national partnership for women & families
Because actions speak louder than words.

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; Market Stabilization (CMS-9929-P)

Dear Acting Administrator Conway:

The National Partnership for Women & Families (National Partnership) represents women across the country who are counting on preservation and continued implementation of the Affordable Care Act (ACA). The ACA and the federally facilitated marketplace (FFM) it created are playing pivotal roles in improving access to health care and coverage, particularly for women.

We appreciate the opportunity to comment on the market stabilization proposed rule. Please find enclosed comments on provisions in the proposed rule that concern, among other topics, the annual open enrollment period, network adequacy standards and requirements for contracting with essential community providers. Market stability is of utmost importance to the women and families who, because of the ACA, now have comprehensive, affordable coverage. The proposals set forth in this rule, however, are not effective, consumer-centered strategies to stabilize the marketplace. To the contrary, we believe the proposed rule would undermine enrollment and cause marketplace plans to become more expensive for enrollees. We urge the Department of Health and Human Services (HHS) to find ways to promote real market stability while protecting and advancing the health care needs of consumers.

If you have any questions about our comments and recommendations, please contact Theresa Chalhoub, Health Policy Counsel, at tchalhoub@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness, President

1875 connecticut avenue, nw ~ suite 650 ~ washington, dc 20009 ~ phone: 202.986.2600 ~ fax: 202.986.2539
email: info@nationalpartnership.org ~ web: www.nationalpartnership.org

The National Partnership is dismayed by the Administration's decision to only provide a 20-day comment period for this proposed rule. This is a drastic departure from past opportunities to comment, which typically offer 30, 60-, or 90-day comment periods, especially for a rule of this significance. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer comprehensive recommendations; many affected parties will likely be unable to weigh in with comments.

Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

Initial and annual open enrollment periods (§155.410)

We strongly urge the Centers for Medicare & Medicaid Services (CMS) to keep the length of open enrollment periods to three months, as was the case for the most recent open enrollment period. Cutting the open enrollment period in half, as proposed, significantly reduces people's ability to learn about *and* enroll in coverage within the given timeframe. Additionally, if this proposal is finalized, there will be limited time for consumers to learn about the changed length before the next open enrollment period begins. We know that consumers continue to have gaps in knowledge about the coverage options available to them, and we believe a three-month open enrollment period should continue in order to ensure that all eligible consumers enroll in coverage.

We also have concerns about consumers' ability to access in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with enrollment for Medicare and many employer plans. We appreciate that CMS is specifically seeking comment on the effect of the shortened open enrollment period on assisters and Navigators because we believe the effects will be substantial. Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors have been stretched to capacity in the past and have had to turn consumers away during times of high demand.[1] Many consumers also rely on assisters and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Further, ending the open enrollment period in December is problematic because it is often when consumers have heightened financial constraints and are distracted by the holiday season.[2] As Florida Blue Cross Blue Shield noted, ending open enrollment in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[3]

We appreciate CMS's stated intent "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the administration scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is abundantly clear that outreach and education have a profound and positive impact on enrollment.[4] We urge CMS to provide more detail about what these activities will include. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help.[5]

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

Levels of coverage (actuarial value) (§156.140)

We strongly oppose the proposal to broaden the allowed *de minimis* variation in actuarial value (AV) for each plan metal level to -4/+2 percent. This policy will open the door for insurers to sell plans with even higher deductibles and other cost sharing. In total, this policy will shift significant costs to families, either through higher premiums or higher cost sharing, and will likely reduce enrollment due to cuts in financial assistance. The proposed rule will not boost enrollment and lower premiums among people eligible for financial assistance. In fact, it will likely lead to fewer people enrolling in coverage as their costs increase.

While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans requiring significantly higher consumer cost sharing. Looking at different hypothetical silver plan designs, a Families USA analysis found that reducing the actuarial value of plans from the current floor of 68 percent to the proposed floor of 66 percent could increase deductibles by more than $1,000.[6]

This policy will be particularly damaging for people who receive premium tax credits to lower their monthly premium for marketplace coverage. Reducing the minimum actuarial value of silver level coverage will effectively reduce the size of the premium tax credit these individuals and families receive, as premium tax credit amounts are tied to the cost of the second-least-expensive silver plan in the market. Some families could see their tax credit cut by hundreds of dollars; a Center on Budget and Policy Priorities analysis found that a family of four making $65,000, or about 264 percent of the federal poverty level, would see their premium tax credit reduced by $327 per year under this policy.[7]

We appreciate that the proposed rule does not weaken the actuarial value of coverage provided to people receiving cost-sharing reductions and strongly urge that this safeguard be maintained. However, millions of families receiving premium tax credits do not qualify for cost-sharing reductions. Under this proposal, these families will be forced to either pay higher premiums to keep the same coverage they have today *or* purchase coverage with hundreds to thousands of dollars in higher cost sharing. Either way, these consumers will pay much more for coverage and care.

