



Charles N. Kahn III
President and CEO

November 27, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Affordable Care Act: Proposed HHS Notice of Benefit and Payment Parameters for 2019 –CMS - 9930-P

Dear Administrator Verma:

The Federation of American Hospitals (FAH) appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) on the above notice of proposed rulemaking (Proposed Rule), published in the *Federal Register* on November 2, 2017 (82 FR 51052). The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members are diverse, including teaching and non-teaching, short-stay, rehabilitation, long-term acute care, psychiatric, and cancer hospitals in urban and rural America, and they provide a wide range of acute, post-acute, and ambulatory services.

The ability to shop for and purchase coverage through a marketplace has been an important success for America's previously uninsured. The Affordable Care Act's (ACA) coverage expansion has meant millions more Americans can now receive needed health care services. It is important that these successes be sustained by making the improvements needed to maintain a well-functioning Exchange. As such, we are concerned about proposed changes that could lead to higher cost, lower value and reduced benefit adequacy of health insurance sold in the individual and small group markets. We appreciate CMS's desire to provide more flexibility to states in administering the Exchanges, but believe a number of the provisions in the Proposed Rule move too far in that direction and have the potential to be harmful to consumers.

Health Insurance Issuer Rate Increase: Disclosure and Review Requirements (§154.200)

The FAH has supported the ACA's rate review requirements and its implementing regulations because they provide an important layer of transparency and scrutiny to annual rate filings by insurers. Before the ACA, many states did little in the way of rate review, often simply approving whatever rates insurers filed with state insurance departments. As a result, large annual premium increases were common, even when underlying cost trends did not justify them.

The ACA's rate review provisions, along with the Minimum Medical Loss Ratio (MLR) standards, have helped to ensure that, in any state, large proposed rate increases for individual and small group insurance plans are evaluated by insurance regulators (or in the case of a state without effective rate review, by CMS) to determine whether those increases are based on reasonable cost assumptions and solid actuarial evidence and do not discriminate between insured individuals within similar risk categories. The ACA requires insurance companies to provide readily accessible and understandable information to their customers about their reasons for significant rate increases, as well as to publicly justify and post on their websites any unreasonable rate increases. CMS posts on a website state review results, and CMS and the states use the rate review information to assess qualified health plan (QHP) certification and compliance with the ACA's single risk pool requirement. Together, these steps are designed to provide the kind of transparency and scrutiny that helps to moderate increases in premiums.

We recognize that average individual and small group insurance rate requests have risen significantly in the past few years. Some of the steep increases were justified on the basis of high claims experience and underlying cost trends. Some amount of those increases, however, has been driven by insurer uncertainty over the ACA's future including its individual mandate, federal premium, and cost sharing subsidies, the market reforms and federal support for Exchange and enrollment activities. To ensure the integrity of the rates and the sustainability of the individual and small group markets, continuation of a robust rate review process, with review to ensure that proposed rates are actuarially sound and reasonable, needs to assured.

The FAH thus opposes CMS's proposed change to the current effective rate review requirement that review be triggered if an insurer's proposed rate is 10 percent or more for the coming plan year. Under the proposal, the threshold for rate review would be raised to 15 percent. In addition, only those insurers with 15 percent or higher rate increases would be required to submit a *Consumer Justification Narrative* for those rate filings whereas, under existing rules, insurers with rate increases of 10 percent or more are required to do so. This proposed change would dilute the moderating pressures of rate review on the cost of individual and small group health insurance. Moreover, it would reduce public access to the type of pricing information and underlying trend, claims, and other data that enable experts as well as consumers to evaluate the value of the health insurance products being offered. We urge CMS not to finalize this proposal.

In addition, current rules permit a state – with the Secretary's approval – to establish a lower or higher threshold for rate review. Under CMS's proposed change, a state would only have to seek approval from the Secretary for a higher threshold. This seems reasonable in order to reduce state burden. However, the proposal that CMS only post on its website the state thresholds that exceed the 15 percent "default" federal threshold would mark a step backwards in terms of transparency. We urge CMS to retain information on all of the state rate review thresholds on the CMS rate review website. We

also urge CMS to continue to post the other rate review information that is currently included on those websites.

Network Adequacy Standards and Other QHP Requirements (§156.230 etc.)

In its 2018 Market Stabilization rule,¹ CMS finalized its proposed change to rely on states for QHP certification related to network adequacy and Essential Community Providers (ECPs). We opposed that change because we support a federal floor against which network adequacy can be assessed. In this Proposed Rule for 2019, CMS proposes changes to the ACA's network adequacy requirements and certain other criteria for QHP certification that, in our view, would further reduce the possibility of achieving a meaningful set of minimum federal consumer protection standards for coverage sold through the Exchanges.

