



**COMMENTS to the Centers for Medicare & Medicaid Services, Department of Health  
and Human Services, CMS-9930-P  
RE: HHS Notice of Benefit and Payment Parameters for 2019  
Submitted by Community Catalyst  
November 27, 2017**

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) in response to the Notice of Benefit and Payment Parameters for 2019, released October 27, 2017.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

We appreciate the opportunity to provide comments to the proposed Benefit and Payment Parameters for 2019. However, we are concerned by the compression of the public comment period to less than 30 days from the date of publication in the Federal Register. Such a short public comment period for a proposed rule that makes considerable changes to many areas of the Affordable Care Act (ACA) does not leave enough time for consumers, advocates and other stakeholders to meaningfully comment. In future rulemaking, we urge HHS to adopt a comment period of at least 30 days from rule publication and to fully comply with notice and comment requirements under the Administrative Procedure Act.

Overall, we are concerned that the proposed changes in this rule would undermine important consumer protections in the ACA, such as those regarding access to Navigators, health insurance rate review, the medical loss ratio (MLR), and essential health benefits (EHBs). These programs work in concert to ensure that consumers have access to affordable coverage with a baseline of critical services covered. Taken as a whole, we believe the proposed changes would negatively impact consumers shopping in the nongroup and small group markets in the following ways:

- Diminish the value of health insurance offered to consumers;
- Complicate purchasing insurance for consumers seeking to make the most appropriate purchasing decision for themselves and their families;
- Make the quality of coverage dependent upon the state where a consumer lives.

Our full comments to the proposed changes are below.

## **Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act**

### **§ 153.320 – Proposed Updates to the Risk Adjustment Model**

In the proposed rule, HHS provides authority to states to reduce the magnitude of risk adjustment charges for some insurers by requesting a percentage adjustment (up to 43 percent) in the calculation of risk adjustment transfer amounts in their small group market. **We urge HHS to set a much lower limit on the allowable percentage adjustment.** We understand that some smaller insurers and co-ops have faced significant charges in the nongroup market as a percentage of their premiums, and understand the need for some states to reduce the amount of transfers that can be made to minimize disruptions. However, adjustments of this magnitude go too far. Adjustments of up to 43 percent would substantially mute the disincentive for carriers to cherry-pick the healthiest that is otherwise created by the risk adjustment program, and generally undermine the program’s effectiveness.

HHS also indicated that they are also exploring allowing states to reduce these charges in the individual market as well. **For the reasons laid out above, and because the individual market lends itself even more to cherry-picking, we are opposed to allowing this kind of adjustment in the risk adjustment program in the individual market.**

## **Part 154 - Health Insurance Issuer Rate Increases: Disclosure and Review Requirements**

Comprehensive review of health insurance rates and rate filing justifications plays a key role in ensuring that consumers pay a fair price for their health insurance coverage. This process is a key consumer protection. Therefore, ***we strongly oppose the following proposed changes to the rate review process:***

- *Increasing the threshold for review of “unreasonable” premium increases from the current ten percent to fifteen percent;*
- *Allowing for different timelines by which insurers of QHPs and of non-QHPs must submit completed rate filing justification to HHS or the state; and*
- *Allowing effective rate review states to post proposed and final rate filing information on a rolling basis.*

### **§ 154.200 - Rate Increases Subject to Review**

**We strongly oppose HHS’s proposal to increase the threshold for review of “unreasonable” premium increases from the current ten percent to fifteen percent.** Maintaining strong, consistent regulatory review over double-digit rate increases – especially at a time when HHS and Congress continue to consider changes that will likely increase premiums – is vital to ensuring that exchange enrollees have access to affordable health insurance. The purported justification for this increase – that there have been significant rate increases in the past few years – should be reason to strengthen, not weaken, the threshold for review. We are extremely worried that increasing the threshold would send a signal that normalizes double-digit rate increases and further jeopardize the affordability of exchange plans.

If finalized, this proposal would also mean fewer plans would be required to submit a narrative justification for their rates. This would result in less transparency in the rate-setting process, since the narrative justification provides important information to consumers about why their rates are increasing. Moreover, the proposal to stop publishing a notice indicating which thresholds apply to which states will further reduce transparency in an already-opaque process.

### **§ 154.301 and §154.220 – Timing of Providing the Rate Filing Justification; Determination of Effective Rate Review Programs**

**We oppose HHS’s proposal to allow for different timelines by which insurers of QHPs and of non-QHPs must submit completed rate filing justifications to HHS or the state.**

Establishing a uniform timeline has increased transparency and, while dependent on state adherence to the timeline, added a level of predictability that has helped to increase awareness about the rate review process and public comment periods. Rate review has not been a topic that has historically received a great deal of public participation, and we believe that moving toward more uniformity in the markets across state lines will help increase public understanding and ability to comment on the rate review process. For the same reasons we also **oppose the proposal to allow effective rate review states to post proposed and final rate filing information on a rolling basis.** This proposal would also make the rate review process much more difficult to follow, create confusion among consumers, and create more barriers to public participation in the rate review process.

