November 27, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9930-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019 Proposed Rule—AHIP Comments

Dear Administrator Verma:

On behalf of America’s Health Insurance Plans (AHIP), thank you for the opportunity to offer comments in response to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Notice of Benefit and Payment Parameters (NBPP) for 2019 Proposed Rule (CMS-9930-P), published in the Federal Register on November 2, 2017.

Americans deserve access to affordable coverage and care. The stability of the individual and small group markets is essential to that goal. AHIP is committed to working with the Department to finalize policies that will promote stability to ensure consumers have affordable coverage options. 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.

Many regulatory changes proposed in the NBPP would promote State flexibility, support innovation, and promote affordability. We support policies that promote the role of States to regulate their own insurance markets, and to have greater input into the products being offered to their residents. It is critical that policies to promote State flexibility are workable, result in minimum disruptions to consumers, and do not increase costs or administrative burdens for States or issuers. Such policies should encourage innovative plan designs that balance comprehensive, evidence-based benefits with affordable coverage. A stable regulatory environment with clear rules of the road is critical to ensure that such changes are successful and provide needed predictability for States and issuers.
As we make these recommendations, we recognize that open enrollment for 2018 is nearing its end, and issuers are beginning to plan their product offerings for 2019. It is critical that policy changes adopted through the NBPP and other Administrative actions promote stability in the individual market, support a balanced risk pool, and ensure consumers have a choice of affordable coverage options.

The individual mandate plays an important role in ensuring that Americans get covered and stay covered, which helps ensure that coverage is more affordable for everyone who buys their own health plan. If the individual mandate is repealed through legislation, we urge HHS to implement regulatory policies that create strong incentives for consumers to maintain continuous coverage. Without such incentives, there would likely be significant and greater disruptions to the individual market risk pool. For example, HHS could implement recommendations previously submitted by AHIP to require continuous coverage for consumers who are eligible for a special enrollment period (SEP).\(^1\) Alternatively, if the underlying statute remains intact, we do not support administrative actions that would further expand exemptions from the individual mandate or otherwise seek to further reduce its effectiveness.

**Major AHIP Comments and Recommendations on the Proposed 2019 Rule**

Our recommendations are based on certain key principles: enhancing State flexibility; stabilizing the individual and small group markets to promote affordability and consumer choice; ensuring predictability and a stable regulatory environment; and streamlining regulatory and operational requirements. Below we summarize AHIP’s major comments and recommendations:

- **Risk Adjustment Program:** Continue to implement methodological changes to the risk adjustment program, which were finalized through prior rulemaking. Adopt other targeted updates to ensure accuracy, improve the model’s predictive ability, and ensure appropriate alignment of incentives. Consistent with prior processes, use the white paper and formal comment and rulemaking process for future substantive changes. We support the Department’s proposals to make methodological updates to the risk adjustment model for the 2019 plan year, consistent with prior rulemaking. We agree with other proposed updates, including recalibrating the risk adjustment model using EDGE server data and modifications to prescription drug utilization factors.

- **Essential Health Benefit (EHB) Benchmark Plan Selection:** Provide States greater input into EHB benchmark plan selection through a process that allows for necessary, evidence-based changes while preventing major disruptions to the market or consumers’ coverage. We support the goal of enhanced State flexibility and agree that States should have additional tools at their disposal to select an EHB benchmark plan that balances affordability and the coverage needs of their residents. However, we are concerned the proposal to allow benchmark plan selection on an annual basis and the new selection options would be a significant burden on States to implement, increase costs for issuers, and result in disruptions in coverage for consumers. Instead, we

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recommend States have the option to select a new benchmark plan as frequently as every three years and have the flexibility to make targeted, evidence-based updates to balance affordability with comprehensive coverage to meet the needs of their residents.

- **EHB Substitution:** Do not permit plan-level benefit substitution across EHB categories. States select a benchmark benefit plan that they believe will best meet the needs of their residents, including through a balanced set of basic benefits offered across EHB categories. Allowing plan-level substitutions across benefit categories would undermine this balance and the consistency of benefits offered across issuers in the market. It could result in overly complicated plan designs making it difficult for consumers to compare plans.

- **Rate Review:** Reduce administrative costs by eliminating unnecessary reviews, and provide additional State flexibility in rate filing timelines, but ensure appropriate guardrails are in place to ensure a fair and level competitive playing field in the market. We support the Department’s proposal to adopt an amended threshold of rate increases of 15 percent or greater. However, we recommend that HHS apply the 15 percent threshold at the product level, or a 20 percent threshold at the plan level. We further support the proposal to allow States to set different submission deadlines for rate filings. However, we do not support public posting of proposed and final rate increases on a rolling basis. Such a practice could disadvantage issuers who file early and provide an unfair competitive advantage to those who file later.

- **Medical Loss Ratio (MLR):** Permit issuers to exclude certain taxes from MLR and rebate calculations and allow them to streamline reporting of quality improvement activity (QIA) qualifying expenses. We support the proposed modification to allow issuers to exclude these taxes from their MLR and rebate calculations. To reduce the administrative burden of submissions, we support the flexibility for streamlined reporting of QIA expenses.

- **Federal Exchange User Fee:** Provide transparency into the application of user fee funds to support various functions of the Federal Exchange. HHS proposes to maintain the 3.5 percent user fee paid by issuers participating in the Federal Exchange. However, recent announcements by the Department and policy changes proposed in this rule seek to reduce HHS’ role in supporting administrative functions of the Exchange. We recommend an annual report on how the user fee is applied to support various Exchange functions.

- **Value Based Insurance Design:** Allow greater flexibility in plan benefit designs, expand preventive care in high deductible health plans, and permit adjustments to consumer notices that enable plans to better explain and prioritize high value medical care. We support the goal of encouraging more value based insurance design in all market segments. Presently, there are barriers to wider adoption of these plan designs, particularly in high deductible health plans and the individual market. We recommend expanding the preventive care safe harbor for high deductible health plans to include chronic care services at the plan’s discretion and allowing adjustments to cost-sharing
rates for services, medications, or treatments that provide low clinical value. Further, we recommend maximizing the impact of these permitted changes by allowing for the option to inform a consumer of the value based design aspects of a plan they may be purchasing or enrolled in, through both plan documents and the exchange website.

Again, we appreciate the opportunity to offer comments on the proposed 2019 Payment Notice. We remain committed to working with the Administration and other stakeholders to bring greater stability to the individual and small group markets to improve affordability and choice.

Sincerely,

Matthew Eyles
Senior Executive Vice President &
Chief Operating Officer
Detailed Comments on the Proposed Notice of Benefit and Payment Parameters for 2019

Our detailed comments on the proposed rule are organized into the following sections:

I. Updates to the HHS Risk Adjustment Model
II. Essential Health Benefits
III. Rate Review
IV. Medical Loss Ratio
V. Other Exchange Establishment Standards (Part 155)
VI. Other Health Insurance Issuer Standards (Part 156)
VII. Market-wide Reforms

I. Updates to the HHS Risk Adjustment Model

A. Proposed Updates to the Risk Adjustment Model (§153.320)

The 2019 NBPP proposes continued methodological improvements to the risk-adjustment model with updates for the 2019 benefit year, such as modifying the incorporation of prescription drug utilization factors. In addition, HHS proposes providing States with flexibility to request a percentage adjustment (up to 50 percent) in the calculation of risk-adjustment transfer amounts in the small group market.