Under the CMS Proposed Rule for 2019, CMS proposes to continue its 2018 policy to defer to the states' reviews to assess issuer network adequacy. In states that do not have the authority and means to conduct sufficient network adequacy reviews, CMS would rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from a Department of Health and Human Services (HHS)-recognized accrediting entity such as the National Committee for Quality Assurance. Unaccredited issuers would be required to submit an access plan to the state as part of the QHP application, demonstrating that the issuer has standards and procedures in place to maintain an adequate network consistent with the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act. This model act, if enacted into law by a state, establishes a floor of network adequacy standards but is in itself insufficient to ensure that consumers have access to needed providers. Additionally, most states today have not enacted the Model Act's network adequacy standards nor have insurance regulators in most states incorporated the Model Act network adequacy standards into their regulatory process.

To coordinate with state efforts, CMS states that it would track complaints. CMS also proposes to maintain its policy finalized for 2018 to allow issuers to use the ECP write-in process to identify ECPs that are not on the federal list of available ECPs and maintain the 20 percent ECP standard. In the case of an issuer's application that fails to meet this standard, the issuer would be required to include as part of its QHP certification application a satisfactory justification describing how its networks provide an adequate level of service for low-income and medically underserved individuals and the issuer's plans to increase ECP network participation.

The FAH is very concerned about relying on the states to certify that issuers have adequate provider networks in the absence of robust federal criteria to assess an adequate provider network. The proposed policy would reverse rather than bolster consumer safety safeguards. As provider networks continue to narrow in ways not always transparent to consumers, we believe that consumers need to be assured of meaningful access to health care. An accessible range of hospitals and primary and specialty care physicians helps ensure such meaningful access to care. It is important to ensure an enrollee's ability to have a meaningful choice of providers and see a provider in a timely manner and at a location reasonably convenient to the enrollee. To that end, the FAH has long recommended and again urges that CMS adopt and adapt, to the meet the needs of the broader population served by QHPs, the Medicare

¹ Department of Health and Human Services: Patient Protection and Affordable Care Act; Market Stabilization Final Rule, April 18, 2017, 82 *Federal Register* 18346, <https://www.gpo.gov/fdsys/pkg/FR-2017-04-18/pdf/2017-07712.pdf>.

Advantage network adequacy standards for the Exchanges. This would include, in addition to time and distance standards, requirements relating to the minimum number of providers that must be included in a network. We believe that by fully adopting the Medicare Advantage construct, Exchange consumers will benefit from more robust provider networks.

If CMS nevertheless moves forward in finalizing its proposal to defer to state review of network adequacy, we urge the agency to actively monitor states to ensure that they have the tools and resources to engage in meaningful review of network adequacy and that states in fact exercise their responsibility to conduct network adequacy reviews. Third-party accreditation and the NAIC Model Act standards alone are, in our view, insufficient safeguards to ensure that issuer networks are sufficiently populated and accessible to meet the needs of enrollees, especially those requiring a range of specialty providers or those who live in rural and medically underserved areas. This is why we also urge CMS to engage in oversight of accredited and unaccredited issuers to ensure that they, too, meet meaningful and transparent network adequacy standards.

Finally, we urge CMS to ensure the transparency of plan provider networks to consumers throughout the plan year so as to facilitate timely, accurate and easily accessible information on in-network providers when in active need of medical care. Assurances on these fronts is necessary for building and maintaining robust provider networks that ensure the healthy functioning of the Exchanges, as well as the individual and small group markets more generally, and consumer access to strong provider networks of hospitals, primary and specialty care physicians and other providers.

FAH also urges CMS not to finalize its proposal to defer to the states for the review of issuer compliance with QHP certification requirements at §156.275, performance of QHP compliance reviews at §156.715, issuer satisfaction of the service area requirements at §155.1055, and quality improvement strategy reporting at §156.1130. Each of these QHP sets of requirements should be carefully analyzed to more fully assess and explain where federal and state oversight activities are duplicative and where state resources may or may not be sufficient to carry out each of these functions in the absence of ongoing federal engagement. Moreover, any proposed changes to the current federal requirements should be made through the formal notice and comment process of a proposed rule and not through sub-regulatory guidance (which CMS says it will use).

