COLORADO CENTER
on LAW & POLICY
Forging Pathways from Poverty

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Patrick Conway
Acting Administrator
Centers for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Comments on CMS-9929-P, Market Stabilization Rule

Dear Acting Administrator Conway:

Thank you for the opportunity to comment on the proposed market stabilization rule issued by the U.S. Department of Health and Human Services (HHS). The Colorado Center on Law and Policy is a nonprofit, nonpartisan organization that is dedicated to promoting economic security and access to affordable health care for low-income Coloradans. The Colorado Cross-Disability Coalition, Colorado's premier disability-rights advocacy organization, joins these comments.

Introductory comments

The proposed regulatory changes in CMS-9929-P are in theory geared toward stabilizing the health insurance market. However, we are concerned that the rule exceeds HHS authority in some respects, that the agency has curtailed stakeholder input by limiting the public comment period, that the short timeline for implementation is inadequate, and that even the agency concedes that prospective gains are speculative (Rule, p. 60993, col.3, ¶1; p. 10995, col. 1, ¶4, col. 2, ¶2, col. 3, ¶2; p. 10996, col.1, ¶3 et seq.). We would add that the rule would appear to decrease affordability, and would interfere with consumers' ability to assess and compare plans and get the level of coverage they need.

Enrollment in coverage through Colorado's state-based exchange, Connect for Health Colorado, is 12% above last year's level. The exchange, a quasi-governmental entity that currently receives no state general funds, has continued to solidify its financial footing while improving enrollment processes, and the proposed changes will have negative effects on both the exchange finances and its ability to function as a source of coverage and consumer information about insurance. In general, we believe the changes proposed and the compressed timeline for effectuating those changes, are in fact likely to destabilize the market, decrease enrollment, worsen the risk pool, make the shopping process more opaque, and lead to higher and less predictable out-of-pocket costs. A rule that makes coverage less affordable and reduces enrollment would be impermissibly inconsistent with the purpose of the statute.

If the Administration's goal is to stabilize the market, this could be best achieved through two different actions: first, by enforcing the individual mandate and second, by zealously supporting the continued availability of existing levels of cost-sharing reductions and premium tax credits for 2018 and beyond.

Regarding specific sections of the proposed rules, the Colorado Center on Law and Policy submits the following comments.

1. Guaranteed availability of coverage (45 CFR §147.104)

Proposed language would permit carriers to refuse coverage to certain enrollees. As described in the Proposed Rule, the issuer could apply a premium in the new plan year to outstanding debt in the prior year, and refuse to effectuate coverage. We believe that HHS lacks legal authority to issue rules that change ACA provisions on guaranteed availability.

Beyond the lack of legal authority, the proposed solution – denial of coverage – will neither stabilize the market nor improve the risk pool. Rather, it may deter younger, healthier consumers from getting coverage. In addition, the proposed solution will have a disproportionate impact in the fourteen primarily-rural Colorado counties that have above-average premium costs and a single carrier. It will penalize enrollees who encountered accounting irregularities, including premium billing errors, as well as those who got new coverage through employment and did not formally cancel prior coverage. And last, it will result in some consumers incurring medical costs early in the new plan year under the mistaken belief that coverage has been effectuated.

The expressed concern about potential gaming on the part of enrollees is speculative, and we suggest that data collection and analysis should be a prerequisite to taking corrective steps. If HHS moves forward on changes to guaranteed availability, we propose that issuers instead be permitted to effectuate coverage and recoup outstanding payments through an installment plan. At a minimum, consumers must be provided with notice during the current plan year that missing premium payments may result in their being denied future coverage. For 2018 enrollment, consumers should also be given advance notice that coverage will not be effectuated in the following year until debt is repaid.

2. Initial and annual open enrollment periods (45 CFR §155.410)

We recognize the benefit of getting greater numbers of enrollees into coverage as of January of the plan year, but are concerned that truncating the enrollment period will significantly depress enrollment, particularly because the proposed rule provides inadequate time for implementation. No basis is given for the assertion that the current enrollment period results in adverse selection because less healthy individuals sign up late in open enrollment. Rather, it is equally or more likely that the numbers of younger and healthier enrollees, who in Colorado typically enroll late in open enrollment, will be reduced and that the risk pool will worsen as a result. In addition, the reduction of time for open enrollment is likely to result in additional costs to our exchange budget and state budget, for reasons described below. As such, this may amount to an unfunded mandate.

