ways that conflict with the law. Alternative approaches to those suggested here would be: robust investment in outreach and enrollment efforts that focus specifically on key transition points when people face coverage disruptions (i.e., aging out of Medicaid or a parent's plan, losing job-based coverage); improved eligibility systems and streamlined processes that reduce rather than increase complexity and paperwork requirements for consumers; improved affordability in premiums and cost-sharing charges by increasing subsidies for moderate-income people; ensuring that all states adopt the ACA's Medicaid expansion; and maintaining the current individual mandate penalty and helping people understand how it impacts them.

Levels of Coverage and Actuarial Value (§156.140)

We strongly oppose the proposal to broaden the allowed *de minimis* variation in actuarial value (AV) for each plan metal level to -4/+2 percentage points. This policy will permit insurers to raise the deductibles and other cost-sharing charges in the plans they sell in the individual and small-

[19] Some 36 percent of Americans ages 4 to 64 (89 million people) went without coverage for at least one month between 2004 and 2007, and about one-quarter of this group lost coverage more than once, according to a study by the Commonwealth Fund: http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance

[20] Nearly one-quarter of people with pre-existing health conditions (31 million people) experienced at least one month without health coverage during 2014, according to data from the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

group markets. In addition, this change would effectively reduce the amount of financial assistance that millions of lower- and moderate-income people receive to help purchase marketplace coverage. Overall, this policy would shift significant costs to families, either through higher premiums or higher cost-sharing, and would likely reduce enrollment due to cuts in financial assistance.

This policy will be particularly damaging for people that receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size of premium tax credit many of these individuals and families receive, as premium tax credits amounts are tied to the cost of the second-least expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars -- a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit cut by $327 per year under this policy.[21]

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today *or* purchase coverage with hundreds to thousands of dollars in higher cost-sharing- either way they will have to pay much more for coverage and care.

While allowing insurers to reduce the AV of their plans by two percentage points may not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[22]

The administration should not proceed with a policy that will knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current *de minimis* actuarial value requirement of -2/+2 percent be maintained for all metal levels. We note that a broader level of variation is no longer *de minimis* and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare different plan options and also to place some parameters around the amount of cost-sharing charges that issuers may include in their plan designs. Further, it is hard to see how a *de minimis* variation that is asymmetric is consistent with the statute.

If the administration is insistent on pursuing a policy that reduces the actuarial value of available plans, however, we strongly urge that such change be limited to bronze level coverage only. We disagree with the assumption that the remaining uninsured are only looking for coverage with lower premiums, as many people, including young adults, report being just as concerned about high cost-

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[21] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, Feb 2017), available online at: http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

[22] Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense,* (Washington, DC: Families USA, February 15, 2017), available online at http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

sharing.[23] As such, we are skeptical that reducing the floor of bronze coverage offered in the marketplace will attract a large number of new enrollees. However, if the premise of this proposed policy change is to expand marketplace offerings to include skimpier, lower-premium plans than currently are available through the marketplace, then lowering the minimum actuarial value for *only* bronze level coverage does that without undercutting vital financial assistance.

Network Adequacy (§156.230)

The proposed changes to network adequacy would gut the protections HHS currently has in place to identify and improve the most egregiously inadequate provider networks. The proposal would instead punt authority for provider-network review to states that have no metrics in place to assess whether marketplace plans provide adequate networks.[24] The rule fails to describe how consumers' access to providers will be affected by the removal of federal network adequacy review. HHS should explain how it will ensure consumers have the same or better access to providers in all states if this proposal is implemented. We urge HHS to maintain §156.230 as is and not to adopt the proposed changes. Otherwise, insurers will again be able to offer health plans that do not include a sufficient number of different types of providers, which would jeopardize the health and financial security of consumers and undermine efforts to hold insurers accountable for selling products that provide adequate access to care.

