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

[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

[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

[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

[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.

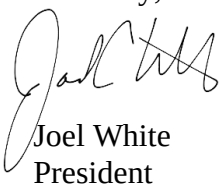
More flexibility should also be granted to plans in designing networks to meet consumer needs. For instance, we believe the Administration should create standards to include telemedicine services for appropriate provider types (such as behavioral health) as part of network adequacy qualifications. Such 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,



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