

Marilyn Tavenner
President &
Chief Executive Officer



July 12, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9928-NC
Baltimore, MD 21244-8016

Submitted electronically via <http://www.regulations.gov>

RE: Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients—AHIP Comments

Dear Administrator Verma:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments in response to the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients, published in the *Federal Register* on June 12, 2017 (82 FR 26885).

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public/private partnerships that improve affordability, value, access and well-being for consumers.

Our members have long supported an approach to health care and coverage that brings as many people as possible into the system. Broad coverage improves the availability and affordability of health insurance coverage options. While the challenges in the individual market remain significant, we are strong believers in private-sector solutions. We have an opportunity to improve the individual market for years to come, so that consumers have access to quality and affordable coverage.

We commend the Administration's actions earlier this year to reduce regulatory burdens, promote a more stable individual market, provide greater flexibility to states, and promote consumer choice. AHIP and its member health plans support these goals and are pleased to submit additional recommendations to aid in achieving a competitive and stable individual insurance market.



More action is needed to deliver the stability we all want. The most pressing priority is to ensure that people have affordable choices for 2018. Health plans are preparing final rate filings now, and they will be required to make their final commitments for 2018 in September. To ensure that consumers have more choices and more affordable premiums, it is vital that HHS make two critical commitments:

- **Commit to continued and uninterrupted cost sharing reduction (CSR) benefits for consumers.** This program helps millions of Americans afford their care. The uncertainty over the program's future has already had consequences on costs and choices in local markets. Without a strong commitment to CSRs, consumers will have fewer, if any, plan choices for 2018, and options that remain in the market will have significantly higher premiums, which will make coverage unaffordable for millions of Americans. This will hurt consumers who shop for coverage; patients who need care; and the taxpayers who help support these programs.
- **Continue to enforce the individual coverage requirement until an alternative approach takes effect.** Insurance markets are strong and stable when everyone participates – those who need the coverage to access needed care as well as those who purchase coverage in case they need care in the future. By not enforcing the law, costs will increase while choices will decrease because fewer younger, healthier people will be incentivized to get coverage.

These two changes will help deliver the stability and certainty that health plans need to best serve consumers in the individual market. Beyond those immediate stabilizing actions, we offer the following recommendations in response to the Administration's RFI. Additional detail is provided in the attachment:

1. Empowering Patients and Promoting Consumer Choice

- Continue marketing, outreach, and communications related to open enrollment, which will help ensure consumers understand their options and encourage broader participation of healthy consumers.
- Streamline renewal and discontinuation notice requirements, which will allow health plans to send more understandable, plain-language information to consumers about their coverage.
- Improve the experience for consumers who directly enroll in a subsidy-eligible plan through a web broker or a health plan rather than through the HHS marketplace website.
- Allow agents and brokers who participate in the federally-facilitated marketplace (FFM) to directly access CMS-approved enrollment training.



- Provide a good faith safe harbor for the Summary of Benefits and Coverage page limits, allowing more accurate disclosures to consumers.
- Earlier in the open enrollment period, allow health plans to communicate information to consumers that is vital to their buying decisions, including tax credits and cost-sharing funding available to them.

2. Stabilizing the Individual, Small Group, and Non-traditional Market

- Propose new regulations regarding third party premium payment rules so health plans are not required to accept premium payments from entities with a financial interest in the enrollment, while improving transparency to allow payments from appropriate charities.
- Extend prior coverage requirements to all special enrollment period (SEP) qualifying events to minimize inappropriate movement in and out of the individual market risk pool. Require state-based marketplaces to implement similar pre-enrollment verification of SEP eligibility.
- Prevent enrollment of Medicare enrollees in qualified health plans (QHPs) and do not require health plans renew Medicare eligible or enrolled individuals in QHP coverage.
- Shorten the timeline for reviewing Section 1332 waiver applications to provide states flexibility and a quicker path to begin innovation.

3. Enhancing Affordability for Consumers

- Require providers, as the entity closest to the delivery of care, to notify consumers about potential out-of-network cost-sharing.
- Provide flexibility to health plans to design benefits with or without embedded individual out-of-pocket maximums.
- Continue to implement planned policy changes to the risk adjustment program for the 2018 benefit year—including inclusion of prescription drug utilization and implementing high cost pooling changes and implement operational and technical improvements to the current EDGE server/distributed data collection process.
- Provide additional flexibility to permitted de minimis variation in actuarial value to improve affordability.
- Simplify requirements to provide information in writing to limited-English proficiency consumers.
- Preserve federal limits on the duration of short-term limited duration policies.
- Revise certain elements of the Medical Loss Ratio calculation to address inconsistency with the language of the statute.

