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VIA ELECTRONIC SUBMISSION

Seema Verma, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,

RE: Patient Protection and Affordable Care Act: Reducing Regulatory Burdens and Improving Health Care Choices to Empower Patients

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment in response to the Request for Information (RFI) titled "Patient Protection and Affordable Care Act: Reducing Regulatory Burdens and Improving Health Care Choices to Empower Patients." Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We serve nearly three million people with Medicare, family caregivers, and professionals through our national helpline and educational programming annually.

We appreciate the opportunity to provide comments about how the U.S. Department of Health and Human Services (HHS) can improve the Patient Protection and Affordable Care Act (ACA) regulatory landscape to empower patients and promote choice; stabilize the individual, small group, and other health insurance markets; enhance affordability; and affirm the traditional regulatory authority of the states. For additional information, please contact Stacy Sanders, Federal Policy Director at SSanders@medicarerights.org or 202-637-0961 and Casey Schwarz, Senior Counsel for Education and Federal Policy, at CSchwarz@medicarerights.org or 212-204-6271.

We are encouraged by this RFI, and we urge HHS and the Centers for Medicare and Medicaid Services (CMS) to work collaboratively with diverse stakeholders, solicit broad input, and act responsively to the concerns of patients, consumer advocates, health care providers, and insurers as the agencies seek to improve the health care market through regulatory reform.

A recent example of this constructive collaboration involves the establishment of Periodic Data Matching (PDM) notices sent to individuals who are dually enrolled in Medicare Part A and a Marketplace plan. These notices serve several essential and sorely needed functions, including: informing individuals of the need to enroll in Medicare,

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telling people that they are not eligible for tax subsidies for their Marketplace plan if they also have Medicare Part A, and directing them to personalized, unbiased assistance.

Issuers, health care providers, and consumer advocates have been working with CMS to identify the problems faced by individuals who have Marketplace coverage and become eligible for Medicare, to target specific information gaps and to direct targeted resources to help such individuals make informed decisions. This collaborative effort culminated in CMS' leadership through the provision of the PDM notices. This is an excellent example of CMS working with a diverse set of stakeholders to find real solutions to problems real patients face, and we encourage CMS to conduct similar outreach efforts to identify and address issues as they arise.

The RFI seeks comment in four areas, including:

1. **Empowering patients and promoting consumer choice.** HHS should preserve and expand upon regulatory protections that ensure consumers have the information they need to choose a plan that meets their needs. Below are important protections that enhance patient empowerment and choice:

- **Improved provider directories.** It is essential that plan provider directories include a range of salient information, including the provider's affiliations, location, capacity for new patients, and specialty type. This regulation is vital to promoting consumer choice, since provider directories that are not up-to-date makes it difficult for consumers to ensure that they are selecting a plan that contracts with the provider of their choice. Surveys in several states in the past few years have revealed serious inaccuracies with provider directory listings, and possible underlying gaps in provider networks.[1]

  For example, a 2017 report from the California Department of Managed Health Care found that most insurers submitted inaccurate directories for review.[2] Most insurers surveyed either overinflated the size of the network or made clerical errors such as failing to include known in-network providers.[3] These discrepancies in network directories limit access to care for consumers, who may not be certain which providers are in-network. HHS' regulations are crucial to ensuring that consumers in the Marketplace have access to the information they need about provider networks to make an informed decision about which plan choice is right for them.

- **Protecting consumers from "surprise bills."** Another regulation that promotes consumer choice reduces the incidence of "surprise bills" starting in 2018. This HHS regulation protects consumers by ensuring that plans provide advance notice to consumers when they receive prior authorization for a service that may be provided all or in part using out-of-network providers.

  These protections are critical to ensure that consumers can choose to use only in-network services from their plan's contracted providers, and avoid a bill if their plan or provider brings in out-of-network providers to perform or assist in the performance of procedures without the consumers' knowledge or consent. HHS' rule

[1] *See, e.g.*, Tribal Self-Governance Advisory Committee, "Network Adequacy and Essential Community Provider Inclusion in Marketplace Health Plans Serving Indian Country" (2015), (many QHPs failed to contract with Indian Health Care Centers), http://tinyurl.com/j3ty3pl; Maryland Women's Coalition for Health Reform, "Network Adequacy in Maryland: A Report on Provider Directories and Women's Access to Health Care" (2015), (finding that Maryland QHPs did not provide access to preventive well-woman visits in a timely manner), http://tinyurl.com/ojn6a6d; Mental Health Ass'n in New Jersey, "Managed Care Network Adequacy Report" (2014), (finding that New Jersey HMOs failed to contract with sufficient numbers of mental health providers), http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf.

[2] Department of Managed Health Care, "Timely Access Report" (2017), https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/SubmittingHealthPlanFilings/MY_2015_Timely_Access_Report.pdf.

[3] *Id*. at 8-9, 13.

prevents plans from "tricking" consumers into seeing a provider they have no desire to see, at great cost to themselves, without any notice.

