



July 12, 2017

Submitted via the Federal eRulemaking Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9928-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: RIN 0938-ZB39 Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients

Families USA is a national nonprofit, nonpartisan organization dedicated to the achievement of high-quality, affordable health coverage and care for all. We are respectfully submitting our comments on the request for information (RFI) on Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients. As a leading voice of health care consumers, we are pleased to have the opportunity to share our insights and feedback. We have seen the historic progress that has been made since the Affordable Care Act (ACA) was passed and understand that there are still remaining challenges that must be addressed.

While we fundamentally disagree with the intent and tone of Executive Order 3765, we do agree that steps need to be taken to further promote choice, stabilize health insurance markets, and improve affordability. However, we remain deeply concerned that the Administration's actions have not and will not address those issues. The most pressing and current challenges relate to the level of uncertainty about the future of the ACA, including the continued funding of cost-sharing reduction subsidies and the Administration's enforcement of the individual mandate. Those major issues need to be addressed in order to fulfill the stated goals of the RFI, to preserve the gains we've made, and to continue to make progress.

Despite ongoing uncertainty over the future of the ACA, the ACA is currently still law. As such, The Department of Health and Human Services (HHS) and other agencies have an obligation and requirement to fully execute and implement the ACA until and unless the ACA is repealed (in whole or in part). Within the ACA hundreds of references to HHS often require rulemaking or other decisions to be made regarding the ACA. Given past statements by Secretary Price, President Trump, and others within the Trump Administration, we have significant concerns about ongoing efforts to undermine the ACA.

Please see below for our responses to the RFI regarding:

1. Empowering patients and promoting consumer choice;
2. Stabilizing the individual, small group, and non-traditional health insurance markets;
3. Enhancing affordability; and
4. Affirming the traditional regulatory authority of the States in being regulating the business of health insurance.

Empowering Patients and Promoting Consumer Choice

As a consumer-focused organization, we appreciate that HHS is seeking comments on consumer choice. We believe consumers should be central to any decisions made about the future of the ACA.

Choice of Plans

Plan participation is an important bottom line component of consumer choice. Families USA is concerned regarding health insurance companies leaving the Health Insurance Marketplaces or significantly increasing rates, and it is clear that much of this recent deterioration in plan choice is due to concerns and uncertainty at the federal level. Insurance companies have made public statements about their rationale for rate increases, with recent analysis showing that non-enforcement of the individual mandate penalty alone would lead to a nine percent increase in premiums.ⁱ Another analysis showed that premiums would need to increase by 19 percent to compensate for the elimination of funding cost-sharing reduction subsidies.ⁱⁱ

Congressional and Administrative uncertainty needs to be addressed in order for consumers to have adequate affordable plans from which to choose. We urge HHS to work with state insurance commissioners and issuers to ensure that there are no counties where consumers have no choice of any issuer. We also urge HHS and the Administration to provide clear commitment to permanently fund cost-sharing reduction subsidies and properly enforce the individual mandate. These measures will go a long way to bring in wary issuers that have expressed reservations about future marketplace participation, thereby improving consumer choice.

Further, choice is essentially meaningless if the choices that are available are unaffordable and consequently out-of-reach. Regulations that increase consumers' costs, such as some of the changes in the recent "Market Stabilization" regulation, reduce meaningful consumer choice. Changes made in that rule will not only increase premiums, but they will increase out-of-pocket costs, thereby limiting consumer choice.

Choice of Providers

We appreciate that HHS is concerned about consumers having adequate choices for providers. However, the Administration took action contrary to this goal by reversing course on network adequacy requirements for plans in the recent Market Stabilization rule. This rule eliminates important time and distance standards for networks and weakens requirements for plans to include in their networks Essential Community Providers (ECPs), which serve predominantly low-income, medically underserved individuals.

We ask that HHS do everything possible to ensure that consumers can access appropriate in-network providers, in a timely manner, without having to travel long distances. As a first step, HHS should restore prior regulations that set a floor of standards for network adequacy and a stronger threshold for plans to contract with ECPs. The Administration should then build upon these regulations to strengthen network adequacy requirements where barriers to access exist and should work with ECPs and plans to maximize the inclusion of ECPs in plan networks.

