



March 7, 2017

Submitted via the Federal eRulemaking Portal

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

**Re: Patient Protection and Affordable Care Act; Market Stabilization**

To Whom It May Concern:

At the AIDS Foundation of Chicago (AFC), we work with communities to create equity and justice for people living with and vulnerable to HIV and other related chronic disease. We have observed first-hand the importance of having meaningful access to the Qualified Health Plans available on the Marketplaces has been for our community. In Illinois, we have made significant progress in the treatment and prevention of HIV, however, there is still much work to be done, particularly in communities most-impacted by HIV, such as young Black gay and bisexual men, transgender women of color, Black women living in high-incidence areas and Latino gay and bisexual men.

We appreciate the opportunity to provide comments to the Department of Health and Human Services (HHS) on the proposed rule regarding market stabilization for the individual and small group markets. We understand that the uncertainty caused by the current health policy debate in Congress may have implications for the stability of the individual health insurance market in many states. We support federal and state efforts to allay uncertainty among both issuers and consumers and to increase robust competition in the Marketplaces for the 2018 plan year. However, we believe that curbing vital consumer protections with regard to affordability and access is not the way to address stability and that many of the proposed changes to individual market regulation, if enacted, will in fact serve to limit enrollment and competition in the individual market and thereby harm consumers who depend on the marketplace for coverage.

To provide meaningful access to care for people living with chronic conditions, such as HIV, and to promote robust enrollment and competition in the individual health insurance market, we urge HHS to consider the recommendations and comments detailed below.

### **OPEN ENROLLMENT PERIOD LENGTH (45 CFR §155.410(e))<sup>1</sup>**

We recognize that an enrollment period that does not cross two plan years would be administratively simpler. However, dramatically shortening the open enrollment period has the potential to result in individuals missing out on the critical open enrollment period. We urge HHS to maintain the existing open enrollment period, or at least allow open enrollment until December 31, 2017. If HHS decides to move forward with a shortened open enrollment period for the 2018 plan year, there will need to be additional consumer outreach and education activities to ensure that consumers understand the new timeline and the importance of enrolling in coverage. This includes additional resources for Health Insurance Navigators and other assisters and a robust educational campaign to promote enrollment.

### **SPECIAL ENROLLMENT PERIODS (45 CFR §155.420)<sup>2</sup>**

Special Enrollment Periods (SEPs) have been an important consumer protection to ensure access to health insurance following a significant life event or evidence of extenuating circumstances that prevented enrollment during the open enrollment period. Absent evidence of abuse (which has not been documented or shown), we do not support proposals that seek to limit availability of SEPs. We urge HHS to maintain current SEP application and verification standards. Creating burdensome documentation requirements before someone may enroll in a plan will only serve as an enrollment barrier for individuals who have in fact had a qualifying life event. The current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, should be left in place.

In particular, we oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

We also oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes 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.

### **CONTINUOUS COVERAGE<sup>3</sup>**

As stated above, we believe that continuous coverage requirements are not in the spirit of the current law and run counter to consumer protections of the ACA. Imposing waiting periods before executing

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<sup>1</sup> Note: The proposed rule seeks to shorten the open enrollment period for 2018 plans from Nov 1, 2017-January 31, 2018 to Nov 1-2017 to December 15, 2017.

<sup>2</sup> Note: The proposed rule seeks to tighten SEPs by requiring pre-enrollment verification for all SEP categories, prevent individuals from changing metal levels of plans during a coverage year through an SEP, limiting eligibility for certain SEPs such as the marriage SEP, and limiting the use of the exception circumstances SEP.

<sup>3</sup> Note: The proposed rule called for feedback on establishing continuous coverage requirements, such as requiring 6-12 months prior coverage or imposing a 90 day waiting period or late enrollment penalty.

enrollment, pre-existing condition exclusions, and penalties for people who experience a gap in insurance coverage will harm consumers, particularly those who may be living with chronic conditions who need consistent access to care to manage their condition. People living with HIV are deemed virally suppression when taking antiretroviral therapy (ART). If a gap in coverage occurs due to life experiences it is extremely important that the individual has access to quality and affordable care so they can resume taking their medication and thus ensure viral suppression. It is also important to notes that individuals who need care but are denied coverage due to such rules are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on.