Recommendations:

- We support incorporating methodological improvements to the risk-adjustment model for the 2019 benefit year consistent with previous rulemaking. HHS proposes moving ahead with updates and improvements in the risk-adjustment model including incorporating preventive care services, utilizing more granular trend rates, accounting for partial year enrollment, including prescription drug utilization factors, adjusting the risk-adjustment model to better account for high-cost enrollees and removing a portion of the premium in the transfer formula to account for administrative costs that do not vary with claims. These targeted reforms hold promise in strengthening the risk-adjustment program so that it can better meet its market stabilizing goals of promoting fair competition and reducing the potential for adverse selection. Moreover, these policies can help enhance the predictive power of the risk-adjustment model while promoting greater accuracy in risk-adjustment payments.

- We support recalibrating the risk-adjustment model using EDGE server data with appropriate safeguards to protect the confidentiality of proprietary plan data. The Department proposes a recalibration of the risk-adjustment model for the 2019 benefit
year using 2016 benefit year EDGE data. Specifically, HHS proposes blending the coefficients calculated from the 2016 benefit year EDGE enrollee-level data with two years of MarketScan data to minimize volatility in risk scores and promoting stability within the risk-adjustment program. We support HHS’ approach of using blended coefficients for the 2019 benefit year—which can help ensure more accurate data and improve the model’s predictive ability—and recommend that the final risk-adjustment model coefficients be made available in the 2019 NBPP final rule. As we have stated in previous comments, we also strongly believe that HHS should limit the collection of enrollee-level data elements to only those necessary to calibrate the risk-adjustment model and, furthermore, that HHS utilize the formal notice and comment process regarding actual data elements used from EDGE for recalibration.

• **We support HHS’ proposed modifications to prescription drug utilization factors in the risk-adjustment model—including removing two severity-only classes for the 2019 benefit year.** Eliminating the two severity-only classes from the risk-adjustment model—including RXC 11 and RXC 12—aims to reduce incentives for over-prescribing and creating misaligned financial incentives (e.g., prescribing a low-cost drug to receive a much larger risk-adjustment payment). We agree with HHS’ approach to restrain incentives for overprescribing (by removing two drug classes) while retaining the remaining prescription drug classes that are strong predictors of plan liability and risk.

• **We recommend HHS promote stability by utilizing the same payment parameters for the high-cost risk pool adjustment for the 2019 benefit year.** We support utilizing the existing payment parameters—e.g., $1 million threshold and 60 percent co-insurance—to more accurately account for insurers’ risk associated with very high-cost enrollees. Establishing a multi-tiered approach—such as establishing multiple threshold amounts and increased co-insurance levels—would introduce additional complexity into the risk-adjustment model which, in turn, could create unintended consequences, such as increasing interstate transfers.

• **HHS’ proposal would provide states flexibility to limit payment transfers under the risk-adjustment program in the small group market for the 2019 benefit year.** AHIP supports an effective and accurate program of risk adjustment for both the individual and small group markets to accompany the market rules to ensure that carriers are appropriately compensated if they enroll a higher mix of individuals who are less healthy. Risk adjustment is critical given the requirements for both guaranteed issue and modified community rating and we continue to support changes to improve the program as noted above.

• **We recommend that any changes to limit risk-adjustment payment transfers be subject to a rigorous and thorough assessment—with input from actuarial experts and stakeholder groups—with the goals of ensuring the goals of risk-adjustment are met and avoiding unintended consequences.** If HHS moves forward with this proposal, such flexibility should be limited to the small-group market and only where states can demonstrate via an actuarial analysis or study that such limits in payment transfers helps promote market stability, consumer choice and/or reduce adverse selection—consistent
with the risk-adjustment program’s intent and market stabilizing goals. Additional considerations may be needed in states that have a merged individual market and small group market risk pool.

B. Risk Adjustment Data Validation (RADV) Requirements (§153.630)
The 2019 NBPP includes provisions addressing RADV requirements under the risk-adjustment program, including: simplifying the approach to payment adjustments as a result of RADV error rates; addressing how payment adjustments would apply to exiting issuers who participate in RADV; specifying the minimum data elements required for validation of mental health or substance abuse disorder diagnoses; and applying the RADV materiality threshold beginning in the 2018 benefit year (instead of 2017).

Recommendations:

• We support HHS’ approach to determining the error rate for RADV, which would evaluate material statistical variation in error rates by applying error rates to risk scores beginning with the 2017 benefit year risk adjustment data validation. We agree that RADV error rates should not be a source of volatility in the market and that this approach can help both streamline the process and promote confidence and stability in risk-adjustment payment transfers.

• We support HHS’ proposal to allow providers to furnish a mental health or behavioral health assessment for validation of a mental health or behavioral health diagnosis—in the event state privacy laws prohibit a provider from furnishing the full mental health or behavioral health record.

• We recommend HHS maintain a public FAQ document for internal validation audits (IVA) to ensure that all IVA vendors are adjudicating issues on a consistent basis.

II. Essential Health Benefits

A. Essential Health Benefits Package (82 FR 51101)
The Department proposes to provide States with additional flexibility in the selection of EHB benchmark plans beginning for plan year 2019 to permit States to increase affordability of health insurance in the individual and small group markets. HHS seeks input on whether this policy should start with the 2019 plan year or with the 2020 plan year. For future years, the Department is considering establishing a Federal default definition of EHB that would better align medical risk in insurance products by balancing costs to the scope of benefits.

Recommendations:

• We share the Department’s interest in exploring a potential future Federal default benchmark plan or prescription drug standard and urge HHS to seek broad stakeholder input through a formal comment opportunity. It is critical that any Federal default not limit State flexibility or issuers’ abilities to develop innovative plan designs that reflect the needs of the market. We agree there may be benefits to
such an option and encourage the Department to explore a more detailed proposal through a future white paper or guidance and seek stakeholder input through a formal comment opportunity. We recommend that any Federal default benchmark or prescription drug standard should be used only to establish a minimum floor of benefits, which States could adopt at their option and build upon to meet the specific needs of their residents. We welcome the opportunity to further explore this option through future comment opportunities.

- **Any State changes to the EHB benchmark plan should apply no earlier than the 2020 plan year.** Implementing benchmark plan changes for the 2019 plan year is not feasible at this late date, and we agree with HHS’ suggestion in the preamble that changes be implemented beginning in 2020. Implementing EHB benchmark plan changes for 2019 would result in hurried decision-making by States and would not promote a thoughtful approach to identifying gaps in the existing benchmark or prioritizing areas for improvement to meet the needs of the State’s residents. Further, the proposed 2019 implementation timeframe does not provide issuers enough time to reasonably implement and operationalize changes. HHS proposes March 16, 2018, as the deadline for States to choose a new benchmark plan for the 2019 plan year. Product development for the 2019 plan year is already underway for most issuers and would be nearly complete by that time. Selection of a new benchmark plan in March 2018 would cause significant disruptions and create unnecessary administrative costs. Issuers would not have time to finalize plan offerings and benefit design to meet Federal and State filing deadlines, which traditionally begin as early as April or May in some states. We support the proposed timeline for benchmark plan selection for the 2020 plan year—by July 1, 2018—and recommend HHS move forward with the proposed requirement that a new benchmark plan be finalized at least 18 months prior to the start of the applicable plan year. This will provide issuers sufficient time to align their products and consumer-facing materials with the new benchmark plan and to ensure HHS can update the Plans and Benefit template add-in to support the filing process.