- **Promoting continuity of care.** HHS' rules ensure that plans make a good faith effort to provide written notice of discontinuation of a provider to enrollees who have seen that provider on a regular basis or who receive primary care. They further protect consumers by ensuring that health plans allow enrollees in active treatment to continue seeing their providers, even when those providers leave the plan's network. These rules protect consumers who are mid-treatment from experiencing a gap or delay in their care if their plan and provider no longer contract with each other. When a consumer chooses a plan in order to receive care from a particular provider, these rules preserve that choice by ensuring that the consumer can continue a relationship with that provider, even if the provider leaves the consumer's plan before the end of the year.

- **Supporting navigator programs and consumer assistance**. Navigators and other consumer assisters provide information and services to consumers in a fair, accurate, and impartial manner according to conflict of interest rules. HHS' rules ensure that consumers who need special help, including people with disabilities and those with limited English proficiency, get the assistance they need, ensuring that all consumers are empowered. HHS' rules have promoted choice and empowerment by ensuring that consumers have access to trusted advisors who can give consumers information to determine which coverage best suits their needs.

- **Reducing consumer confusion and facilitating access to plans that meet care, treatment, and affordability needs.** HHS' rules facilitate choice by providing options in a standard format, outlined in the 2018 Notice of Benefit and Payment Parameters Final Rule. Prioritizing standardized plans allows consumers to more easily make apples-to-apples comparisons of provider networks, cost-sharing, and drug formularies. This helps consumers make informed, cost-effective choices about purchasing insurance.

Going forward, HHS should preserve these and similar rules, and **should work with insurers to encourage and maximize Marketplace participation and avoid bare counties.** Having counties without any insurer participating in the Marketplace would severely limit consumer choice, especially for low-income consumers who rely on premium tax credits that are only available through the Marketplaces. For the last four years, state insurance commissioners and federal regulators have worked together alongside insurers to encourage Marketplace participation and ensure that there were no "bare" counties nationwide.[4] HHS should use its existing authority to continue to work with states to ensure that all consumers have a choice of plan in their county.

2. **Stabilizing the individual, small group, and non-traditional health insurance markets.** The Administration should strengthen the Marketplaces so that enrollees can access affordable, quality care. We urge the following actions:

- **Continue Cost Sharing Reductions.** Cost Sharing Reductions (CSRs) have brought stability to the Marketplace by ensuring that coverage is affordable to consumers, making them more likely to purchase coverage. Uncertainty about the Administration's commitment to this important affordability program makes it very difficult for issuers to set rates for the upcoming plan year and is impacting decisions by some issuers not to continue selling products in the Marketplace. Continuing to fund CSRs over the long term will increase stability to the Marketplace by resolving this uncertainty, and ensuring that coverage remains affordable.

[4] *See* Aviva Aron-Dine, Ctr. Budget & Policy Priorities, "ACA Marketplaces Poised for Greater Price Stability and Competition, But Also Vulnerable to Sabotage" (2017), http://www.cbpp.org/research/health/aca-marketplaces-poised-for-greater-price-stability-and-competition-but-also.

- **Enforce the Individual Shared Responsibility Payment (ISRP).** The ACA requirement to maintain Minimum Essential Coverage (MEC) or pay a tax penalty is designed to ensure that healthier consumers participate in the Marketplace. Enforcing the ISRP will stabilize the risk pool by ensuring that consumers participate regardless of health status.

- **Extend open enrollment.** Given all the potential changes that consumers have to digest this year, HHS' decision to shorten open enrollment could also destabilize the risk pool. HHS commented that shortening the open enrollment period would limit adverse selection and leave insurers with a healthier pool. But people who are sick or have chronic conditions are likely the most diligent about signing up for insurance. Thus the policy change could just as easily lead to a sicker pool, at least in the short term, if young, healthy people end up missing the new deadline for signing up.

- **Ease restrictions on Special Enrollment Periods (SEPs).** Individuals who need care but are denied coverage due to new complex and burdensome verification procedures are more likely to forgo early treatment and prevention and risk needing more expensive uncompensated care later on. Research shows little evidence of SEP abuse, while roadblocks have resulted in underutilization of SEPs with only 5% of those eligible enrolling via this pathway.[5] HHS should ease restrictions and verification procedures for SEPs to bring greater stability to risk pools.

- **Limit the availability of limited benefit and short-term coverage plans.** Current rules protect consumers by ensuring that they have access to full coverage plans that provide the range of health care benefits people need. We do not support changes that would increase the availability of plans that offer limited coverage (either with or without federal subsidies). Prior to the ACA, these types of plans were ubiquitous, providing consumers with little protection when they tried to actually use their benefits. Moreover, the continued existence of these plans may serve to siphon off young, relatively healthy consumers from the Marketplaces, negatively impacting the risk pools for participating insurers.

