July 12, 2017

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

Submitted electronically: www.regulations.gov

RE: Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients (CMS-9928-NC/ RIN 0938-ZB39)

To Whom It May Concern:

The National Health Law Program (NHeLP) appreciates the opportunity to provide comments in response to HHS' Request for Information (RFI) regarding regulatory reforms and improved healthcare choices to empower patients. NHeLP advocates, litigates, and educates at the federal and state levels to protect and advance the health rights of low-income and underserved individuals.

Our comments address the four questions posed in the RFI. The regulations implementing the Affordable Care Act (ACA) discussed below have empowered patients, promoted consumer choice, stabilized the insurance market, and enhanced affordability for consumers. These federal protections have ensured that millions of individuals gained health coverage, including those who prior to the ACA experienced discrimination in accessing and affording the health care they needed. NHeLP urges HHS to continue these federal protections so that consumers are able to obtain affordable, quality coverage while

ensuring a stable, robust health insurance market.

Question #1: *Empowering patients and promoting consumer choice*. What activities would best inform consumers and help them choose a plan that best meets their needs? Which regulations currently reduce consumer choices of how to finance their health care and health insurance needs? Choice includes the freedom to choose how to finance one's healthcare, which insurer to use, and which provider to use.

Over the last several years, HHS has developed regulatory protections designed to ensure that consumers have the information they need to choose a plan that meets their needs. We disagree with the premise that regulation has reduced consumer choice with respect to how to finance one's healthcare, which insurer to use, and which provider to use. For example, the regulations described below have provided important protections aimed at ensuring patient empowerment and choice:

- **HHS has improved provider directories.** HHS has ensured that plan provider directories include a range of salient information, including the provider's affiliations, location, capacity for new patients, and specialty type. This regulation was vital to promoting consumer choice, since ensuring that provider directories are up-to-date is a continuing struggle, making it difficult for consumers to ensure that they are selecting a plan that contracts with the provider of their choice. Surveys in several states in the past few years have revealed serious inaccuracies with provider directory listings, and possible underlying gaps in provider networks.[1] For example, a 2017 report from the California Department of Managed Health Care found that most insurers submitted inaccurate directories for review.[2] Most insurers surveyed either overinflated the size of the network or made clerical errors such as failing to include known in-network providers.[3] These discrepancies in network directories limit access to care for consumers, who may not be certain which providers are in-network. As a result, HHS' regulations are crucial to ensuring that consumers in the

[1] *See, e.g.,* TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE, NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDER INCLUSION IN MARKETPLACE HEALTH PLANS SERVING INDIAN COUNTRY (2015) (many QHPs failed to contract with Indian Health Care Centers). https://tinyurl.com/yc8xxd6o; MARYLAND WOMEN'S COALITION FOR HEALTH REFORM, NETWORK ADEQUACY IN MARYLAND: A REPORT ON PROVIDER DIRECTORIES AND WOMEN'S ACCESS TO HEALTH CARE (2015) (finding that Maryland QHPs did not provide access to preventive well-woman visits in a timely manner), http://tinyurl.com/ojn6a6d; MENTAL HEALTH ASS'N IN NEW JERSEY, MANAGED CARE NETWORK ADEQUACY REPORT (2014) (finding that New Jersey HMOs failed to contract with sufficient numbers of mental health providers), http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf.

[2] DEPARTMENT OF MANAGED HEALTH CARE, TIMELY ACCESS REPORT (2017), *available at* https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/SubmittingHealthPlanFilings/MY_2015_Timely_Access_Report.pdf.

[3] *Id.* at 8-9, 13.

Marketplace have access to the information they need about provider networks to make an informed decision about which plan choice is right for them.

- **HHS has facilitated access to information about plan networks.** HHS' rules have enhanced choice by ensuring plans that participate in the Federally Facilitated Marketplace produce provider information in a template that allows HHS to aggregate the data and present it to consumers in one place. This policy and practice has further promoted choice and empowered consumers by allowing consumers to easily compare plans by their participating providers.