**B. State Selection of EHB Benchmark Plan for Plan Years Beginning on or After January 1, 2019 (§156.111)**

The Department proposes to allow States to update their EHB benchmark plans more frequently, on an annual basis, and to allow States to change their benchmark by: (1) selecting another State’s 2017 EHB benchmark plan; (2) replacing an EHB benchmark category or categories in its 2017 EHB benchmark plan with the same category or categories from another State’s 2017 EHB benchmark plan; or (3) otherwise selecting a set of benefits as a new EHB benchmark plan, so long as it does not exceed the generosity of the most generous plan from among a set of comparison plans. Under each option, a State must continue to defray the cost of any benefits mandated by State action after December 31, 2011 that are currently subject to defrayal, including if the State adopts a benchmark plan or category from another State.

**Recommendations:**

- **While we share HHS’ goal of providing States increased flexibility in designing an EHB benchmark plan, we have significant concerns with the three options proposed**
for State selection of a new benchmark. We agree that States should have greater flexibility in updating the EHB benchmark plan to ensure their residents have access to affordable coverage. However, we are concerned the proposed approach would have the opposite effect of States adopting increasingly expensive EHB packages. While the Department’s goal is to give States flexibility to increase affordability through the EHB benchmark plan selection options, States could also use the proposed selection options to adopt a more generous benchmark plan, or category of benefits, in addition to requiring coverage of existing State mandated benefits. States could adopt more generous benchmark plans or categories of benefits from States with more mandated benefits, without a requirement that the adopting state enact authorizing legislation. We are particularly concerned that costs of new benefits in excess of EHB would not be defrayed, as no State currently defrays the costs of benefits above EHB under existing regulations. Adoption of additional benefits without State defrayal of costs, in addition to the costs of existing State mandated benefits, would have a significant impact on affordability. It is critical that any changes to the EHB benchmark plan carefully balance comprehensive, evidence-based coverage with affordability. We are concerned that the proposed State selection options would undermine this goal and recommend the Department not adopt this approach.

- We recommend the Department provide States the flexibility to adjust the benchmark plan to address existing gaps or to account for changes in medical evidence or new technology. Section 1302(b)(1)(H) of the Affordable Care Act permits the Secretary to periodically update EHBs to address gaps in access to coverage or changes in the evidence based on a periodic assessment of EHBs. Consistent with the Department’s goal of providing increased flexibility to States to define the benchmark, we recommend the Secretary provide States flexibility to determine whether modifications to the benchmark plan are needed to address gaps in access to coverage or changes in evidence. States should carefully assess the current benchmark plan to determine whether gaps exist, identify evidence-based improvements, and solicit input from stakeholders prior to implementing changes to the benchmark. For example, such changes may include modifying or removing visit limits or modifying authorizations. Such an approach would provide States additional flexibility to make updates to the benchmark in a manner that strikes a balance between the needs of its residents, evidence-based changes, and affordability.

- While we appreciate expanding State flexibility with respect to the EHB benchmark plan, annual selection of a new benchmark would undermine predictability and stability, create consumer confusion, and increase costs. Development of a benchmark plan by a State is a significant undertaking, and we are concerned that annual updates would result in a hurried approach rather than a thoughtful, deliberate process to update the benchmark plan. This would likely result in a reactive process in which States constantly change or modify the benchmark year-to-year. Instead, we encourage a process that gives States sufficient time to review the benchmark’s effectiveness or any gaps. Further, changes to the benchmark plan have a significant impact on the product development process as issuers must update plan and benefit designs, review and amend product filings, revise member-facing plan documents, and update their claims processes.
Updating the benchmark plan annually would eliminate predictability and significantly increase the administrative costs for issuers to keep up with these changes. Frequent changes to the benchmark would also create consumer confusion regarding what is and is not covered.

- **We recommend the Department allow States to select a new benchmark plan no more frequently than every three years. We support the proposal to allow States that prefer to maintain their current EHB benchmark plan to do so without action.** To promote stability and predictability and lower administrative costs, we recommend the Secretary allow States to update the benchmark as often as every three years, if the State determines an update is appropriate.

- **If the Department finalizes this proposal, we strongly recommend it consider the following:**
  
  o **HHS should require States to defray the costs of additional benefits that must be covered as the result of the selection of a new EHB-benchmark plan or substitution of an EHB benefit category regardless of whether the state requires the additional benefits by statute.** Currently, States are required to defray the costs of any benefits mandated by State action after December 31, 2011. We are concerned that some States may use the proposed benchmark selection options to expand required benchmark benefits and avoid the requirement to defray costs. This would result in higher premiums, and as a result, higher premium tax credits. As discussed above, we support State flexibility in defining benchmark benefits but encourage States to do so in a manner that balances evidence-based benefits with affordability. Requiring States to defray the costs of benefits added to the benchmark through selection of another State’s benchmark plan or category of benefits would encourage States to pursue this balance. Further, we are not aware of any States that currently defray the costs of State-mandated benefits in excess of EHB. We recommend the Department conduct a review of State actions to correctly calculate costs associated with benefits in excess of EHB and identify steps the Department would take if it is determined that a State is not appropriately identifying benefits in excess of EHB and defraying those costs.

  o **The definition of a typical employer plan for selection of a benchmark under Options 2 and 3 should exclude self-insured plans from being classified as a typical employer plan.** A self-insured plan is a highly customized benefit offering designed for a specific employer and its employees. By design, these plans are atypical and cannot be standardized for a general population. Further, as the Department notes in the preamble discussion, there is no publicly available information for self-insured plans that a State could use for development of a benchmark.

C. **Provision of EHB (§156.115)**
The proposed rule would expand flexibility for issuers with respect to EHB benefit category substitution. Currently, an EHB-compliant plan must provide benefits that are substantially equal to the EHB benchmark plan but may make benefit substitutions within an EHB category. HHS proposes to allow substitution both within the same EHB category and across EHB categories, as long as the substituted benefit being replaced is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit.

Recommendation:

- **We do not support expanding flexibility for benefit category substitution to include substitutions across benefit categories.** Plan-level benefit substitution across categories could lead to overly complex plan designs. This would eliminate the minimum standardization of benefits provided by a benchmark plan, which allows consumers to meaningfully compare benefits across plans. We are also concerned that benefit substitutions across categories could lead to adverse selection and interfere with the stability of the individual market risk pool.

III. **Rate Review**

A. **Applicability (§154.103)**

HHS proposes to exempt student health insurance available only through colleges and universities from the rate review requirements, permitting such coverage to return to its pre-2014 treatment as large group coverage for rating purposes.

Recommendation:

- **We support exempting student health plans from rate review.** This proposed approach is consistent with the preferences of colleges and universities to treat this as large group coverage, which was the standard prior to the implementation of Federal rate review. AHIP had previously recommended such insurance should continue to be treated as large group coverage.

B. **Rate Increases Subject to Review (§154.200)**

Under §154.200(a)(1), rate increases in the individual and small group markets are subject to an additional review (“subject to review”) for reasonableness if proposed rate increases are 10 percent or greater. The Department proposes to amend the threshold to a 15 percent default level, which could be adjusted by States that seek to maintain or establish a lower threshold.

Recommendations:

- **We support the proposed amended threshold of a 15 percent or greater increase in rates to be deemed subject to additional review.** This proposed change is a reasonable approach to identify potential unjustified increases, while recognizing that rate increases of 10 percent are too low a threshold. Rate increases at that lower level have most often been justified, but the reviews have added administrative time and costs to state and
federal regulators and issuers filings. A 15 percent threshold level is a more reasonable review threshold level for review.