Essential Community Providers (§156.235)

The proposed changes to this section would narrow networks for consumers, because insurers could include fewer Essential Community Providers (ECPs) – which serve predominately low-income, medically underserved individuals -- in their networks. As HHS itself notes in the proposed rule, consumers could be required to travel farther or wait longer to a see a health care provider, or the continuity of their care could be diminished if they lose access to the providers they currently see. HHS should maintain its commitment to vulnerable marketplace enrollees by not finalizing the rollback to an ECP standard of 20 percent and should instead increase the threshold over the next three years until it reaches 75 percent.

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[23] Liz Hamel, Jamie Firth, Larry Levitt, Gary Claxton and Mollyann Brodie, *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Washington, DC: Kaiser Family Foundation, May 20, 2016), available online at http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/ and Kara Brandeisky, *Why Millennials Hate Their Least Expensive Health Care Option,* Time Magazine (Dec 8, 2014), available online at http://time.com/money/3614626/millennials-health-insurance-high-deductible/.

[24] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

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Many of the proposed rule changes in CMS-9929-P, though they MAY address some of the issues brought up, will do more harm to the public and the insurance market.

1. Reducing the OEP from Nov 1 - Jan 31 to Nov 1 - Dec 15 will reduce membership and keep members from changing into plans they want. As a manager for our sales agents for the past decade I can tell you that the perception of our government and the reality on the street are far apart. Consumers who HAVE plans are SOMEWHAT aware of what and when the OEP is. Clients that DONT'T HAVE COVERAGE because they did not enroll during an enrollment period are BARELY AWARE of OEP. Our agency spends every bit of the current 3 month OEP trying to meet with all our existing members and reaching out to the public to educate, quote, enroll and service written policies and we don't come close to meeting the needs of the public. Most people don't know about the OEP and we as agents of the insurance industry need as much time as possible to reach as many people as possible. I don't believe there should be a never ending OEP but 7 weeks is not enough. You may argue that there are ads and news articles to educate the public. People fast forward thru ads on TV or change channels and don't pay attention to them. The media picks and chooses which sensational story lines they want to run about Obamacare/Health Care and do little to educate the public on the actual regulations of it.

Though there may be a small percentage of enrollees that are diagnosed with a condition between Dec 16th and Jan 31st and could "take advantage" of the system, that is small percentage of enrollees during OEP and a small percentage of adverse risk of those that wish to enroll throughout the rest of the year. But you could make that arguement for any enrollment period. I could say that some people during your proposed OEP might find out about a diagnosis on Dec 1 and enroll in a plan when they otherwise would not have without that diagnosis. With a guaranteed issue product, you cannot completely get rid of adverse risk.
Also, by reducing the OEP timeframe, particularly to the proposed dates, you are putting undue, insurmountable stress on the insurance industry to do enrollments and plan

changes. With Medicare's AEP running from Oct 15 - Dec 7, both enrollment periods run on top of each other. You have EVERYONE in the country that is not enrolled in a group plan (and even some of those that are) doing plan elections at the same time. Agents and agencies have to split their focus and can only reach half of their clients because of this.

Though we (insurance agents) were not widely publicized as as source for the public, we are seeing that more and more clients are choosing not to go directly to the marketplace or buy direct online because they need the help of an experienced agent to understand the plans and their options and ramifications for the choices they make. Reducing the AEP will limit the availability of agents to the public and consumers will be forced to make uneducated, ill-informed choices on their healthcare.

2. For the expansion of SEP enrollment verification, I have serious concerns about the government or insurrance companies being able to process those in a timely manner. For marketplace enrollees that are required to submit additional document to prove income or citizenship, it can take weeks for the marketplace to process that documentation after it's been submitted. With this new rule on SEP eligibility proof, this could cause a delay of weeks before they are covered. Now even if the coverage is retro-active back to the original date they should have received based on the application date, there would also be claims issues arise. Many physicians and hospitals will refile claims, but must pharmacies will not. So if a member has to get an Rx filled they would have to pay out of pocket even if they were covered.