### **Part 155 - Exchange Establishment Standards and Other Related Standards under the Affordable Care Act**

We believe that modifications to how the exchanges function, including the standards for plans sold on the exchange, should aim to simplify the enrollment process and ensure that consumers are able to find the best coverage available to them and their families. Therefore, in particular, *we oppose the following proposed changes:*

- *Elimination of the standardized plan option;*
- *Removal of federal oversight and enforcement of network adequacy and essential community provider standards; and*
- *Scaled-back standards in the Navigator program.*

### **§155.20 – Standardized Plan Options**

**We urge HHS not to adopt the proposal to end the sale of standardized plan option designs.** HHS states its reasons for doing so are to “encourage free market principles” in the individual market, and out of concern that standardized plan offerings with differential displays may have previously limited enrollment in non-standardized plans, and therefore discouraged insurers from offering “innovative” plan designs or otherwise participating in the market. We believe that standardized plan options are important to offer on the individual market for several reasons and therefore urge HHS not to adopt this proposal and instead continue to provide these options in the individual market.

Standardized plans can help ease the information overload that can often occur when consumers are presented with many coverage options to weigh. Research confirms that individuals who are presented with too many choices are often less likely to make decisions.<sup>1</sup> Offering standardized plan options with uniform cost-sharing requirements and benefit designs presents consumers with less factors to compare and can therefore help them make a final plan selection. Moreover, helping individuals choose a plan, and thereby maximizing enrollment in the individual market in the process, is one of the primary ways to ensure its stability and viability. Not only that, but individuals who are younger and healthier individuals are less likely to need as much or as detailed health plan information to compare, and therefore are most likely to take advantage of and benefit from the offering of standardized plans and their differential display. **Thus, while HHS believes that discontinuing the standardized plan option will strengthen the individual market, we believe the opposite is true, and therefore urge HHS to continue to make this option available.**

### **§155.106 and §155.200 – Flexibility for State-based Exchanges and State-based Exchanges on the Federal Platform**

HHS seeks to support state-based Exchange (SBE) efforts to utilize commercial platform services when developing its exchange website and performing other exchange functions, as well as explore strategies to make the state-based exchange on the federal platform (SBE-FP) model more appealing and viable to states with federally-facilitated exchanges (FFE). While in general we do not object to FFE states transitioning to SBE-FP or SBE models, we ask that any commercial platform HHS allows states to use contain the same consumer protections and offer the same services as HealthCare.gov, both to minimize consumer confusion and ensure smooth transitions for enrollees from one platform to the next. **We strongly believe the HealthCare.gov platform standard should serve as a floor for SBE-FP and SBE states to build upon rather than a ceiling.** Any alternative commercial platform or transition of authority or responsibility to the state during an exchange web-based platform transition should strengthen the consumer experience to facilitate enrollment easily and strengthen the individual market.

### **§155.200 – Functions of an Exchange**

Overall, and as mentioned in more detail below, **we strongly urge HHS to continue their role in oversight and enforcement of network adequacy and essential community provider standards** to ensure a sufficient choice of providers and to provide information on the availability of network and out-of-network providers. HHS is proposing to eliminate requirements that SBE-FPs enforce FFE standards for network adequacy and essential community providers (ECPs), and instead allow SBE-FPs to have the flexibility to determine how to implement the network adequacy and ECP standards for their exchange. Additionally, HHS is removing the requirement that SBE-FPs establish and oversee network adequacy and ECP standards that are no less strict than the federal standards. In 2019 and beyond, HHS is proposing to have FFE states rely on state review of network adequacy standards, in states that

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<sup>1</sup> Simona Botti and Sheena S. Iyengar (2006) The Dark Side of Choice: When Choice Impairs Social Welfare. *Journal of Public Policy & Marketing*: Spring 2006, Vol. 25, No. 1, pp. 24-38.

have been found to have an adequate review process. We strongly believe that federal standards should continue to serve as a floor of protection and that state's should have the flexibility to strengthen standards for network adequacy and ECPs. Any flexibility to adhere to weaker standards would be harmful to consumers.

### **§ 155.210 – Navigator Program Standards**

We are deeply concerned about the proposed rule's changes to scale back the Navigator program. We strongly believe that continued investment in the Navigator and Certified Application Counselor programs is critical to promoting a healthy risk pool and ensuring that consumers, especially those who are low-income, enroll in a plan that best suits their needs. HHS states its reasoning for these change is that it will allow for improved flexibility for exchanges to award funding to the number and type of entities most appropriate for the state, as well as for the exchange to optimally use the funding amounts available, which may include selecting a single, high-performing grantee. However, we believe that community and consumer-focused nonprofit groups and groups that are physically located in the state to provide in-person support are necessary to the enrollment process.