- **We also recommend the 15 percent threshold should be applied at the product level.** The 2016 Notice of Benefit and Payment Parameters required the threshold to be applied at the more granular plan level instead of the more aggregated product level. Prior to that change, the threshold had been applied at the product level. This is a more rational approach and was common practice in the states. Rates at the plan level will vary due to various market factors and reviewing an entire product based on the increase for a single plan is unnecessary work. This approach also differed from state processes.

- **If this proposal threshold is to be applied at the plan level, we recommend that HHS apply a 15 percent threshold at the product level or a 20 percent threshold for a plan level review.** Plan levels reviews at a threshold of 15 percent would likely result in a large number of reviews of proposed rate increases with the vast majority found to be reasonable. Thus, we recommend plan level review threshold, if maintained, should be set at a 20 percent threshold.

**C. Timing of Providing Rate Filing Justifications (§154.220)**

The Department proposes to allow a State with an Effective Rate Review program to set different submission deadlines for rate filings in the individual and small group market single risk pools for issuers that do not offer any qualified health plans (QHPs) in those markets. HHS indicates it will still collect preliminary rate filing information and final rate determinations to monitor premium increases in health insurance coverage, pursuant to 2794(b)(2)(A) of the PHS Act, but will coordinate with States to meet that requirement.

**Recommendation:**

- **We support State flexibility to set submission deadlines for rate filings. However, we do not support separate filing deadlines for QHP issuers and non-QHP issuers that file single risk pool adjusted community rating filings.** We understand this creates a significant volume of work for State rate reviewers but believe it is justified and necessary to maintain the competitive integrity of the market. Filings in the individual and small group markets are both for a future calendar plan year. However, the issuer group with the later filing deadline—whether QHP or non-QHP—would have the advantage of additional time, claims experience and other information to inform their rate filings. This could create an inherent advantage to one of those issuer groups.

- **Instead, we recommend that States be permitted to set uniform filing submission deadlines** for all issuers that file individual single risk pool market coverage rates and, similarly for all issuers that file small group single risk pool coverage rates.

**D. Determinations of Effective Rate Review Programs and Publication of Rates (§154.301)**

The proposed rule would modify §154.301(b)(2) to reduce the notice requirement for States to notify HHS in writing from no later than 30 days before publicly posting proposed or final rate filing information to an advance notification of five business days. HHS also proposes to
eliminate the requirement under §154.301(b)(3) that States’ rate increase information be available at a uniform time, thereby allow States to post proposed and final rate filing information on a rolling basis to accommodate State flexibility and prior practice. HHS would, however, post all proposed and final rate changes on their website at a uniform time on the Federal Rate Review website.

Recommendation:

- We recommend that all single risk pool individual market rate filings for on exchange coverage and off exchange coverage to be posted at the same time within a state. Likewise, we recommend that all small group rate filings for SHOP coverage and off SHOP coverage to be posted at the same time. We oppose public posting of proposed and final rate increases at different times or on a rolling basis (as they are received) as suggested in §154.130(b)(3). Proposed rate filings contain information that could create an unlevel competitive playing field by disadvantaging issuers whose filings were released earlier. To assure a fair competitive market, all proposed rate filings should be posted at a uniform time, by market – for the individual market single risk pool, and the small group single risk pool.

IV. Medical Loss Ratio

A. Reporting of Federal and State Taxes (§158.162)

HHS proposes to allow the reporting of employment taxes (such as the Federal Insurance Contributions Act (FICA), the Railroad Retirement Tax Act (RRTA), and the Federal Unemployment Act (FUTA) taxes; State unemployment/reemployment insurance and State employment training taxes; and other similar taxes and assessments) and Federal and State taxes (§158.162) and permit insurers to exclude those taxes from earned premiums in their MLR and rebate calculations. In prior years of MLR reporting, many insurers had included such taxes, but HHS subsequently determined not to allow these taxes to be excluded beginning with the 2016 reporting year.

Recommendations:

- We support the Department’s proposal to allow issuers to exclude these taxes from their MLR and rebate calculations. AHIP had previously recommended that such taxes be excluded from earned premium. Issuers are subject to those taxes, which they cannot limit or control. Thus, from a policy perspective, including those taxes in earned premium, while other taxes and fees are exempt, is both inconsistent and inequitable. We support the proposed change and recommend issuers be permitted to exclude those taxes from earned premium in the 2017 MLR and rebate calculation reporting.

- With respect to the 2017 Health Insurance Tax (HIT) moratorium, we recommend HHS allow issuers to defer premium collection for non-calendar plans for 2017 MLR filings in the same manner as it did for 2013. This adjustment would be indicated in the OMB MLR and Rebate Calculation Instruction Manual. For the first year of the HIT, in MLR Filings, HHS allowed issuers to defer until 2014 the premiums
collected for non-calendar plans in 2013. This was needed to allow issuers to align HIT fees collected in 2013 with the related 2014 premiums. Due to the 2017 HIT moratorium, issuers will be in a similar situation in 2017 and 2018. As a result, we recommend a similar treatment for the 2017 MLR filings to address this issue, align HIT fees with related premiums (as previously recognized) and be consistent with accrual accounting principles and practices.

B. Allocation of Expenses (§158.170)
In §158.170(b), HHS proposes an amendment with a new option for reporting the allocation method and amount expended on quality improving activity (QIA) qualifying expenses. As outlined in a newly added paragraph (b)(8) in §158.221, an issuer could streamline their reporting by using a default standard of 0.8 percent of earned premium.

Recommendations:

- **We support the proposal to give issuers the option to use a default standard of 0.8 percent of earned premium in their line item for QIA expenses in the MLR calculation.** We also support the option for issuers to maintain the current reporting of process for QIA expenses that exceed 0.8 percent of earned premium.

- **We also recommend the recognition and inclusion of fraud detection and prevention expenses in the MLR and rebate calculation.** HHS has recognized the challenge of fraudulent actions in government programs and permitted the inclusion of fraud fighting costs in MLR calculations for those programs. For example, HHS recently proposed to revise the Medicare Advantage and Part D MLR calculations to allow expenditures related to fraud detection activities. We strongly recommend HHS similarly allow these expenses to be included in MLR calculations in the individual and group markets.

Issuers work with the Office of Inspector General and other Federal agencies such as the Federal Bureau of Investigation to pursue and enforce actions against fraudulent actors. Issuers work to protect enrollees and consumers’ health care quality through detection of fraud, follow up enforcement, and the resulting prevention through a deterrence effect that protects and improves the quality of care received by consumers. Issuers also devote substantial resources to programs used to identify medical identity theft (which could lead to medical errors in care and treatment of that identity theft victim), detect false credentials, and/or identify bogus providers delivering medically-unnecessary services or substandard care. These are examples of fraudulent activities that can have a devastating impact on health care quality and consumers’ health. We believe the detection and prevention of such fraudulent and potentially harmful actions constitutes a quality improving activity that should be recognized in §158.150(b)(2).

C. Formula for Calculating an Issuer’s Medical Loss Ratio (§158.221)
As noted above, HHS proposes to allow an option for insurers to either report the QIAs in the five specified categories codified in §158.150(b)(2)(i)-(v) as they are currently doing (particularly if they have incurred a greater estimated amount) or to report a flat 0.8 percent of
earned premium in the MLR numerator in their calculation. HHS indicated it has observed the substantial effort expended by insurers to identify, track, and report QIA.

Recommendations:

- We support the proposed approach, providing issuers the option to report a flat 0.8 percent, or using the current QIA category reporting approach.

V. Other Exchange Establishment Standards (Part 155)

A. Standardized Options (§155.20)
For 2019, HHS does not specify any standardized options for the 2019 plan year and will not provide any differential display on Healthcare.gov. The proposed rule removes corresponding requirements for agents and brokers and third-party websites regarding display of standardized plan options.

