American Cancer Society/ Cancer Action Network ☙ Actors Fund ☙ Children's Defense Fund-New York
Community Service Society of New York ☙ Consumers Union ☙ Empire Justice Center
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority
Young Invincibles

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: NPRM (RIN 0938-AT14) – Patient Protection and Affordable Care Act; Market Stabilization

Dear Sir/Madam:

Health Care For All New York (HCFANY) respectfully submits the following comments to the Department of Health and Human Services (HHS) in response to the Notice of Proposed Rulemaking released on February 15, 2017.

HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that the concerns of real New Yorkers are heard and reflected. For more information on HCFANY, visit us on the web at **www.hcfany.org**.

HCFANY greatly appreciates the opportunity to provide comments on the proposed rule. Many of the proposed changes would make it more difficult or costly for consumers to get health insurance without improving the risk pool or lowering premiums. HCFANY recommends leaving existing rules and interpretations in place. This includes those for guaranteed availability, open enrollment, special enrollment periods, actuarial value, network adequacy, and essential community providers. In the event that the Department of Health and Human Services (HHS) moves forward with the proposed regulation, HCFANY strongly urges HHS to guarantee state flexibility in these matters. States with State-based Exchanges (SBEs) or state regulatory guidance in these areas should be permitted to continue to operate in a manner consistent with the best interests of consumers in their local regulatory environment.

We address each of these proposed regulatory changes in turn below.

Guaranteed Availability of Coverage (§ 147.104)

This section proposes to modify the interpretation of § 147.104 to allow insurers to attribute premium payments for coverage under the same or a different product from the same insurer during the previous 12 months and refuse to effectuate new coverage for failure to pay premiums.

HCFANY strongly urges the Secretary to maintain the current interpretation of the ACA's guaranteed availability provision. The proposed reinterpretation would allow insurance companies to apply payments meant for a new plan year to outstanding debt, instead of using them to cover the first month of a new policy. Those customers would then be left without coverage for the new plan year due to a failure to pay the first month's premium. In New York, as elsewhere, there are areas where people have only one plan available. Under the proposed rule, they would have no other options if locked out with one company. The stated goal of this change is protecting insurance companies from beneficiaries who only pay premiums when experiencing a health problem. However, it is likely that this method for enforcing premium payments will simply lead to fewer people overall in the risk pool, a result certain to raise premiums in the future. Insurers should use other tools to collect overdue premiums that will not push people with overdue payments out of the market altogether.

Recommendation: HCFANY recommends the following: (1) HHS should maintain the present interpretation of § 147.104. (2) If HHS decides to move forward with the proposed modification to the interpretation of § 147.104, HCFANY implementation should be optional for states. (3) HHS should make an exception to this provision for insurer or Marketplace administrative error. (4) HHS should require insurers to extensively disclose this new rule on all relevant notices to consumers.

Initial and annual open enrollment periods (§ 155.410 (e))

HCFANY opposes shortening the open enrollment period. The proposed rule would allow consumers six weeks to purchase plans instead of three months. The stated goal of shortening the open enrollment period is to discourage customers from waiting until they have a health problem to start paying premiums, and to limit the administrative burdens of signing people up after the plan year has started.

However, the most likely result of a shorter open enrollment period that falls over a major holiday season (Thanksgiving, Christmas, Chanukah) is reduced enrollment overall, rather than reduced enrollment of unhealthy people. A shortened open enrollment period would greatly increase the burden on health plans, providers, navigators, and other assistors who help people enroll. It is not clear that it would reduce administrative burdens on plans overall, given that in the best case scenario, they would be asked to complete enrollments for the same number of people in a very compressed timeline. Moreover, the Secretary provides no data to support the idea that a large number of people come down with serious health conditions at the end of December and in January and thus decide to purchase health plans when they otherwise would not.

A better way to alleviate the burden of enrolling people for partial plan years would be to shift open enrollment to October 1 through December 15 so that all new coverage starts on January 1. This would give everyone ample time to shop and select a plan, while giving insurance companies a smoother enrollment process.

