March 7, 2017

Patrick Conway, MD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Attention: CMS-9929-P
Submitted via https://www.regulations.gov

RE: Patient Protection and Affordable Care Act; Market Stabilization; Proposed Rule

Dear Dr. Conway:

The Alliance of Community Health Plans (ACHP) is pleased to comment on the Affordable Care Act (ACA) Market Stabilization proposed rule (CMS-9929-P).

We appreciate that the Department has issued this proposed rule to begin to stabilize the individual market in response to concerns raised by ACHP and others. Our member plans are committed to providing affordable, high quality health coverage, but stability and predictability are critical to maintaining a well-functioning market. ACHP commends HHS for its ongoing efforts to stabilize the individual insurance market and improve the risk pool, and in particular for taking steps to minimize the abuse of Marketplace rules and encourage individuals to maintain health coverage. While we continue to have concerns about federal financing in 2018, we support many of the proposed changes in this proposed rule.

ACHP is a national organization bringing together innovative health plans and provider groups leading the nation towards a value-based health care financing and delivery system. Members are non-profit organizations or subsidiaries of non-profit health systems. They provide coverage and care for nearly 19 million Americans in the commercial market and Marketplaces and for Medicare, Medicaid, and federal, state, and local public employees.

Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

Guaranteed Availability of Coverage (§147.104)

ACHP strongly supports HHS' proposal to change its interpretation of the guaranteed availability of coverage rules. The changes would allow issuers, subject to state law, to attribute a premium payment for coverage under the same or a different product to an individual's outstanding debt owed to the issuer for coverage within the prior 12 months, and to refuse to effectuate new coverage for failure to pay premiums. ACHP members have seen many instances in which consumers have not paid premiums in the final months of the benefit year and then enroll in another product the next year. This clarification from HHS will help mitigate potential gaming of guaranteed availability rules.

We recommend HHS administer this proposed change at the member level instead of the subscriber level. Specifically, if a subscriber's spouse attempts to enroll his or her family into a new plan using his or her own social security number and name, issuers should be allowed to collect any outstanding premium before re-enrolling the same family members into a new plan. ACHP member plans have seen subscribers change frequently in the individual market, particularly spouses alternating back and forth as the subscriber on a family plan after a special enrollment period change. Allowing issuers to collect outstanding premiums at the member level will prevent gaming through the use of different subscribers in a family plan.

We also recommend issuers be permitted to require a specific payment method (e.g., check, ACH payment, credit/debit card) for the payment of outstanding premium or allow issuers to require a secondary payment method be on file if the first payment fails.

Part 155—Exchange Establishment Standards and Other Related Standards under the ACA

Initial and Annual Open Enrollment Periods (§155.410)

ACHP supports the proposal to change the open enrollment period for plan year 2018 so that it begins on November 1, 2017 and ends on December 15, 2017. We agree that having an earlier end date that ensures all consumers will have coverage for a full year will simplify operational processes for issuers and Marketplaces, and could help improve the risk pool**.** The revised enrollment period would be similar to that used in Medicare Advantage, which has worked successfully. That program's enrollment is successful in part because of extensive marketing and consumer outreach, and we urge HHS to devote adequate resources for outreach efforts that will be especially important in the first, shortened year.

HHS seeks comment on the capacity of State-based Marketplaces to shift to a shorter open enrollment period for the 2018 year. Given past experiences, it may be beneficial for State-based Marketplaces to have the option to add two weeks at the beginning of open enrollment (starting October 15) in order to help with processing.

Special Enrollment Periods (§155.420)

We appreciate that HHS is taking these important steps to address concerns regarding the abuse of special enrollment periods and adverse selection. At the same time, the Department must ensure consumers who legitimately encounter qualifying events have access to coverage during a special enrollment period and are not confronted with a process that is too complex or onerous. We believe the proposals in this rule strike the right balance.

ACHP strongly supports HHS' proposal to conduct pre-enrollment verification of eligibility for Marketplace coverage for all categories of special enrollment periods for new consumers in states using

the HealthCare.gov platform. We also support HHS' proposal to limit the ability of existing Marketplace enrollees to change plan metal levels during the coverage year.

HHS requests comment on whether it should retain a small percentage of enrollees outside the pre-enrollment verification process in order to assess the impact of the process. ACHP opposes this idea. We believe that the previous years of 2014-2016 provide an adequate baseline of what can happen in a market without a verification process. To ensure the viability of the individual market and align with longstanding rules in the group market, verification and documentation should be conducted for all special enrollment period enrollees.

HHS also seeks comment on its proposal to allow enrollees to start coverage one month later than their effective date would ordinarily have been, if the special enrollment period verification process results in a delay in their enrollment such that they would be required to pay two or more months of retroactive premium to effectuate coverage or avoid termination for non-payment. We oppose this proposal. It would lead to healthier enrollees electing a coverage effective date one month later in order to save on premium, while enrollees who need services will elect the original coverage effective date. This adverse selection impact is one of the same reasons HHS noted in implementing an earlier end date for open enrollment. Healthier enrollees should be encouraged to have a full year of coverage (or as close to a full year as possible) in order to protect the risk pool. HHS also notes in the proposed rule that they do not expect the pre-enrollment process to result in significant delays. Given that, and given the enrollee's responsibility to provide documentation in a timely manner, we do not believe allowing for a later coverage effective date is necessary or in the best interest of the broadest possible risk pool.

Finally, we recommend that HHS share special enrollment period verification documentation with issuers upon request.

Continuous Coverage

ACHP appreciates that HHS is actively exploring additional policies in the individual market that would promote continuous coverage. Continuous coverage is essential in reducing adverse selection and stabilizing premiums, particularly if policymakers are considering eliminating the individual mandate. It is also vital in improving the health of patients – ACHP member plans have shown that individuals who maintain coverage demonstrate significant improvements in their risk profile in relatively short periods of time.

We would support a return to continuous, creditable coverage requirements that existed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We also recommend continuous coverage requirements be tied to open enrollment rules, such as a payment penalty added to premiums if an individual does not enroll when initially eligible (similar to Medicare). These steps to promote continuous coverage would help improve and stabilize the risk pool..

Part 156—Health Insurance Issuer Standards under the ACA, Including Standards Related to Exchanges

Network Adequacy and Essential Community Providers

ACHP strongly supports HHS' proposal to rely on state reviews of network adequacy in states with a with a sufficient network adequacy review process and to rely on accreditation for states that do not

have that review. Given that states determine network requirements for other lines of business, they are better suited to develop and enforce standards that are most appropriate for their markets.

We also support HHS's proposal to lower the standard for essential community providers from 30 percent to 20 percent and to allow issuers to use a write-in process to identify essential community providers who are not on the HHS list for 2018. We agree that this will lessen the regulatory burden on issuers while ensuring adequate access to care.

Stabilizing the Marketplaces is critical to safeguarding the coverage and care of millions of individuals, and we appreciate HHS' efforts towards this end. Clarity around sufficient financing is also crucial for plans attempting to commit to operate on the individual market in 2018. If we can answer any questions or provide additional information, please contact Howard Shapiro, Director of Public Policy, at hshapiro@achp.org.

Thank you for your consideration of ACHP's comments.

Sincerely,

Ceci Connolly
President and CEO