- **HHS has protected consumers from "surprise bills."** Another regulation that promotes consumer choice reduces the incidence of "surprise bills" starting in 2018. This HHS regulation protects consumers by ensuring that plans provide advance notice to consumers when they receive prior authorization for a service that may be provided all or in-part using out-of-network providers. These protections are critical to ensuring that consumers can choose to use only in-network services from their plan's contracted providers, and avoid a bill if their plan or provider brings in out-of-network providers to perform or assist in the performance of procedures without the consumers' knowledge or consent. HHS' rule prevents plans from "tricking" consumers into seeing a provider they have no desire to see, at great cost to themselves, without any notice.

- **HHS' rules promote continuity of care.** HHS' rules ensure that plans make a good faith effort to provide written notice of discontinuation of a provider to enrollees who have seen that provider on a regular basis or who receive primary care. They further protect consumers by ensuring that health plans allow enrollees in active treatment to continue seeing their providers, even when those providers leave the plan's network. These rules protect consumers who are mid-treatment from experiencing a gap or delay in their care if their plan and provider no longer contract with each other. When a consumer chooses a plan in order to receive care from a particular provider, these rules preserve that choice by ensuring that the consumer can continue a relationship with that provider, even if the provider leaves the consumer's plan before the end of the year.

- **HHS' rules support navigator programs and consumer assistance**. Navigators and other consumer assisters provide information and services to consumers in a fair, accurate, and impartial manner according to conflict of interest rules. Brokers working on commission, by contrast, often steer clients to plans that pay the highest, leading consumers to purchase health coverage that does not fully meet their needs. HHS' rules ensure that consumers who need special help, including people with disabilities and those with limited English proficiency, get the assistance they need,

ensuring that all consumers are empowered. HHS' rules have promoted choice and empowerment by ensuring that consumers have access to trusted advisors who can give consumers information to determine which coverage best suits their needs.

- **HHS' standardized benefit options to reduce consumer confusion and facilitate access to plans that meet care, treatment, and affordability needs.** HHS' rules facilitate choice by providing options in a standard format, outlined in the 2018 Notice of Benefit and Payment Parameters Final Rule. Prioritizing standardized plans allows consumers to more easily make apples-to-apples comparisons of provider networks, cost-sharing, and drug formularies. This helps consumers make informed, cost-effective choices about purchasing insurance.

- **HHS should monitor and enforce transparency requirements.** Transparency of plan information – including ensuring plans provide up-to-date and accurate formularies and provider networks to both prospective and current enrollees – is critical to ensure that consumers have the information they need to choose the best plan. We are concerned that formularies and provider network information posted online are oftentimes still outdated, incomplete, and do not provide consumers with accurate information needed to select plans that best meet their prescription drug and provider network needs. This information is critical for those living with chronic illnesses and disabilities to ensure that these individuals have the information they need to select plans that cover necessary medications and provide access to providers with the appropriate experience and expertise to treat their conditions.

- **HHS should work with insurers to encourage and maximize Marketplace participation and avoid bare counties.** Having counties without any insurer participating in the Marketplace would severely limit consumer choice, especially for low-income consumers who rely on premium tax credits that are only available through the Marketplaces. For the last four years, state insurance commissioners and federal regulators have worked together alongside insurers to encourage Marketplace participation and ensure that there were no "bare" counties nationwide.[4] HHS should use its existing authority to continue to work with states to ensure that all consumers have a choice of plan in their county.

[4] *See* AVIVA ARON-DINE, CTR. BUDGET & POLICY PRIORITIES, ACA MARKETPLACES POISED FOR GREATER PRICE STABILITY AND COMPETITION, BUT ALSO VULNERABLE TO SABOTAGE (2017). http://www.cbpp.org/research/health/aca-marketplaces-poised-for-greater-price-stability-and-competition-but-also.

Question #2: *Stabilizing the individual, small group, and non-traditional health insurance markets*. What changes would bring stability to the risk pool, promote continuous coverage, increase the number of younger and healthier consumers purchasing plans, reduce uncertainty and volatility, and encourage uninsured individuals to buy coverage?

The Administration should strengthen, and not undermine, Marketplaces so that enrollees can access affordable, quality care. We urge the following actions:

- **Continue Cost Sharing Reductions.** Cost Sharing Reductions (CSRs) have brought stability to the Marketplace by ensuring that coverage is affordable to consumers, making them more likely to purchase coverage. Uncertainty about the Administration's commitment to this important affordability program makes it very difficult for issuers to set rates for the upcoming plan year and is impacting decisions by some issuers not to continue selling products in the Marketplace. Continuing to fund CSRs over the long term will increase stability to the Marketplace by resolving this uncertainty, and ensuring that coverage remains affordable.