Recommendation: HCFANY recommends that HHS maintain the existing open enrollment period for the 2018 plan year. Alternatively, HCFANY recommends that open enrollment for the 2018 plan year begin on October 1, 2017 and end on December 15, 2017. If HHS decides to move forward with a shortened open enrollment period, HCFANY strongly recommends that states be able to choose whether or not to implement this change.

Special Enrollment Periods (§ 155.420)

This section proposes: (1) to increase the scope of pre-enrollment verification of special enrollment periods (SEPs) to all applicable SEPs beginning in June 2017 for Federally-facilitated exchanges and State-based exchanges on the Federal platform; (2) to prevent consumers from changing metal levels when they enroll in new plan through SEPs; and (3) to make continuous coverage a pre-condition of SEP availability under certain circumstances.

HCFANY opposes the modifications proposed for special enrollment periods, including pre-verification, a prohibition on changing metal levels, and continuous coverage requirements. The stated purpose of these rules is to stop consumers from using special enrollment periods to avoid paying for health insurance until they have a health problem. However, no evidence is provided that such abuse is occurring in numbers large enough to degrade the market's risk pool. The likely outcome of these changes will be to decrease enrollment altogether, rather than keep a balance between healthy and sick consumers. If these changes to special enrollment periods are pursued, HCFANY strongly urges HHS to make the implementation optional for State-based Exchanges.

Pre-Enrollment Verification

HHS proposes pending enrollment in a plan until insurers verify documentation after a qualifying life event. HCFANY opposes this because of the barrier it will create for consumers. HHS justifies many of the proposed changes as efforts to alleviate administrative burdens, but this proposal would only greatly increase administrative burdens on consumers and plans. Additionally, exceptions should be included for pregnant women, newborns, and people whose eligibility for Marketplace plans changes mid-year and are thus forced to enroll in a new plan. Access to health care is particularly critical for pregnant women and newborns. There should not be any additional barriers to enrollment in health coverage for these populations.

Prohibition on Changing Metal Levels

Consumers should be allowed to reevaluate their choice of plan when enrolling new dependents because of marriage, birth, or adoption. These life events may alter the amount of

advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their health and affordability needs. This is particularly true for people living with chronic conditions for whom appropriate plan choice is critical to affordable health care access. Consumer choice during SEPs is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

Continuous Coverage Requirements

Life circumstances will inevitably result in occasional gaps in health insurance coverage, particularly for lower income individuals. This should not preclude consumers from being able to enroll in coverage during an SEP when they meet all other criteria. The proposed documentation requirements would be burdensome for consumers and insurers, and will create an enrollment barrier for the general population, not just those who have waited until they have a health need to enroll. Moreover, healthy people are more likely to be dissuaded from enrolling when faced with a difficult enrollment process. A difficult enrollment process could therefore reduce the number of healthy people entering the risk pool.

Loss of Minimum Essential Coverage

HHS proposes to store information about consumers who have been dropped from coverage due to non-payment in order to prevent them from enrolling with a different carrier using a Loss of Minimal Coverage special enrollment period. As stated above, it is inappropriate and inconsistent with the goal of increasing enrollment to permanently lock consumers out of health coverage after missing premium payments. Past due premiums should be negotiated between consumers and their previous insurer, not used to prevent individuals and their dependents from getting insurance with other companies.

Recommendation: In summary, HCFANY has the following recommendations: (1) HHS should maintain the current scope of pre-enrollment verification for SEPs; (2) if HHS decides to move forward with increasing the scope of pre-enrollment verification for SEPs, implementation should be optional for State-based Exchanges that do not use the federal platform; (3) exceptions to the pre-enrollment verification provision should be made for pregnant women, newborns, and consumers who experience mid-year changes in Marketplace eligibility; (4) consumers should continue to be allowed to change plan metal levels during an SEP; and (5) consumers who have experienced gaps in coverage should continue to be allowed to enroll in coverage through an SEP for which they otherwise qualify.