*Therefore, we urge HHS to forgo the proposed changes and maintain the following current standards:*

- *Each exchange must have at least two Navigator organizations;*
- *At least one of the Navigator Programs must be a community and consumer-focused nonprofit group; and*
- *Each Navigator Program must maintain a physical presence in the exchange service areas.*

For example, community and consumer-focused nonprofits, such as churches and social service organizations, oftentimes already possess a strong understanding of and relationship to the communities they serve, making them uniquely positioned to reach uninsured individuals and offer this population information and counseling from a trusted source. In the third open enrollment period, almost half of all exchange enrollees received assistance from an in-person assister, with 8 in 10 reporting<sup>2</sup> they went to an assister because they did not feel confident enrolling on their own. Additionally, the longstanding community ties that many of these organizations already have has allowed them to offer and develop services unique to their communities, such as services in languages other than English, translation or transportation services.

While HHS recognizes that “entities with a physical presence and strong relationships in their service areas tend to deliver the most effective outreach and enrollment results,” the agency also believes that each exchange is best suited to determining whether or how having a physical presence within a state would help a Navigator entity achieve its goals. We understand HHS’s stated goal of ensuring the strongest applicants are selected to be Navigators and understand additional flexibility within the Navigator program may help some exchanges reach their

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<sup>2</sup> Kaiser Family Foundation, 2016 Survey of Health Insurance Marketplace Assister Programs and Brokers, June 8, 2016: <https://www.kff.org/report-section/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers-section-1-assister-programs-characteristics-and-people-helped/>

remaining uninsured population. However, we believe the Navigator programs should still meet certain standards so that they can perform their intended goals to the greatest extent possible. We believe that the proposed changes, coupled with the 40 percent cut in funding to Navigators this year, will likely result in few Navigator options and potentially no in-person enrollment assistance from a navigator or certified application counselor, which will hurt consumers and their ability to successfully enroll in a plan that meets their needs. **Therefore, we urge HHS to reconsider the proposed changes and maintain the current requirements.**

### **§155.305 – Eligibility Standards**

We are very concerned to see that HHS is proposing to remove the requirement that an exchange must provide direct notice to the tax filer informing him or her that APTCs will be discontinued beginning January 1 for failing to file a federal tax return and reconcile APTCs received in a previous year. HHS believes this requirement is already met by the current practice of notifying the household contact listed on a HealthCare.gov application, rather than the exact tax filer. HHS states that “in cases where the household contact has not been the tax filer, because the notification has been clear that it concerns APTC eligibility, we expect that the household contact likely has shared the notice with the tax filer on whose behalf APTC was paid.” **We believe this is a misguided assumption that assumes all household contacts and taxpayers on an application can readily and easily communicate with one another, which overlooks the reality of many relationships and household makeups.** There are many instances in which a household contact may be unable to communicate with the taxpayer or vice versa, such as if the household contact dies, experiences a medical emergency or other type of emergency that renders him or her unable to communicate, or otherwise becomes unable to communicate with the taxpayer, such as through separation, divorce, domestic violence or spousal abandonment. **Indeed, we believe requiring survivors of domestic violence to communicate with their abuser in order to continue their exchange coverage is an unfair and dangerous requirement that would put the health, wellbeing and lives of these individuals at risk.**

Additionally, while HHS states that removing this requirement would reduce burdens on exchanges, we believe that sending notices directly to taxpayers is a small price to pay to be able to provide these individuals with the notice and information needed to allow them to continue their coverage.

### **§ 155.320 - Income inconsistencies**

**We urge HHS not to finalize the proposed new income inconsistency category** for applicants who attest to having an annual income above 100% FPL on their application, but trusted federal income data sources reflect an annual income below 100% FPL. Currently, income inconsistencies are only triggered when an applicant attests to having annual income that is 25% or \$6,000 lower (whichever is greater) than what’s reflected in trusted data sources.

This new income inconsistency category is presumably an attempt to prevent individuals who are ineligible for APTCs due to having incomes below 100% FPL from initially receiving them. However, our experience working with enrollment stakeholders over the last few years has shown that the income inconsistency process is often inefficient and ineffective, imposing an



immense administrative burden on both individuals and exchanges and often resulting in eligible individuals erroneously losing coverage or financial assistance. At a time when HHS is seeking to reduce burdens for exchanges as well as seek ways to strengthen the individual market, we believe instituting a new income inconsistency process would only hinder these important goals and therefore urge HHS not to finalize this proposal.

### **Verification of eligibility for employer-sponsored coverage**

HHS proposes to allow exchanges to conduct an HHS-approved alternative process for verifying attestations of access employer-sponsored insurance (ESI). If HHS finalizes the proposal to codify an optional and piloted alternative called “sampling” – in which the exchange may contact a sample of employers who have employees enrolled in exchange coverage with APTCs by telephone and ask whether the specified employees were also enrolled in a qualifying employer-sponsored plan or were offered the opportunity to enroll in the plan – then **we ask that HHS undertake the following recommendations:**

- Exchange personnel tasked with implementing the sampling process should be sufficiently trained on screening for whether the coverage is affordable to the employee and meets minimum value.
- Privacy guidelines and training should be provided to exchange personnel so that the privacy and security of survivors of domestic violence are protected when exchange personnel contact an applicant’s employer.
- Additional guidance and resources should be provided to consumers, assisters, agents/brokers, HealthCare.gov Call Center staff and employers on how to obtain and provide information regarding whether an offer of employer-sponsored insurance is affordable and meets minimum value, including providing guidance on how to complete the Employer Coverage Tool.<sup>3</sup>