- **Enforce the Individual Shared Responsibility Payment (ISRP).** The ACA requirement to maintain Minimum Essential Coverage (MEC) or pay a tax penalty is designed to ensure that healthier consumers participate in the Marketplace. Enforcing the ISRP will stabilize the risk pool by ensuring that consumers participate regardless of health status.

- **Extend open enrollment.** Given all the potential changes that consumers have to digest this year, HHS' decision to shorten open enrollment could also destabilize the risk pool. HHS commented that shortening the open enrollment period would limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance. Thus the policy change could just as easily lead to a sicker pool, at least in the short term, if young, healthy people end up missing the new deadline for signing up.

- **Support navigator programs and consumer assistance**. Existing rules ensure that navigators and other consumer assisters provide information and services to consumers in a fair, accurate, and impartial manner according to conflict of interest rules. Brokers working on commission, by contrast, often steer clients to plans that pay the highest, leading consumers to purchase health coverage that does not fully meet their needs. HHS should extend and expand support for navigators and other consumer assistance programs to help stabilize the Marketplaces and ensure that consumers can make informed choices on the coverage that best suits their needs.

- **Ease restrictions on Special Enrollment Periods (SEPs).** Individuals who need care but are denied coverage due to new complex and burdensome verification procedures are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on. Research shows little evidence of SEP abuse, while roadblocks have resulted in underutilization of SEPs with only 5% of those eligible enrolling via this pathway.[5] HHS should ease restrictions and verification procedures for SEPs to bring greater stability to risk pools.

- **Review plans for discriminatory benefit design.** HHS has implemented robust consumer protections by ensuring that plans undergo rigorous compliance review and enforcement of non-discrimination standards. For example, adverse tiering works for insurers by steering persons with significant health needs, such as HIV/AIDS, away from their plans. As a result, plans with more balanced tiering structures become more likely to enroll high-need patients. This can lead to a "race to the bottom" effect where the plans put their medications in the highest-cost tiers to discourage persons with significant health needs from enrolling. Meanwhile, people who most need coverage are left with few options. We urge HHS not to roll back these protections.

- **Limit the availability of limited benefit and short-term coverage plans.** Current rules protect consumers by ensuring that they have access to full coverage plans that provide the range of health care benefits people need. We do not support changes that would increase the availability of plans that offer limited coverage (either with or without federal subsidies). Prior to the ACA, these types of plans were ubiquitous, providing consumers with little protection when they tried to actually use their benefits. Moreover, we believe the continued existence of these plans may serve to siphon off young, relatively healthy consumers from the Marketplaces, negatively impacting the risk pools for participating insurers.

Question #3: *Enhancing affordability.* What steps can HHS take to enhance the affordability of coverage for individual consumers and small businesses?

Premiums are not the only factor that determines the affordability of a plan. Consumers also need out-of-pocket costs that are manageable and comprehensive benefits that meet their needs. NHeLP believes that commitment to maximum out-of-pocket costs, standardized plans with *limited* deductibles and co-insurance, and strong actuarial value

[5] STAN DORN, URBAN INST. HELPING SPECIAL ENROLLMENT PERIODS WORK UNDER THE AFFORDABLE CARE ACT (June 2016), http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

standards are critical in ensuring plans will meet the prevention, care, and treatment needs of consumers. In addition, HHS should maintain and enforce protections of the ACA that have helped individual consumers gain affordable, quality coverage. These protections include the Essential Health Benefits (EHBs) and the ACA's nondiscrimination protections under Section 1557. Specifically, we recommend that HHS:

- **Discourage the use of high co-insurance and high deductible health plans by issuers in the Marketplace.** Co-insurance and high deductible health plans should be avoided as they do not help consumers afford the care they need. High deductible health plans are not suitable for individuals with disabilities or chronic conditions because they encourage people to go without needed care due to cost. Co-insurance often results in high beneficiary costs because it conceals the real out-of-pocket costs that beneficiaries must pay for their care. We also urge HHS to not further erode the Actuarial Value requirements that have protected consumers against prohibitively high out-of-pocket costs.