There are also some SEPs where members may not have documentation or it takes a while to get the documentation. Losing MEC is one where multiple issues arise. If a consumer that will be losing group coverage is diligent and comes in ahead of time (they can complete enrollment form 60 days in advance of the loss), there is no documentation they can provide proving they WILL lose coverage. They will get a creditable coverage letter from their carrier after the loss occurs but that could take

weeks to receive. Carriers don't send that out until the member has been removed from the plan and the employer has the entire month to submit that information to the insurance company. So it may take 2-6 weeks from the termination date of the prior coverage before the member receives documentation to prove loss of coverage and the dates that apply. Allowing a member to enroll and giving that member 60 days to show proof of eligibility before termination of coverage is a more viable option. Allow insurance companies to suspend claims until proof is recd.

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March 7, 2017

Submitted via the Federal eRulemaking Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Re: RIN 0938-AT14 Patient Protection and Affordable Care Act; Market Stabilization

To Whom It May Concern:

We are writing on behalf of the Chronic Illness and Disability Partnership (CIDP). CIDP consists of national organizations representing individuals living with a wide range of chronic illnesses and disabilities, including cancer, cystic fibrosis, diabetes, HIV, Hepatitis C, behavioral health concerns, multiple sclerosis, and renal disease. We represent the 117 million Americans estimated to be living with a chronic illness and/or disability, many of whom rely upon the Marketplaces to obtain needed care.[1] While our organizations are national in scope, we also affiliate with strong regional, state, and community based advocacy networks. We appreciate the opportunity to provide comments to the Department of Health and Human Services (HHS) on the proposed rule regarding market stabilization for the individual and small group markets.

We understand that the uncertainty caused by the current health policy debate in Congress may have implications for the stability of the individual health insurance market in many states. We support federal and state efforts to allay uncertainty among both issuers and consumers and to increase robust competition in the Marketplaces for the 2018 plan year. However, we believe that curbing vital

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[1] U.S. Centers for Disease Control and Prevention, Chronic Disease Overview (February 23, 2016), available at https://www.cdc.gov/chronicdisease/overview/.

consumer protections with regard to affordability and access is not the way to address stability and that many of the proposed changes to individual market regulation, if enacted, will in fact serve to limit enrollment and competition in the individual market and thereby harm consumers who depend on the marketplace for coverage.

To provide meaningful access to care for people living with chronic illnesses and disabilities and to promote robust enrollment and competition in the individual health insurance market, we urge HHS to consider the recommendations and comments detailed below.

OPEN ENROLLMENT PERIOD LENGTH (45 CFR §155.410(e))

We recognize that eventually moving to an open enrollment period that does not cross two plan years will be administratively simpler and more efficient. However, we are concerned that given the uncertainty and confusion that surrounded the final days of the 2017 open enrollment period as well as the ongoing uncertainty that Congressional health policy debates have caused, the 2018 plan year is too soon to dramatically shorten the open enrollment period and will ultimately prevent robust enrollment and a balanced risk pool.

We urge HHS to maintain the existing open enrollment period, or at least allow open enrollment until December 31, 2017. If HHS decides to move forward with a shortened open enrollment period for the 2018 plan year, we strongly support additional consumer outreach and education activities to ensure that consumers understand the new timeline and the importance of enrolling in coverage. This includes additional resources for Health Insurance Navigators and other assisters and a robust educational campaign to promote enrollment. In the Proposed 2018 Notice of Benefit and Payment Parameters, the Secretary solicited comments on how to use remaining funds in the Pre-Existing Condition Insurance Plan (PCIP) to transition PCIP clients to exchange plans. In the Final Notice of Benefit and Payment Parameters, the Secretary indicated that it would take no action at this time on the proposal. We encourage the Secretary to use remaining PCIP funds to support consumer outreach and education activities that will facilitate greater enrollment, such as Consumer Assistance Programs, particularly if the Secretary finalizes the shortened open enrollment period.

SPECIAL ENROLLMENT PERIODS (45 CFR §155.420)

Special Enrollment Periods (SEPs) have been an important consumer protection to ensure access to health insurance following a significant life event or evidence of extenuating circumstances that prevented enrollment during the open enrollment period. Absent evidence of abuse (which has not been documented or shown), we do not support proposals that seek to limit availability of SEPs.

We urge HHS to maintain current SEP application and verification standards. Creating burdensome documentation requirements before someone may enroll in a plan, particularly absent evidence of consumers abusing SEPs, will only serve as an enrollment barrier for individuals who have in fact had a qualifying life event. We believe that the current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, should be left in place.