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4. Affirming the Traditional Regulatory of the States in Regulating the Business of Health Insurance

- Remove federal rate and form reviews and return all review authority to the States.
- Provide health plans greater flexibility in setting minimum premium payment policies.
- Eliminate the requirement to change effective dates based upon the amount of premium paid by the enrollee.
- Streamline federal data submission requirements for the Plan Finder website.
- Streamline submission requirements for off-exchange dental plans.

We appreciate the Administration's work to create a simpler, more robust, and more affordable individual market. We look forward to working with you to ensure consumers have access to quality, affordable coverage and care for years to come.

Sincerely,

A handwritten signature in blue ink that reads "Marilyn B. Tavenner". The signature is written in a cursive, flowing style.

Marilyn B. Tavenner
President and CEO

Attachment



ATTACHMENT
Detailed Recommendations

(1) Empowering Patients and Promoting Consumer Choice

- **Continue marketing, outreach, and communications related to open enrollment, which will help ensure consumers understand their options and encourage broader participation of healthy consumers.** A stable individual market requires broad participation by individuals who are healthy and sick, young and old. It also requires that consumers enroll for a full plan year and maintain twelve months of coverage, as opposed to enrolling only when they need care. Open enrollment provides an annual opportunity for new consumers to enroll in marketplace coverage and allows existing enrollees to reenroll in coverage or choose a different plan that best meets their needs. Marketing, outreach, and education are critical to ensure that all consumers are aware of the upcoming open enrollment period, understand the new timeline, and enroll by the deadline. Such efforts will be more important than ever for the 2018 plan year because open enrollment is only six weeks long and the final deadline on December 15th is earlier than past years. In prior years, if an enrollee missed the December 15th deadline, they could still enroll in coverage with a later effective date. This year, consumers who miss the deadline will not be able to enroll in coverage until the 2019 plan year, unless they experience a qualify life event for a special enrollment period (SEP). Marketing and outreach throughout the open enrollment period is always important and will be even more critical due to the newly shortened open enrollment period.

- **Streamline renewal and discontinuation notice requirements which will allow health plans to send more understandable, plain-language information to consumers about their coverage.** Current regulations require health plans in the individual market—both on- and off-exchanges—to use standard renewal and discontinuation notices using templates developed by CMS. These notice requirements are overly prescriptive and do not allow health plans to clearly communicate important information about benefits, premiums, advance premium tax credit (APTC), and cost sharing to enrollees. Many health plans develop additional materials (e.g., cover letters) to better communicate this information to consumers. Beginning with notices for the 2019 plan year, we recommend CMS create a standard list of information that health plans are required to include in discontinuation and renewal notices (e.g., premium, APTC, changes in benefit and cost-sharing amount, how to update eligibility information, health plans and exchange customer service contact information) and make standard notice templates available but optional. Such flexibility would lower administrative burdens on health plans, lower costs, while ensuring consumers receive accurate, actionable information about renewals.



- **Improve the experience for consumers who enroll in a subsidy-eligible plan through a web broker or a health plan rather than through the HHS marketplace website.** Through recent rulemakings¹, HHS has indicated an interest in implementing changes to the current direct enrollment process. Direct enrollment allows consumers to enroll in coverage through a health plan or web broker’s website. Today, this process requires consumers to bounce between the broker or health plan portal on which they chose to shop and the marketplace site, making for an unsatisfying user experience. As a result, many consumers do not complete the enrollment process. We commend CMS on their recently issued guidance to implement “proxy” direct enrollment for the 2018 open enrollment period. While this is a helpful first step, we encourage CMS to continue to work with health plans and other direct enrollment partners to implement enhanced direct enrollment for the 2019 plan year.
- **Allow agents and brokers who participate in the FFM to directly access CMS-approved enrollment training.** Direct access to training provided by CMS-approved training providers will make it easier for agents and brokers to enroll in an approved training course that best meets their needs. Currently, brokers need to first access the FFM website even when they know in advance that they plan to complete training offered by a CMS-approved partner. If CMS permits direct access, agents and brokers could begin the training process with the training provider of their choice and that training partner could then transmit enrollment data to CMS and link those who successfully complete training to CMS to sign any necessary agreements. Allowing streamlined access to the training program chosen by the agent or broker would not only simplify the training process, but encourage more agents and brokers to participate in the FFM. Allowing direct access to certified training providers would reduce FFM costs for maintenance of the current system that requires the FFM to collect information on agents/brokers who plan to complete their training with another training provider and to then again gather information from them when they have completed their training. In a direct access model, CMS should continue providing annual training guidelines to certified training providers, similar to how the Medicare training program is regulated.
- **Provide a good faith safe harbor for health plans that must exceed the Summary of Benefits and Coverage (SBC) page limit to effectively comply with requirement to provide accurate and complete disclosure allowing more accurate disclosures to consumers.** Prior to the publication of the 2015 SBC and Uniform Glossary Final Rule,² health plans were permitted to exceed the specified page limit for SBCs if necessary to ensure the information included in the SBC was accurate and complete as required by