Essential Health Benefits (EHB) – Benchmark Plan (§§156.100 – 156.115)

The FAH recommends that the proposed changes to EHB and “typical employer plan” not be finalized. We are concerned that the proposed changes to the choices states would have in identifying a benchmark plan, including changes to the definition of a “typical employer plan,” place too much emphasis on providing flexibility to health insurers and states to the possible detriment of consumers and health care providers. The proposed changes could potentially undermine the ACA’s goal of ensuring that plans sold in the individual market provide meaningful coverage. They would also undermine the statutory mandate and congressional intent that requires CMS to develop an approximate national benchmark so that consumers across the nation have access to a similar scope of benefits without regard to the state in which they reside. We question CMS’s statutory authority to relinquish such responsibility to the states.

The Proposed Rule includes changes that CMS notes are intended to increase flexibility for states and reduce the burden for health insurers. The FAH believes, however, that the proposed changes to EHB, when considered as a whole, risk leaving enrollees with significant gaps in their health insurance coverage, thereby undermining the benefit adequacy objectives of the ACA. Coverage losses might result within specific categories of essential benefits or more broadly across all EHBs. We also are concerned that the increased flexibilities and reduction in uniformity of plan offerings could re-introduce opportunities for risk segmentation. If the standard for EHB is lowered, the temptation for many plans will be to offer benefit designs limited to the lower EHB standard. This approach has the potential to return the marketplaces to the individual and small group market present in many states prior to the ACA, where only healthy consumers could afford limited benefit plans, and those with needs for broader benefits could not afford or could not access the broader benefits they needed. This is what the ACA was, in large part, intended to correct.

The 10 categories of EHBs that must be covered by all plans would remain the same under the Proposed Rule, but states would have greater flexibility to alter their definitions of those benefits and to incorporate changes to their base benchmark plans annually. States could choose each year to continue with the benchmark plan that they identified for 2017; or change the benchmark by adopting a separate state's benchmark plan altogether; or alter their 2017 benchmark by swapping in another state's definition of one or more of the 10 categories of EHBs. Finally, states could develop a new benchmark benefit plan altogether.

Current law includes a floor on the coverage provided by a state's benchmark by requiring that a state's base benchmark plan offers coverage that is at least as generous as a "typical employer plan." But CMS proposes to alter the definition of a "typical employer plan" in a way that could potentially undermine this essential protection. A "typical employer plan" would be defined to be an employer plan designated by the state that is sold either in the small group or large group market in one or more states and that has at least 5,000 enrollees. A state would be able to choose any single plan meeting that enrollment threshold and designate it as "typical." We think this proposed application exhausts the definition of "typical" under the statute in that it suggests employer plans that are neither representative or popular in many states. The Proposed Rule does not provide any calculation or methodology to ensure that such a plan is representative of offerings within the state or in any other way is "typical" of employment-based plans in the state. This change would essentially allow the minimum benefit standard to be interpreted as requiring that EHB base-benchmark plans be as comprehensive as *any* plan with 5000 enrollees (subject to the state's designation).

The FAH is concerned that these proposed rules would introduce the ability and the incentives for states so inclined to annually chip away at essential benefits. They could result in significant coverage loss perhaps resulting in more limited prescription drug formularies, fewer days of hospital coverage, less expensive treatment options for chronic illnesses, or fewer rehabilitative visits. Coverage losses are bad for enrollees as well as providers whose provision of uncompensated care and bad debt could escalate.

Consumer Friendly Marketplace

The role of the Exchanges under the ACA was to create a marketplace where shopping for health insurance in the individual market would be simpler. Plan differences would be evident and transparent,

issuers would compete for enrollees based on quality and price, and assistance would be available to help consumers understand their options. The FAH believes that HHS is proposing changes, which taken altogether, would undermine this vision of the Exchange and instead introduce confusion, increased difficulty, and reduced consumer assistance. We are concerned that the consumer friendly vision of Exchanges would be considerably undermined by these changes and that the result could reintroduce instability and reduce coverage in the individual market for insurance. Some of the provisions that could undermine the consumer friendly Exchange include the following:

Navigators (§155.210). HHS proposes to eliminate the requirements that states: (1) provide for at least two Navigator contracts, (2) ensure that Navigators have a local presence so that a prospective enrollee can get face-to-face enrollment assistance if necessary, and (3) include at least one community and consumer focused non-profit as one of the two required Navigators. According to CMS's own website "Navigators play a vital role in helping consumers prepare electronic and paper applications to establish eligibility and enroll in coverage through the Marketplaces and potentially qualify for an insurance affordability programs." Navigators have traditionally provided local in-person assistance to help consumers navigate, shop, and enroll in Exchange plans. Under the Proposed Rule, there would likely be both fewer navigators to provide assistance and, in many cases, no local Navigators to provide face-to-face assistance if needed.