The proposals to limit plan metal level changes during SEPs and to require evidence of continuous coverage are prohibited by statute. The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1) While issuers "may restrict enrollment … to open or special enrollment periods," this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement. The Secretary's authority to "promulgate regulations with respect to enrollment periods" is limited to just that – defining the enrollment periods under which the issuer "must accept every employer and individual in the State that applies for such coverage."

We oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs; this is particularly true for people living with chronic illnesses and disabilities for whom appropriate plan choice is critical to affordable health care access. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

Finally, we oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria. Again, we understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

CONTINUOUS COVERAGE

As we stated above, we believe that continuous coverage requirements are antithetical to the guaranteed issue consumer protections of the ACA. Imposing waiting periods before effectuating enrollment, pre-existing condition exclusions, and penalties for people who experience a gap in insurance coverage will harm consumers, particularly those who may be living with disabilities or with serious chronic conditions who are more likely to experience changes in employment and life circumstances throughout the year. Additionally, we note that individuals who need care but are denied coverage due to such rules are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on.

GUARANTEED AVAILABILITY (45 CFR §147.104)

The proposed reinterpretation of the guaranteed availability provision is unlawful and outside the Secretary's authority. We encourage the Secretary to abandon the proposed reinterpretation and

instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment.

The statute is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1(a)) Enrollment may only be restricted to open or special enrollment periods, and the Secretary does not have authority to expand these restrictions to include prior non-payment of premiums. The Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual clearly articulated the appropriate enrollment procedures for enrollees with prior non-payment, and the Secretary must maintain those procedures.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support additional measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments. The Secretary should establish procedures, however, for past due premiums to be pro-rated and added to the insurance premiums for the following year (or partial year, in the case of a special enrollment period) for the enrollee. This would allow issuers to recoup past due premiums while respecting the statutory requirement to accept all applicants. Consistent with statute, issuers could not deny or terminate enrollment for failure to pay the pro-rated past due amount if the current premium is paid; the pro-rated repayment option simply facilitates an issuer's collection of debts that could be recouped under other legal remedies.

Pro-rating the past due amount will facilitate beneficiary re-payment and enrollment in the prior issuer's plan, as requiring the full past due amount at enrollment may be financially impossible for many enrollees. We urge the Secretary to develop clear procedures to notify consumers beneficiaries of past due amounts at the time of plan selection, the pro-rated repayment schedule, and an opportunity to contest the past due amount.

Importantly, many consumers only have access to plans from one issuer due to limited Marketplace competition. Under the Secretary's proposal, if these consumers are unable to fully repay past due premiums upon enrollment, they will be completely unable to obtain any coverage. We believe the possibility of such lockouts could have a chilling effect on enrollment by healthier individuals, especially those with limited incomes, because they might worry that if they do not maintain continuous coverage they will never again be able to purchase insurance and access care when they need it. Pro-rated repayment plans will facilitate these consumers' re-entry into the insurance market, supporting Marketplace stability. Without affordable repayment plans, these consumers may postpone enrollment until they are sick, increasing adverse selection. Clear guidelines on pro-rated re-payment plans are necessary to protect consumers and encourage them to re-enter the marketplace, particularly in jurisdictions with only one issuer.

We support the Secretary's proposal to allow issuers to develop a premium payment threshold policy. Issuers could, for example, allow a beneficiary to pay 60 percent of the past due amount in one payment at enrollment and have the balance of the past due amount forgiven rather than participate in an installment re-payment. Issuers should be allowed to experiment with these repayment models so long as they offer an annualized installment option for the full past due amount. The issuer must be required to provide consumers with a clear and consumer-friendly explanation of all repayment options when the issuer enrolls the past-due consumer.