¹ [Market Stabilization Final Rule](#), [2018 Notice of Benefit and Payment Parameters](#), and [2017 Notice of Benefit and Payment Parameters](#)

² [Summary of Benefits and Coverage and Uniform Glossary Final Rule June 2015](#)



law.³ We recommend HHS issue guidance clarifying that four pages means no more than eight sides and that carriers are permitted to exceed eight sides in those situations where they believe in good faith that the extra length is required to clearly and adequately complete the SBC template.

- **Revise mental health parity guidance to permit an employer or health plan to aggregate data for substantially all/predominant analysis to the necessary level, which may be line of business, market segment, entity, or product.** In April 2016 a tri-agency frequently asked questions (FAQ) document noted that regulations permit “any reasonable method” to be used to determine the dollar amount of all plan payments for substantially all/predominant analysis, but also stated that “book of business” testing is not a “reasonable method” for those purposes.⁴

Book of business level data, a level of analysis prohibited by the FAQ, is almost always the most credible level of analysis for individual and small group plans. Use of plan level data would not lead to sufficient volume for all but the very largest of groups, leading to testing results that are driven by statistical variation rather than being an indication of a plan with a design that is not in parity.

Testing at the plan level, as currently required, can create distortions due to outliers and variance that can skew the data and produce an inaccurate picture of plan spending when a single year is reviewed. This distortion can lead to health plans having to change benefit levels for copays and other cost-sharing to respond to fluctuations in utilization of mental health or addiction treatment services from year to year.

Additionally, current guidance for the individual and small group markets is inconsistent with how plans are required to rate those products under federal law, since plans must rate products based on the experience of the total individual risk pool, and the total small group risk pool. Determining financial quantitative requirements and non-quantitative treatment limitations on a different basis –at each separate plan level, introduces significant inconsistencies that complicate managing premiums.

- **Earlier in the open enrollment period, allow health plans to communicate information to consumers that is vital to their buying decisions, including tax credits and cost-sharing funding available to them.** Due to limitations in the availability of data from the Internal Revenue Service (IRS), health plans typically do not receive updated information about eligibility for APTCs and cost sharing reductions (CSRs) in time to include updated information in the renewal notice. Thus, in recent years, for the

³ [FAQ Part VIII Issues 3 March 2012](#)

⁴ [Tri-Agency FAQ# 31 Question 8](#)



Federally-Facilitated Marketplace (FFM), CMS has allowed health plans to provide this information through the January billing statement (typically sent in early December) or a supplemental notice at the same time as the January bill. Further, during 2017 open enrollment, CMS allowed health plans receiving alternate enrollees⁵ to notify those enrollees in late November about the coverage with a new qualified health plan (QHP) issuer into which they would be auto-enrolled.

Although open enrollment begins on November 1st and plans must provide the mandated renewal or discontinuation notice to enrollees by that date, existing sub-regulatory guidance prohibits health plans from doing additional outreach earlier than December to help their customers understand their options for the coming year. The rationale for this policy has been that this restriction on communication from health plans to their customers will encourage consumers to return to the marketplace to update their information and actively shop for plans. We share the goals of encouraging consumers to update their applications, review available plans, and enroll in the coverage that best meets their needs. However, with the earlier open enrollment deadline of December 15th, delays in providing consumers with critical information about their eligibility and coverage could be disruptive and lead to missed deadlines. If consumers do not receive information about financial assistance or changes to their coverage until early December, per current CMS guidance, there will not be enough time for many consumers to make an informed plan selection by December 15th. We recommend CMS provide flexibility to send additional information and reminders to all passive enrollees⁶ as early in open enrollment as possible to ensure consumers have all critical information to choose the coverage that best meets their needs.

(2) *Stabilizing the Individual, Small Group, and Non-Traditional Health Insurance Markets*

- **Propose new regulations regarding third party premium payment rules so health plans are not required to accept premium payments from entities with a financial interest in the enrollment, while improving transparency to allow payments from appropriate charities.** 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 offer additional benefits and services, should not be inappropriately steered into the commercial insurance market. Further, we recommend that HHS guidance specifically allow health plans to reject third party premium payments in such situations.

⁵ In this context “alternate enrollees” are consumers who were auto-enrolled with a new issuer at the direction of the marketplace because their current issuer was no longer offering marketplace plans in that area.

⁶ In this context “passive enrollees” means 2017 customers that do not go to the marketplace to actively choose a 2018 plan after receiving their November 1 renewal notice from their 2017 issuer.