Recommendation:

- We support the removal of standardized plans from the Exchange and appreciate the Department’s emphasis on supporting innovative product design. While some issuers have adopted standardized plans since their introduction in the 2017 plan year, we have raised concerns about the value of these plans and their differential display on healthcare.gov. Standardized plans limit consumer choice and hinder flexibility for issuers to respond to market needs. Issuers are in the best position to create innovative plan designs that support consumer preferences. Essential health benefit requirements, limits on out-of-pocket expenses, actuarial value requirements and the metal level classification system already establish guardrails that ensure the plans offered in any marketplace provide quality coverage for a wide range of consumers. Beyond that, we urge HHS to allow the market to define what types of plans are needed and desired by consumers.

B. Flexibility for SBMs and SBMs-FPs (§§155.106 and 155.200)
The Department seeks comment on how HHS can best support State-based Exchange (SBE) efforts to utilize commercial platform services, including what type of technical support would be useful and what regulatory changes would facilitate use of these platforms. HHS is also exploring strategies for State-based Exchanges using the Federal Platform (SBE-FPs) to be more viable and seeks comment on how to streamline current requirements and leverage private sector and Federal platform technologies to increase opportunities for more States to become SBE-FPs.

Recommendation:

- We support the Department’s goal of better supporting State-based Exchanges and State-based Exchanges using the Federal Platform through streamlined regulatory requirements and technical support. For many States, the costs associated with building the technological platform and infrastructure to host an Exchange is a major barrier to establishing a State-based Exchange. HHS could expand access to existing
Federal platform services while providing flexibility for States to tailor the software and processes to meet their State-specific needs. Such a solution could be managed centrally to ensure a minimum level of consistency (e.g., related to key eligibility requirements), scalability, and performance and minimize the burden on States to make updates to adhere to new features or regulations.

C. Navigator Program Standards & Standards Applicable to Non-Navigators (§§155.210 and 155.215)

The proposed rule would remove the requirement that each Exchange must have at least two navigator entities and that one of these entities must be a community and consumer-focused nonprofit group. It would remove the requirement that each navigator maintain a physical presence in the Exchange service area.

Recommendations:

- We recommend that any changes to the navigator program ensure that low-income, vulnerable, and underserved populations continue to receive the outreach, education, and assistance needed to support enrollment and post-enrollment activities. We are concerned that the proposed changes could result in a reduction in enrollment education and assistance for underserved and vulnerable populations. Combined with the significant reduction in Federal funding for the navigator program, these changes could negatively impact enrollment by these populations. Some communities, such as non-English speakers or minority populations, have no access to local assistance in their native language through more traditional channels like agents and brokers.

- HHS should establish metrics to assess the impact of the various functions that navigators serve, not limited to enrollment volume, when determining navigator funding for future years. Enrollment is only one of the many functions navigators undertake; assessing the success or impact of navigators based on enrollment volume alone ignores the impact they have on open enrollment more broadly. Navigators serve an important role in education and outreach, making consumers aware of open enrollment and enrollment deadlines, helping consumers understand coverage options, completing applications (which may lead to enrollment in coverage through the Exchange or Medicaid), and reviewing plan details such as benefits, provider networks, and consumer costs (e.g., co-payments). We know from experience in other programs, such as Medicare Advantage, that low-income populations often do not understand or have limited comprehension of the coverage they enroll in, resulting in underutilization of medical services and low satisfaction. Navigators help to educate low-income and underserved populations on the benefits of coverage and review specific coverage options to identify the plan that will best meet their needs. Thus, we recommend that HHS establish additional metrics to assess the impact of the navigator program, including hours spent conducting education and outreach when determining navigator funding for the 2019 plan year and beyond.
D. Standards for Third-Party Entities to Perform Audits of Agents, Brokers, and Issuers Participating in Direct Enrollment (§155.221)

HHS proposes to implement an approach whereby agents, brokers, and issuers that participate in direct enrollment (“direct enrollment partners”) would select their own third-party entities to conduct operational readiness reviews and audits. This would remove the requirement that HHS initially review and approve audit entities.

**Recommendation:**

- **We recommend HHS maintain oversight of third party audit entities by conducting an initial review and approval rather than allowing agents, brokers, and issuers to select their own third-party auditors.** Prior review and approval by HHS of third party audit entities provide direct enrollment partners with assurance that an auditor meets HHS’ criteria. If HHS removes this pre-approval standard, direct enrollment entities will each make independent assessments of whether the auditor meets HHS’ standards and result in inconsistency across agents, brokers, and issuers. With the upcoming implementation of enhanced direct enrollment and expanded requirements for operational readiness, including privacy and security standards, consistency in third party auditors and their assessments of direct enrollment partners will be critical to ensure consistent implementation of direct enrollment and protection of consumers. Thus, we recommend HHS not remove the requirement that HHS conduct an initial review and approval of third party audit entities.

E. Exchange Eligibility Standards (§155.305)

The 2018 Payment Notice required an Exchange to directly notify each tax filer if advance premium tax credit (APTC) was at risk of being discontinued due to failure to file a tax return and reconcile APTC. The notice was intended to provide detailed messaging to tax filers highlighting the need to file and reconcile. HHS proposes to eliminate the direct notification requirement to reduce the burden on the Exchange.

**Recommendations:**

- **Consumers should receive specific, actionable notices regarding the potential loss of APTC eligibility due to failure to file and reconcile.** In prior years, HHS has interpreted requirements related to protection of Federal tax information (FTI) as preventing the Exchange from sending specific notices to enrollees at risk of losing APTC due to a failure to file a tax return and reconcile APTC. As a result, enrollees would receive a general notice without the specific cause of APTC loss or actionable steps to maintain eligibility. As HHS notes in the preamble, in the past, this resulted in only 60 percent of consumers taking the necessary action to file a tax return and reconcile APTC in order to retain APTC eligibility for the upcoming plan year. While the Department asserts this demonstrates the success of the general APTC discontinuation notice, we believe this demonstrates that the notices are not providing consumers with sufficient information to take the correct action.
We recommend the Department maintain the new notice for tax filers at risk of loss of APTC due to failure to reconcile, as well as the general loss of APTC notice sent to the household, until HHS can assess the impact of the new notice. We believe it is too early to know the impact of the new direct tax filer notice for failure to reconcile. Following 2018 open enrollment, HHS should assess whether there is an increase in consumers who take the correct action to reconcile APTC and a decrease in consumer confusion (e.g., via call center questions). HHS should also consider whether any change is due to the cumulative impact of the two notices. In the interim, we believe it would be premature to eliminate this new notice.

F. Verification Process Related to Eligibility for Insurance Affordability Programs ($155.320)

Income Inconsistencies
Currently, if an applicant attests to having a projected annual income that is more than data from sources like the Internal Revenue Service (IRS) and Social Security Administration (SSA), the Exchange must accept the attestation without further verification. HHS proposes to create an income-based data matching inconsistency (DMI) when trusted data sources return income under 100 percent FPL and the consumer attests to income between 100 and 400 percent FPL when certain other criteria are met. HHS plans to issue future rulemaking related to program integrity, including processes for matching enrollment data with Medicare and Medicaid to remove duplicate enrollments, as well as other enrollment and eligibility processes.