A six-week enrollment period will burden our state exchange, Connect for Health, doubling the load on processing systems, on exchange staff, and on the assisters and brokers who have typically had many additional weeks to help customers enroll. Because Colorado has developed a shared eligibility system (SES) that relies on the state's benefit management system (CBMS) to determine Medicaid eligibility, the burden will be on not just the exchange, but on the state Medicaid system. Preparing for the additional load will entail additional staff time and expenditure of funds for enhanced IT, and could interfere with timely determinations for Medicaid and CHIP for Colorado's most vulnerable residents. We understand that the Federal Data Services Hub already experiences "time-outs" during peak use times, and expect that problem to be intensified with the abbreviated open enrollment, causing further delays. The expected delays in determining real-time eligibility could cause many consumers to miss the open enrollment window; unless rules stipulate that applications must pend until eligibility determinations are complete, the expected delays could effectively exclude some consumers from coverage for as much as a year.

The need for "extensive outreach to ensure that all consumers are aware of this [calendar] change" will also increase costs for both our exchange and our assister and broker communities (Rule, p. 10984, col. 2, ¶1). No funds have been provided, to our knowledge, for state efforts in this area. An additional complication is that contracting for assister activities for the next open enrollment is now underway, but terms of those contracts are now thrown into question. Some potential customers will undoubtedly be caught unawares and miss the opportunity to get covered.

Based on the foregoing, we expect reduced enrollment in exchange plans and significant additional costs to our state exchange and state Medicaid system, and strongly oppose the change for the 2018 enrollment period.

3. Special enrollment periods (45 CFR §155.420)

After a stakeholder process in the fall of 2016, Connect for Health Colorado agreed to conduct a pilot program to evaluate whether requiring verification for different types of SEPs would be beneficial. This decision followed the CMS announcement of its own plan[1] to test whether pre-enrollment verification would affect the risk pool, and the decision of Covered California to sample consumers regarding documentation of a SEP.[2]

No changes should be made to the SEP enrollment process unless data resulting from these processes supports a documentation requirement for specific SEPs. Currently, the evidence of gaming in the SEP enrollment is anecdotal at best; reliable data should be the basis of any change. Analysis of data from these pilots would allow more efficient use of document verification processes, ensuring that those processes are applied only to SEP categories that show evidence of gaming. In addition, states like Colorado that operate a

[1] Pre-Enrollment Verification for Special Enrollment Periods. Available at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf

[2] 2017 Special Enrollment Verification Quick Guide for Certified Enrollers. Available at: http://hbex.coveredca.com/toolkit/pdfs/Special-Enrollment-Verification-Quick-Guide-Final.pdf

state-based exchange should retain the choice as to whether or not to implement a verification system for SEPs, and should be able to choose a schedule for implementation that works for the state. For 2018, we strongly support Colorado having the option to use available data on SEPs prior to instituting any change in verification processes.

Currently, SEPs are under-utilized.[3] The SEP-eligible pool includes many younger and healthier people who are likely to encounter SEP opportunities such as marriage, geographical moves, and the birth of a child, and requiring additional paperwork creates a deterrent to enrollment. Bringing in more SEP-eligible enrollees would likely improve the risk pool; requiring additional documentation will have the opposite effect, and limit the SEP group to the most motivated enrollees – those who have the greatest health care needs.

Continuous coverage requirements for some SEPs would violate the statutory provisions on guaranteed issue. As currently framed, proposals regarding continuous coverage would create significant obstacles to enrollment, especially for American Indian and Alaska Native applicants, lower-income enrollees, and those with pre-existing conditions. We believe that the proposals outlined in the preamble would reduce enrollment in coverage, especially among healthier people, and therefore oppose those options.