We oppose any effort to expand the list of third party entities from which health plans must accept premium and cost sharing payments beyond those outlined in existing regulations and guidance. Any expansion of eligible entities will result in higher premiums for all consumers and decreased affordability. Third party payments have negative effects on the individual market risk pool in most markets with charities that are funded by entities with a financial interest in the enrollment seeking to pay the enrollee's premium payment. Many of the organizations that are making the premium payment stand to benefit financially. Health plans will accept premium payment from appropriate charities. Existing guidance provides that private foundations are permitted to pay premiums in certain scenarios: if they are made on behalf of enrollees who satisfy defined criteria that are based on financial status and do not consider the enrollee's health status and the premium payment is made for an entire year.

We support additional federal rulemaking to increase transparency: (1) Funds must be donated to a legally independent foundation that is separate and independent from (and not affiliated with or controlled by) the organization with a potential financial interest. (2) Foundations must make premium assistance available for all QHPs in a particular area and must not direct individuals to specific QHPs that may benefit a health care provider or other organization with a potential financial interest (i.e., those with richer benefits, higher reimbursement, or in-network coverage). (3) Conflict of interest standards should prohibit health care providers from referring patients to foundations that pay the premiums of individuals.

- **Extend prior coverage requirements to all SEP qualifying events to minimize inappropriate movement in and out of the individual market risk pool.** We support the adoption of a prior coverage requirement for certain SEPs under the Market Stabilization final rule with an appropriate phase-in time. However, this requirement is limited to certain qualifying events (loss of minimum essential coverage, marriage, and permanent move) and not sufficient to encourage consumers to maintain continuous coverage throughout the plan year. We recommend this requirement be extended to all SEP qualifying events. As discussed in our comments on the Market Stability proposed rule, we believe statute grants the Secretary rulemaking authority to impose limitations on both SEPs and open enrollment. As such, we recommend the Secretary extend the prior coverage requirement to all SEPs with certain exceptions (newborns, adoption, placement for foster care, release from incarceration, an individual who previously lived outside of the U.S., victims of domestic violence, or individuals wrongly determined ineligible for Medicaid or the Children's Health Insurance Program).



- **Require State-Based Marketplaces (SBMs) to implement pre-enrollment verification of SEP eligibility.** In the Market Stabilization final rule, CMS announced the planned implementation of pre-enrollment verification of SEPs for the FFM and encouraged, but did not require, SBMs to do the same. CMS did provide SBMs flexibility to determine whether and how to conduct pre-enrollment verification, including allowing health plans to conduct pre-enrollment verification if the SBM is not able to. While this provides a helpful stop-gap for state marketplaces that are working to implement SBM-based pre-enrollment verification, it is not an optimal long-term solution. In the absence of a federal requirement to conduct pre-enrollment SEP verification, some SBMs have been reluctant to implement consistent SBM-managed pre-enrollment verification.

Data shows that SBMs are experiencing the same adverse selection and gaming through misuse of SEPs as the FFM. Lack of pre-enrollment SEP validation increases premiums for all consumers and leads to a higher burden on taxpayers. The Government Accountability Office demonstrated that the lack of validation of SEPs in SBMs can also lead to consumers being enrolled in subsidized plans for which they were not eligible.⁷ Given CMS' intent to enact policy changes that will put downward pressure on premiums a federal requirement that SBMs conduct pre-enrollment SEP verification is appropriate and necessary.

- **Prevent enrollment of Medicare enrollees in qualified health plans (QHPs) and do not require health plans to renew Medicare eligible or enrolled individuals in QHP coverage.** In the 2018 Notice of Benefits and Payment Parameters, CMS clarified the relationship between guaranteed renewability requirements and Medicare anti-duplication requirements. CMS provided that individual market health plans are permitted to not renew coverage if the health plan has positive knowledge that the enrollee is entitled to Medicare Part A or enrolled in Medicare Part B.

Inappropriate enrollment of Medicare-eligible beneficiaries in the individual market results in higher premiums for all individuals enrolled in the individual market. Such practices also expose consumers and health plans to Medicare penalties and Medicare beneficiaries face federal tax liabilities for receiving subsidies (i.e., premium tax credits) to which they were not entitled.

While the clarification in the 2018 Notice was helpful, it only addresses a small percentage of duplicate enrollments because health plans do not have access to comprehensive data about which individual market enrollees have Medicare. Currently, health plans are only aware of duplicate coverage if the enrollee happens to have a Medicare product issued by the same company.

