Every American deserves affordable coverage of high-quality care. Given the experience of the last three years in the individual market, it is now clear that some regulations to implement provisions of the Affordable Care Act are overly cumbersome or have not worked as intended. As a result, hard-working Americans who buy coverage in the individual market have faced higher premiums and fewer choices. To provide strong signals that would promote greater stability in the individual market, improve affordability and choice, and enhance the value of coverage to consumers, we recommend the following regulatory and administrative fixes be acted upon as soon as possible in tandem with our recommendations for ensuring a stable transition.

Recommendations to Stabilize the Risk Pool

- Expand and Accelerate the Pre-Enrollment Verification Process during Special Enrollment Periods (SEPs): Some individuals have used lax SEP rules to gain coverage and use services only when care is needed, which raises premiums for everyone. We recommend implementing a pre-enrollment verification process for all SEPs as soon as possible to prevent misuse and strengthening the marketplace risk pool by promoting continuous coverage. We also recommend revising rules around SEP definitions to align with continuous coverage.

- Prohibit Improper Third-Party Premium Payments and Inappropriate Steering: People should be enrolled in the health insurance program that best meets their needs, not because it offers higher payments to some providers. People who are eligible for public programs (e.g., Medicare and Medicaid), which may offer additional benefits and services, should not be inappropriately steered into the commercial insurance market to generate greater reimbursement. Further, third-party payment of premiums in such situations should be prohibited as it leads to a skewed risk pool and higher costs for all consumers.

- Shorten the 3-month Grace Period for Individual Plan Enrollees Who Buy with an Advance Premium Tax Credit: Current federal rules allow individuals who buy coverage with federal premium assistance to effectively get three months of coverage but only pay for one month’s premium. They also allow individuals with outstanding premium balances to re-enroll with the same plan without making good on past amounts due. Reverting to state grace period laws will align the rules with state laws and regulations and avoid scenarios where enrollees have coverage when they are behind on their premiums.

Recommendations to Improve Affordability

- Reduce Exchange Fees and Improve the Consumer Experience: Existing exchange rules impose excessive user fees—3.5 percent of premium—that are passed on to consumers. We recommend reducing the rate and investing available fees in a more consumer-friendly
experience. Specifically, we recommend that CMS invest in new systems and processes that improve the enrollment experience for consumers.

- **Improve the Approach to Risk Adjustment:** Current regulations governing the risk adjustment program have led to inaccuracies and unpredictable results for many issuers. To promote greater accuracy and predictability, we recommend risk adjustment program changes for the 2018 plan year that include accounting differently for enrollees who are enrolled for a partial year, incorporation of prescription drug data, and risk adjustment model updates remain in place. No changes should be made for the 2017 plan year, which is already underway and has been incorporated into plan premiums.

### Recommendations to Simplify Rules and Requirements

- **Defer to Long-Standing State Expertise in Key Regulatory Areas:** Prior to the ACA, health insurance regulation was primarily a state responsibility. State insurance regulators are experienced and well-equipped to oversee the insurance market in their state. This includes determining whether a health plan’s provider network will adequately serve its residents and other key plan features. We recommend that the federal government end its network adequacy reviews, and instead let these reviews occur at the state level.

- **Streamline and Modernize Notice Requirements:** Current federal rules offer inconsistent and occasionally conflicting guidelines to plans on certain member communications (e.g., notices and taglines). Moreover, some overly prescriptive rules require paper communications rather than allowing for electronic notices, which increases costs. We recommend modifying rules to allow communications to be more convenient and consumer-friendly, especially when consumers often prefer electronic distribution.

- **Ensure Those Closest to the Delivery of Care Notify Consumers about Potential Out-of-Network Cost-Sharing:** Currently, CMS rules require health plans to notify its members 48 hours in advance that additional costs may be incurred when an essential health benefit is provided by an out-of-network ancillary provider (e.g., anesthesiologists) while at an in-network setting. In almost all cases, the facility or provider is in the best position to convey network status to patients. Consequently, we recommend that the facility and/or provider take on that responsibility.

AHIP looks forward to working on a bi-partisan basis to improve health care for all Americans. Working together, we can improve health care for all Americans.