ACTUARIAL VALUE DE MINIMIS VARIATION (45 CFR §156.135)

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces. Instead, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

The proposed expansion of the de minimis actuarial value variations is unlawful. Per statute, the allowable variance authority granted to the Secretary can only be used to "account for differences in actuarial estimates." (42 U.S.C. § 18022(d)(3)) However, the proposed rule states that the intent behind the proposed variation is "to help issuers design new plans for future plan years, thereby promoting competition in the market." The authority to establish de minimis variation is clearly limited to accounting flexibility and does not permit the manipulation of statutorily defined actuarial valuations for particular plan metal levels. The statute is clear – Congress established firm actuarial valuations for each plan metal level and only permitted de minimis variation "to account for differences in actuarial estimates." The proposed expansion exceeds the Secretary's authority and undermines the plain meaning of the statute.

Contrary to the proposed rule's assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium (benchmark plan) and the applicable percentage of the enrollee's income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation

will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. For example, consider a single 35 year-old non-smoker with an income of $25,000. This individual's expected contribution towards premiums is 6.8% of income or $1,700. If the person selects the benchmark plan, his/her net premium will be $1,700, regardless of whether the benchmark plan has a 70, 68, or 66 percent actuarial value and regardless of the gross premium before the advance premium tax credit. Gross premium reductions through reduced actuarial value requirements will not increase enrollment because enrollee net premiums for benchmark plans will remain constant.

Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living expensive to manage chronic illnesses and disabilities who depend on access to plans with a higher actuarial value to defray high cost sharing. Consider three possible silver benchmark plans:[2]

Benchmark Plan Costs, 2018						
Actuarial Value	Gross Premium	Deductible	Maximum Out-of-Pocket	Co-Insurance	Advance Premium Tax Credit	Net Enrollee Premium*
70	$4,138	$1,600	$7,200	30%	$2,438	$1,700
68	$4,020	$2,100	$7,200	30%	$2,320	$1,700
66	$3,902	$2,750	$7,200	30%	$2,202	$1,700

* *Examples assume consumer enrolls in the benchmark second lowest cost sliver level plan; net premium amount would increase if consumer enrolled in a higher AV plan*

While reductions in actuarial value reduce gross premiums, they do not reduce the net enrollee premium when selecting the benchmark plan resulting in less purchasing power for the consumer. Deductible increases allowed by the actuarial value reductions, however, will discourage enrollment, leading to a death spiral.

To stabilize the Marketplaces, the Secretary should instead lower net premiums to enrollees through selecting a higher premium reference plan for computation of the advance premium tax credit. The Affordable Care Act clearly defines silver plans as those with "benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan." (42 U.S.C. § 18022(d)(1)(B)) The second lowest cost silver plan, then, must be the second lowest cost plan with an actuarial valuation of 70 percent. While plans with a de minimis variation from the 70 percent actuarial

[2] Actuarial values were calculated using the 2018 Actuarial Value Calculator for silver plans. Premiums assume 85 percent of costs are medical and 15 percent are administrative. Advance premium tax credit is based on a $25,000 income for a single 35 year-old enrollee, resulting in a $1,700 expected annual contribution from the enrollee and a $2,438 tax credit on average nationwide. This example assumes enrollment in the benchmark second lowest-cost sliver level plan. The applicable income percentage and gross premium for the 70 percent actuarial value plan were calculated using the Kaiser Family Foundation's 2017 Health Insurance Marketplace Calculator.

value threshold may be sold on the Marketplace, Congress was clear in its definition of a silver plan. The actuarial value thresholds were carefully crafted to ensure that plans with the specified coverage generosity were affordable to enrollees; the intent behind the silver plan threshold carries additional weight because it establishes the advance premium tax credit amount.

Under the plans above, using the 70 percent actuarial value plan as the benchmark would result in a 15 percent net enrollee premium reduction for enrollment in the 66 percent actuarial value plan because of the increased advance premium tax credit. This substantial net enrollee premium decrease will likely spur increased Marketplace enrollment even with increased deductible costs. Enrollees currently in 70 percent actuarial value plans can maintain their plan benefit design without an increase in premium costs, which they would face if the advance premium tax credit were calculated from a lower actuarial value plan.