### **§ 155.420 – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans**

We appreciate HHS’s clarification of when dependents newly enrolling in exchange coverage can be added to an enrollee’s plan, and whether and when the enrollee and dependent can enroll in a new or separate QHP. For example, if a dependent is newly enrolling in coverage, an enrollee may either add the dependent to his or her existing plan or enroll the new dependent in a separate QHP at any metal level. However, if both an enrollee and a new dependent qualify for a SEP, the enrollee can either add the dependent to his or her plan or use the SEP to switch to a new metal level.

We further support HHS amending the SEP rules to provide an exemption to the prior coverage requirement, defined as the requirement that applicants for certain SEPs demonstrate having had prior coverage for at least one day in the 60 days prior to the qualifying event, for individuals in service areas where no QHPs are offered through the exchange. We agree with HHS that individuals in this situation should not later be prevented from enrolling in coverage when they were previously unable to enroll in exchange coverage because it was unavailable or

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<sup>3</sup> <https://www.healthcare.gov/downloads/employer-coverage-tool.pdf>

inaccessible. We further support HHS applying this requirement to the individual market outside the exchange so that insurers offering coverage outside an exchange could not require individuals to demonstrate prior coverage if they lived for at least 1 of the 60 days prior to their qualifying event in a service area with no exchange plans. Lastly, we support HHS clarifying that pregnant women who lose CHIP coverage are eligible for the loss of coverage SEP, similar to pregnant women losing pregnancy-related Medicaid coverage.

#### **§ 155.430 – Effective Dates for Termination.**

Overall, we support HHS’s decision to remove the 14-day notice requirement for termination of exchange coverage, particularly if insurers are reporting they do not need 14 days to process terminations and can process these requests in much earlier time. We further support the desire to streamline the termination policy so that exchange coverage can be terminated either on the same day the enrollee requests the termination or on a prospective date requested by the enrollee. **However, we disagree with the decision to remove the option for enrollees to request termination of coverage when they are determined eligible for Medicaid to the date before the Medicaid eligibility determination.** We believe allowing retroactive coverage terminations for enrollees who transition between the exchange and Medicaid is the best way to ensure these enrollees do not end up liable for APTC repayment. Therefore, we urge HHS to continue this policy.

#### **§ 155.6057 – Eligibility Standards for Exemptions**

We support HHS’s proposal to amend the definition of the affordability exemption based on projected income so that exchanges may use the annual premium for the lowest-cost exchange metal level plan available in the exchange rather than the lowest-cost bronze plan in the exchange, particularly if there is no bronze-level plan sold through that rating area. We agree with HHS that allowing the exchange to use the lowest-cost metal level plan available will best allow these individuals to qualify for an exemption.

### **Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges**

#### **§ 156.111 and § 156.115 - State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019 and Provision of EHB**

##### **Essential Health Benefits**

For the nearly 133 million consumers with a preexisting condition, access to comprehensive health insurance is critical.<sup>4</sup> For these consumers—and the millions more who may develop a medical condition or need treatment in the future—the Affordable Care Act’s (ACA’s) essential health benefits (EHB) requirements greatly improved the adequacy of individual market health insurance, requiring some plans to cover prescription drugs for the first time and key services

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<sup>4</sup> Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act, U.S. Department of Health and Human Services (2017).



such as treatment for substance use disorders. Prior to the passage of the ACA, individuals and families who purchased coverage in the individual market did not have coverage for many critical services. For example, 62 percent did not have coverage for maternity services; 34 percent did not have coverage for substance use disorder services; 18 percent did not have coverage for mental health services; and 9 percent did not have coverage for prescription drugs.<sup>5</sup>

The EHB benchmark now ensures that consumers have access to these critical benefits when they need them. In turn, EHBs also serve to protect the financial stability of consumers and their families because they are tied to key consumer protections including out-of-pocket cost caps and lifetime and annual maximum limits.

***We urge HHS to reconsider the proposed changes to EHBs and the selection of benchmark plans. In particular, we oppose the following changes that would likely result in states electing to scale back EHBs and consumers losing access to critical services and financial protection:***

- *Offering new options for selecting an EHB benchmark plan for plan years beginning on or after January, 1 2019;*
- *Modifying the definition of a typical employer plan;*
- *Allowing benefit substitution within and between different statutorily required EHB categories; and*
- *Continuing the policy requiring states to defray the cost of state-mandated benefits after 2011.*

**Plan Design:** We fear that an annual option to alter EHB plan design will lead to a race to the bottom across states, pursuing less generous, narrow benefit designs that will increasingly harm, and discriminate against, consumers facing health challenges. The proposed approach for selecting a new EHB package, which includes an annual selection from three different state options, relies on the premise that plans should be less generous than what is currently offered. This will narrow states' opportunity and flexibility to respond to consumers' needs by allowing states to select or develop plan designs that are less generous than what are currently available, risking key benefits for people with chronic illness, people with disabilities, children and other beneficiary groups.