Outreach, Education, and Enrollment Assistance

We appreciate that HHS is inquiring about activities that help inform consumers and help them choose plans. Marketplace success requires that consumers know about their options and have adequate pathways to enrollment. Since the first open enrollment periods (OEPs), HHS has provided much-needed funding for outreach, education, marketing, and in-person and telephonic enrollment assistance. Those activities remain critical and are particularly important now due to consumer confusion over the fate of the ACA, changing coverage options, and new rules from the Market Stabilization rule.

We urge HHS to provide investments in outreach, education, marketing, in-person enrollment assistance, and call center staff that are consistent with prior years' investments. This is not only critical for getting people covered, it is critical for maintaining and improving the risk profile of the marketplaces. Investments for in-person assistance should include grants, ongoing training, support, and technical assistance resources. We also ask that HHS maintain current regulations and standards for Navigator programs. It is abundantly clear that these activities are critical to consumers successfully enrolling in coverage.ⁱⁱⁱ These issues are also of importance to insurers.^{iv} The cuts to advertising and marketing that occurred at the end of the last OEP were destructive and destabilizing. Those cuts played a significant role in the reduction of enrollments at the end of the OEP.^v If HHS fails to fund outreach and marketing in future open enrollments, it will both reduce overall coverage levels and also foster adverse selection in the marketplace.

Recent changes in HHS policy to increase the number of consumers enrolling in coverage through web brokers will have a negative impact on consumers and consumer choice due to confusion that leads to plan choices that don't fit consumer needs, consumers not being provided with the full range of choices available to them, and web brokers unscrupulously using or sharing consumers' personally identifiable information. HHS should prioritize improving healthcare.gov before using federal resources and capacity in this way.

Renewals

It is critical to maintaining coverage levels and the stability of the marketplace that CMS maintain current policies and regulations related to auto-renewal for consumers who do not actively select a plan. These policies allow consumers to maintain continuous coverage—a stated goal of the RFI—without taking being required to take active steps. While we encourage consumers to actively shop for plans, automatic renewals comprised about 23 percent of total enrollments last OEP.^{vi} Given that the next OEP will be half the length of the fourth OEP, these policies will be even more critical for successful enrollment.

Section 1557 Protections

We urge HHS to maintain existing federal rules that prohibit discrimination based on health status, disability, age, race, gender, gender identity, and sexual orientation, among other factors, under Section 1557 of the ACA. These protections apply at the point of enrollment, in benefit design, and in health care more and are critical to ensuring that consumers receive the full benefit of coverage. Such protections have already been used by state regulators. Any changes to federal rules that would result in fewer nondiscrimination protections could, most importantly, allow insurers to actively discriminate against consumers. In addition, weakening these core consumer protections would be disruptive for the insurance industry, because insurers have already taken significant steps to come into compliance with the Section 1557 rule. Making broad changes now would be disruptive to insurers and consumers alike and would result in an uneven playing field among insurers who would want to continue to offer nondiscriminatory benefits and those who would not.

Standardized Benefit Design

We ask that HHS continue its optional standardized plans for 2018 and beyond. We support the standardized options outlined in the 2018 Notice of Benefit and Payment Parameters rule to foster better consumer understanding of available plan choices. Having available plans with identical cost-sharing enables consumers to more easily make apples-to-apples comparisons of different insurers' plans based on other important factors such as premiums, provider networks, and additional covered benefits. It is

particularly important for low-income consumers to have standardized plans with first-dollar coverage for primary care and lower cost-sharing for prescription drugs and other high-value benefits.

Stabilizing the Individual, Small Group, and Non-Traditional Health Insurance Markets

Cost-sharing Reduction Payments

The Administration should continue to make CSR payments as it has done so far, and top officials should stop suggesting they may not be paid from one month to the next. The CSRs lower deductibles, copayments, and other out-of-pocket charges for more than 6 million low-income marketplace enrollees. If they are not paid, insurers would reconsider their decision to offer coverage or raise premiums significantly – the Kaiser Family Foundation estimates that silver plan premiums would have to increase an average of 19 percent if these subsidies go unfunded.^{vii}

Individual Mandate Enforcement

The Administration should commit to enforcing the individual mandate. While the individual mandate remains in force currently, after the President's ACA executive order the IRS abandoned plans to tighten reporting of health coverage this tax-filing season, leading to a flurry of media coverage that likely confused the public and made some think the individual mandate is no longer in effect. That alone could have undermined market stability by leading some healthier people not to enroll in coverage and appears to have caused some skittishness in the insurance industry. Going forward, and particularly in connection with open enrollment, HHS should clearly communicate to consumers the consequences of the mandate penalty. This is likely to help encourage more healthy people to enroll and to maintain their enrollment throughout the year.