Meaningful difference (§156.298). Existing rules require issuers of QHPs to offer a product that is meaningfully different from its other QHP offerings. The standard was created to make it easier for consumers to choose among distinct plan options to more easily identify the one that is right for them. HHS notes that because fewer insurers are participating in Exchanges, this standard is no longer necessary. While in some Exchanges we expect that to be true, many Exchanges remain with multiple choices of plans within several metal categories. By increasing the likelihood of multiple duplicative options in those markets, these proposed rules will make it more difficult for consumers to distinguish differences between plans, and likely increase confusion among consumers, undermining a consumer friendly marketplace.

Increased income verification (§155.320). HHS proposes to increase the documentation and verification procedures for certain individuals at the bottom of the income scale. For individuals who attest to having income that is above the federal poverty level, but for whom Internal Revenue Service (IRS) or Social Security Act (SSA) data (or data from other trusted sources) indicates that their income is below that threshold, Exchanges would be required to request additional documentation and begin additional income verification proceedings. Without supporting evidence of significant fraudulent enrollments, income inconsistencies, or mistaken subsidy payments, we do not support the addition of bureaucratic barriers imposed on a population that is highly likely to experience swings in income because they work in part-time jobs or have irregular work hours.

File and reconcile (§155.305). A notification requirement for individuals whose premium tax credit is being discontinued because they have failed to meet existing "file and reconcile" requirements would be eliminated under the Proposed Rule. Under current rules, Exchanges cannot discontinue an advance premium tax credit (APTC) due to an enrollee's failure to file and reconcile an associated APTC unless direct notification is first sent to the tax filer. HHS states that it is proposing this change because it determined that notification practices in place prior to adoption of the direct notification requirement were sufficient, and it would reduce burden on Exchanges and improve program integrity.

We oppose this change because it eliminates the opportunity for an individual who is justifiably eligible for and receiving subsidies to speed up their attempt to meet the file and reconcile requirements before their subsidy is discontinued.

Individually, each one of these changes would represent a small step backwards in supporting a simple competitive individual market for insurance. Together they present a considerably more concerning picture in which the principles of a consumer friendly, competitive marketplaces are eroded with real consequences for enrollment, coverage, and stability. We urge HHS to consider the holistic impact of these provisions on undermining a well-functioning individual health insurance market.

Issuer Use of Premium Revenue: Reporting and Rebate Requirements

Federal and State Employment Taxes (§158.162)

A number of concerns for the FAH are raised by CMS's proposals to modify the rules related to the ACA's MLR requirements and rebate requirements. First, CMS is considering changing its policy in §158.162 related to reporting of federal and state taxes to allow issuers to deduct federal and state employment taxes from premiums in their MLR and rebate calculations, starting with the 2017 MLR reporting year for reports to be filed by July 31, 2018. FAH opposes such a change. These taxes had earlier been considered as employment costs rather than the kind of taxes that the ACA intended to exclude from premiums in rebate calculations. Although this change would increase issuers' MLRs, nothing would in fact be changed to produce greater value of coverage for consumers. We also do not believe that this change is needed to produce greater stability for the individual and small group markets. It would be more helpful to the stability of those markets to maintain consistency and predictability in regulatory requirements.

Formula for Calculating an Issuer's Medical Loss Ratio (§158.221, §158.170)

Based on CMS's experience for previous MLR reporting years, the agency also proposes to allow issuers to report a single quality improvement activity (QIA) amount equal to 0.8% of earned premium in the relevant state and market, instead of tracking and reporting the issuer's actual expenditures for QIA in terms of five specific quality improvement categories. CMS states that this proposed change would reduce unnecessary issuer compliance burden since CMS audits and issuers have indicated that identification, tracking and reporting of QIA for this purpose requires substantial effort. Moreover, CMS has found that the average issuer QIA amounts of those that reported such activities for 2011 and then 2012 through 2015 were 0.7% and 0.8% of earned premium, respectively so allowing all issuers to report a single amount equal to 0.8% would be reasonable and appropriate policy. Issuers with actual, higher amount QIA expenditures could elect to report the total actual, higher amount spent and would have to report QIA in the five categories as well as comply with the allocation of expenses requirements established under §158.170.

