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November 27, 2017

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

***RE: CMS-9930-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019***

Dear Ms. Verma:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including nearly 90 of which offer health plans, and our 43,000 individual members, we thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2019. **While we appreciate CMS's efforts to reduce regulatory burden within the health care system and provide states with increased flexibility, we are concerned that several of the proposals in the rule would reduce patient access to care, including some that could result in health plans that cover fewer benefits and expose patients to greater cost sharing.**

The AHA is committed to the health insurance exchanges as a source of comprehensive and affordable coverage, and we urge the agency to carefully consider how the changes proposed would affect the millions of individuals who rely on them. We are deeply concerned that several of the proposals in the rule would drive up the cost of coverage, including proposed changes to state options for identifying the essential health benefit (EHB) package. These changes could result in lower premiums but drive up out-of-pocket costs significantly for those who need care – whether due to an unplanned accident or illness or to manage a chronic condition. In addition, proposed changes to the Navigator Program could reduce the number of individuals enrolled, which also could increase costs by concentrating risk among fewer individuals.

Below we provide comments on specific proposals in the rule. However, we also have a general concern regarding the shortened comment period, which did not provide a full 30 days after publication in the *Federal Register* (Nov. 2, 2017) for stakeholder comments. A number of proposals in the rule could have a significant impact on the millions of individuals who purchase coverage through the exchanges, and such changes warrant a thorough evaluation process. We



are committed to continuing to work with the agency to ensure that access to care and coverage through the exchanges are protected.

### **ESSENTIAL HEALTH BENEFITS**

CMS proposes to give states additional flexibility in defining the EHBs for plans sold for 2019 and beyond. The agency proposes to permit states to change their benchmark plan on an annual basis and to select from a broader range of benchmark plans, including those used by other states, either in whole or in part. According to CMS, states would continue to be required to meet statutory requirements that the EHB package equals the benefits provided under a typical employer plan; however, the agency proposes new criteria for what would qualify as a typical employer plan.

We have a number of concerns with CMS's proposal. First, we question whether CMS has strayed too far from the legislative text, which requires that the Secretary of Health and Human Services (HHS) define the EHBs. While the federal government has since implementation of the Affordable Care Act (ACA) given a level of deference to the states in the identification of the EHBs, this proposal would greatly expand those parameters, especially in identifying a typical employer plan. Today, states are given several options for defining a typical employer plan, including one of the three largest plans serving the small group market, the state employee health benefit plan, the Federal Employee Health Benefit Plan, or the plan with the largest commercial non-Medicaid enrollment in the state. This proposed rule would allow a state to look at any employer-sponsored plan so long as that plan covers at least 5,000 enrollees, which, in most states, would likely increase the plans available for selection. Prior experience demonstrates that not all employers provide adequate or comprehensive coverage, even after actuarial value requirements were implemented as part of the ACA. For example, our members have treated patients enrolled in plans through their employers who only subsequently learned that common services were not covered.

Stakeholders, including patients, providers, insurers and others, are invaluable to states in identifying the appropriate benefit package. Yet, the proposed rule also would reduce state requirements for stakeholder engagement. While federal rules would technically still require states to engage stakeholders in the selection of EHBs, states would be allowed to define what constitutes a reasonable public notice and comment process, which could effectively eliminate this requirement.

Finally, and as we stated above, we do not believe that reducing the benefit package is the most appropriate or effective way to reduce the cost of coverage. Reducing the EHB package would only reduce the cost of *premiums*. However, patients would face higher out-of-pocket costs for services no longer covered, which also would not be subject to cost-sharing limits or prohibitions on annual or lifetime limits. Faced with higher cost sharing, patients may delay or forego care, potentially driving future costs up as conditions exacerbate. **We urge CMS to abandon the proposed changes to the EHBs.**

## **NETWORK ADEQUACY STANDARDS & ESSENTIAL COMMUNITY PROVIDERS (ECPs)**

CMS proposes to continue its commitment, as outlined in the agency's 2017 market stabilization final rule, to grant states greater flexibility and oversight over how qualified health plan (QHP) issuers develop their provider networks. Specifically this proposed rule would allow states using the federally-facilitated exchange (FFE), as well as states with state-based exchanges that leverage the healthcare.gov platform (SBE-FP) to set their own network adequacy rules. These states, however, would have to meet the "reasonableness access standard" as defined in federal regulation. In states that do not have the authority or means to provide sufficient network adequacy review, the state could rely on the insurers' accreditation body or a CMS-recognized accrediting body. For unaccredited insurers, the proposed rule requires that insurers submit an access plan that is consistent with the standards based on the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act #74. **Consistent with our comments on the market stabilization rule, we support CMS's approach that relies on states to manage network adequacy to the extent they are able. We also support CMS's proposed guidance to states on acceptable reasonableness access standards if they lack the means to provide sufficient oversight.** However, we encourage the agency to monitor state oversight of networks to ensure that they in fact have the capacity to ensure health plan compliance.