Essential Health Benefits

EHB requirements are a core protection for people with chronic and/or pre-existing health conditions. But EHB requirements also help make coverage attractive to young people and a mix of healthy and sick enrollees. Although young adults depend on all 10 categories of EHBs, young people most utilize maternity care, mental health and substance use disorder services, and preventive services.^{viii} For instance, 83 percent of new mothers are between the ages of 18 to 34, and mental health care was the single biggest reason that nearly 8 million young adults sought health care in 2013.^{ix} These and other EHB requirements, such as prescription drugs and rehabilitative and habilitative services and devices, are especially important for the estimated one-in-four young adults with a preexisting condition who need access to comprehensive health benefits.^x Capped out-of-pocket costs, the ban on annual and lifetime limits, and minimum actuarial value requirements also provide financial protection to millions of low-income young adults who, without these protections, likely would not be able to afford health care services in the face of a serious accident or chronic illness.

It is not accurate that eliminating EHBs would make insurance more attractive to younger and healthier people. Young people value these consumer protections and do not want low-premium, high-deductible coverage: for plan year 2017, enrollment in catastrophic plans was only 1 percent, which is consistent with very low enrollment levels in these plans each year.^{xi} Given the importance of the EHB package to all Marketplace enrollees, we urge CMS not to adopt changes to federal EHB requirements, which already defer to many existing state laws and standards.

Continuous Coverage Provisions

While we support the goal of consumers having continuous coverage, the best way to promote continuous coverage is invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program. HHS does not have the authority to adopt so called “continuous coverage” provisions without a statutory basis, such as the requirements suggested in the Market Stabilization proposed and final rule. Unless legislation changes the guaranteed availability requirements of the ACA, issuers are generally still required to “accept every employer and individual in the State that applies for coverage” during open and special enrollment periods (SEPs). Thus, HHS does not have existing authority to allow issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage.

Continuous coverage barriers to enrollment are also misguided on policy grounds. These type of requirements are counterproductive to enrolling younger people who often experience spells of uninsurance. Adopting waiting periods before effectuating enrollment, allowing preexisting condition exclusions, or imposing penalties for people who experience a gap in coverage will disproportionately affect young people and exacerbate concerns about a balanced risk pool. Up to one-third of consumers aged 19 to 34—about 20 million young people—experience a gap in coverage over the course of a year. Instead of penalizing young consumers by making it harder for them to get the coverage they should have, HHS should invest in marketing and outreach to ensure that young, healthy consumers sign up for coverage.

Special Enrollment Periods

We urge CMS to not make any further changes to policies related to SEP policies until and unless HHS has clear evidence of the need for more change. Of particular importance will be data on the extent to which SEP verification deters enrollment of those eligible for SEPs, especially those who are younger and healthier who can improve the risk pool. Collection of this information will help ensure that any further changes to SEP rules be made only if there is actual evidence that consumers are abusing the SEP process.

In the absence of strong evidence to the contrary, restrictions on SEPs intended to alleviate adverse selection may have the opposite effect. SEPs are critical to ensuring that consumers have access to insurance following a significant life event, but they are significantly underutilized.^{xii} This is especially true for young adults, who are more likely than older adults to experience most of the major events that may trigger an SEP, but persistently underutilize SEPs.^{xiii} HHS data already shows that young consumers are disproportionately likely to fail to complete the verification process compared to older applicants.^{xiv} Restricting SEPs risks excluding young people entirely from coverage rather than steering them toward open enrollment.

Limited Benefit and Short-term Coverage Plans

The Administration should not pursue regulatory changes that would increase the availability of plans that offer limited coverage, with or without federal subsidies. These plans would likely destabilize the Marketplaces and reduce the number of people purchasing major medical coverage. Prior to the ACA, these types of plans were ubiquitous, providing consumers with little protection when they tried to actually use their policy due to coverage limitations like preexisting condition exclusions and lifetime dollar caps. Moreover, we believe the continued existence of these plans segments the market into compliant and non-compliant components, resulting in a less balanced risk pool in comprehensive plans. We urge HHS against changes to current rules on short-term limited duration insurance and excepted benefits and any other regulations that would increase or incentivize enrollment in non-major medical coverage.