For example, a state could simply select a less generous benefit category from another state replacing their own. As such, a state could select a benefit from another state that eliminated autism services, infertility treatment or hearing aids--as a result, these consumers would incur the cost of these medically necessary services. In addition, this approach could severely harm efforts to address addiction and overdose deaths if a state chose to replace its mental health and substance use disorders benefit category with one that limits or excludes medication-assisted treatment, residential treatment, and recovery supports to prevent relapse. Moreover, if states select the third option of creating a new EHB altogether, although the benchmark plan would have to include coverage of the 10 statutorily prescribed EHB categories, states could select a benchmark plan that would significantly scale back coverage relative to current ACA plans.

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<sup>5</sup> Office of the Assistant Secretary for Planning and Evaluation, [Essential Healthy Benefits: Individual Market Coverage](#), U.S. Department of Health and Human Services (2011).

Therefore, we urge HHS to reject any approach that diminishes the scope and benefits of EHB benchmark.

**Definition of a Typical Employer Plan:** We are deeply concerned that HHS's proposed definition of a typical employer plan—any group plan, including a self-insured group health plan, with enrollment of at least 5,000 enrollees—would create a loophole for states to select a benchmark plan that, for instance, sharply limits the number of hospital days or doctor visits available each year, covers only generic medications, or offers only preventive services. Although states would have to supplement such plans to ensure that all 10 EHB categories are covered, states would only have to do so if the benchmark did not cover any items or services in that EHB category. Many of these plans may severely limit key benefits for consumers, reducing the overall value of the plan for consumers. This approach will lead to more limited and imbalanced EHBs that will fail to meet the health needs of many, leaving consumers under-insured and at risk. Therefore, we urge HHS to maintain the current definition of typical employer plan.

**Benefit Substitution:** Aside from the proposed EHB-benchmark plan process, we are concerned about HHS's proposal to allow benefit substitution *between* different statutorily required EHB categories. This approach was rejected by the Obama administration, which allowed benefit substitution *within* an EHB category, but not between categories. If insurers are allowed to swap within and between benefit categories even while retaining the actuarial value, consumers will be left with gaps in coverage. For example, hospital care services and habilitative and rehabilitative care could be limited while outpatient visits are enhanced, leaving a consumer in need of both hospital care and rehabilitation with fewer available resources in their plan to support a hospital stay and post-hospital care. For children, this could translate into restricted access to habilitative services often required for children with developmental delay or autism. Mental health and substance use disorders services could also be limited, preventing people from getting the care needed to live healthier lives and hold down jobs. Over time, this practice will erode the EHB benchmark and result in bare bone plans that do not serve consumers. **We respectfully urge HHS to reject substitution *between* benefit categories.**

**State Mandates:** We are concerned about HHS's proposal to continue its policy on state-mandated benefits while proposing to change many of the underlying standards regarding the EHB-benchmark plan. Under this policy, a state does not have to defray the cost of a benefit mandated prior to or on December 31, 2011 but must defray the costs of benefits mandated after that date. This policy was adopted when states were largely limited to selecting an EHB-benchmark plan option that already existed in their state and, for the most part, reflected many of the state's existing mandates. Combined with the other proposed changes to the EHB benchmark selection process, this policy discourages states from developing more robust plans to meet consumers' needs. **If finalized, we urge HHS to review the state mandate policy as they refine their cross-state selection model so that it does not target vulnerable populations who rely on a variety of mandated services.**

We acknowledge HHS's attempt to revise the EHB approach in order to support more robust exchanges, but the current proposed approach does not account for the needs of a diverse set of consumers. We strongly reject this proposed EHB framework because it harms those consumers

who face ongoing health care needs. We are deeply concerned that people with chronic illness will be denied needed benefits if states begin to limit coverage of key benefits. Those facing harm could include but are not limited to older adults, people with disabilities, women, LGBTQ people, people of color, people with chronic illnesses such as mental health and substance use disorders. This could return us to a tragic time when insurers only covered minimal treatment for mental health or substance use disorders.

If the proposed changes are finalized, **we urge HHS to delay the implementation of any changes to the essential health benefits (EHB) approach, granting states time to fully analyze and communicate to the public the implications of changes to the benchmark package.** The EHB benchmarks have evolved over multiple years, allowing states to respond to missing benefits and refine the definition of key benefits such as habilitative care. Employing a new approach will spur instability in the exchanges and lead to consumer confusion; any attempt to alter the EHB must be done slowly with a robust, transparent process that sets clear requirements around consumer engagement and public comment periods at both the state and federal levels.