#### **GUARANTEED AVAILABILITY (45 CFR §147.104)<sup>4</sup>**

The proposed reinterpretation of the guaranteed availability provision, in which insurers may withhold services to enrollees who failed to pay some of last year's premiums, has the potential to severely curtail access to care for enrollees. We believe the possibility of such lockouts could have an adverse effect on enrollment by healthier individuals, especially those with limited incomes. The proposal is also contrary to law because the ACA requires that an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg-1(a)) Enrollment may only be restricted to open or special enrollment periods, and the Secretary does not have authority to expand these restrictions to include prior non-payment of premiums.

We encourage the Secretary to abandon the proposed reinterpretation and instead allow issuers to recoup unpaid premiums through an installment plan while maintaining enrollment. The Secretary could establish procedures for past due premiums to be added to the insurance premiums for the following year for the enrollee. This would allow issuers to recoup past due premiums while respecting the statutory requirement to accept all applicants. Consistent with statute, issuers could not deny or terminate enrollment for failure to pay the pro-rated past due amount if the current premium is paid; the pro-rated repayment option simply facilitates an issuer's collection of debts that could be recouped under other legal remedies. We urge the Secretary to develop clear procedures to notify consumers beneficiaries of past due amounts at the time of plan selection, the pro-rated repayment schedule, and an opportunity to contest the past due amount.

#### **ACTUARIAL VALUE DE MINIMIS VARIATION (45 CFR §156.135)<sup>5</sup>**

We oppose the proposed expansion of the de minimis actuarial value variations. While we understand the intent to stabilize Marketplaces through reductions in premiums, we believe that the proposed expansion is unlawful, would hurt consumers, and would increase deterioration of Marketplaces. The proposed expansion of the de minimis actuarial value variations is unlawful. The ACA is clear – Congress

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<sup>4</sup> Note: The proposed rule seeks to allow insurers to refuse to start coverage for enrollees if they still owe the insurer premium payments from last year until those premiums were paid. Under the current rule, insurers still need to enroll that individual and provide coverage.

<sup>5</sup> Note: The proposed rule seeks to loosen the actuarial value requirements to allow for greater variation. Actuarial value is the percentage of the total cost of health care expenses of a standard enrollee paid for by the plan rather than out of pocket by the enrollee. For individuals with higher medical spending, a higher actuarial value protects them against significant cost sharing expenses.

established firm actuarial valuations for each plan metal level and only permitted de minimis variation “to account for differences in actuarial estimates.” (42 U.S.C. § 18022(d)(3)). Also, contrary to the proposed rule’s assertion, expanding the de minimis actuarial value variation would further undermine the Marketplaces by decreasing enrollment of healthy consumers in plans that meet the required actuarial values. The proposed rule provides no support for the estimated 1-2 percent reduction in premiums due to the de minimis expansion, but even if this premium reduction materialized, it would not sufficiently accrue to consumers to encourage enrollment.

This proposal will also harm lower income individuals by lowering the subsidies they receive to purchase health insurance coverage. Per 26 U.S.C. § 36B, the advance premium tax credit is the difference between the second lowest cost silver plan premium and the applicable percentage of the enrollee’s income. Any reduction in gross premium amounts will simply reduce the total amount of the advance premium tax credit, but the expected enrollee contribution will remain constant. Expanding the de minimis variation will encourage issuers to begin offering silver plans with a minimum actuarial valuation of 66 percent and likely lower gross premiums; one of these plans will likely be the second lowest cost silver plan used to establish the advance premium tax credit. Potential enrollees will face lower benefits for the same cost if de minimis variation is expanded, discouraging enrollment. This will have a particularly detrimental impact on people living with chronic illnesses and disabilities who depend on access to plans with a higher actuarial value to defray high cost sharing.

If this proposal is adopted, we encourage the Secretary to clearly require that the advance premium tax credit be calculated in reference to the second lowest cost silver plan in the Marketplace with an actuarial value of 70 or greater, consistent with the definition of a silver plan under statute. Adopting this reference for computation of the advance premium tax credit would better stabilize markets by reducing the enrollee share of premiums for all consumers while still allowing de minimis variation in plan actuarial values. Reducing enrollee premiums through this approach will lead to greater Marketplace enrollment, stabilizing the Marketplace without reducing the quality of insurance coverage (which could discourage enrollment).