In addition, we note that many of the recommendations in the first section of these comments also would help support market stability. Helping to ensure that consumers understand their plan options, can enroll in coverage through as streamlined a process as possible, and that state and federal regulators work with insurers to prevent “bare” counties are all critical components of promoting market stability and continuous coverage.

Enhancing Affordability

Considering Out-of-Pocket Costs and Benefits in Efforts to Improve Affordability

Families desire high value coverage that ensures that the services they need are covered and affordable to them. As such, consumers are as much concerned about maintaining affordable of out-of-pocket costs and comprehensive benefits as they are about affordability of premiums. This is important for individuals living with chronic conditions who require greater utilization of health care and who could face serious financial strain if constrained to bare bones policies with high deductibles or benefit limitations, and it is also important for healthier people who will have little use for essentially catastrophic policies that do not pay for their routine use of health care.

We are deeply concerned with any policies focused on reducing premium costs at the expense of core benefit and provider network standards, consumer protections, or out-of-pocket cost protections. Such policies could put comprehensive coverage further financially out-of-reach for families and actually leave the care they need less affordable. Further, such policies will not attract younger adults, as research has found that young people desire plans that offer value in exchange for their premium dollar and are not attracted to high deductible, low value catastrophic coverage.

We urge HHS not to further erode actuarial value requirements or EHB protections that have protected consumers against prohibitively high out-of-pocket costs and rather to pursue policies that encourage more plan offerings that provide pre-deductible coverage of high-value benefits and services, through the FFE optional standardized plans and other mechanisms. In particular, we urge against changes to existing rules related market reforms, EHBs, qualified health plans, and nondiscrimination protections and urge HHS to maintain plan oversight standards for qualified health plans as outlined in the annual letter to issuers.

1332 Waivers for Statewide Reinsurance Models

To improve premium affordability, HHS should work with states to develop state reinsurance programs that reimburse plans for the costs of high-risk enrollees. HHS has already taken some steps to do so by releasing guidance on Section 1332 waivers and a checklist to encourage reinsurance programs. We believe that reinsurance programs serve the interests of consumers much better than state high-risk pools, many of which were plagued by low enrollment, high premiums, high deductibles, preexisting condition exclusions, and lifetime dollar limits. We urge HHS to explore and approve state waivers for reinsurance programs that meet the guardrails outlined in existing guidance on Section 1332 waivers.

Several aspects of the 1332 waiver rules and guidance are essential to protecting consumers and must be preserved. First, the law requires that coverage must be as comprehensive and affordable and would cover as many people as would be provided without the waiver, and we fully support the guidance that this includes consideration of how a waiver will affect vulnerable populations, including older residents, those with serious health issues or risks, and those with lower incomes. Secondly, a public comment process remains essential to ensuring that proposals do take into account the needs of consumers and other interested parties. Rules already provide a great deal of flexibility in the length of a comment period, requiring that a notice and comment period be “sufficient” to ensure meaningful input. Public notice and

comment, both at the state and federal level, must be maintained. Pursuant to the Administrative Procedures Act, this should be at least a 30 day period at the federal level.

Affirming the Traditional Regulatory Authority of the States in Regulating the Business of Health Insurance

We are supportive of states' role in the regulation of their health insurance markets and their efforts to improve access and quality of coverage for residents through innovative policies and programs. However, it is critical to maintain a strong federal-state partnership through maintaining a federal floor of standards for health coverage in all 50 states. People in every state should have the guarantee of basic protections related to nondiscrimination, affordability of premiums and out-of-pocket costs, adequacy of benefits and provider networks, and enrollee rights within a plan. In combination with state authority to establish more protective standards, minimum federal standards in these areas have ensured that people have basic protections no matter their address and have helped address problems that span state lines. For example, federal regulations related to nondiscrimination under section 1557 of the ACA and nondiscrimination requirements under the Essential Health Benefits have helped combat discriminatory formulary and benefit design trends across multiple states. Moving forward, it is critical that such federal state partnership be maintained.