#### **§ 156.150 - Application to stand-alone dental plans inside the Exchange**

We support HHS's continued requirement that stand-alone dental plan (SADP) issuers continue to provide pediatric dental benefits as an EHB and that they comply with annual cost-sharing limits. **However, we urge HHS to also ensure that standards are in place with respect to the value of SADPs to ensure adequate information and transparency for consumers.** We understand that some SADPs have expressed difficulty in offering comprehensive plans at the low actuarial value level and that issuers are not required by the ACA to offer SADPs specifically at the 70% (low) and 85% (high) AV levels. However, AV levels are important in providing consumers with information about how much a plan will cover and how much they may have to pay out of pocket. We are concerned that removing this requirement altogether could lead to confusion and difficulty among consumers in making informed decisions about their dental coverage. Relatedly, we are also concerned that the flexibility provided to SADPs by removing the AV requirement may create an environment where consumers are left to choose among more bad options. **We urge the Secretary, as per the ACA, to issue regulations to SADP issuers on selecting and calculating AVs and applying them to coverage levels. We encourage HHS to prioritize consumer protections and maintain a standard that provides consumers with the information they need to make informed decisions about their coverage.**

#### **§ 156.230 and §156.235 – Network Adequacy Standards and Essential Community Providers**

Health insurance plans with limited networks of providers are not new and are not confined to the ACA exchanges. Although narrow networks can reduce the cost of health insurance while providing some level of care, for many individuals, especially those with chronic conditions, they are often inadequate. Beyond the breadth of a network, inadequate or outdated provider directories can lead to consumers unwittingly receiving out-of-network care resulting in exorbitant bills. Although most states have adopted some sort of regulatory framework for

network adequacy, oversight is uneven across and within states and state network adequacy requirements often only apply to certain types of network designs, such as HMOs but not PPOs. Therefore, we believe it is sensible to defer to state oversight in some cases, but necessary to maintain strong minimum federal network adequacy standards that are at least as protective as the current ACA standards.

***We strongly urge HHS to:***

- *Continue their role in oversight and enforcement of network adequacy standards to “ensure a sufficient choice of providers;” and*
- *Increase the Essential Community Providers (ECPs) inclusion threshold for 2019 from 20 percent to at least 30 percent in a plan’s service area.*

The rule as proposed will gut federal protections to identify and improve the most egregious of inadequate insurer networks. In states with insufficient standards for network adequacy review, relying on accreditation standards is not a sufficient substitute for regulatory review. Accreditation network adequacy standards are not publicly available, have no mechanism for resolving consumer complaints and do not allow for action to be taken against an insurer for failing to meet standards beyond downgrading their accreditation. Additionally, plans sold on the exchanges must be able to serve a diverse set of enrollees. It is critical that plans are able to meet the needs of diverse populations by maintaining a sufficient number of ECPs with experience providing quality care to consumers from diverse backgrounds and low-income families with the greatest health needs. Reducing the standards on ECP inclusion will fail to ensure reasonable and timely access to care for low-income and medically underserved individuals and their families.

**§ 156.298 - Meaningful Difference Standard for Qualified Health Plans in the Federally-Facilitated Exchanges**

**We strongly oppose the proposed elimination of the meaningful difference standard for qualified health plans sold on Healthcare.gov.** This provision exists to make shopping for health insurance a more informed and less difficult endeavor for consumers. The meaningful difference standard requires plans wishing to be certified as Qualified Health Plans (QHPs) to show that a reasonable consumer would be able to identify one or more material differences among five key characteristics between the plan and other plans offered by the same issuer. It helps ensure that exchange plans reflect substantive distinctions among benefit design features, such as cost-sharing levels, to allow for meaningful consumer choices, rather than simply a bewildering array of similar options by the same issuer. Too many choices, without meaningful, clear distinctions can be confusing for consumers and lead to sub-optimal choices – or the inability to decide at all. Therefore, instead of having a reasonable number of curated, consumer-friendly, distinguishable designs, this proposal, combined with the proposal to eliminate the standardized plan option, if finalized, will make it harder for consumers to shop and enroll in coverage that best meet their needs.

**Part 158 -- Issuer Use of Premium Revenue: Reporting and Rebate Requirements**

The Affordable Care Act (ACA) established a federal minimum medical loss ratio (MLR) standard. The ACA’s standard requires insurers in the individual and small group markets to

meet an 80% MLR while insurers in the large group market must attain an 85% MLR. The ACA applies this standard to an insurer's aggregate performance in a market rather than each individual policy. If insurers fail to meet this standard, they are required to provide a rebate to consumers.

