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March 7, 2017

Patrick Conway, M.D.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization

Dear Dr. Conway:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to improve stability of the Health Insurance Marketplaces.

The Health Insurance Marketplaces continue to face challenges related to plan pricing and participation, putting consumer access to coverage at risk. The AHA has long advocated for measures to stabilize the marketplaces, and we appreciate that the Administration has signaled its commitment to achieve this goal. We believe many of the Administration's proposals have the potential to make participation in the marketplaces more appealing to insurers and consumers, such as allowing insurers to offer less-expensive options. However, we are concerned that several of the proposals actually threaten consumer access to coverage and care, particularly for vulnerable populations who rely on essential community providers.

Below we provide our specific comments. In addition, we include recommendations for other actions the agency could take to improve the stability of the marketplaces.

Special Enrollment Period (SEP) Pre-enrollment Verification: CMS proposes to implement a pre-enrollment verification process for individuals seeking to enroll in coverage using an SEP. Specifically, the agency would require individuals to submit evidence of eligibility and be



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subject to approval prior to enrollment. CMS is scheduled to launch a pilot project to test such a process in June; however, if finalized, the agency would eliminate the pilot and make the proposed process permanent for all SEP applicants at that time.

In [previous comments](#) to the agency, the AHA supported implementation of a pilot project to test a pre-enrollment verification process for use of SEPs. We encouraged a pilot because we recognized that there was both potential for gaming of SEPs by some consumers and also risk that such a process could create barriers to enrollment for other consumers. **We continue to support implementation of a pilot so that CMS can identify and subsequently address any unintended problems that could arise as the result of such a process. We also encourage CMS to not make such a process mandatory for State-based Marketplaces, which should retain the flexibility to determine whether such a policy is beneficial.**

We are particularly concerned about individuals who rightfully qualify for an SEP, but who may be unable to produce the required documentation. For example, we can imagine a scenario where a victim of domestic abuse cannot show evidence of either the abuse or of prior coverage. An individual in this circumstance may have chosen not to file a police report or otherwise officially document the abuse and may have left a dangerous situation quickly without paperwork demonstrating prior coverage. **As such, we strongly urge CMS to ensure that there is an exceptions process as part of any pre-enrollment verification program to account for such situations.** While these situations may fortunately be rare, such individuals and their dependents likely will need immediate access to physical and behavioral health services, and any coverage delays or denials could be catastrophic to their physical, mental and financial well-being.

Other Changes to the SEPs: The agency proposes other changes to the SEPs, including prohibiting most individuals who are currently enrolled in coverage but eligible for an SEP to use the SEP to change into a product of a different “metal” tier. We support this change in general but, again, encourage the agency to allow for certain exceptions not contemplated in the proposed rule. For example, we do not believe it is appropriate to deny an individual or family the opportunity to switch plan types during an SEP if the reason they qualify for the SEP is a clear sign that they may need different coverage, such as when a dependent is added to a policy. We could imagine a scenario where a woman or couple has a child unexpectedly and, once the child is born, realizes that their coverage is insufficient to meet the needs of the baby. In this instance, we believe it is entirely appropriate to allow for the family to switch products to one of a higher metal tier. Again, we expect these instances will be rare and will likely have a very small impact on insurers’ overall risk. However, they could have significant implications for the individuals who find themselves in need of additional coverage mid-year.

Guaranteed Issue: Under this proposal, insurers would be permitted to require consumers to repay any past premium debt before re-enrolling the consumer in coverage for the subsequent year. This only would apply when a consumer with unpaid premiums from the prior year attempted to enroll in any plan offered by the same insurer.

We appreciate that, when consumers enroll in an insurance product, the expectation (and contractual relationship) is for a full plan year, or the remainder of what is left in the year in

cases of mid-year enrollments via an SEP. We, therefore, agree that it is appropriate to allow plans to require repayment of past debt prior to enrollment in a subsequent year in a product offered by the same insurer, and we encourage CMS to require that plans apply such a plan uniformly for all of their consumers. We agree that plans should be able to develop their own specific repayment policies; however, plans should make information on their policies available to potential enrollees as they are shopping for coverage so that they can make an informed selection.

However, we want to caution CMS that there are instances in which this policy may create a barrier to enrollment for certain low-income individuals. We can imagine a scenario where a self-employed individual loses a significant amount of income mid-year and cannot continue to pay his or her premiums. However, later in the year, the individual begins earning enough to pay for coverage but not enough to repay their past premium debt. While, again, we believe that such instances may be infrequent, it is important for CMS to be aware and monitor whether such a policy is unduly burdening lower-income individuals and creating an excessive barrier to enrollment.

Actuarial Value: CMS proposes to increase the “de minimus” range used for determining the level of coverage offered by an issuer. In other words, a plan that qualifies as a qualified health plan (QHP) at a particular metal level could vary farther from the set actuarial value (AV) while retaining its metal level designation, thereby providing lower cost (but also lower coverage) options to consumers. These changes would apply to bronze (60 percent AV), silver (70 percent AV), gold (80 percent AV) and platinum (90 percent AV), but not to silver plan variations (73, 87 and 94 percent AV). The new de minimus range beginning in the 2018 benefit year would be -4/+5 percent for certain bronze plans and -4/+2 percent for silver, gold and platinum plans.

