



One Prince Street
Alexandria, VA 22314-3318
☎ 703.838.0033
☎ 703.548.1890

March 7, 2017

Dr. Patrick Conway
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Dr. Conway:

On behalf of the AMGA we appreciate the opportunity to comment on the “Patient Protection and Affordable Care Act: Market Stabilization” proposed rule. Founded in 1950, AMGA represents more than 440 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups work diligently to provide innovative, high quality, patient-centered medical care that both improves patient outcomes and is spending efficient. For these reasons we have a significant interest in expanding and improving coverage under the state health insurance marketplaces.

The proposed rule attempts to accomplish six goals. Briefly summarized, these are:

Open Enrollment Periods

The proposed rule would reduce the 2018 open enrollment period from three months to six weeks or from November 1 to January 31 to November 1 to December. 15. CMS argues a month-and-a-half “provides sufficient time for consumers to enroll.” CMS also believes a shorter enrollment period “may have a positive impact on the risk pool because it will reduce opportunities for adverse selection by those who learn they will need services in late December or January.”

Guaranteed Availability

As CMS states in the proposed rule the guaranteed availability provision in the ACA has been interpreted, CMS writes, “to mean that an issuer may not apply any premium payment made for coverage . . . to any outstanding debt owed from any previous coverage and then refuse to effectuate the enrollment based on failure to pay premiums.” Assuming state law does not prohibit, the proposed rule would allow an issuer to collect past due premiums before re-enrolling an individual in coverage.

Special Enrollment Periods (SEPs)

For those attempting to sign up for insurance via a Special Enrollment Period (SEP), the proposed rule would require pre-enrollment verification for all SEP categories for all applicants served by the Healthcare.gov platform beginning in June 2017. Consumers would have 30 days to upload or email documentary verification. CMS argues “self-attestation without verifying documents . . . could allow applicants to obtain subsidized coverage they would otherwise not qualify for” and “undermines the incentive for enrolling in the full year of coverage,” therefore, “such behaviors can create a sicker risk pool, leading to higher rates and less availability of coverage.”

The proposed rule would also generally prohibit the ability of an existing marketplace enrollee to upgrade from one metal level to another during the coverage year using a SEP.

CMS is proposing to allow an issuer to reject an enrollment, i.e., not violate the ACA's “guaranteed availability” provision, due to nonpayment of premiums unless or until the individual pays premiums owed for previous coverage. That is an issuer could attribute payments from a re-enrolling consumer to outstanding debt from coverage under the same insurer during the previous 12 months. For those recently married and seeking SEP coverage, CMS proposes requiring at least one spouse demonstrating coverage for one or more days preceding the date of marriage or lived outside the US or in in a US territory for one or more days. CMS is proposing similar requirement for those making a permanent move. CMS is also proposing to “significantly limit” the use of exceptional circumstances.

In sum, “we believe,” CMS states, “the [SEP] changes . . . are needed to stabilize the risk pool and encourage robust issuer Exchange participation.”

Levels of Coverage (De Minimus Coverage)

CMS proposes to change or reduce the de minimus actuarial value (AV) of plans from +/-2 percent to -4/+5 percent beginning in plan year 2018 or 2019 (excluding sliver plan variations or plans with an AV of 73, 87 and 94 percent). For 2018 expanded bronze plans, CMS proposes a change from +5/-2 percent to +5/-4 percent. CMS states, “we believe that further flexibility is needed for the AV de minimis range for metal levels to help issuers design new plans for future plans years, thereby promoting competition in the market” and that the proposed change “would help retain and attract issuers to the non-grandfathered individual and small group markets, which would increase competition and help consumers.”

Network Adequacy

CMS proposes to allow states to replace the Department of Health and Human Services (DHHS) in determining plan network adequacy provided the state has such capabilities. If the state does not, DHHS would rely on an insurer's accreditation, either commercial or Medicaid, from a DHHS-recognized accreditation body such as NCQA, URAC, or others.

Essential Community Providers

CMS proposes to lower the percent of Essential Community Providers (ECPs), for example, community health centers, safety-net hospitals and Ryan-White providers, a plan needs to include in its network from 30 percent to 20 percent, or return to the percent used in plan year 2014. For those that cannot meet the 20 percent threshold, CMS will allow them to offer a

narrative explanation. CMS states, “we believe this standard will substantially lessen the burden on issuers while preserving adequate access to care provided by ECPs.”

Proposed Rule's “Regulatory Impact Analysis”

Under the proposed rule's “Regulatory Impact Analysis” the agency admits:

1. Its solution to “potential gaming” under its proposed guaranteed availability change is based on no evidence. CMS states it is unable “to determine the amount of past due amounts that consumers would have to pay in order to resume coverage with the same issuer.”
2. Shortening the open enrollment period by six weeks “could lead to a reduction in enrollment” because the agency recognizes, “primarily younger and healthier enrollees . . . usually enroll late in the enrollment period.”
3. “The additional steps required to verify [SEP] eligibility,” CMS states, “might discourage some eligible individuals from obtaining coverage, and reduce access to health care for those individuals, increasing their exposure to financial risk.” CMS also notes, requiring 100 percent SEP verification, “if it deters younger and healthier individuals from obtaining coverage, it could also worsen the risk pool.” Therefore, CMS states, the “net effect of pre-enrollment verification and other proposed changes on premiums and enrollment is uncertain.”
4. Proposed changes in the de minimus values could, CMS admits, “reduce the value of coverage to consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risk associated with high medical costs.”
5. The agency is “uncertain” what net effect transferring network standard reviews to states would have. Lessening the percent of ECP participation CMS also recognizes could lead to cost increases in “the form of increases travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuer's networks.”