Recommendations:

- We do not support the proposed change because creating a DMI in this scenario will create an unnecessary burden for low-income enrollees. While HHS notes in the preamble that such a change could help individuals avoid having to repay APTC upon filing a tax return, this would apply only if the individual reported income with “intentional or reckless disregard for the facts.” Lower-income individuals may have more difficulty projecting annual income or providing documentation to prove such income, though this would not necessarily constitute intentional or reckless disregard for the facts. For example, an individual may have a new job without a paystub to demonstrate income or own a small business that is projected to be profitable in the coming year. In both scenarios, the individual may not have sufficient documentation to resolve the inconsistency and would lose APTC eligibility. Scenarios such as these are likely to be more common for low-income individuals and, unlike higher income enrollees, these individuals cannot afford coverage without APTC. Thus, we recommend HHS not finalize the proposed change and continue to accept projected annual income that is more than the income from other data sources like IRS and SSA.

- We welcome the opportunity to comment on future rulemaking related to Exchange program integrity and urge the Department to implement more robust processes to reduce duplicate enrollments across the Exchange, Medicare, and Medicaid and

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ensure consumers enroll in the coverage that is appropriate based on their eligibility circumstances. We have previously raised significant concerns about consumers who are enrolled in both Exchange and Medicare or Medicaid as well as consumers who are eligible for Medicare or Medicaid but instead enroll in coverage through the Exchange. We urge HHS to issue a new proposed rule to prohibit third party payments that inappropriately steer Medicare and/or Medicaid beneficiaries to Exchange coverage and implement other needed policy and operational changes to prevent duplicate enrollments. With respect to duplication of Medicare coverage, the Exchange should prevent Medicare-enrolled or Medicare-eligible individuals from enrolling in coverage through the Exchange during the application process, adopt more robust data matching to identify duplicate enrollees and remove APTC, and end Exchange coverage without auto-renewal for the next plan year. To ensure accurate and consistent eligibility determinations, the Exchange should remain the “source of truth” for eligibility and issuers should not be required to assess Medicare status at the time of renewal, as implemented for the first time in 2018.

G. Annual Eligibility Redetermination (§155.335)
The Department is considering amending the length of time (currently five years) that individuals may authorize the Exchange to obtain updated tax return information. The Department seeks comment on whether five years is an appropriate amount of time or whether a shorter amount of time should be considered.

Recommendation:

- We recommend maintaining the current five-year authorization period for the Exchange to obtain updated tax return information. In order for the Exchange to redetermine eligibility for APTCs and cost-sharing reductions (CSRs) for passive reenrollment—i.e., when an enrollee does not return to the Exchange to actively update the application and obtain a new eligibility determination—the individual must authorize the Exchange to check tax return information. If the enrollee did not authorize the Exchange or the authorization has expired, the enrollee is at risk of losing eligibility for APTC and CSRs. Reducing the authorization period could result in this authorization expiring and loss of subsidy eligibility for an increased number of enrollees.

- We share the goal of encouraging consumers to return to the Exchange to update their eligibility application, including changes to annual income and household, which could impact subsidy eligibility. Auto-redetermination of eligibility and auto reenrollment are critical for continuity of coverage for almost half of Exchange enrollees. Reducing the authorization period could cause an unnecessary loss of subsidy eligibility due to an administrative issue. Thus, we recommend maintaining the five-year authorization timeframe.
H. Special Enrollment Periods ($155.420)

Plan options under select SEPs ($§155.420(a)(4)(iii) and 147.104)

HHS proposes to differentiate between when an existing enrollee qualifies for an SEP or an enrollee and their dependent(s) qualify for certain SEPs\(^3\) and when only new dependents qualify for an SEP and are enrolling in Exchange coverage with an existing enrollee. HHS proposes to align the plan selection options for all scenarios when a new dependent qualifies to enroll through an SEP. In the preamble discussion under guaranteed availability (82 FR 51059), HHS seeks input on whether for the off-Exchange individual market, SEPs for gaining or becoming a dependent should apply to new dependents and existing dependents or only to the new dependent.

Recommendations:

- **We support the proposed change to ensure new dependents are treated the same when being added to an existing enrollee’s coverage regardless of the SEP for which they qualify.** The proposed rule aligns plan options, under (a)(4)(i) and (a)(4)(iii)(B), when only a dependent who is not currently enrolled qualifies for an SEP and wishes to be added to an existing enrollee’s coverage. When a new dependent qualifies for an SEP, we agree that the dependent may be added to the existing coverage, but this should not permit other existing enrollees to make a plan change, enrollment by other new dependents, or make other changes to the enrollment group.

- **HHS should align on- and off-Exchange SEP rules to ensure consistency across the individual market.** Consistent rules across the individual market will reduce confusion, eliminate opportunities for gaming, and reduce administrative costs for issuers. We do not interpret subparagraph (a)(4)(i) as providing an opportunity for existing enrollees or dependents, such as parents or siblings of a newborn, to enroll in or change plans when a dependent qualifies for an SEP as HHS discusses in the preamble (82 FR 51059). Thus, in the off-Exchange and on-Exchange individual markets, existing enrollees and dependents should not be permitted to enroll or change plans when a dependent qualifies to newly-enroll in coverage through an SEP.

Exception for prior coverage requirement for individuals who lived in an area where no QHP is offered through an Exchange ($§155.420(a)(5) and 147.104(b)(2)(i))

Individuals who qualify for certain SEPs—permanent move and becoming or gaining a dependent through marriage—must demonstrate they had prior coverage for at least one day in the 60 days preceding the date of the qualifying event. HHS proposes to exempt individuals from the prior coverage requirement if, for at least one of the 60 days prior to the date of the qualifying event, they lived in a service area where there were no QHPs offered through an Exchange. HHS proposes to also apply this exception off Exchange.

\(^3\) Excludes gaining a dependent through birth, marriage, or adoption/foster care ((d)(2)(i)), an enrollment error ((d)(4)); new eligibility for APTC or CSRs (((d)(6)(i)) or (d)(6)(ii)); an American Indian or Alaskan Native((d)(8)); exceptional circumstances ((d)(9)); and domestic abuse or spousal abandonment ((d)(10)).
Recommendations:

- **We support the proposed change in an area where no QHPs are offered through the Exchange but recommend other processes to verify the qualifying event remain in place.** Verification of SEP eligibility continues to be a priority to stabilize the individual market. To avoid potential misuse of the marriage SEP or permanent move SEP, which has been particularly susceptible to misuse in the past, we recommend that HHS continue to verify eligibility for these SEPs prior to enrollment. Specifically, the Exchange should collect documentation to verify that the qualifying event, regardless of whether the enrollee is required to demonstrate prior coverage.

- **We support the corresponding proposal under §147.104 to align this modification in the prior coverage requirement off-Exchange.** Alignment of SEP requirements across the individual market—both on- and off-Exchange—is critical to avoid potential gaming of SEPs and ensure smooth implementation of one set of rules by issuers. HHS should publish a list of service areas in which no QHPs are offered to ensure issuers apply this policy accurately and consistently in the off-Exchange individual market. This should be the same list that the Exchange uses to verify bare counties for consumers enrolling in Exchange coverage.

**Retroactive Effective Dates for Enrollment Subject to SEP Verification (§155.420(b)(5))**

The pre-enrollment verification (SEP-V) regulations finalized under the 2018 Payment Notice and Market Stabilization rules at §155.420(b)(5) require the Exchange to allow an enrollee the option for a later effective date if SEP-V results in a delayed enrollment that would require payment of two or more months of retroactive premium to effectuate coverage. However, the corresponding effective date and binder payment rules under §155.400(e)(1) create a different set of requirements for retroactivity in this scenario compared to other retroactive scenarios.