#### **NETWORK ADEQUACY<sup>6</sup>**

Simply put, we oppose any proposal that erodes critical network adequacy standards and that would jeopardize access to providers with the appropriate experience and expertise to treat people living chronic illnesses and disabilities. While we support efficient and non-duplicative monitoring and enforcement of insurance standards between state and federal regulators, we do not support using accreditation as a substitute for regulator enforcement. Accreditation standards are not readily accessible, thus it will be impossible to determine adequate compliance with the ACA’s network adequacy requirements with the only requirement being that plans have been accredited.

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<sup>6</sup> Note: Under the ACA HHS must evaluate the provider network to ensure that it provides a sufficient choice of providers. The proposed rule seeks to move that oversight to state regulators, when feasible, and to private accreditation bodies when not.

In states with robust network adequacy standards and review processes that are at least as protective as the ACA's federal standards and the National Association of Insurance Commissioners (NAIC) *Managed Care Plan Network Adequacy Model Act* (#74), we support deference to the state regulatory process. This must include quantitative time and distance standards. But currently, nearly half of states have no metrics in place to assess whether marketplace plans provide adequate networks.<sup>7</sup>

This rule will eradicate the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks. If the Administration aims to promote adequate provider networks, HHS must be able to step in to review plan justification of compliance with federal standards when there is absent evidence of a robust state monitoring and enforcement of network adequacy.

### **ESSENTIAL COMMUNITY PROVIDERS<sup>8</sup>**

We urge the Secretary not to finalize the proposed reduction in Essential Community Provider (ECP) network percentage to 20 percent. The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries. The reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 30 percent of ECPs – as the proposed rule notes, in 2017, only six percent of issuers were required to submit a justification for their networks. This means that 94 percent of plans need only maintain their existing ECP networks, meaning there is little regulatory burden to lessen.

We are deeply concerned that the proposed reduction in ECP coverage would harm beneficiaries through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

We also urge the Secretary to implement continuity of care requirements for beneficiaries whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, we are concerned issuers will attempt to shed high-cost enrollees by eliminating their ECP from the provider network. This protection would discourage discriminatory benefit design and support beneficiary continuance within the same plan, promoting market stability. Importantly, it would reduce treatment interruptions for beneficiaries who roll over into the same plan without realizing that their provider has been eliminated from the network. These protections would provide enrollees with

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<sup>7</sup> Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks* (Washington, DC: Georgetown CHIR, May 2015), available online 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)

<sup>8</sup> *Note: The proposed rule lowers the percentage of local essential community providers from 30 to 20 percent, meaning that insurers can exclude more providers who serve vulnerable individuals.*

notice that their provider has been terminated, allowing them to switch plans during open enrollment or to facilitate an orderly transition to a new provider if they choose to keep their plan (or if only one issuer is participating in the marketplace in their jurisdiction).

#### **COMPRESSED PUBLIC COMMENT PERIOD<sup>9</sup>**

Finally, we would be reminded if we did not express concern about the compressed public comment period for this proposed rule. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the significant proposals included in the rule. We urge comment periods of at least 30 days to meet the notice and comment requirements of the Administrative Procedures Act.

Thank you, again, for the opportunity to comment on Market Stabilization Proposed Rule. We urge HHS to continue its commitment to ensuring that the ACA is implemented in ways that ensure that people have the best possible access to care.

Unfortunately, we believe the proposed rule will result in decreased enrollment including among health individuals, increased out-of-pocket costs for consumers and fewer choices of providers with less reliable networks. Instead of undermining the enrollment process and the integrity of the plans sold on marketplaces across the country, we encourage HHS to focus on ways to boost enrollment, such as by improving plan affordability, demonstrating an increased commitment to outreach and education, and removing, rather than adding, barriers to enrollment. Additionally, HHS should ensure that plans in 2018 and beyond can offer the same levels of coverage and cost-sharing reduction assistance promised by the ACA; it should strengthen, not undermine, the provisions of the ACA that are in place to ensure that we continue to grow a large and diverse risk pool.

Please contact us if we can be of further assistance.

Sincerely,

A handwritten signature in black ink that reads "Alaina Kennedy". The signature is written in a cursive, flowing style.

Alaina Kennedy  
Manager of Health Equity  
AIDS Foundation of Chicago

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<sup>9</sup> Note: It is highly unusual to provide such a short comment period. Typically, the shortest comment period is 30 days. Although it is only ten days, there is a concern that the Administration will continue to provide shorter and shorter comment periods to cut out public input.