CLASP
policy solutions that work for low-income people

March 7, 2017

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

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed rule to stabilize the health insurance marketplace. The Center for Law and Social Policy (CLASP) advocates for public policies and programs at the federal, state, and local levels that reduce poverty, help low-income people become economically self-sufficient, and create ladders to opportunity for all.

The Affordable Care Act (ACA) created important protections to ensure that low-income people can access and afford high quality health insurance. Having health insurance increases timely access to care, improves health outcomes, and makes the cost of getting health care affordable and predictable. Moreover, it protects individuals and families from unexpected out-of-pocket costs from an illness or injury, and can help minimize medical debt. The ACA put coverage in reach for millions of low and moderate-income families and overall has helped to dramatically reduce the number of people who are uninsured.

This rule rolls back key protections for individuals and families who purchase health insurance on the marketplace, and has dramatic implications for people whose income fluctuates from month to month. A 2016 study by the Federal Reserve on economic well-being found that 20% of respondents indicated that their monthly income varies occasionally, and 12% report that their income varies quite a bit from month to month[1]. For low-income people whose income fluctuates, eligibility may switch from Medicaid to the marketplace, or to other coverage options depending on the state. CLASP encourages CMS to maintain the protections that allow people to efficiently get and maintain health insurance through the marketplace—despite fluctuations in income or changes in circumstance. We are concerned that, as proposed, this rule will result in delayed or denied coverage for the very populations who need it the most.

This rule makes significant policy changes that will impact the health insurance coverage of millions of people—yet it only had a 20-day comment period. It is unacceptable to allow so little public review of policies of such magnitude, particularly given the real-life impacts on health and wellbeing. CLASP calls on CMS to maintain traditional comment periods (e.g., 45 or 90 day comment periods) in future rulemaking to allow the public and stakeholders sufficient time to review the proposals and to prepare comments.

[1] Federal Reserve. May 2016. Report on the Economic Well-Being of U.S. Households in 2015. Accessed online at: https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf

We urge CMS withdraw the proposal and to reissue it with a 90-day comment period as is appropriate for a rule of this magnitude. If, however, it does move forward, this proposal must be significantly changed to ensure that coverage on the marketplace remains available to the people who need it, and that the enrollment process reflects the needs of consumers. CLASP recommends that CMS:

- Rescind section §147.104 of the proposed rule that allows issuers to require payment of past premiums and to terminate coverage for unpaid premiums;
- Modify section §155.410 to ensure a longer open enrollment period and guarantee an extensive outreach and enrollment period;
- Eliminate the requirement in §155.420 that pre-verification for special enrollment periods (SEPs) for all consumers; and ensure that states, and not consumers are responsible for providing documentation about Medicaid terminations;
- Eliminate section §156.140 (Levels of coverage) of the proposed rule and maintain comprehensive coverage in all metal tiers; and
- Maintain federal network adequacy standards rather than the changes included in section §156.230 of the proposed rule.

Our specific comments on the proposed rule follow.

§147.104 Guaranteed availability of coverage

This section would allow issuers to require payment of any past premiums a customer may owe, and to terminate coverage for unpaid premiums. It allows issuers to refuse to start coverage (including for SEPs) for consumers with past-due premiums until these debts are paid. This means that plan issuers could terminate or refuse coverage to any consumer with a past debt, without offering a grace period or a minimum payment to allow them to continue their health insurance coverage.

CLASP shares the Administration's goal that all consumers have access to continuous coverage. To do this, grace periods are critical for consumers who temporarily periodically lack sufficient funds to catch up on past debts to maintain coverage. This provision is particularly problematic for consumers with incomes that may fluctuate and or do not have the ability to pay outstanding bills. In 2016, only 4 in 10 Americans said that they would be able to rely on savings to cover anything beyond their usual bills[2], and another survey found that 46% of Americans indicated that it would be challenging to handle a hypothetical emergency expense of $400[3]. The survey also found that only 23% thought they would be able to handle an emergency bill by cutting other spending. These consumers may rely on grace periods to catch up on past bills.