⁷ [GAO, Results of Enrollment Testing for the 2016 Special Enrollment Period, November 2016](#)



We recommend CMS take additional actions—using available data such as CMS Medicare enrollment and eligibility databases—to prevent Medicare/QHP duplication: (1) Prior to enrollment, verify whether an applicant is eligible for or enrolled in Medicare. Do not send health plans an enrollment for an individual who is enrolled in Medicare. (2) Continue conducting periodic data matching to identify current QHP enrollees who become eligible for or are enrolled in Medicare and discontinue APTC payments for QHP enrollees who are also enrolled in Medicare. (3) As part of reenrollment, verify that QHP enrollees are not enrolled in Medicare. Do not send a reenrollment to a health plan for an individual who is also enrolled in Medicare.

- **Shorten the timeline for reviewing Section 1332 waiver applications to provide states flexibility and a quicker path to begin innovation.** Section 1332 of the Affordable Care Act (ACA) allows a state to request a waiver from various ACA requirements under certain statutory conditions. Currently, it can take up to six months for a state to get approval of its waiver after submitting a complete application, which states have found challenging. We make the following recommendations that will remove administrative obstacles currently preventing states from using the 1332 waiver process: (1) Streamline and shorten the application review timeline to 20 days. (2) Expand streamlined templates for applications. The recent checklist provided by CMS for waivers proposing high risk pool or reinsurance waivers is very helpful.⁸ To further help states efficiently submit “complete” applications, provide similar checklists for other common waiver proposals. (3) Update regulations to require determinations to be made within 90 days for waivers that are substantially similar to 1332 waiver applications already approved.

(3) Enhancing Affordability

- **Require providers, as the entity closest to the delivery of care, to notify consumers about potential out-of-network cost-sharing.** Beginning in 2018, current HHS rules will require a health plan to notify members 48 hours in advance that additional costs may be incurred when an essential health benefit (EHB) is provided by an out-of-network ancillary provider (e.g., anesthesiologists) while at an in-network setting. Our goal is affordability for the consumer, and solutions for “surprise billing” must include requirements for physicians, hospitals and other inpatient and outpatient facilities. In almost all cases, the provider of services is in the best position to convey network status to patients.

⁸ [Checklist for Section 1332 State Innovation Waiver Applications, including specific items applicable to High Risk Pool/State-Operated Reinsurance Program Applications](#)



Providers know which insurance companies they are contracted with and what prices they charge for their services; therefore, they are the only stakeholder with the information necessary to notify a patient of the specific amount they may end up owing if they receive out-of-network care. Conversely, health plans do not typically require prior authorization 10 days before admission; in fact, preauthorization often occurs within one day of admission. Thus, health plans cannot meet the current requirement except in rare circumstances where elective procedures are authorized weeks ahead of time.

To reduce the frequency and impact of surprise billing, HHS can exercise its Medicare conditions of participation (CoP) authority to hold hospitals accountable and ensure they have available physicians in each specialty who contract with the same health plans as the hospital. Providers who do not contract with the same health plan as the hospital have a responsibility to notify the patient *prior* to any service that they do not accept the patient's insurance, and an in-network physician should be accessible for the patients' care. We also support placing limits on the out-of-network charges that providers may charge. For example, California law requires non-contracted providers in contracted facilities to get patient consent prior to providing a service or accept the greater of the average plan contracted rate or 125% of the Medicare allowable amount.⁹

If the rule set to take effect for 2018 is maintained, we recommend that HHS clarify that any notification requirement would apply to out-of-network "hospital-based providers" rather than "out of network providers at an in-network setting." The term could apply to any provider who practices in a hospital with whom the plan does not contract.

- **Provide flexibility to health plans to design benefits with or without embedded individual out-of-pocket maximums (MOOP).** In the 2016 Notice, CMS clarified that the ACA's MOOP limits apply to individuals, whether enrolled in individual or family coverage. Thus, cost sharing amounts for any individual, whether enrolled in self-only or other than self-only coverage, cannot exceed the \$7,350 MOOP for self-only coverage. This interpretation limits the ability of health plans to develop products that meet the needs of a range of consumers. We recommend CMS eliminate the requirement that in-network out-of-pocket maximums apply to each individual enrolled in a plan, including those enrolled on other than self-only coverage, giving health plans the option to design products with or without embedded individual MOOPs. Removing the embedded MOOP may allow health plans to reduce premiums, incentivizing younger, healthier individuals to enroll.