The ACA's MLR standard has successfully improved value for consumers by incentivizing insurers to increase the percentage of premiums spent on medical care and decrease overhead costs.<sup>6</sup> According to the Congressional Research Service, during the first year that the MLR was in effect, insurers paid out over a billion dollars in rebates to nearly 13 million individuals.<sup>7</sup> In contrast, by 2016, insurers paid just under \$397 million to approximately 4.8 million people.<sup>8</sup> Additionally, the average MLR for the individual market was 91.8% while for the small group market the average was 85.6%. Based on the data, *most insurers are meeting or exceeding the MLR standard.*<sup>9</sup>

Despite the success of the MLR standard, HHS has proposed several harmful methods of undermining this provision of the ACA. These changes will shift the focus away from the impact on consumers and focus instead on the impact to insurers. ***We urge HHS to continue to ensure that insurers are selling policies that provide value to consumers, and not to adopt the following changes:***

- *Allowing insurers to exclude employment taxes from premiums in calculating their MLR;*
- *Permitting insurers to automatically claim 0.8 percent of earned premium as a quality improvement expense; and*
- *Simplifying the process for states to apply for a reduction in their MLR standard.*

### **§ 158.162 - Reporting of Federal and State taxes**

The Affordable Care Act requires insurers to report the amount they pay in federal and state taxes but permits them to exclude that amount from premium revenue when calculating their MLR. Although the statute does not explicitly define federal and state taxes, rulemaking has since described federal and state taxes that insurers must report but can exclude from premiums. However, some confusion remained on how to treat employment taxes. To address this confusion, HHS issued an amended rule requiring issuers to include employment taxes in earned premiums and prohibiting their deduction from MLR and rebate calculations. This amended rule took effect beginning with the 2016 MLR reporting year.

HHS expresses concerns about market stability and proposes to ameliorate that issue by permitting issuers to exclude federal and state employment taxes from premiums in their MLR

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<sup>6</sup> The Commonwealth Fund, Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3 (March 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/mar/medical-loss-ratio-year-three>.

<sup>7</sup> Congressional Research Service, Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress (August 26, 2014), <https://fas.org/sgp/crs/misc/R42735.pdf>.

<sup>8</sup> Centers for Medicare and Medicaid Services, 2015 MLR Rebates by State (October 19, 2016), [https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2015\\_Rebates\\_by\\_State.pdf](https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2015_Rebates_by_State.pdf)

<sup>9</sup> Centers for Medicare and Medicaid Services, The 80/20 Rule Increases Value for Consumers for the Fifth Year in a Row (November 18, 2016), [https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Medical\\_Loss\\_Ratio\\_Annual\\_Report\\_2016-11-18-FINAL\\_005.pdf](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Medical_Loss_Ratio_Annual_Report_2016-11-18-FINAL_005.pdf).



and rebate calculations starting with the 2017 reporting year. **We urge HHS to maintain the current rule requiring issuers to include employment taxes in earned premiums and prohibiting their deduction from MLR and rebate calculations.** This proposed rule's preamble explicitly states that most issuers were already doing so and there is no indication that this change will improve market stability. Data noted above indicates that most issuers are meeting or exceeding the MLR standard and consumers have benefited from insurer compliance.

#### **§ 158.221 - Formula for Calculating an Issuer's Medical Loss Ratio**

When calculating the numerator of its medical loss ratio (MLR), the Affordable Care Act permits insurers to add quality improvement expenses to the amount of medical claims paid. Accordingly, insurers are required to report their quality improvement activities (QIA) for purposes of MLR and rebate calculation. QIA used by insurers must lead to measurable improvements in patient outcomes or patient safety, prevent hospital readmissions, promote wellness, or enhance health information technology in a way that improves quality, transparency, or outcomes. The proposed rule's preamble notes that HHS audits revealed low and consistent QIA expenditures and insurers indicate that reporting QIA requires substantial effort.

In response, HHS proposes adding an option for insurers to indicate on their MLR reporting form a single QIA amount equal to 0.8 percent of earned premium rather than tracking and reporting the issuer's actual expenditures for QIA. HHS clarifies that the rules would continue to permit those insurers that spend more than 0.8 percent to report the total, actual higher amount. However, as currently required, they would have to track and report QIA expenditures in detail.

**We urge HHS to maintain the current rule requiring issuers to track and report their quality improvement activities in order to claim them as expenditures when calculating their MLR.** The purpose of permitting insurers to include QIA expenditures in the calculation of their MLR is to incentivize activities that improve the health and well-being of consumers. HHS's proposal to permit insurers to include a percentage of QIA activities *without any indication that the insurer implemented those activities* is counter to the spirit of the rule. HHS's proposal would automatically increase insurer's MLR without requiring insurers to take action to improve consumer's health. This option to include 0.8 percent increase could unfairly advantage an insurer who would otherwise fail to meet the required MLR. In effect, this proposal could result in a consumer losing their rebate while essentially providing insurers with an undeserved giveaway.

#### **§ 158.301 - Standard for adjustment to the medical loss ratio**

The Affordable Care Act permits the Secretary of HHS to adjust the medical loss ratio (MLR) standard in the individual market if the Secretary determines it appropriate on account of the volatility of the individual market due to the establishment of exchanges. Currently, federal regulation specifies that the Secretary may only grant the adjustment if there is a reasonable likelihood that application of the 80 percent MLR standard may destabilize the individual market in as state.



HHS proposes to permit the Secretary to adjust the individual market MLR standard in any state if there is a reasonable likelihood that an adjustment to the 80 percent MLR standard will help stabilize the individual market in that State. HHS assumes that 22 states will seek waivers of the MLR standard which would decrease rebate payments from issuers to consumers by between \$52 million to \$64 million annually, for up to 3 years at a time.