Although FAH supports streamlining regulations when they create inappropriate and unreasonable burdens on health insurance issuers, health care providers or other stakeholders, we believe that the current MLR QIA reporting rules for purposes of the federal minimum MLR standards are important to maintaining the integrity of those reports and issuer calculations of their MLRs. First, as CMS notes, many issuers do not report QIA amounts so allowing them to report and factor into their

MLRs QIA expenditures equal to 0.8% means that the MLRs of those issuers would rise whether or not they engaged in any quality improvement activity.

Consequently, the value of the coverage purchased by consumers would look better without any likelihood of actual improved value. To the extent required, issuer rebates to consumers would also be lower. An additional concern is that the loss of specific detail in issuer reporting would reduce transparency and, potentially, issuer accountability in the event of CMS or state insurance department audits.

Standard for Adjustment to the MLR, Proposed Adjusted MLRs and Criteria for Assessing a State's Request for Adjustment to the MLRs (§158.301, §158.321, §158.322 and §158.330)

In another set of MLR-related policy changes, CMS would modify the current criteria and procedures to allow states to petition for a reduction for the year in the minimum MLR standard before rebates would be required. During the first three years of the MLR program, when the individual market issuers were becoming familiar with the ACA reforms and with the resulting changes in risk composition of their enrollees, states were permitted to request adjustments to the MLR during the phase-in of the ACA's market reforms. Seventeen states did so. Since then state MLR adjustments have remained possible but have not been requested by any state. CMS now proposes to resume its policy to allow for MLR adjustments on a state-by-state basis. An adjustment would be allowed whenever CMS determined upon a state's request the reasonable possibility that adjustment of the 80% minimum MLR standard would help stabilize the individual market.

CMS also proposes to modify state MLR reporting requirements in the case of a state that requests an MLR adjustment for its individual market. CMS believes that much of the existing information on a state's MLR standard and formula for assessing compliance, market withdrawal requirements and consumer options for alternate coverage as well as detailed individual market and premium data for each issuer would no longer be needed to determine whether to allow a state to adjust its minimum MLR standard for its individual market below 80%. Whereas the current requirements were established to enable CMS to determine what a state would be able to do to mitigate market instability without an MLR adjustment, the proposed reporting requirements, with more aggregated data elements and less detail, would be viewed as adequate for explaining how the requested MLR adjustment would help stabilize its individual market. In addition, CMS would modify the criteria for assessing a state's MLR adjustment and streamline the adjustment process for itself and for the states. Those criteria focus not just on forestalling insurer exits from state markets, but also on helping to increase issuer competition and consumer plan choices. State requests for MLR adjustments would be treated as public documents, and the public would be provided with instructions for accessing them if they cannot be displayed on the applicable federal website.

Although we appreciate CMS's effort to stabilize the individual markets, we do not believe that making it more likely for state minimum MLR standards to drop below 80% in as many as 22 states (according to CMS's own estimate), would contribute to ensuring the availability of affordable, ACA-compliant, individual market coverage. The ACA's MLR standards have not contributed to market instability. In fact, after the initial years of the ACA's market reform implementation, individual market issuers have reported MLRs that are, on average, higher than 80%. Plan year 2016 was the fifth year in

which rebates were required under the ACA for individual and small group market coverage that did not meet the 80% MLR threshold. Whereas in 2012 (based on 2011 MLR data), \$1.1 billion were returned to consumers in the form of issuer rebates, only about \$400 million was rebated in 2016. The average individual market MLR for plan years 2013 through 2015 was 91.8%.² This suggests that issuers are not having difficulty meeting the 80% threshold. Moreover, other measures to ensure market stability would be far more appropriate than to reduce the rebates to consumers for those issuers that have not learned to reduce excess administrative overhead, which CMS estimates to be a reduction of 74% to 91% of individual market rebates from the 22 states expected to seek an MLR adjustment.

Instead of modifying the MLR standards, the FAH urges CMS to address any market instability by restoring the cost-sharing reduction payments to issuers, providing the risk corridor payments to issuers that are due, increasing resources for enrollment and outreach activities, making it easier rather than harder for qualified individuals and small businesses to enroll in QHPs and providing for greater predictability of HHS/CMS policy as it relates to insurance markets and Exchanges.

Thank you for the opportunity to comment on the Proposed Rule. Should you have any questions regarding these comments please do not hesitate to contact me or my staff at (202) 624-1500.

Sincerely,



² Norris, Louise, Billions in ACA Rebates Show 80/20 Rule's Impact, August 2, 2017, www.healthinsurance.org/obamacare/billions-in-aca-rebates-show-80-20-rules-impact/