**Recommendations:**

- **We recommend the Department align effective date and binder payment rules for all retroactive scenarios to reduce implementation burden for issuers and streamline the enrollment process for consumers.** The current regulations create an overly complex set of rules that an issuer must apply when implementing retroactive effective dates in different scenarios. This requires issuers to interpret the retroactivity scenario to determine the appropriate effective date. It can also lead to confusion for consumers who need to understand the impact of selecting a retroactive effective date.

- **We strongly recommend HHS remove the requirement that issuers determine an effective date based upon the payment amount received from the enrollee.** Specifically, we recommend HHS revise the requirement at 45 CFR 155.400(e)(1)(iii), which requires issuers to interpret the effective date from the payment amount submitted by the enrollee. This rule creates a significant administrative burden for issuers by preventing automation and requiring manual intervention and creates confusion and disruption for consumers. For most issuers, it is operationally complex and, in some cases, not possible to change from a retroactive effective date to a prospective effective date based upon the timing and amount of binder payment. Further, issuers cannot interpret a consumer’s intent from a payment...
amount. Instead, we recommend HHS require that the enrollee return to the Exchange to change to a prospective coverage effective date if they previously elected a retroactive effective date and that HHS work with issuers to define a more workable process going forward.

- **HHS should provide necessary sub-regulatory guidance to support issuer implementation of retroactive effective dates.** Current guidance does not provide sufficient clarity as to how issuers should interpret binder payment and effective date rules, which could lead to issuers inconsistently interpreting the requirements. Clear business rules, definitions, and examples are needed for issuers to accurately implement retroactive effective dates.

I. **Effective Dates for Terminations (§155.430)**

Existing regulations establish a 14-day notice period for enrollee-initiated terminations. HHS proposes to align the effective dates for all enrollee-initiated terminations to the date on which the termination is requested or on another prospective date selected by the enrollee. HHS also proposes to remove the retroactive termination date for enrollees determined newly-eligible for Medicaid, the Children’s Health Insurance Program (CHIP), or a basic health program.

**Recommendations:**

- **We support the proposal for expedited enrollee-initiated terminations but recommend a termination timeframe that is more aligned with current Exchange practices.** We support the objective of closely aligning the effective date of the enrollee-initiated termination with the date of request. The current 14-day termination timeframe can create a frustrating process for consumers. We agree that a same-day termination policy would provide a better consumer experience and reduce the administrative complexity of retroactive terminations. However, current Exchange operations do not support implementation of same-day terminations. In the Federal Exchange, depending on the timing of an enrollee’s request, the Exchange may not send an 834 transaction with the new termination date until the end of the day or the following day. We recommend HHS work with issuers to identify a more realistic timeframe that achieves the same goal of expedited terminations while avoiding the need for issuers and the Exchange to make significant systems changes. For example, we recommend a next-day termination or two-day termination timeframe (from the date of the consumer’s request). If the enrollee does not request an expedited termination, the effective date should default to the end of the month.

VI. **Other Health Insurance Issuer Standards (Part 156)**

A. **User Fees (§156.50)**

For 2019, the Department proposes to maintain the existing user fee of 3.5 percent of total monthly premiums and seeks comment on this percentage. For SBM-FPs, the Department proposes to increase the user fee to 3 percent from the 2 percent amount in effect for the 2018 benefit year.
Recommendations:

- **We recommend greater transparency on spending of the Federal Exchange user fee.**  
  HHS annually collects a user fee based on a percentage of premiums from issuers participating in the Federal Exchange. While the purpose of the user fee is to support Exchange administrative functions, there is no transparency into the collection or allocation of funds to support various Exchange functions. HHS recently announced that it would significantly reduce the outreach, education, and marketing budget for the Federal Exchange for the 2018 plan year. These functions, as well as other functions related to administration of the Exchange, are supported by user fees collected from issuers participating in the Federal Exchange. However, given the complete lack of transparency about the use of the user fee, it is not clear what percentage of the user fee is being applied toward outreach, education, and marketing and how these funds will be reallocated. Further, HHS is preparing to expand the role of direct enrollment in 2019, which would transfer additional Exchange functions to issuers and web brokers, reducing the administrative requirements of the Exchange.

- **We recommend that HHS issue an annual report detailing how funds are applied to support specific Exchange functions, recognizing that user fees do not reflect the totality of Federal Exchange costs.**  
  This report should be used to assess whether the current user fee amount continues to be appropriate for the administrative functions conducted by the Federal Exchange and consider how the user fee may be impacted in the future by the expansion of direct enrollment and the increased transition of administrative functions (e.g., customer service functions) from the Exchange to issuers and web brokers.

**B. Application to Standalone Dental Plans (§156.150)**

Regarding dental plans, the proposed rule removes the requirement that issuers of standalone dental plans (SADPs) meet the low (70 percent +/- 2 percent) and high (80 percent +/- 2 percent) actuarial value (AV) levels. SADPs would continue to be held to the existing out of pocket limits.

**Recommendation:**

- **We support removal of the AV requirement for SADPs.**  
  Eliminating the AV requirement for SADPs will remove the need for SADP issuers to modify plan designs by small amounts on an annual basis in order to align with the AV de minimis range. This will provide SADP issuers more flexibility with plan design and provide consumers more options for dental coverage.

**C. Qualified Health Plan Certification (Subpart C)**

The Department proposes to continue to provide State flexibility in the QHP certification process by deferring to the State for network adequacy, including essential community provider (ECP) reviews, and licensure and good standing. HHS proposes to further rely on State reviews for accreditation requirements, compliance reviews, minimum geographic area of the plan’s service area, and quality improvement strategy reporting. HHS will continue to allow issuers to use the
write-in process to identify ECPs not on the HHS list and will maintain the 20 percent ECP standard and will not require SBE-FP issuers to meet FFE network adequacy and ECP standards.

Recommendation:

- **We support the Department’s proposal to continue and expand upon State flexibility in the QHP certification process to reduce duplicative reviews.** In the Market Stabilization rule, HHS deferred authority to States to conduct additional reviews for QHP certification, including network adequacy and ECP reviews, licensure and good standing, service area, and prescription drug formulary reviews. We support the Department’s efforts to eliminate unnecessary or duplicative reviews and returning authority to States for these reviews as well as the additional reviews proposed in this rule for accreditation requirements, compliance reviews, minimum geographic area, and quality improvement strategies. In addition, we support the continuation of the existing ECP standards. We recommend HHS finalize this as proposed.

D. **Meaningful Difference (§156.298)**

HHS proposes to remove section §156.298 to eliminate the meaningful difference standards for FFEs and SBM-FPs.

Recommendation:

- **We support removal of the meaningful difference requirement beginning for the 2019 plan year.** We agree that removal of this requirement will provide greater flexibility for issuers to develop high-quality, affordable plans that meet consumers’ needs and will remove unnecessary restrictions on issuers.

E. **Other Considerations (82 FR 51111)**

The Department seeks comments on ways to encourage value-based insurance design (VBID), how to encourage high deductible health plans (HDHPs) that can be paired with an (Health Savings Account (HSA)-eligible HDHPs—and how availability of an HSA could be displayed on healthcare.gov. In addition, the Department seeks comments on how it can encourage VBID plan designs that focus on cost-effective drug tiering structures, address overused higher-cost healthcare services, provide innovative network design that incentivizes enrollees to use higher quality care, and promote use of preventive care and wellness services.