This proposal may also disproportionally impact consumers who have chronic conditions and have high costs particularly in the beginning of a calendar year. If consumers are paying towards their deductible or maximum out-of-pocket costs, they may struggle to pay their premiums until those costs are satisfied. 46 percent of those who report a major out-of-pocket medical expense in the prior year also indicate that they currently have debt or unpaid balances related to these medical expenses[4]. Under this proposal, these consumers could lose coverage simply because they incur more medical bills.

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[2] Bankrate Survey: Just 4 in 10 Americans have savings they'd rely on in an emergency. January 17, 2017. Accessed online at: http://www.bankrate.com/finance/consumer-index/money-pulse-0117.aspx

[3] Federal Reserve. May 2016. Report on the Economic Well-Being of U.S. Households in 2015. Accessed online at: https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf

[4] Federal Reserve. May 2016. Report on the Economic Well-Being of U.S. Households in 2015. Accessed online at: https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf

To help consumers maintain continuous coverage, a grace period is necessary to allow repayment of past premiums. CMS must play an important role in helping consumers by requiring issuers to allow significant grace periods to catch up on past premium payments before they can be terminated from a plan or denied coverage. At a minimum, consumers should be offered a minimum catch-up payment that they can make in order to maintain their coverage.

Recommendation:
Rescind this section of the proposed rule that allows issuers to require payment of past premiums and to terminate coverage for unpaid premiums. At a minimum, require issuers to set a minimum percentage threshold for "pay back" to maintain coverage. CMS could also adopt a standard threshold for repayment that is sufficiently protective to ensure that all consumers have a reasonable option to pay back past premiums without losing coverage.

§155.410 Initial and annual open enrollment periods

CLASP stresses the importance of a sufficiently long Open Enrollment Period (OEP), combined with sustained outreach and promotion about health insurance options. In 2017, the open enrollment period lasted 3 months (November 1, 2017-January 31, 2017).

Unfortunately, this proposed rule recommends cutting in half the OEP for coverage in CY 2018, and apply this change to all states including state-based marketplaces.

A shortened OEP means that fewer people will enroll overall, and it may deter younger, healthier applicants from enrolling. Young people, who tend to be healthier, tend to wait until later in the OEP to enroll. This could negatively impact the risk pool.

Cutting the OEP in half may also have a dampening effect on Medicaid enrollment. Medicaid enrollment data suggest that expansion states see a bump in Medicaid enrollment during OEPs thanks to the "welcome mat" effect of open enrollment on Medicaid enrollment[5]. This means that consumers, hearing that health insurance is available during the OEP, seek out coverage and are deemed eligible for Medicaid, rather than the marketplace.

Lower income consumers tend to be the least aware of their coverage options. To maximize enrollment in the marketplace, and to capture positive "spillover" into Medicaid, CMS must maintain a robust outreach and marketing campaign. Marketing and outreach around Open Enrollment work to promote coverage—and the longer and more sustained the effort, the more enrollment will take place, both in the marketplace and in Medicaid. While Medicaid does not have an open enrollment period, beneficiaries benefit from the efforts to promote health insurance overall.

We also have concerns about consumers' ability to gain in-person assistance and assisters' ability to provide assistance during a shorter open enrollment period that also coincides with Medicare and many employer pans. 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.

[5] Two Year Trends in Medicaid and CHIP Enrollment and Findings from the CMS Performance Indicator Project. June 2016. Kaiser Commission on Medicaid and the Uninsured. Accessed online at: http://files.kff.org/attachment/Issue-Brief-Two-Year-Trends-in-Medicaid-and-CHIP-Enrollment-Data

Even with longer open enrollment periods, Navigators, in-person assisters, and certified application counselors were stretched to capacity and had to turn consumers away during times of high demand.[6] Many consumers also rely on agents and brokers to enroll in coverage, and their capacity will now be significantly limited during this time.

Recommendation:
Modify this section of the proposed rule so that there is a three-month OEP for 2018 coverage, and maintain outreach and education efforts.

§155.420 Special enrollment periods

CLASP raises strong concerns about the unreasonable paperwork burden that the proposed pre-verification requirement will place on consumers—and the impact it will have on reducing coverage and delaying needed care.