Similarly, while we support state efforts to improve affordability and quality of coverage through 1332 innovation waivers, it is critical that CMS maintain current waiver requirements that ensure that every state pursuing 1332 waivers preserves residents' access to the level of coverage and financial protections that they are entitled to under the law.

Sale of Insurance Across State Lines and Association Health Plans (AHPs)

We have serious concerns with policies that would allow the sale of insurance across state lines or exempt association health plans (AHP) from states' insurance regulations. Such policies would undermine states' ability to regulate their health insurance market and enforce critical state-level protections for their residents. Such policies would also lead to risk segmentation that would destabilize the individual market and undercut affordability of comprehensive coverage. The sale of insurance across state lines would lead to a race to bottom as insurers flock to states with weaker consumer protections, and would lead to insurers cherry picking the healthiest enrollees. Exempting AHP from state solvency requirements, patient protections and insurance regulations would have a similarly destabilizing impact on the small group market, with AHPs attempting to cherry pick enrollment of only the healthiest small businesses. Both policies would drastically skew a state's insurance risk pool, and make comprehensive coverage unaffordable for individuals and small businesses within a state. We urge HHS not to adopt policies or rule changes that would allow for such policies and that would otherwise undermine state consumer protections.

We appreciate the opportunity to provide feedback on this rule. If you have any questions, please contact Eliot Fishman (EFishman@familiesusa.org).

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- ⁱ Kurt Giesa, *Analysis: Market Uncertainty Driving ACA Rate Increases* (Oliver Wyman, June 14, 2017), available online at: http://health.oliverwyman.com/content/oliver-wyman/hls/en/transform-care/2017/06/analysis_market_unc.html.
- ⁱⁱ Kaiser Family Foundation, *Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies* (Washington: Kaiser Family Foundation, April 06, 2017), available online at: <http://www.kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/>.
- ⁱⁱⁱ Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: <http://familiesusa.org/sites/default/files/documents/enroll-america/2014%20-%20In-Person%20Assistance%20Maximizes%20Enrollment%20Success.pdf>.
- ^{iv} See Cigna's 2018 proposed rate filing with Maryland, which has since been withdrawn, here: <http://www.healthrates.mdinsurance.state.md.us/AllRecentDecision.aspx?MrktType=rqwULQeVlhggwvyuCpMQK06pibxO2QJ7smc6VNd/9Iw=&CompID=Yhd3cqLje8RCuznBqQGxwX6J3X35V7ZC0iR5gx4CPEo=&mode=pqk9HMSrF+RZCIr8DNdnR N4zbNINAXxRwmFaSbikYVY=#focusrow>.
- ^v 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>.
- ^{vi} Centers for Medicare and Medicaid Services, *Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016 to January 31, 2017* (March 15, 2017), available online at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html>.
- ^{vii} Kaiser Family Foundation, *Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies* (Washington: Kaiser Family Foundation, April 06, 2017), available online at: <http://www.kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/>.
- ^{viii} Erin Hemlin, *What's Happened to Millennials Since the ACA? Unprecedented Coverage & Improved Access to Benefits*, (Young Invincibles, April 2017), available online at: <http://younginvincibles.org/wp-content/uploads/2017/05/YI-Health-Care-Brief-2017.pdf>.
- ^{ix} *Id.*
- ^x Department of Health and Human Services, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans* (HHS, Nov. 2011), available online at: <https://aspe.hhs.gov/pdf-report/risk-pre-existing-conditions-could-affect-1-2-americans>.
- ^{xi} See: Department of Health and Human Services, *Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report* (HHS, March 2017), available online at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html> and Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (HHS, May 2014), available online at: https://aspe.hhs.gov/system/files/pdf/76876/ib_2014Apr_enrollment.pdf. Enrollment in catastrophic plans peaked at 2 percent for plan year 2014; even then, only 5 percent of the young adults aged 18 to 34 who selected a plan through the federal Marketplace selected a catastrophic plan.
- ^{xii} 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>.
- ^{xiii} Young Invincibles, *Young Adults More Likely to Qualify for Special Enrollment* (Washington: Young Invincibles, April 16, 2014) available online at: <http://younginvincibles.org/reports-briefs/report-young-adults-more-likely-to-qualify-for-special-enrollment/>.
- ^{xiv} Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (December 12, 2016), available online at: <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf>.