In addition, the proposed rule would maintain current policy with regard to QHP certification of the ECP standard. ECPs are providers who serve predominately low-income, medically underserved individuals. The proposed rule would allow QHP insurers to write-in ECPs rather than require that the ECP register in advance with CMS. The AHA supports this policy as it reduces administrative burden without negative consequences for patients. However, the proposed rule would continue a policy implemented last year that requires QHPs to only contract with 20 percent of ECPs, as opposed to the 30 percent threshold implemented in prior years. **The AHA continues to oppose the reduction in the minimum threshold of ECPs with which a QHP must contract. We remain concerned that the access needs for vulnerable communities may not be met. If finalized, we particularly encourage CMS and the states to monitor the impact of this policy on patient access to care, as well as any signs that plans are selectively contracting to develop products that only appeal to certain types of consumers.**

## **QHP CERTIFICATION STANDARDS**

CMS proposes a number of other changes to the QHP certification process for the FFE to expand states' oversight role. The agency proposes for states to assume responsibility for reviewing QHP adherence to accreditation, compliance, quality improvement and service area requirements. CMS also proposes to eliminate the "meaningful difference" requirement, which is intended to reduce consumer confusion by prohibiting insurers from offering multiple plans that are essentially the same (e.g., not meaningfully different). CMS suggests that this requirement is no longer necessary given the limited choice available in many markets. CMS seeks comment on additional ways in which states can have a larger role in QHP certification.

**We support reducing duplicative reporting requirements and oversight whenever possible.** Not only is duplication wasteful, but it leads to confusion over which regulatory entity has responsibility. However, we encourage CMS to monitor proactively state performance in this oversight function. Our experience is that states have differing capabilities with respect to health plan oversight, and some states do not have the expertise or staff capacity to monitor fully health plan performance.

### **MEDICAL LOSS RATIO (MLR)**

CMS proposes significant increases in the flexibility for health plans and states with regard to the MLR requirements. The MLR measures how much of the premium dollars goes toward health care services. Current rules require that, if the MLR is less than 80 percent in the individual and small group market or 85 percent in the large group market, the insurer must rebate to its enrollees the difference. Total rebates paid to enrollees since 2012 has steadily declined. The average individual market MLR, in 2016, was almost 92 percent and the average small group MLR was almost 86 percent.<sup>[1]</sup> The data suggest that insurers are spending more of the premium dollar on health care services. CMS, however, has proposed added flexibility to the MLR standard that could weaken its effectiveness as an accountability measure. The rule proposes to allow:

- states to adjust the 80 percent MLR standard for the individual market;
- plans to deduct federal and state employment taxes from the MLR calculation; and
- plans to claim a standardized amount for quality improvement activities (QIA).

According to the proposed rule, CMS would allow states to adjust the 80 percent MLR standard for the individual market if the state can demonstrate that a lower MLR standard would stabilize the individual market. The AHA believes that the MLR standard is an important tool for CMS and states to hold insurers accountable for how premium dollars are spent. **While CMS needs to exercise flexibility to ensure market stability, the AHA does not support the proposal to diminish the MLR standard.** The current MLR standard is not the primary reason health plan insurers have withdrawn from or chosen not to participate in the marketplaces. CMS's primary responsibility should remain with protecting consumers' and taxpayers' health care dollars.