The proposed rule acknowledges the harm that many consumers could experience, stating: "*A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government"* and "[T]*he proposed change in AV could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs.*"

The Administration should not proceed with a policy that could knowingly increase out-of-pocket costs and erode financial assistance for lower- and moderate-income people. We strongly recommend that the current *de minimis* actuarial value requirement of -2/+2

percent be maintained for all metal levels. We note that a broader level of variation is no longer *de minimis* and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare different plan options and to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

Network adequacy (§156.230)

Of high priority to women and families is the guarantee that their plans include adequate provider networks that ensures enrollees are able to get the care they need when they need it. This rule would gut the national protections HHS currently uses to identify and improve inadequate insurer networks and instead allow states – including those that have no adequacy metrics – to maintain authority for provider network review. Currently, nearly half of states have no metrics in place to assess whether marketplace plans provide adequate networks.[8] This rule would take the health care system backwards in time to 2014, before HHS implemented critical network adequacy reviews that currently protect patients. The rule fails to describe how consumers' access to providers will be impacted by the removal of federal network adequacy review. We are interested in understanding how HHS will ensure consumers have the same or better access to providers in all states if this proposal is implemented.

We urge HHS to maintain the implementation of §156.230 as it stands now. Proposed changes to defer to state oversight will result in insurers selling health plans that do not include sufficient numbers and types of providers to serve enrollees. The proposed changes to network adequacy would jeopardize the health and financial security of consumers and we urge HHS to reject them.

Essential community providers (§156.235)

We are concerned about the proposal to reduce the percentage of essential community providers (ECPs) necessary to meet the participation standard in the marketplaces. We strongly believe this proposal, if finalized, will jeopardize women's access to timely, high-quality, and affordable health care.

Congress designed the ECP provision of the ACA to ensure that newly insured individuals have guaranteed access to trusted providers, including family planning centers, community health centers, safety net and children's hospitals, and HIV/AIDS clinics. By enacting this provision, Congress underscored the important point that when expansions in health insurance coverage are not matched with strong provider access standards, consumers are too often left with new coverage options but without access to the providers in their communities with the appropriate experience and expertise to meet their medical needs.

Consumers in medically underserved communities and low-income populations with complex, chronic conditions are disproportionately impacted by access gaps and rely on ECPs for their care. The ECP provision, Section 1311(c)(1)(C) of the ACA, was specifically designed to address these health care challenges head on by ensuring that essential community providers are included in qualified health plan (QHP) networks, thereby assuring continuity of care and timely access to critical health services.

The ECP provision is especially impactful for access to essential health care for women of reproductive age, between 18 and 44 years old. As reiterated in 15 letters from Members of Congress to HHS, this provision was intentionally devised to assure strong access to family planning providers, in addition to other types of outpatient and inpatient providers. By passing this provision into law, Congress understood that many women of reproductive age rely on OB/GYN providers, including family planning providers, as their main or only source of care. Furthermore, many women of reproductive age report that these providers serve their most pressing health care needs, including birth control, annual exams, pap tests, and other essential preventive care.

We urge CMS not to finalize the proposal to reduce the ECP participation standard. Reducing the ECP participation threshold for QHPs as proposed would allow issuers to eliminate up to a third of currently participating ECPs from their provider networks. This proposal significantly undermines Congressional intent, as well as diminishes coverage for low-income people by undermining their access to providers who can meet their core health care needs, including HIV/AIDS care, primary and preventive care, and women's health services.

It is imperative that HHS continue to implement the law as Congress intended and ensure that enrollees are able to access critical health care services in a timely manner from the providers they trust. A growing body of evidence has shown that when access to health care is limited, consumers delay or forgo needed care, their health outcomes suffer, and costs to the entire system rise.[9] We strongly urge HHS to place a special emphasis on strong essential community provider participation, in line with both the intent and spirit of this important ACA protection.

Thank you for the opportunity to comment on the proposed regulation. If you have any questions about our comments and recommendations, please contact Theresa Chalhoub, Health Policy Counsel, at tchalhoub@nationalpartnership.org or (202) 986-2600.

---

[1] Pollitz, P., Tolbert, J., & Ma, R. (2015, August). *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers.* Kaiser Family Foundation. Retrieved 6 March 2017, from http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers

[2] Dorn, S. (2015, February). *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration*. Urban Institute. Retrieved 6 March 2017, from http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf

[3] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018 at https://www.regulations.gov/document?D=CMS-2016-0148-0492

[4] The final two weeks of the fourth open enrollment period had less than half of the number of enrollees through HealthCare.gov than the last two weeks of the third open enrollment period. See Hagan, E. (2017, February). *Fourth Open Enrollment Numbers Reveal High Demand for Affordable Care Act Coverage.* Families USA. Retrieved 6 March 2017, from http://familiesusa.org/blog/2017/02/fourth-open-enrollment-numbers-reveal-high-demand-affordable-care-act-coverage

[5] Baron, Z. (2014, March). *In Person Assistance Maximizes Enrollment Success*. Enroll America. Retrieved 6 March 2017, from https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf

[6] Mitts, L., Morris, C., & Hagan, L. (2017, February 15). *President Trump's Proposed ACA Changes Favor Health Insurers at Consumers' Expense.* Families USA. Retrieved 6 March 2017, from http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-insurers-consumer-expense

[7] Aron-Dine, A., & Park, E. (2017, February). *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families*. Center on Budget and Policy Priorities. Retrieved 6 March, 2017, from http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for

[8] Giovannelli, J., Lucia, K.W., & Corlette, S. (2015, May). *Implementing the Affordable Care Act:*

State Regulation of Marketplace Plan Provider Networks. Georgetown CHIR. Retrieved 6 March, 2017 from http://www.commonwealthfund.org/~/media/files/publications/issuebrief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

[9] Angier, H., Gregg, J., Gold, R., Crawford, C., Davis, M., & DeVoe, J.E. (2014). Understanding how low-income families prioritize elements of health care access for their children via the optimal care model. *BMC Health Services Research*, *14*, 585.