Concerns about the risk pool being skewed by those who seek coverage only when sick are most appropriately addressed through enforcement of the individual mandate.

a. Document verification

We appreciate the proposal that SEPs should be verified wherever possible through electronic means, and where documentation is necessary, the establishment of a 30-day period for submission of documents. Consumers who need additional time to submit documents should be able to request an extension; without the possibility of an extension, eligible applicants who encounter obstacles to gathering documentation may time out of their SEP period and be locked out of coverage. In order to prevent consumers from going without coverage for an extended period, we also request that the exchange be required to review documents and determine eligibility within 15 days, and to grant the SEP if not determination is made timely.

b. Changes in metal levels

The guaranteed issue provision requires issuers to "accept every employer and individual in the State that applies for such coverage." (42 U.S.C. § 300gg–1). We note as well that the proposals that limit access to coverage and restrict consumers' plan options to a particular tier contradict prefatory comments that a stabilized market "will depend on greater choice to draw consumers to the market" and presumably to retain them (p. 10981, col. 1, ¶ 3). In circumstances like marriage or the birth or adoption of a

[3] Stan Dorn. "Helping Special Enrollment Periods Work Under the Affordable Care Act." June 2016. Urban Institute. Available at: http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf

child, changing metal levels could make be necessary because of coverage needs and available funds. We oppose the proposal to prohibit consumers from changing metal levels mid-year through a SEP. In the case of Colorado and other SBE states, we support states having choice as to whether to adopt this or similar restrictions.

c. Payment of past premiums

We oppose the proposal that issuers be permitted to reject SEP applicants who have been previously terminated due to non-payment of premiums. As stated earlier, accounting and billing errors are fairly common nationally and here in Colorado, with approximately 10% of signups in 2015 involving such problems.[4] This policy will also affect rural Coloradans disproportionately, since rural counties are most likely to have a single carrier. At a minimum, carriers should be required to offer a repayment plan along with the offer of new coverage.

4. Actuarial value (45 CFR §156.140)

We oppose the proposed changes to the actuarial values of the metal levels. The primary effect of lowering AV by 2 points will be to shift costs to consumers, who are likely to receive a smaller premium tax credit and will see increased out-of-pocket costs. One analysis of a sample silver plan suggested that deductibles could increase by more than $1000.[5] The proposal exceeds HHS' regulatory authority, which is limited by statute. 42 USC §18022(d)(3).

Secondary effects include the necessity for later plan filing and finalization dates that give the state exchange less time to derive PTC, load and post plans, and test processes. This requires staff time and additional costs, and increases the risk of a rocky roll-out. If carriers make widespread changes to their plans to take advantage of the new AV, fewer consumers will be able to re-enroll in the plan that worked for them in 2017.

Last, changes to the actuarial values will mislead consumers, who rely on the premise that metal tiers are meaningful indications of value. Consumers will be unable to assess plans within and across metal levels. With these AV changes, potential enrollees will face less coverage for the same cost; future skepticism about how carriers' design and present products, and how exchanges display them, would be justified.

In sum, we believe changes in AV would reduce enrollment, especially for healthier individuals, and risk pools would worsen. We strongly oppose any change, but if some adjustment is allowed, we suggest that it be limited to the bronze level, so that premium tax credits are not affected.

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[4] John Daley. The State of Colorado's Health Exchange: Progress, Plus Problems. CPR News. June 11, 2015. Available at: http://www.cpr.org/news/story/state-colorados-health-exchange-progress-plus-problems

[5] Lydia Mitts, Caitlin Morris, and Liz Hagan, President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense. Families USA, February 15, 2017. Available at: http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

5. Network adequacy (45 CFR §156.230)

Colorado engaged in a rigorous stakeholder process during 2016 to develop stronger network adequacy regulations, including requirements for inclusion of 30% of Essential Community Providers (ECP) in a plan's service area, and we support states retaining authority to regulate networks.

We would oppose use of the default standard, accreditation by an HHS-recognized accrediting entity, as insufficient to address concerns about narrowing of networks[6] and the effect on access to specialty and hospital care.[7] We would also oppose reducing the ECP to 20% from 30%. A reduction in the number of Federally Qualified Health Centers, Ryan White provider, family planning providers, and Indian health care providers in plan networks would reduce access to care for specific populations, including American Indians, African-Americans, Latinos, LGBT individuals, and women.

Conclusion

Thank you for consideration of our comments. If you have any questions, please contact Bethany Pray, bpray@cclponline.org.

Very truly yours,

Bethany Pray

[6] Donald Trump Issues Health Care Mission Statement. November 11, 2016. Managed Care Magazine. Available at: https://www.managedcaremag.com/news/donald-trump-issues-health-care-mission-statement

[7] Stephen Dorner, Douglas Jacobs, Benjamin Sommers. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. JAMA. October 27, 2015. Available at: http://jamanetwork.com/journals/jama/fullarticle/2466113