We appreciate that this proposed policy may have several positive impacts on insurers and consumers. For example, allowing insurers greater flexibility in plan structure may lead to increased plan choice for consumers, especially among plans with lower premiums. In addition, this flexibility could enable insurers to offer the same plan structure from one year to the next, something that can be challenging when underlying costs change from one year to the next, impacting the plan’s AV.

However, we have several concerns and one question about this proposed policy change. **First, we are very concerned that allowing silver plans with an AV as low as 66 percent would decrease the overall tax credit available to consumers, as the value of the second-lowest cost silver plan is likely to decrease in most, if not all, markets. This would have wide-ranging implications for the 85 percent of marketplace consumers who rely on the tax credits to purchase coverage.** In addition, we believe that allowing silver plans with 66 percent AV and bronze plans with 65 percent AV would undermine the usefulness of tiering plans for purposes of helping consumers evaluate and select a plan. We estimate that the differences will be small between such plans and, yet, a consumer may assume that a silver plan is a significantly better choice than a bronze plan.

Our outstanding question is in regard to the discussion in the preamble about whether allowing such variation in AV would enable the agency to provide cost-sharing reductions (CSRs) to individuals between 250 percent and 400 percent of the federal poverty level. CSRs were authorized for such individuals in law, but the agency was not able to implement them because of conflicts with the AV requirements. **We strongly urge the agency to provide a more detailed analysis of whether such changes in the AV requirements would enable payment of CSRs to this population.** If the proposed changes allow for more individuals to access CSRs, the benefits of this policy change may outweigh the concerns we raise above.

Network Adequacy: The rule would make several changes to the network adequacy requirements and oversight process. First, states with sufficient minimum access standards and review processes would assume responsibility over insurer compliance with network adequacy requirements. Also, the rule would change the network adequacy requirements related to essential community providers (ECPs), which are providers who serve predominately low-income, medically underserved individuals. Specifically, the agency would allow insurers to indicate in writing the ECPs that are in their networks, as opposed to using the list established by CMS as a result of provider applications. The agency also would reduce the percentage of ECPs that plans would be required to contract with from 30 percent to 20 percent.

We agree with the agency's proposal to rely on states to manage network adequacy to the extent they are able, and we encourage CMS to provide specific direction to states about what are acceptable standards. In instances where states may not have the standards or processes to oversee network adequacy, CMS should have the insurer develop an access plan based on the National Association of Insurance Commissioners' network adequacy model act. We also agree with CMS's proposal to allow plans to write in ECPs, which will minimize the administrative burden on providers.

However, we strongly disagree with the agency's proposal to reduce the percentage of ECPs that a plan must contract with, and we are unclear of the impetus behind this proposal. For example, the agency provides no compelling data showing that the 30 percent standard has created an excessive burden on plans. Yet, if finalized, this policy could result in networks that cannot meet the needs of vulnerable populations in their service areas, with the exception, perhaps, of integrated delivery systems, which may not include 30 percent of all ECPs in their networks but have increased capabilities to facilitate care coordination and access to care. **We encourage the agency not to finalize a uniform reduction in the ECP contracting and instead continue to allow for integrated delivery systems to meet an alternate ECP standard.** This approach would allow for the development and growth of integrated systems of care while ensuring that appropriate access is available to vulnerable populations.

Open Enrollment Periods: CMS proposes to shorten the annual open enrollment period for 2018 to be Nov. 1, 2017 to Dec. 15, 2017 instead of until Jan. 31, 2018. This change would accelerate by one year the agency's plans to align the annual open enrollment period for the marketplaces with other coverage programs, including employer-sponsored coverage and the Medicare program.

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We generally agree that moving toward an open enrollment period that is more aligned with employer and Medicare coverage makes sense. However, we also recognize that the latter part of the open enrollment period has always been one of the most active for consumers. **Therefore, if this policy is finalized, we strongly urge the agency to engage in a robust outreach and enrollment campaign to educate consumers about the changes for this year.**

Other Policy Options: We believe more should be done to help stabilize the marketplaces. Specifically, we encourage CMS to take the following steps:

- **Make reinsurance payments for 2016 as planned.** The temporary reinsurance program was authorized through 2016 to help protect insurers from very high-cost enrollees. This program is self-funded by insurers; CMS collects reinsurance payments from all insurers in the individual, group, and self-funded markets and uses these funds to make reinsurance payments to eligible individual market plans. For 2016, these payments totaled approximately \$4 billion. CMS is scheduled to disperse these payments in 2017 after determining the final plan payment amounts. It is important that CMS continue to make these payments as scheduled.
- **Fully fund the risk corridor program.** The temporary risk corridor program was intended to protect insurers from unintentional mispricing of products. Due to the unexpected risk profile of the marketplace population, more insurers underpriced their products than overpriced them, leaving insufficient funds for the program. As a result, full risk corridor payments have not been made for any of the three years of the program (2014-2016). While CMS previously indicated that it intended to fully fund the risk corridor program for all years, it is unclear whether, how or when such funding and payments will be made. We encourage the Administration to work with Congress to ensure that sufficient risk corridor funds are available and make issuers whole.
- **Support the development of state-level solutions.** Marketplace performance varies significantly by state, and may be enhanced through state-specific programs and policies. We encourage the Administration to assist states in developing state-level marketplace solutions. For example, states may consider wrap-around risk-adjustment, reinsurance and risk corridor programs. We encourage CMS to work with states to develop such solutions and to provide technical expertise, such as legal analyses of what is permissible under federal law.

Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, senior associate director of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President