Levels of coverage (actuarial value) (§ 156.40 (c))

HCFANY opposes reducing the actuarial value to consumers of health insurance plans. Any changes should be optional for states. HHS proposes to allow de minimis variation in actuarial value (AV) from -4 to +2 percentage points for QHPs (except certain bronze plans, which could vary from -4 to +5 percentage points) instead of the current +/-2 percentage points. The stated purpose of this change is to reduce premiums. However, the effect would be to

substantially decrease the tax credits received by most Marketplace consumers, which would coverage less affordable.

The amount of advanced premium tax credits (APTCs) is calculated based on the second-lowest cost silver plan. An expansion of the de minimis variation in AV from -4 to +2 percentage points would mean that a silver plan could have an AV ranging from 66 percent to 72 percent. If a silver plan with a low AV (e.g. 66 percent) becomes the second-lowest cost silver plan, APTCs for moderate income consumers would be reduced.

Most consumers would thus experience increased premiums, the exact opposite of what the rule is meant to achieve. As HHS explains, higher premiums lead to reduced enrollment overall and hurt the risk pool. Affordability is already the largest issue consumers face when purchasing health coverage.[1] Many consumers would no longer be able to afford coverage that meets their needs with reduced tax credits.[2]

HCFANY supports maintaining the existing de minimis variation of +/- 1 percentage point for the silver plan variations with AVs of 73, 87, and 94 percent.

Recommendation: HCFANY urges HHS to maintain the current de minimus variation in AV for all QHPs. If HHS decides to move forward with the proposed change in de minimis variation, HCFANY strongly recommends that implementation of this change be optional for states. HCFANY supports maintaining the de minimus variation of +/- 1 percentage point for silver plan variations.

Network adequacy (§156.230)

The proposed rule indicates several departures from HHS's previous enforcement of provider network adequacy requirements. HHS proposes to: (1) rely on state reviews for network adequacy in states with a Federally Facilitated Exchange (FFE), provided the State has a sufficient network adequacy review process, rather than performing a time and distance evaluation; (2) defer to the states' reviews in states with the authority that is at least equal to the "reasonable access standard" defined in §156.230 and means to assess issuer network adequacy, regardless of whether the Exchange is a SBE or FFE, and regardless of whether the state performs plan management functions; and (3) rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity in states that do not have the authority and means to conduct sufficient network adequacy reviews.

HCFANY opposes the proposed rule, as it removes federal oversight of issuer compliance with federal network adequacy requirements and abandons the time and distance criteria for assessing reasonable access. Network adequacy remains a concern for consumers,

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[1] Robin Osborn, David Squires, Michelle M. Doty, Dana O. Sarnak, and Eric C. Schneider. "In New Survey of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care." *Health Affairs*. November 2016. DOI: 10.1377/hlthaff.2016.1088.

[2] Aviva Aron-Dine and Edwin Park. "Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs For Millions of Moderate Income Families." *Center on Budget and Policy Priorities*. 15 February 2017. http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for

particularly as issuers continue to utilize narrow networks for exchange-based products. The trend towards narrow networks continues into 2017, and narrow networks can impacts consumers' ability to access medical services, particularly specialists, mental health and substance abuse providers.

First, HHS would no longer review issuer provider networks under the time and distance criteria in States with an FFE, but would rely on states with a sufficient network adequacy review process. HCFANY opposes this approach, as it delegates the crucial role of enforcing compliance with federal network adequacy requirements to states without federal oversight or review, and without requiring states perform the easily applied and quantified time and distance criteria. Even states with authority to perform network adequacy reviews should be subject to federal oversight to ensure compliance with federal network adequacy requirements, particularly if states choose to implement less stringent methodology than the established time and distance criteria.

Second, HHS would "defer to state reviews of network adequacy in states with the authority that is at least equal to the "reasonable access standard" defined in §156.230 and means to assess issuer network adequacy, regardless of whether the Exchange is a State-based Exchange (SBE) or FFE, and regardless of whether the State performs plan management functions." HCFANY opposes this approach as it removes federal oversight of issuer compliance with federal network adequacy standards, and permits states that meet a relatively open-ended and vague standard perform the sole review of issuer provider networks. This is particularly concerning for states that lack the means to perform plan management, as it is likely that such states lack sufficient capacity to ensure compliance with federal network adequacy requirements.