In sum, CMS recognizes “the net effect of the proposed rule provisions on enrollment, premiums and total premium tax credit payments are ambiguous.” “On the one hand,” CMS writes, premiums could fall if “more young and healthy individuals obtain coverage” and issuers “are able to lower costs due to reduce regulatory burden and greater flexibility in plan design.” “On the other hand,” CMS writes, a “shortened open enrollment period, pre-enrollment verification . . . , reduced actuarial value of plans, less expansive provider networks result in lower enrollment, especially for younger, healthier adults, it would tend to increase premiums.”

AMGA's Conclusion

On balance, the evidence suggests the net effect of the proposed rule is not, as CMS states, “ambiguous.” The evidence suggests, these proposed changes will, on balance, adversely affect enrollment beginning in 2018.

CMS believes “that the[se] changes are urgently needed to stabilize markets.” The evidence does not support this conclusion. After accounting for 2017 increases, marketplace premiums approximate CBO’s initial projections. For example, in 2016 premiums were 12 percent to 20 percent below CBO’s initial estimates. As for so called “death spiraling” premium increases, the ACA ensures that an individual’s contribution to the benchmark plan is capped at a certain percentage of their income. ACA enrollment has increased every year since 2014 and enrollees are becoming healthier. CMS’ own estimates show that per member per month spending slightly decreased between 2014 and 2015.¹

Concerning the proposed shortened open enrollment period, we realize the proposed rule simply moves up the 2019 open enrollment window to 2018. This point aside, CMS presents no evidence that a shortened open enrollment period “reduces opportunities for adverse selection.” We believe CMS wise to recognize shortening open enrollment could be doubling damaging by both reducing overall enrollment as well as lowering the number of younger and healthier who enroll.

The proposed SEP changes are problematic for several reasons. First, CMS presents no evidence the SEPs are being misused or moreover that SEP enrollees consume more health care spending. As Laurel Lucia’s noted in her February 16 Health Affairs essay, if anything research by the Urban Institute and the University of Minnesota shows only approximately 9 percent to 10 percent of those eligible to enroll during a SEPs do so.² The short duration of SEP enrollment is, or should be, anticipated since pre-ACA data shows there’s considerable churn in the individual market. It is neither surprising nor unusual for SEP enrollees to utilize comparatively more services in part since SEP enrollment takes considerable effort and those with the greatest health care needs are those most motivated to enroll. Lucia argues instead of making SEP enrollment more onerous the regulatory change should be to improve SEP awareness and make the enrollment process easier, for example, by improving the process by which individuals can transition from Medicaid to the marketplace. This is particularly important since, per CMS’s own research, those 18 to 24 are far less likely to complete the verification process due to “hassle costs” than those 55 to 64. In sum, as Brookings’ Matthew Fielder noted, “even if the entire cost differential between SEP enrollees and other enrollees resulted from inappropriate use of SEPs, the overall implications for average claims costs in the individual health insurance market would be modest.” At most, CMS should continue to conduct pilot studies to make an informed, evidence-based decision in how to improve the SEP provision.³

CMS believes expanding AV de minimus values would help issuers design new plans thereby promoting competition. Again, the agency provides no evidence in support of this belief. Research shows however that allowing up to 4 percentage points below standard values would reduce premiums as well as premium tax credits since tax credits adjust dollar-for-dollar. This change would allow for less generous silver benchmark plans for as many as 9 million silver plan enrollees. The Center for Budget and Policy Priorities (CBPP) estimated that a silver plan with a 66 percent AV would increase costs for a family of four with an income of \$65,000 by \$550 per person.⁴

Considering the substantial criticism by patients concerning narrow networks, we do not believe the better alternative is for DHHS to default to the states determination of network adequacy.

AMGA does support the agency's intent to reduce ECPs to 20 percent. We strongly support readily available ECPs. However, because CMS counts a single location as a single ECP, i.e., the agency does not recognize the number or variety of providers at each ECP location, the number or percent of ECPs is likely adequate at 20 percent. We would recommend that should CMS return to the 2014 plan year minimum participation percentage, the agency evaluate whether the 20 percent standard is adequate.

In sum, AMGA strongly believes proposed rule changes to improve ACA marketplaces should not be inexact or left to chance. Again, CMS admits the net effect of pre-enrollment verification is "uncertain." The proposed change in network adequacy is "uncertain." The "net effect of these proposed provisions" are "ambiguous" and "the effect on total healthcare spending is uncertain."

Based on the evidence it appears the provisions in the proposed rule will not increase but decrease overall enrollment, reduce enrollment among younger or healthier individuals, and leave state market places less stable by driving up premiums due to reduced competition by fewer participating plans.

We thank CMS for consideration of our comments. Should you have questions please do not hesitate to contact AMGA's David Introcaso, Ph.D., Senior Director of Public Policy at 703.842.0774 or at dintrocaso@amga.org.

Sincerely,



Donald W. Fisher, Ph.D., CAE
President and CEO

End Notes

1. CMS, "Changes in AA Individual Market Costs from 2014-2015," Near-Zero Growth Suggests an Improving Risk Pool." (August 11, 2016).
2. Laurel Lucia, "How Do We Make Special Enrollment Periods Work?" Health Affairs Blog (February 16, 2016). At: <http://healthaffairs.org/blog/2016/02/16/how-do-we-make-special-enrollment-periods-work/>.
3. Matthew Fielder, "Trump Administration's Proposed Change to ACA Special Enrollment Periods Could Backfire," Brookings Institution, February 17, 2017. At: <https://www.brookings.edu/blog/up-front/2017/02/17/trump-administrations-proposed-change-to-aca-special-enrollment-periods-could-backfire/>.
4. Aviva Aron-Dine and Edwin Park, "Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families," Center on Budget and Policy Priorities (February 15, 2017). At: <http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for>.