- **Ensure coverage of EHBs for all enrollees.** The ten categories of EHBs ensure a mixed pool of both healthy and sick enrollees. Because a person's health status may change over time, the EHBs are necessary to ensure that individuals receive the care they need. Without EHBs, consumers may need to pay additional out-of-pocket costs for their care or may be unable to afford coverage at all. Women and individuals living with disabilities, chronic conditions, and with HIV would not have comprehensive treatment and care without the EHBs. For instance, prior to the implementation of the EHBs, 75 percent of non-group plans did not cover inpatient and delivery services for maternity care and some plans had severe limits or restrictions on mental and behavioral health services.[6] If insurers are able to provide bare bone benefit packages, this will segment the market—resulting in separate plans for healthy people and for those with more significant health care needs. This will drive up the costs of health care for those who need it most. Healthy individuals may find themselves without needed coverage if they develop an illness or face unanticipated health care costs mid-year. EHBs are also important in ensuring that individuals in large employer plans receive comprehensive coverage. We urge HHS to guarantee EHBs for all enrollees to ensure a fair and affordable individual market.

- **Enforce Section 1557, the nondiscrimination protection of the ACA.** Section 1557 ensures each individual can access care without fear of discrimination. For the first time, discrimination on the basis of sex, including gender identity and sexual orientation, is prohibited in health care and longstanding important protections

[6] GARY CLAXTON, ET AL., THE HENRY J. KAISER FAMILY FOUND., WOULD STATES ELIMINATE KEY BENEFITS IF AHCA WAIVERS ARE ENACTED, (2017) http://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/.

against discrimination on the basis of race, national origin, disability and age were reiterated. Under this protection, discriminatory plan designs are prohibited. As stated earlier, issuers have engaged in discriminatory plan design by using adverse tiering to select medications needed to treat specific health conditions on the highest cost-sharing tier. This practice has greatly impacted individuals living with HIV and those with chronic conditions and disabilities. Issuers have also excluded care for transgender individuals in the past. HHS should continue to enforce Section 1557, implementing the final rule as is and including its prohibition regarding discriminatory plan designs, to ensure that consumers receive the benefits that meet their needs.

Question #4: *Affirming the traditional regulatory authority of the States in regulating the business of health insurance*. Which HHS regulations or policies have impeded or unnecessarily interfered with States' primary role in regulating the health insurance markets they know best?

We disagree that HHS has impeded or interfered with the role of states in the regulation of health insurance. We understand the traditional authority of states in regulating insurance and believe there should be a strong federal and state partnership with federal minimum standards that consumers can rely on no matter what state they live in. Many of these minimum standards are established in federal regulations, which are key to maintaining existing consumer protections, and should not be changed. We urge HHS to work with states to ensure that there is adequate monitoring and oversight to enforce essential nondiscrimination and access protections. HHS should also:

- **Continue to develop templates and tools for use by state insurance regulators to assess compliance with federal rules.** HHS has developed a number of tools to help assess compliance with federal market rules. These include qualified health plan application templates and tools, submission checklists, drug count review tools, a formulary outlier review, a nondiscrimination clinical appropriateness review for prescription drugs, and examples of potentially discriminatory benefit design. These types of tools are key to providing guidance to state regulators and to ensuring that federal rules are enforced consistently across states. We urge HHS to continue to develop enforcement tools and templates to aid states in ensuring compliance with federal consumer protections.

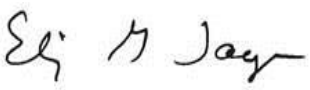
- **Work with states to ensure adequate monitoring and enforcement of network adequacy requirements.** Given the increased reliance on state network adequacy review for the 2018 plan year, we urge HHS to work with states to ensure that sufficient capacity exists to conduct these reviews and that review processes are robust enough to ensure plan compliance with important network adequacy requirements.

- **Oppose the sale of insurance across state lines.** We urge HHS to oppose the sale of insurance across state lines which would lead to a “race to the bottom” and allow insurers to choose their state regulators and select those with weak standards. This would lead to risk segmentation and undermine state consumer protections.

Conclusion

Thank you for your attention to our comments. If you have any questions or need further information, please contact Michelle Lilienfeld (lilienfeld@healthlaw.org) at the National Health Law Program.

Sincerely,



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