Third, HHS, would rely on issuer accreditation in lieu of federal oversight of issuer provider networks in states without the authority or means to conduct sufficient network adequacy reviews. HCFANY opposes this approach as HHS will accept issuer accreditation for either Medicaid or commercial products, with no guarantee that all products offered by the issuer comply with federal network adequacy standards. It is likely that under this approach, issuers' provider networks will not be sufficiently reviewed across all products to ensure that issuers are compliant with federal network adequacy standards.

Under the proposed changes, HHS would no longer review issuer provider networks but would merely rely on state assessments or issuer accreditations. Both state assessments and issuer accreditations require additional federal oversight to ensure that consumers have access to sufficiently robust provider networks. Time and distance criteria for network adequacy is an appropriate metric for determining provider network adequacy. Time and distance criteria provide an easily applied and verifiable means to assess issuer provider networks against the open-ended "reasonable access" standard. Without time and distance criteria, there is a risk that state assessments and issuer accreditations will employ a weaker methodology and fail to ensure that provider networks are sufficiently robust to protect consumer access to medical services. Federal oversight, and time and distance criteria, are therefore critical to ensure that issuer provider networks ensure reasonable access to care.

Recommendation: HCFANY recommends that HHS continue to review issuer provider networks under the "reasonable access" standard, using the time and distance criteria, for all States. If HHS decides to move forward with the proposed changes, HCFANY recommends that implementation be optional for states.

Essential community providers (§156.235)

The proposed rule modifies inclusion requirements of Essential Community Providers (ECPs) in two ways: (1) it reduces the required minimum percentage standard of ECPs in a provider network from 30 percent to 20; and (2) it permits issuers to count write-in ECP providers towards the percentage standard, on the condition that the ECP files an ECP petition and the issuer includes the ECP on its ECP template.

HCFANY opposes the reduction of the required minimum percentage standard of ECPs in provider networks. HHS notes that only 6 percent of issuers were required to provide justification for failing to meet the ECP standard, and that all of these justifications were deemed sufficient. The other 94 percent of issuers were able to meet the current minimum standard of 30 percent. A reduction in the ECP standard would permit all issuers to reduce ECP participation in their networks, which would further reduce consumer access to ECPs. Given how critical ECPs are for medically underserved areas and populations, any potential reduction in availability of ECPs to consumers must be critically weighed against the potential benefit. HCFANY opposes a potential reduction in the availability of ECPs for the benefit of reducing the administrative burden on only 6 percent of issuers.

HCFANY supports the limitation of issuers' ability to count write-in ECPs towards the percentage standard, on the condition that the ECP files an ECP petition and the issuer includes the ECP on its ECP template. HCFANY recognizes that not all ECPs are currently on the HHS ECP list, and supports the inclusion of ECPs with appropriate measures to ensure that the ECPs join the HHS list.

Recommendation: HCFANY opposes any reduction of the required minimum percentage standard of ECPs in a provider network. HCFANY supports the conditional inclusion of write-in ECPs towards an issuers' ECP percentage standard.

Public comment period

HCFANY recommends that future proposed regulations include a much longer comment period. Insurance markets are highly complex and rushed policy changes could have enormous impacts on consumers. Consumers do not have as much access to government as industry stakeholders do while such policies are being developed. They therefore need more time after policy changes are publically released to understand the proposed changes and to inform HHS of how those changes could affect their ability to access health care.

Recommendation: HCFANY recommends that future proposed regulations include a public comment period of at least 30 days.

Thank you for the opportunity to provide comments on the Patient Protection and Affordable Care Act; Market Stabilization proposed rule. If you have any questions about our comments, please contact Taylor Frazier at tfrazier@cssny.org or at (212) 614-5541.

Very truly yours,

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