**We urge HHS to maintain the current requirement permitting the Secretary to adjust a state's MLR only if application of the 80 percent standard may destabilize the individual market.** Most insurers are meeting or exceeding the MLR standard. As noted above, the average MLR for the individual market was 91.8% while for the small group market the average was 85.6%.<sup>10</sup> In addition, there is little evidence that states want these waivers. Although seventeen states and one territory initially requested MLR waivers shortly after implementation of the rule, no state has done so since.<sup>11</sup> Given this context, it is unlikely that the MLR standard is a primary driver of market instability. Further, the MLR standard helps ensure that insurers mainly use consumers' premiums to cover the cost of medical care, which in turn creates a valuable product for the consumer. Allowing the Secretary broader discretion to waive the MLR requirement will undermine the product's value to consumers, cost consumers millions of dollars in rebates and is unlikely to create a more stable market.

#### **§ 158.321 - Information regarding the State's individual health insurance market**

Current federal regulation requires the state to provide a range of information regarding the individual market when requesting a waiver from the medical loss ratio (MLR) standard. The required information includes: a description of the state MLR standard and formula for assessing compliance, its market withdrawal requirements and the mechanisms available to the state to provide consumers with options for alternate coverage. States are also required to provide enrollment and premium data for each insurer at the product level and describe each insurer's market share. HHS proposes to eliminate these requirements.

Instead, HHS proposes to require states to submit total premium data rather than product level data. HHS would also require states to submit information on agent and broker commissions and risk-based capital information for insurers with more than 1,000 enrollees in a state. HHS would additionally require states to provide data on insurers actively participating in the individual market disaggregated by factors such as on or off exchange and grandfathered status. HHS would require states to report individual market net underwriting gain and submit information on insurers' entrances and exits. **We urge HHS to maintain the current information requirements rather than adopting these new proposals.** When requesting a waiver, states should continue to provide the current level of detail in order to provide the best available information for the Secretary's analysis.

#### **§ 158.322 - Proposal for adjusted medical loss ratio**

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<sup>10</sup> Centers for Medicare and Medicaid Services, The 80/20 Rule Increases Value for Consumers for the Fifth Year in a Row (November 18, 2016), [https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Medical\\_Loss\\_Ratio\\_Annual\\_Report\\_2016-11-18-FINAL\\_005.pdf](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Medical_Loss_Ratio_Annual_Report_2016-11-18-FINAL_005.pdf).

<sup>11</sup> [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state\\_mlr\\_adj\\_requests.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state_mlr_adj_requests.html)

Current federal regulation requires states to justify how their proposed MLR adjustment was determined and how it would affect rebates to consumers. Instead, HHS proposes that a state provide its own proposal as to the adjustment it seeks to the MLR standard and explain how it would help stabilize the individual market. **We urge HHS to maintain the current requirements when states initiate a proposal for adjusting their MLR standard.** The goal of the MLR standard is to ensure value for consumers and the purpose of a waiver was to address destabilization in the market. As we have noted above, there is no indication that the MLR standard is currently a primary driver of market instability. As a result, HHS should retain the current focus on consumer value rather than trying to undermine the efficacy of the MLR standard.

#### **§ 158.330 - Criteria for assessing request for adjustment to the medical loss ratio**

Current federal regulation requires the Secretary to consider a range of criteria when evaluating a proposal for adjustment to a state's MLR standard which is aimed at determining the likelihood of individual market insurers exiting the state. HHS proposes eliminating those requirements and replacing it with criteria related to increasing insurer participation and the proposed adjustments effects on premiums and cost-sharing. **We urge HHS to maintain the current criteria for assessing a request for adjustment to a state's MLR.** As we have repeatedly noted, there is no indication that the MLR standard is currently a primary driver of market instability. As a result, HHS should retain the current focus on consumer value rather than trying to undermine the efficacy of the MLR standard.

#### **§ 158.341 - Treatment as a public document**

Currently, not all documents that states submit with their request for waiver of the MLR standard are in formats that cannot be posted on federal websites. HHS proposes that a state's request for an adjustment to the MLR standard and all accompanying information be treated as a public document. HHS further proposes to provide instructions for accessing documents that cannot be displayed on the applicable federal website. **We applaud HHS's effort to improve transparency and support the proposal to treat state requests for adjustments to the MLR standard as public documents.**

#### **§ 158.350 - Subsequent requests for adjustment to the medical loss ratio**

HHS proposes to make conforming amendments to the information a state must submit with a subsequent request for an adjustment to the MLR standard. **In accordance with our above comments, we urge HHS not to make these changes.**

On behalf of Community Catalyst, thank you for the opportunity to provide comments to the proposed Benefit and Payment Parameters for 2019. We ask that you reconsider the proposals outlined above that, if finalized, would weaken important consumer protections built into the ACA and threaten consumers' ability to make informed shopping choices for themselves and their families.

Respectfully submitted,

A handwritten signature in cursive script that reads "Robert Restuccia".

Robert Restuccia  
Executive Director  
Community Catalyst