American Association on Health & Disability

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LAKESHORE

March 6, 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: ***Comments on HHS Notice of Proposed Rule-Making for the Patient Protection and Affordable Care Act; Market Stabilization, CMS-9929-P***

To Whom It May Concern,

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

Initial and Annual Open Enrollment Periods (§155.410)

The proposed rule would reduce the open enrollment period for 2018 to 45 days, from November 1 to December 15, 2017. We are very concerned that a shorter time period for consumers to consider their options could result in depressed enrollment if consumers are unable to get answers to questions about plans they are considering. This is especially true for consumers with disabilities as their unique medical needs require them to review the networks to ensure their current providers are included and calculate how out-of-pocket costs will affect their overall financial burden. The many of the other changes in the proposed rule, especially those with respect to actuarial values (§156.140) and network adequacy (§156.230), would make reviewing the details of each plan much more crucial this year.

Additionally, shortening the open enrollment period will place a greater stress on in-person assisters and could result in consumers not having the opportunity to meet with an in-person assister to fully review their options. If this does result in depressed enrollment then this change could actually undermine rather than reinforce the stability of the risk pool. We are pleased that HHS recognizes this difficult and will "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." We urge HHS to explain what this outreach will entail and 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.

We do recognize that ending the open enrollment on December 15 is a way to ensure that all consumers receive a full year of coverage, but shortening the length of the open enrollment period is not the only way to achieve this goal. We would recommend that if HHS desires the open enrollment period end on December 15, that consideration be given to starting the open enrollment period earlier, such as October 1. If it is not possible for issuers to meet an October 1 deadline, then we urge HHS to leave the open enrollment period as was originally scheduled for November 1, 2017-January 31, 2018. It is crucially important that everyone has sufficient time to analyze their options and select a plan.

We also urge HHS to allow state-based marketplaces (SBMs) to make their own determination with regards to enrollment periods.

Special Enrollment Periods (§155.420)

While we appreciate HHS' efforts to curb the misuse of special enrollment periods (SEPs), there does not appear to be a true problem with ineligible individuals are enrolling through SEPs.[1] As HHS recognized in the Notice of Benefit and Payment Parameters for 2018, there are "very low

[1] Health and Human Services Department, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 246 (Dec. 22, 2016) ("We have found that the attrition rate for any particular cohort is no different at the end of the year than at points earlier in the year, suggesting that any such gaming, if it is occurring, does not appear to be occurring at sufficient scale to produce statistically measurable effects").

take-up rates for special enrollment periods among eligible individuals."[2] The extra requirements to enroll using an SEP could very well discourage additional eligible individuals from enrolling.

We are very concerned about the burden of additional verification processes on consumers, especially consumers with disabilities. This is especially true for individuals who have ongoing medical needs as the proposed rule requires the application be held in limbo until eligibility is verified. This delay could affect the continuity of care and has the potential to have negative consequences on these individual's health. HHS should not hold applications in limbo until eligibility is verified and we urge HHS to revoke that part of the proposed rule.

Also under current rules, the SEP verification process is to be conducted in a pilot program for 2017. The proposed rule would extend these verification processes to everyone without determining whether or not there are any unintended consequences as a result of the new verification process. We urge HHS to return to its original plan to conduct the SEP verification process as a pilot so that it can be evaluated for possible unintended consequences.

We are also concerned about some of the restrictions on SEPs which are part of the proposed rules. For a marriage SEP, the requirement that one of the spouses must have minimum essential coverage at some point during the prior 60 days is problematic as the individuals who are marrying may have been ineligible for coverage through the marketplace prior to getting married. This is especially likely in Medicaid non-expansion states. Both individuals may have been below 100% FPL in a non-expansion state and thus in the coverage gap. A marriage could increase their joint income to over 100% FPL and make them both newly eligible for coverage yet the proposed rule would not allow them to enroll.

For similar reasons, the prohibition against changing metal levels during an SEP is also problematic as the triggering event for the SEP may have had a significant change on an individual or family's eligibility for premium tax credits or cost-sharing reductions. This is especially true for the qualifying life events which have a direct impact on the size of a family unit (marriage, birth or adoption). Additionally, for those consumers who have a child born with a disability or adopt a child with a disability, they may realize that their current metal level is not the best fit for them given the special health care needs of the child. Many times, these complications are unforeseen and a parent should not be locked into a plan which will not adequately address the needs of their child with a disability. For these reasons, we would urge HHS to reject the proposed rules which would prohibit individuals from changing metal levels during an SEP.

Health Insurance Issuer Standards – Network Adequacy (§156.230)

People with disabilities have unique medical needs and require access to a broad range of providers, including specialists. We are concerned that the proposed rules would result in qualified health plans which have more narrow networks, thereby restricting access of people with disabilities to their providers. The proposed rule shifts the responsibility of regulating the adequacy of networks to the states, where states have the authority to regulate the adequacy of

[2] Health and Human Services Department, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Proposed Rule, 81 Fed. Reg. 172, 61502 (Sept. 6, 2016).

networks, and where states do not have the authority, the rule would defer to insurer accreditation agencies. On its face, it might seem redundant for HHS to regulate network adequacy standards where states are already regulating the area. However, almost half of the states currently have no clear standards which assess whether marketplace plans provide adequate networks.[3] How can states enforce a non-existent standard? While there are some states which have adequate standards, in any state without a standard that is not at least as protective as the ACA's federal standards, HHS must review plan justification of compliance with federal standards. To do otherwise would jeopardize the health and financial security of consumers.

The proposed rules' plan to use accrediting bodies as a means of judging network adequacy is also insufficient. Accreditation agencies are also not the same as federal and/or state regulatory oversight as the accreditation standards are not publicly available, cannot be enforced, cannot resolve consumer complaints and are not subject to public input. This is not only contrary to public interest, this is contrary to statute, which requires the Secretary to "by regulation, establish criteria for the certification of health plans" to "ensure a sufficient choice of providers."[4]

Health Insurance Issuer Standards – Essential Community Providers (§156.235)

Under the current rules, qualified health plans must include at least 30 percent of Essential Community Providers (ECPs) within their network or provide a written explanation as to why they are unable to do so. The proposed rules would reduce this to only 20 percent of ECPs. However, the proposed rules themselves state that for 2017 only 6 percent of insurers had to submit explanations as to why they were unable to meet the 30 percent requirement. As such, it seems that this proposed change is addressing a problem which simply does not exist. The ECPs provide care to some of the most vulnerable, and often are the only providers of certain services for people with disabilities, and reducing the requirement to only 20 percent would only create a larger burden on this population. We urge HHS to maintain the current rules which require plans to include 30 percent of ECPs or provide a written explanation.

Compressed Public Comment Period

Finally, we would like to express concern that the public comment period for this proposed rule was so compressed. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the significant proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Thank you for the opportunity to comment. If you have any questions please contact Karl Cooper at kcooper@aahd.us.

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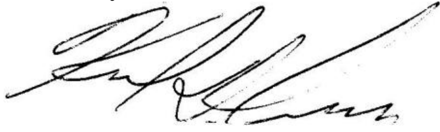
[3] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

[4] 42 U.S.C. § 18031.

Sincerely,



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