⁹ California AB 72



- **Continue to implement planned policy changes to the risk adjustment program for the 2018 benefit year—including inclusion of prescription drug utilization and implementing high cost pooling changes to better account for very expensive medical conditions.** Moving ahead with these changes will strengthen the risk-adjustment program by improving the model’s accuracy and effectiveness which, in turn, can help better promote the program’s market stabilizing goals. We do not recommend further changes to the risk adjustment program at this time. However, as CMS continues to evaluate the program, and if additional changes are considered in the future, transparency, stakeholder collaboration, and adequate advanced notice of changes will be critical to ensuring the program’s ongoing success.
- **Implement operational and technical improvements to the current EDGE server/distributed data collection process to better promote program effectiveness and efficiency.** Working collaboratively, CMS and health plans have made significant improvements to the EDGE server data submission process. To promote further enhancements and improvements, we recommend the following technical and operational changes to the edger server data submission process.

We recommend CMS leverage health plan expertise and create efficient channels for answering health plan questions by: (1) organizing an annual CMS-sponsored meeting to solicit and incorporate stakeholder feedback on best practices to improve the data collection/EDGE server business rules, processes, and reports; and (2) designating a single point-of-contact at CMS for plans to get technical questions resolved or escalate issues, where appropriate.

In order to improve the efficiency and accuracy of the edge server processes and outputs, we recommend that CMS: (1) improve CMS EDGE server business rules for key functional areas, such as duplicate and transparent claims, to reduce or eliminate administratively burdensome processes; (2) promote operational efficiency and enhance business planning by improving testing and planning timeframes, (e.g. provide greater advance notice (at least 30 days) for CMS planned testing and software updates); (3) update reference tables and data uploads sooner in the process to assure a smoother data submission process; (4) draft a timeline of plan reference table and source updates for health plans; and (5) implement parallel processing to allow health plans to continue submitting data while prior year data is finalizing, similar to Medicare Advantage risk adjustment data submission.

- **Provide additional flexibility to permitted de minimis variation in actuarial value (AV) to improve affordability.** In the Market Stabilization final rule, CMS finalized expanded flexibility for the AV de minimis range to -4/+2 percentage points. This increased flexibility applies to all metal level plans except for CSR silver plan variations



(where the current -1/+1 percentage point standard still applies). Separately, this change allows an expanded de minimis range for certain bronze plans that provide pre-deductible coverage for certain services (+5/-4 percentage points). We supported expanded de minimis flexibility to promote stability and reduce disruptions by allowing more plans to maintain their cost sharing from year-to-year. However, in our comments on the proposed rule, we noted that a -4/+2 percentage point de minimis range would have a limited ability to impact affordability due to existing maximum out-of-pocket (MOOP) limitations. We recommend CMS solicit comments through the 2019 Notice of Benefit and Payment Parameters on regulatory options that would provide more meaningful AV flexibility to improve affordability, such as a de minimis variation of -4/+4 percentage points (as we recommended in our comments on the Market Stabilization proposed rule) or reexamining the MOOP adjustment percentage.

- **Simplify requirements to provide information in writing to limited-English proficiency (LEP) consumers.** Health plans that participate in exchanges are subject to three rules that include overlapping but inconsistent requirements to provide language support with written materials.¹⁰ These overlapping but inconsistent rules impose administrative burdens for health plans and increased costs for consumers. In particular, rule §92.8 includes ambiguous requirements about which written communications must include information in the most commonly spoken 15 languages on how to get LEP support. This ambiguity on what is considered a “significant document” has led to the inclusion of 2-4 extra pages in almost all health plan communications sent by mail to enrollees. Health plans have received complaints from consumers about the paper wasted and associated cost of providing these inserts.

Health plans find that LEP consumers greatly appreciate the option to get help from their health plans in their preferred language on the phone with support from a phone interpreter. Phone interpreters, which QHP issuers are specifically required to provide in at least 150 languages, are a very effective way to support LEP consumers. This service can be accessed by calling the number on the insurance ID card. Health plans are also required to display information on how to get help in the 15 most commonly spoken languages on their websites.

Our recommendations include: (1) provide guidance to indicate that health plans have met their obligations under on §92.8 to send notices and taglines with written materials if

¹⁰ §155.205(c) specifying LEP-support requirements for QHP health plans; §147.136(e) specifying LEP-support requirements for internal claims and appeals processes for all health plans that aren’t grandfathered, including QHP health plans; and §92.8 which applies to all health programs offered by a health plan that receives federal funds, which includes all QHP health plans.



they provide the notice and taglines at least twice a year; and (2) update §147.136 to deem health plans that are in compliance with §92.8 to also be in compliance with §147.136(e); and (3) update §155.205 (c) to eliminate references to QHP issuers in light of the more comprehensive accessibility requirements that apply to QHP issuers under §92.8.