In addition, the rule proposes that, for purposes of the MLR calculation, health plans should be allowed to deduct federal and employment taxes from premium revenue. Examples of federal and state employment taxes include Social Security, Medicare, unemployment, railroad and training assessments. Currently, the MLR denominator includes all premium revenue minus federal and state taxes. As the MLR denominator decreases, the overall MLR increases making it easier for health plans to meet the standard. While CMS suggests this proposal could entice insurers to participate in the health insurance marketplaces, it also proposes an alternative to this recommendation. The alternative would be to postpone any action until the agency collects information on employment taxes and assesses how such a policy would affect the MLR

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<sup>[1]</sup> <https://www.healthinsurance.org/obamacare/billions-in-aca-rebates-show-80-20-rules-impact>

standard. **The AHA prefers CMS's alternative proposal of information gathering to learn more about the implications of removing employment taxes from the MLR calculation before amending the current regulation.**

Lastly, the proposed rule would give plans an option on how QIA expenses can be claimed. For purposes of determining the numerator for the MLR calculation, plans are allowed to include medical claims and QIA expenses. CMS proposes to allow health plans to use a standardized amount of 0.8 percent of earned premium for QIA expenses. CMS arrived at the 0.8 percent figure after conducting MLR audits from 2011 through 2015. While AHA generally supports including legitimate QIA expenses in the numerator of the MLR, we are concerned that using a standardized amount would not be sufficient to hold health plans accountable for their quality improvement programs. **The AHA recommends that CMS continue to require that health plans report and document their level of QIA.**

#### **NAVIGATOR PROGRAM**

CMS proposes significant changes to Navigator Program requirements, including to allow states to contract with only one Navigator entity (current rules require two), to no longer require that at least one Navigator entity be a community and consumer-focused nonprofit group, and to no longer require that Navigator entities maintain a physical presence in the exchange service area. CMS acknowledges that these changes may reduce the availability of in-person consumer assistance. These changes come on top of a 40 percent reduction in Navigator Program funding for the 2018 open enrollment period, as well as a 90 percent reduction in advertising.

The AHA is deeply concerned about the direction the agency is taking with respect to consumer outreach and education and marketing of the exchanges. Navigators are an important source of information for communities that may not otherwise be reached through traditional outreach. In addition to enrollment assistance, Navigators also provide education around what insurance is and how to use coverage once enrolled. The proposed changes could reduce the availability of these resources and negatively impact the ability of individuals in vulnerable communities to get and use coverage. **We encourage CMS to abandon this proposal and fully fund the Navigator Program while simultaneously finding ways to encourage enrollment through other forms of assistance, such as agents and brokers.**

#### **RATE REVIEW**

CMS proposes a number of changes related to rate review that the agency expects will reduce the regulatory burden on states and health plans. The proposed changes would increase the threshold for premium rate increases that require plans to submit a narrative justification to 15 percent from 10 percent. The agency also proposes to allow states to post proposed and final rate increases on a rolling basis instead of all at the same time and reduce the amount of advanced notice that states must give CMS about the posting of rate increases from 30 days to five business days, among other changes.

The narrative justification helps protect consumers from excessive price increases and the federal government from paying too much in premium subsidies. In many instances, rates have changed

after plans have submitted additional information to state regulators. As the marketplaces stabilize, average annual premium increases should continue to decline. **Therefore, we oppose CMS's proposal to change the threshold to 15 percent and would urge CMS to retain the current 10 percent threshold as an important accountability measure for both consumers and the U.S. Treasury.**

#### **SPECIAL ENROLLMENT PERIODS (SEPs)**

In addition to experiencing a qualifying event, individuals must demonstrate that they had qualifying health coverage for a certain period of time to be eligible for several SEPs, such as the SEP for permanent move. In other words, an individual would not qualify for the permanent move SEP if they did not have qualifying coverage for one or more days during the 60 days prior to the move. CMS proposes to exempt individuals who did not have access to a health plan because they lived in a market without any QHPs on the exchange from this requirement. CMS also proposes to create a new SEP for women who lose coverage through the Children's Health Insurance Program (CHIP) post-pregnancy, among other changes to the SEPs. **The AHA supports CMS's proposals to exempt individuals who did not have access to a health plan from the qualifying coverage requirement and the adoption of a new SEP for women who lose CHIP coverage post-pregnancy.**

#### **MINIMUM ESSENTIAL COVERAGE (MEC) DESIGNATION FOR CHIP BUY-IN PROGRAMS**

The agency proposes to designate automatically CHIP buy-in programs that provide identical coverage to the state's CHIP program as MEC without going through an application process. **The AHA supports this proposal.**

Thank you for the opportunity to provide input. Please contact me if you have questions, or feel free to have your team contact Molly Smith, vice president of policy, at (202) 626-4639 or [mollysmith@aha.org](mailto:mollysmith@aha.org).

Sincerely,

/s/

Thomas P. Nickels  
Executive Vice President