The proposed rule requires pre-verification of special enrollment period (SEP) eligibility for all categories of SEPs beginning in June in all federally-facilitated marketplaces. CMS would attempt to use electronic data sources to verify eligibility when possible (e.g. birth certificates or loss of Medicaid/CHIP coverage). Enrollment would be pended until the consumer successfully verifies eligibility; enrollment information would not be transferred to the issuer until eligibility is verified.

From our experience under Work Support Strategies (WSS), a foundation-funded initiative led by CLASP to help a bipartisan group of six states integrate and streamline service delivery of core economic and work support programs, we learned that excessive and unnecessary verifications were a major obstacle to providing timely and accurate eligibility determinations. Every piece of paper a customer submits must be processed, which is a slow and time consuming process that can be prone to errors. Consumers often did not understand what verifications were needed and had to seek out answers; they might later call again to confirm that the documents submitted had been processed. Each of these steps took time. Rather, efforts to streamline verification policies can both improve the customer experience and increase efficiency.

The pre-verification requirement proposed in this rule will delay effectuation dates of coverage and make it difficult for consumers to maintain continuous coverage.

It is critical that eligible consumers successfully finish the SEP verification process with minimal burden. The preamble says HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We recommend that the documentation burden be entirely on the state. The state must develop a process by which the marketplace is notified that a consumer has lost Medicaid and may be eligible for an SEP—and this process must occur in a timely way. The SEP applicants' coverage should not be pended while this is happening. Instead, their attestation should be accepted with eligibility verified afterward by the marketplace in order to ensure continuity of their health care and coverage.

[6] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

CLASP therefore recommends that pre-verification for beneficiaries who have lost Medicaid/CHIP coverage should be delayed until it can be demonstrated that the Medicaid system and the marketplace systems can appropriately share data. Further, we seek clarification about the timeline for building effective electronic verification systems and recommend that there are strong manual systems in place should electronic verification not be ready by June 2017 or should electronic verification not work for all consumers. It is also critical that marketplaces, not issuers, should continue conducting SEP verification, consistent with the law.

Recommendation:
Rescind the pre-verification requirement for SEPs as proposed in this section. At a minimum, delay the implementation of this provision until it can be assured that Medicaid and marketplace systems can appropriately share data.

§156.140 Levels of coverage (actuarial value)
This proposal loosens actuarial value (AV) requirements for plans in each of the metal tiers (Gold; Sliver; Bronze), making it easier for issuers to offer less generous coverage in exchange for lower premiums. This will ultimately have the effect of also decreasing the value of the APTC (e.g. if the benchmark silver plan premium is lower). While reducing the minimum AV of plans by two percent does not seem like a large difference, in practice it translates to plans having significantly higher cost-sharing. Looking at different hypothetical silver plan designs, 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.[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. This means a cost shift to consumers who are receiving premium tax credits but do not qualify for cost-sharing reductions. They will be forced to choose between paying significantly more for comprehensive coverage, or paying more for out-of-pocket expenses in a bare-bones plan. What is more, this leads to a dramatic cliff for any individual that increases their income just enough to no longer qualify for cost-sharing reductions—and will just receive the premium tax credit. These individuals will have no incentive to increase their income when faced with significant increases in health care spending.

Recommendation:
Entirely eliminate this section of the proposal on actuarial value, and maintain strong and uniform protections to ensure all consumers are able to purchase a comprehensive benefit package. The protection for families receiving cost-sharing reductions must be maintained.

§156.230 Network adequacy
A strong network of providers is needed to ensure that consumer can get the care they need, when they need it. The ACA ensures network adequacy by providing federal oversight of state network adequacy metrics. The proposed rule shifts enforcement of network adequacy standards from HHS to states. But currently, nearly half of states have no metrics in place to assess whether marketplace plans provide

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

adequate networks.[8] This rule will gut the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allow states that have no adequacy metrics to maintain authority for provider network review.

Recommendation:

CLASP recommends that CMS maintain the implementation of §156.230 as it stands now, as 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.

Thank you for the opportunity to provide comments and recommendations in response to this proposed rule. For any questions or for more information about the impact of this proposal on low-income individuals, please contact Elizabeth Lower-Basch (elowerbasch@clasp.org) or Suzanne Wikle (swikle@clasp.org).

[8] 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