- **Preserve federal limits on the duration of short-term limited duration policies.** In the interest of stabilizing the risk pool, AHIP supports continuing to limit short-term, limited duration coverage to three months. Short-term, limited duration policies are designed to provide coverage for consumers and their families who may have a need for a “bridge” before enrolling in permanent coverage and are not integrated into the individual market single risk pool. Short-term policies usually exclude coverage for pre-existing conditions and do not provide affordable care in the long term for consumers. A blanket extension of the permitted length of short term policies will draw lower risk people out of the individual market single risk pool and drive up premium costs for consumers.
- **Revise certain elements of the Medical Loss Ratio (MLR) calculation to address inconsistency with the language of the statute.** For purposes of MLR calculations, we recommend CMS allow fraud prevention and detection expenses to be excluded from premium, as they provide consumer protections and increased value for consumers. CMS has recognized the importance of anti-fraud activities, yet the current MLR standard fails to properly account for plan efforts to improve quality and root out fraud and abuse by only allowing recoveries from fraud programs to be counted towards the MLR.

We also recommend excluding payroll taxes from premiums in the MLR calculation, as health plans were previously permitted to do. Current law specifically refers to state taxes, and health plans should be permitted to exclude state payroll taxes. We recommend that health plans be permitted to exclude state and federal payroll taxes from premium in the MLR calculations. The 80 percent/85 percent rebate thresholds were established based on the exclusion of all taxes from premiums, so payroll taxes should likewise be excluded from the MLR calculations.

Finally, we recommend removing the large group market from the MLR reporting requirements. The language in Title 1 in the ACA regarding market reforms is geared toward protections in the individual and small group market – e.g. in rate review, in essential health benefits, in the premium stabilization programs, etc. Large group coverage has group customized policies and premium arrangements. Typically, large group customers prefer any “excess” or “rebates” to be a part of their contract, and not distributed to other groups in the larger shared pooled distribution process that the MLR creates.



- **Leverage health plan expertise to identify and eliminate inappropriate or fraudulent marketplace enrollments.** Health plans have identified situations in which APTC payments are being made for individuals who are not eligible for the coverage in which they are enrolled. In some cases, it appears that the enrollment is fraudulent. In other cases, the inappropriate enrollment may be unintentional – likely related to gaps in the enrollment process, such as when the policy holder is deceased.

While existing guidance has attempted to address fraudulent enrollments, more can be done. Existing FAQs state that people visiting an exchange area for a transitory purpose, such as to obtain medical care, do not meet the residency requirement to purchase coverage on that exchange.¹¹ Some fraud and abuse schemes enroll an individual in a health plan with rich out-of-network benefits in a state in which the applicant does not reside so that an out-of-network provider in another state can bill the plan for services. One example of this practice may involve residential treatment centers for addiction treatment. These practices drive up premiums for consumers who live in the service area of the affected plans and federal spending on CSRs. The practice also creates a disincentive for health plans to offer coverage that includes out-of-network benefits.

The 2018 Notice of Benefit and Payment Parameters included new regulations that permit health plans to terminate fraudulent enrollments, but only if the health plan can “demonstrate that the rescission is appropriate by demonstrating the enrollment was fraudulent or due to an intentional misrepresentation of material fact.” One common flag that an enrollment should be investigated is when a residential address in the plan’s service area cannot be confirmed. In cases where the plan is certain the enrollee does not reside at the address provided in obtaining coverage, but is not certain of the person’s intent, meeting this regulatory test is difficult. Health plans are eager to work with state and federal marketplaces to implement processes to ensure inappropriate or fraudulent marketplace policies are terminated. We ask CMS to adopt policies allowing plans to terminate policies for which they have confirmed that either the enrollee does not reside in the plan’s service area or the enrollee is deceased.

- **Eliminate unnecessary regulations under Section 1104 of the ACA (Administrative Simplification).** The ACA created new requirements for health plans related to the electronic transactions between health plans and providers. One requirement was for a new health plan identifier for health plans to use in electronic communications with providers. Since 2014, CMS has not been enforcing the regulatory requirements, and recently the National Committee on Vital and Health Statistics recommended that HHS rescind the Health Plan ID (HPID) regulation published in September of 2012.¹²

¹¹ [FAQs on the Marketplace Residency Requirement and the SEP due to a Permanent Move, January 2016](#)

¹² [NVCHS Letter to HHS Secretary, June 21, 2017](#)



We do not see any value in the HPID model established by current HHS regulations. Requiring issuers to obtain and maintain these identifiers imposes unnecessary administrative costs with no anticipated return on investment. We do not see value in using the HPID in transactions with health care providers as it is duplicative of existing identifiers that are working well today. We recommend that CMS not move forward with implementing HPID for use in transactions, for health plan certification, or for any other purposes and withdraw the existing HPID regulation.