Recommendations:

- **We share the Department’s goal of encouraging VBID within the individual and small group markets and using cost sharing to incentivize more cost-effective enrollee behavior and higher quality health outcomes.** We recommend HHS take the following actions to help foster greater use and utility of value-based insurance design in the individual and small group markets:
  
  o **Expand the list of preventive care services to include the option to manage chronic conditions.** A HDHP is a plan that meets the requirements of Section
223(c) of the Internal Revenue Code, detailing minimum deductibles and maximum out-of-pocket expenses. It is these plans alone that may be paired with an HSA. The general rule is that an HDHP may not pay for benefits in any plan year until the minimum deductible for that year has been satisfied. There is an exception to that rule, however, in the form of the preventive care safe harbor. Under this safe harbor, HDHPs may voluntarily provide coverage for preventive services before an individual consumer satisfies the minimum deductible. Preventive services are those determined either (a) pursuant to section 1871 of the Social Security Act or (b) as provided for by the Secretary of the Treasury. Treasury was given the authority to expand the definition of preventive services as the best practices of the health care industry evolved. Value based insurance design is an excellent example of evolving best practices, and the safe harbor should be updated to allow for utilization of VBID principles in the individual and group markets. For VBID to succeed in practice, the safe harbor must include the management of chronic conditions. This is an essential part of preventing further complications and comorbidities that arise from chronic health conditions and critical to reducing costs through VBID principles. High-value services that manage chronic conditions could then, at a plan’s discretion, be covered before a minimum deductible is satisfied thereby reducing or eliminating the barrier to seeking high value care.

- **Allow for adjustments to cost-sharing rates to discourage low-value services.** While allowing for plans to apply VBID principles to chronic health conditions, the cost savings achievable through these principles require a carrot and stick approach. The reduced or eliminated cost-sharing for high-value services must be paired with disincentives to pursue low-value services – i.e., those that demonstrate minimal clinical benefit. Determining low-value services is a function of clinical-effectiveness and cost-effectiveness evaluations and expertise, which recognize that health care utility varies depending on who receives care, who provides care, and where that care is provided. For both HDHPs and traditional plans, HHS should allow for otherwise uniform cost sharing (i.e., co-pays and co-insurance) to be increased when a service is deemed to be of low clinical value.

- **Signal to the consumer the availability of HSA-eligible plans.** The Notice helpfully recognizes that there are technical barriers for issuers choosing to offer HDHPs on the Marketplace. Neither the benefits of HSAs nor those of VBID can be fully realized if consumers are unaware of the nature of the plan in which they are enrolled or are not directed towards a plan that could meet their health needs while saving money. Some options for highlighting the availability of HDHPs to Marketplace consumers include a pop-up message prior to browsing, color-coding or visual icons to indicate an HDHP option. In addition to being better signaled that a plan is an HDHP, most consumers would likely benefit from basic education on what it means to be enrolled in an HDHP. The Marketplace comparison and shopping panels could be adjusted to include written text, visuals or video that explains the fundamentals of HDHPs. Navigators may also benefit
from additional training on HDHPs and how to explain the pros and cons to an interested consumer.

- **Allow for notices and the Exchange website to detail the VBID benefits of a plan.** Like HDHP plans, VBID plans face challenges in alerting consumers of the unique plan features. For VBID to succeed in individual and small group plans, those who have chronic health conditions or at high risk for certain conditions aided by preventive interventions need assistance in understanding the benefits of VBID compliant plans. Through healthcare.gov, plan notices, or other documents, consumers should be presented information in clear, simple terms that their plan includes reduced or eliminated cost-sharing requirements for certain high-value services. For example, if a plan eliminated cost sharing for eye exams for patients with diabetes, those patients would need to know that their plan had no cost-sharing for this high-value service. The QHP Plans and Benefits template should be modified to allow, but not require, notes so that issuers can easily describe the VBID features of a plan.

- **Existing Tri-Agency guidance limits the use of reference-based pricing, which is an effective plan design tool to address overused, higher cost health services.** We recommend HHS rescind the 2014 sub-regulatory guidance that limits the applicability of reference-based pricing.\(^4\) In general, reference-based pricing allows purchasers to set a maximum allowed payment amount—i.e., a reference price—for a specific medical service or procedure in a specific market. If enrollees receive care at a facility that has an allowed amount above the reference price, the enrollee must pay the additional amount out of pocket. AHIP’s members utilize reference-based pricing strategies on behalf of employer customers today and are evaluating additional uses in the future. Evidence from existing reference-based pricing efforts demonstrates the value of providing incentives for patients to choose health care services from providers that deliver quality care at lower costs. We strongly believe the Departments should not restrict the use of reference-based pricing strategies that promote value in our health care system and help keep premiums and co-payments affordable for all Americans. AHIP recommends the Departments clarify that insurers in the individual and group markets should be allowed to treat health care providers that accept a reference price for a service or procedure as the only in-network providers for such health care.

**F. Quality Rating System (§156.1120)**

The Department does not propose changes to the Quality Rating System (QRS) at this time but continues to evaluate what method or combination of methods would be most appropriate for accounting for social risk factors in the QRS as well as other HHS quality rating programs. HHS seeks comment on the types of social risk factors that could be employed without masking potential disparities or minimizing incentives to improve outcomes for disadvantaged populations. Examples discussed include low-income subsidy, race and ethnicity, and

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geographic area of residence. Approaches discussed include stratifying measures sources or risk adjustment of a particular measure.

Recommendations:

- **We commend HHS for pursuing a meaningful, long-term solution to account for disparities in quality measurement resulting from social risk factors and other beneficiary-level characteristics, such as geographic area and other social determinants of health.** We encourage HHS to work with ASPE in addressing this important issue. We are committed to working closely with HHS, our industry, and other stakeholders to advance our collective policy goals in this area.

- **We recommend that HHS develop and test a robust methodology that uses a combination of factors to account for social risk, including race, ethnicity, income, geographic area of residence, low-income subsidy eligibility status (e.g., CSR eligibility), and other emerging risk factors such as gender identity.** QHP issuers currently do not have reliable data on the race and ethnicity of their enrollees as these factors are not required fields on the Exchange application and are not always included on the enrollment file.

- **We encourage HHS to provide more information on its efforts to address QRS issues, including a work plan and timeline.** Any proposals should provide enough information about potential adjustments to enable plans and other stakeholders to understand how it is determined and the validity of its results. We recommend HHS provide clarification on whether the results produced by accounting for social risk will be made public or if it intends to use those results for internal adjustment only. We also recommend that HHS provide more detail on whether it intends to use social risk factors to directly adjust QRS star ratings. We encourage HHS to increase opportunities for collaboration across all HHS quality rating programs, including the Exchange QRS, Medicare Advantage and Medicaid health plans, as this issue is of critical importance to our members and the at-risk beneficiaries they serve.

VII. **Market Reforms**

A. **Small Group Coverage Effective Dates (§147.104)**

HHS proposes to update § 147.104(b)(1)(i)(C) to explicitly state that for a small group plan selection received by the fifteenth of the month, the effective date “must” be the first day of the following month unless the employer chooses a later effective date. In some cases, health plans may be able to effectuate small group coverage on the first of the next month when the employer’s plan selection is completed later than the fifteenth of the previous month.

**Recommendation:**

- **We recommend the Department allow, but not require, health plans to effectuate coverage on the first of the month for small group plan selections received later than the fifteenth of the previous month.** Health plans should be permitted to effectuate
small group coverage on the first of the next month for a plan selection received later than the fifteenth of the previous month in accordance with state law, as applicable. This option should be permitted on the condition that the health plan apply the same application deadlines and effective dates for all employers applying for small group coverage.