Impact of Requiring 70 Percent Actuarial Value (AV) Benchmark Plan					
Actuarial Value	Gross Premium	Advance Premium Tax Credit (70 AV benchmark)	Net Enrollee Premium ($)	Net Enrollee Premium Reduction (%, compared to benchmark contribution of $1,700)	Increased Deductible (compared to $1,600 under 70 AV benchmark)
68	$4,020	$2,438	$1,582	7.0%	$500
66	$3,902	$2,438	$1,464	13.9%	$1,150

While we do not support expanding the de minimis actuarial value threshold to -4/+2 percent, if the Secretary finalizes this proposal, calculating the advance premium tax credit from plans with a true 70 percent actuarial value will reduce net enrollee premiums and encourage the enrollment of healthier, younger individuals, promoting Marketplace stabilization.

The Secretary must require that plans with a 70 percent actuarial value be offered for enrollees with household incomes between 250 and 400 percent of the Federal poverty line. By statute, issuers are required to offer reductions in out-of-pocket limits for all enrollees between 100 and 400 percent of Federal poverty line. (42 U.S.C. § 18071) Enrollees between 200 and 300 percent of the line must receive a one-half reduction in out-of-pocket costs, while enrollees between 300 and 400 percent must receive a one-third reduction. The Secretary is given authority, however, to modify the out-of-pocket reduction only if it would “result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan” above certain thresholds (70 percent for enrollees between 250 and 400 percent of the Federal poverty line).

The statute therefore requires that the Secretary establish cost-sharing reduction plans for enrollees between 250 and 400 percent of the Federal poverty line unless such reductions would result in plans with an actuarial value greater than 70 percent. Silver plans with a 66 percent actuarial value and no reduction in out-of-pocket cost sharing fail to meet this statutory requirement. The Secretary then has two options: establish cost-sharing reduction plans for this group or ensure that plans with 70 percent actuarial value are available. We support the February 24, 2012 *Actuarial Value and Cost-Sharing*

Reductions Bulletin's explanation for not establishing cost-sharing reduction plans with a 70 percent actuarial value for these enrollees, but this explanation depended on the availability of 70 percent actuarial value plans for these enrollees. We encourage the Secretary to establish 70 percent actuarial value cost-sharing reduction plans for these enrollees, as required by statute, but to allow issuers to not offer such cost-sharing reduction plans if they offer another plan with a 70 percent actuarial value. This would maximize issuer flexibility, as it allows issuers to offer 70 percent actuarial value plans with full out-of-pocket maximums and lower deductibles rather than the required cost-sharing reduction plans that may contain higher deductibles, which could discourage enrollment.

We support the maintenance of the +/-1 percent de minimis actuarial value variation for cost-sharing reduction plans available to enrollees with household incomes below 250 percent of the Federal poverty line, and the Secretary should extend this requirement to 70 percent actuarial value plans offered in lieu of cost-sharing reduction plans for households between 250 and 400 percent of the Federal poverty line.

Requiring this 70 percent actuarial value plan will support Marketplace stability if combined with our proposed definition of the second lowest cost silver plan. Ensuring that silver plans are offered at precisely 70 percent actuarial value while allowing plans to be offered with de minimis lower values will support higher advance premium tax credits that will lower net premium costs for many individuals, promoting marketplace enrollment and stability. Not only must this 70 percent plan be offered by statute, but it can support greater marketplace stability and lower net enrollee premiums.

NETWORK ADEQUACY

We oppose any proposal that erodes critical network adequacy standards and that would jeopardize access to providers with the appropriate experience and expertise to treat people living with chronic illnesses and disabilities. While we support efficient and non-duplicative monitoring and enforcement of insurance standards between state and federal regulators, we do not support using accreditation as a substitute for regulator enforcement. Because accreditation standards are not readily accessible, it will be impossible to determine adequate compliance with the ACA's network adequacy requirements with the only requirement being that plans have been accredited.

The proposal to defer network adequacy review to external accreditors is contrary to statute. The Secretary "shall, by regulation, establish criteria for the certification of health plans" to "ensure a sufficient choice of providers." (42 U.S.C. § 18031) These criteria must be subject to the full notice and comment requirements of the regulatory process. The proposed deferral to private standards, however, does not meet the requirements for criteria established by regulation, as the public is unable to review and comment on these private standards.