(4) Affirming the Traditional Regulatory of the States in Regulating the Business of Health Insurance

- **Remove federal rate and form reviews and return all review authority to the States.** Federal rate and form reviews duplicate existing, well-established state standards, placing an unnecessary burden on health plans to meet duplicative requirements. In the Market Stabilization final rule, CMS deferred to state regulators to review network adequacy for QHPs participating in the exchanges. We support this deference to state authority and recommend CMS continue it in future plan years, and expand to other areas of review. To the extent possible, federal reporting and standards should rely on state-based systems and reporting, and should recognize states' authority in those markets. Thus, we recommend CMS return full rate and form review authority to states, permitting health plans to work directly with their state regulators.
- **Provide health plans greater flexibility in setting minimum premium payment policies.** Current regulations permit health plans to establish a premium payment threshold to accept a percentage of the total member responsibility amount due without triggering a grace period.¹³ We recommend providing health plans additional flexibility in setting minimum premium payment policies, including tolerances and thresholds. Specifically, health plans should be given discretion to establish both a percentage amount and a dollar value minimum (e.g., member responsibility is one dollar and tolerance is 95%).
- **Do not require health plans to change effective dates based on the amount of premium paid by the enrollee.** Existing regulations require that for coverage effectuated under retroactive effective dates, the binder payment must consist of all months of retroactive coverage through the first prospective month of coverage. However, if the enrollee only pays one month of premium, the health plan should move the effective date and only effectuate coverage prospectively.¹⁴ This policy creates a risk for adverse selection as well as an unnecessary operational burden on health plans.

¹³ [45 CFR §155.400\(e\)](#)

¹⁴ [45 CFR §155.400\(e\)\(1\)\(iii\)](#)



First, an enrollee who elects a retroactive effective date, but does not have health care claims during the retroactive months, may only pay one month of premium to avoid paying the full amount due. Enrollees should not be able to pay premiums only for months in which they use services, as this undermines the risk pool and drives up premiums. Second, health plans should not be required to interpret an enrollee's intent behind the amount of premium paid in order to move an effective date. We recommend CMS align the premium payment requirements for all retroactive effective dates such that the enrollee must pay the entire binder payment to enroll in coverage. If the enrollee does not pay the full amount, the health plan should cancel coverage. Health plans should not be required to change effective dates based on a premium amount paid.

- **Streamline federal data submission requirements for the Plan Finder website to reduce unnecessary administrative burdens and avoid federal and state duplications.** Existing regulations require health plans to submit extensive data related to the individual and small group markets to CMS for the Plan Finder website.¹⁵ We recommend CMS take a phased approach to streamline data submission requirements for Plan Finder by reducing the submission frequency and ultimately removing the Rate and Benefit Information System (RBIS) submission requirement.

We recommend CMS immediately modify sub-regulatory guidance so that health plans are only required submit product information to the CMS IT systems (HIOS and RBIS) annually, as opposed to the current schedule that requires HIOS submissions quarterly and RBIS submissions every 10 weeks.¹⁶ This annual submission should be coordinated with the annual QHP submission in late Spring/early Summer and use the same templates to streamline submission requirements.

We also recommend that CMS modify existing regulations at 45 CFR §159.120 to remove the RBIS submission requirement. Eliminating RBIS would streamline regulatory requirements and administrative burdens that do not deliver significant consumer value. However, there are other uses for this data that should be addressed prior to eliminating the RBIS requirement. (1) RBIS data is currently used to populate EDGE reference tables used for risk adjustment. We recommend CMS collect plan data through EDGE designed specifically for this purpose as opposed to using RBIS data. We also recommend CMS modify existing EDGE server templates to support any data collection necessary for risk adjustment. We plan to submit additional recommendations related to EDGE server in the near future. (2) Health plans are currently deemed in compliance with the SBC pre-notification requirement by submitting plan information to RBIS.

¹⁵ [45 CFR §159: Health Care Reform Insurance Web Portal](#)

¹⁶ HIOS and RBIS are existing CMS data submission portals. – The Health Insurance Oversight System and Rates and Benefits Information system, respectively.



We recommend CMS modify this deemed compliance provision under 45 CFR 147.200(a)(4)(iii)(C) to provide additional flexibility. Specifically, we recommend health plans that continue to submit RBIS data annually to be deemed compliant or may satisfy the pre-notification requirement by making SBCs available on publicly accessible websites.

- **Streamline submission requirements for off-exchange dental plans.** CMS guidance on the offer of the pediatric dental essential benefit in the market outside the Exchange indicates that if a medical plan is “reasonably assured” that an individual “has obtained” an Exchange-certified stand-alone dental plan, the medical plan would not need to include the pediatric dental benefit in its medical plan. Thus, since the 2014 plan year, CMS has been certifying off-exchange dental plans. We recommend CMS revisit required processes around off-exchange coverage and the requirement of Exchange certification by the stand-alone dental plan is withdrawn.