3. **Enhancing affordability.** Premiums are not the only factor that determines the affordability of a plan. Consumers also need out-of-pocket costs that are manageable and comprehensive benefits that meet their needs. A commitment to out-of-pocket maximums, standardized plans with *limited* deductibles and co-insurance, and strong actuarial value standards are critical to ensuring Marketplace plans will meet the prevention, care, and treatment needs of consumers. In addition, HHS should maintain and enforce protections of the ACA that have helped individual consumers gain affordable, quality coverage. These protections include the Essential Health Benefits (EHBs) and the ACA's nondiscrimination protections under Section 1557. Specifically, we recommend that HHS:

    - **Discourage the use of high co-insurance and high deductible health plans by issuers in the Marketplace.** High co-insurance and high deductible health plans do not help consumers afford the care they need. High deductible health plans are not suitable for individuals with disabilities or chronic conditions because they encourage people to go without needed care due to cost. Co-insurance often results in high beneficiary costs because it conceals the real out-of-pocket costs that beneficiaries must pay for their care. We also urge HHS to not further erode the Actuarial Value requirements that have protected consumers against prohibitively high out-of-pocket costs.

[5] Stan Dorn, Urban Inst., "Helping Special Enrollment Periods Work under the Affordable Care Act" (June 2016), http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

- **Ensure coverage of EHBs for all enrollees.** The ten categories of EHBs ensure a mixed pool of both healthy and sick enrollees. Because a person's health status may change over time, the EHBs are necessary to ensure that individuals receive the care they need. Without EHBs, consumers may need to pay additional out-of-pocket costs for their care or may be unable to afford coverage at all. Women and individuals living with disabilities, chronic conditions, or HIV would not have comprehensive treatment and care without the EHBs.

  For instance, prior to the implementation of the EHBs, 75 percent of non-group plans did not cover inpatient and delivery services for maternity care and some plans had severe limits or restrictions on mental and behavioral health services.[6] If insurers are permitted to provide bare bones benefit packages, this will segment the market—resulting in separate plans for healthy people and for those with more significant health care needs. This will drive up the costs of health care for those who need it most. Healthy individuals may find themselves without needed coverage if they develop an illness or face unanticipated health care costs mid-year. EHBs are also important in ensuring that individuals in large employer plans receive comprehensive coverage. We urge HHS to guarantee EHBs for all enrollees to ensure a fair and affordable individual market.

- **Enforce Section 1557, the nondiscrimination protection of the ACA.** Section 1557 ensures each individual can access care without fear of discrimination. For the first time, discrimination on the basis of sex, including gender identity and sexual orientation, is prohibited in health care and longstanding important protections against discrimination on the basis of race, national origin, disability, and age were reiterated. Under this protection, discriminatory plan designs are prohibited.

  Issuers have engaged in discriminatory plan design by using adverse tiering to select medications needed to treat specific health conditions on the highest cost-sharing tier. This practice has greatly impacted individuals living with HIV and those with chronic conditions and disabilities. Issuers have also excluded care for transgender individuals in the past. HHS should continue to enforce Section 1557, implementing the final rule as is and including its prohibition regarding discriminatory plan designs, to ensure that consumers receive the benefits that meet their needs.

4. **Affirming the traditional regulatory authority of the States.**We believe there should be a strong federal and state partnership with federal minimum standards that consumers can rely on no matter what state they live in. Many of these minimum standards are established in federal regulations, which are key to maintaining existing consumer protections, and should not be changed. We urge HHS to work with states to ensure that there is adequate monitoring and oversight to enforce essential nondiscrimination and access protections. HHS should also:

   - **Continue to develop templates and tools for use by state insurance regulators to assess compliance with federal rules.** HHS has developed a number of tools to help assess compliance with federal market rules. These include qualified health plan application templates and tools, submission checklists, drug count review tools, a formulary outlier review, a nondiscrimination clinical appropriateness review for prescription drugs, and examples of potentially discriminatory benefit design. These types of tools are key to providing guidance to state regulators and to ensuring that federal rules are enforced consistently across

[6] Gary Claxton, et al., The Henry J. Kaiser Family Found., Would States Eliminate Key Benefits if AHCA Waivers Are Enacted, (2017) http://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/.

states. We urge HHS to continue to develop enforcement tools and templates to aid states in ensuring compliance with federal consumer protections.

- **Work with states to ensure adequate monitoring and enforcement of network adequacy requirements.** Given the increased reliance on state network adequacy review for the 2018 plan year, we urge HHS to work with states to ensure that sufficient capacity exists to conduct these reviews and that review processes are robust enough to ensure plan compliance with important network adequacy requirements.

- **Oppose the sale of insurance across state lines.** We urge HHS to oppose the sale of insurance across state lines which would lead to a "race to the bottom" and allow insurers to choose their state regulators, selecting those with weak standards and undermining the authority of each state to establish enhanced protections for its citizens. This would lead to risk segmentation and undermine state consumer protections.

Thank you for the opportunity to provide comment.