

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<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup> 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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<sup>1</sup> Center for Consumer Information and Insurance Oversight, Pre-Enrollment Verification for Special Enrollment Periods Fact Sheet, available at <https://www.cms.gov/ccio/resources/fact-sheets-and-fags/downloads/pre-enrollment-sep-fact-sheet-final.pdf>.

<sup>2</sup> 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>.

<sup>3</sup> 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>.

<sup>4</sup> 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.<sup>5</sup>

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.<sup>6</sup>

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.

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<sup>5</sup> Center for Consumer Information and Insurance Oversight, *supra* note 1.

<sup>6</sup> 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.<sup>7</sup>

### **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.<sup>8</sup> 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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<sup>7</sup> 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>.

<sup>8</sup> 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](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](mailto: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 Health Care Advocacy Team  
New Jersey Association of Mental Health and Addiction Agencies, Inc.  
New Yorkers for Accessible Health Coverage  
North Carolina Justice Center