In states with robust network adequacy standards and review processes that are at least as protective as the ACA's federal standards and the National Association of Insurance Commissioners (NAIC) M*anaged Care Plan Network Adequacy Model Act* (#74), we support deference to the state regulatory process. This must include quantitative time and distance standards. However, absent evidence of robust state

monitoring and enforcement of network adequacy, HHS must step in to review plan justification of compliance with federal standards.

ESSENTIAL COMMUNITY PROVIDERS

We urge the Secretary not to finalize the proposed reduction in Essential Community Provider (ECP) network percentage to 20 percent. The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Continuity of care and access to experienced medical providers are critical for managing many chronic illnesses and disabilities.

Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. Issuers have already developed these networks and must only maintain them. Issuers have developed and maintained these networks for the past three plan years, meaning that they are well-equipped to maintain these networks going forward. The justification for the proposed reduction – lessening the regulatory burden on issuers – is specious. Ninety-four percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen. Indeed, the proposed rule anticipates that this change will result in only $1,155 in reduced disclosure burden in aggregate, nationwide – and affecting only 20 issuers. This is an insufficient justification to exclude 10 percent of the providers who see the most vulnerable beneficiaries.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs, particularly people living with chronic illnesses and disabilities, have long-standing relationships with these providers and have built relationships that are a key component of successful management of their conditions. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

Any treatment interruptions from a change in provider networks can substantially increase issuer costs. Among cancer patients, treatment interruptions increase total healthcare costs at a statistically significant level.[3] Similarly, people living with HIV who faced drug benefit design changes in Medicare Part D are six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality[4] – similar outcomes may occur if Ryan White Program or other HIV ECPs are dropped from plan networks.

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[3] Darkow, Theodore, et al. "Treatment interruptions and non-adherence with imatinib and associated healthcare costs." *Pharmacoeconomics* 25.6 (2007): 481-496.

[4] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1.

Because cost-savings under any reduction in ECP coverage are minimal, if not actually cost-increases, issuers' desire to reduce ECP coverage suggests an intent to discriminate against high-cost beneficiaries who predominantly use ECPs. Issuers have repeatedly discriminated against people living with chronic illnesses and disabilities, such as HIV and HCV, by discouraging enrollment through restrictive formularies, and excising key ECPs from plan networks would likewise discourage these vulnerable individuals from enrolling. Because issuers have been successfully able to maintain 30 percent ECP networks for the past three plan years, any attempt to remove ECPs may be a proxy for removing the higher-cost beneficiaries who visit those ECPs. We strongly urge the Secretary to maintain the current 30 percent ECP network threshold and to carefully monitor plans that do eliminate ECPs for discriminatory benefit design.

We support maintenance of the existing 2017 write-in and narrative justification standards for ECP networks in 2018.

We urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, we are concerned that issuers will attempt to shed high-cost enrollees by eliminating their ECP from the provider network. Specifically, the Secretary should extend the continuity of care protections under 45 C.F.R. § 156.230(d) to provider discontinuations across plan years. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

Extending continuity of care provisions will have negligible impact on issuers because issuers must already follow these requirements for provider discontinuations within a plan year. A provider-issuer relationship will already be in place to facilitate provider reimbursement during the transition period. While we urge the Secretary to extend this protection to all consumers, regardless of provider, it is essential for those who see ECPs, particularly if the Secretary finalizes the ill-conceived reduced ECP network requirement.

COMPRESSED PUBLIC COMMENT PERIOD

Finally, we would like to express concern that the public comment period for this proposed rule was so compressed. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the significant proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Thank you, again, for the opportunity to comment on Market Stabilization Proposed Rule. We urge HHS to continue its commitment to ensuring that the ACA is implemented in ways that ensure that people living with chronic illnesses and disabilities have access to quality, affordable health care coverage. Please contact Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org), Carmel Shachar with the Treatment Access Expansion Project (cshachar@law.harvard.edu), or Jean McGuire at Northeastern University (j.mcguire@neu.edu) if we can be of assistance.

Respectfully submitted by the co-chairs of the Chronic Illness and Disability Partnership,

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