AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St., Chicago, IL 60611-2864 ph (312) 202-8000 | (800) 621-1773 | www.osteopathic.org

March 7, 2017

Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9929-P
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

Re: Notice of Proposed Rulemaking – Patient Protection and Affordable Care Act; Market Stabilization

Dear Dr. Conway:

On behalf of the American Osteopathic Association (AOA) and the nearly 130,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule, "Patient Protection and Affordable Care Act; Market Stabilization" (herein referred to as 'proposed rule').

Health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families will have access to coverage and care when and where they need it. Among the core principles of osteopathic medicine are providing coordinated care across the health care spectrum. The AOA's comments reflect our concern about the growing potential for market instability and the deleterious effect that a collapse would have on patients' access to insurance coverage and health care services. With that said, the AOA unequivocally believes that the primary focus of any policy and/or operational changes should be to expand or at least maintain access to comprehensive, affordable coverage and care. The AOA urges CMS to finalize only proposed alterations to existing rules and/or marketplace standards that support sustainability in the marketplace without posing harm to patients' ability to enroll in individual or small group coverage that provides unimpeded access to high-quality care at the appropriate time and in the appropriate setting.

Guaranteed Availability of Coverage (§ 147.104)
We appreciate CMS' effort to address certain unintended consequences related to the three-month grace period for enrollees who purchased a plan through the Exchange and received advanced payments of the premium tax credit. Currently, a Qualified Health Plan (QHP) issuer must provide a grace period of three consecutive months for an enrollee, who when failing to make timely premium payments, is receiving advance payments of the premium tax credit. During the grace period, a QHP

issuer is required to: (1) pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) notify CMS of such non-payment; and (3) notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. Under current guidance, should an enrollee make the initial premium payment to start their coverage, enter a grace period, and fail to pay all outstanding premiums before the grace period expires, coverage can be terminated retroactively to the last day of the first month of the grace period. Subsequently, providers often do not receive payment from insurers for covered services rendered in the second and third months of said grace period. This policy poses a financial risk to providers, and is often time consuming and administratively burdensome to administer from a practice management and operations perspective.

We request that CMS consider a policy that would better support physicians and other providers during this grace period. When a patient enters a grace period, insurers should notify providers in writing within 15 days of its start. In addition, when a physician makes an inquiry about the patient's eligibility status, the information provided must be up-to-date, clearly identifying the coverage as an on-Exchange option, the enrollee as APTC-eligible, and the plan's status in regards to CMS and/or state grace period rules for APTC recipients. If, during the three-month grace period, a physician receives notification based on his/her inquiry that the patient is enrolled, the insurer should be obligated to promptly pay the claims based on the information provided by the insurer. As well, if during the grace period a physician is subsequently notified that the patient's eligibility status changed after services were rendered, the issuer should continue to be held financially responsible for any covered services the physician provided based on the original eligibility inquiry that indicated the patient was, in fact, enrolled and eligible. The AOA also contends that in instances whereby the past due premium is paid in full during the grace period, issuers must pay all pended claims without the need for the provider to resubmit the claim or claims within 30 days of the enrollee's account becoming current.

We are concerned with the proposal to require consumers to pay past-due premium payments to QHPs in advance of effectuated coverage with those QHPs on current accounts. While we understand the need for QHPs to recoup monies owed, we are concerned that the requirement that payments for past-due funds be made upfront and in advance of coverage being effectuated is a challenge to consumers seeking coverage. We are especially concerned that this may shut out patients in states with limited plan options available through the Exchange.

In fact, the proposed rule points to these disturbing trends on pages 52-53. This language states that one in 10 enrollees had their coverage terminated due to non-payment of premiums in 2016. Further, of the aforementioned individuals who are living in an area where their insurer was the *only* insurer offering non-grandfathered, single risk pool compliant plans in 2017, 23 percent of them had an active plan in 2017. This means that 77 percent of these consumers are no longer covered. We are concerned that these statistics demonstrate a trend of non-coverage when the Affordable Care Act (ACA) was intended to increase the number of covered people in the United States. Thus, the AOA does not support CMS' modified interpretation of the guaranteed availability rules with respect to non-payment of premiums as described in the proposed rule. While we agree that issuers should be allowed to recoup unpaid premiums, we don't believe that requiring the full past due amount at enrollment is financially feasible for a large majority of APTC-eligible enrollees.

In the event CMS finalizes its modifications to the guaranteed availability standards as proposed, the AOA believes a premium payment threshold policy, under which the issuer can consider an individual to have paid all amounts due, should be allowed and supported. We would also support the establishment of alternative mechanisms for collections, such as payment plans or the proration of past due amounts spread across premium payments for the following coverage year on a bifurcated basis, so as to facilitate the maintenance of plan enrollment and continued access to coverage. In instances whereby an alternate payment arrangement is entered into, the AOA reiterates its position that issuers must pay any and all pended claims without the need for the provider to resubmit the claim or claims within 30 days of the enrollee either making the full threshold payment or making the first of a series of arranged payments.

The AOA cautions against any retroactive application of CMS' proposed interpretation of the guaranteed availability requirements. Should the revised policy be finalized, it should apply only to individuals entering the grace period and past-due premiums accrued after the effective date of the final rule.

Annual Open Enrollment Period (§ 155.410)
The AOA urges CMS to maintain the period from November 1, 2017 through January 31, 2018 as the annual open enrollment period for non-grandfathered, single risk pool compliant individual market coverage in 2018. While we agree that an open enrollment period beginning on November 1, 2017 and terminating on December 15, 2017 would align more closely with Medicare's annual election period and many of the annual enrollment periods established for employer-sponsored coverage, the AOA cautions CMS that there continues to be a significant degree of consumer confusion surrounding plan options, enrollment processes, eligibility determinations and other decision factors for purchasers accessing coverage via the individual market. Thus, we do not believe that a month-and-a-half open enrollment period provides sufficient time for consumers to review their options and enroll in or change QHPs for the upcoming plan year. We are concerned that shortening and/or shifting the enrollment window, regardless of the level of outreach conducted, may make it less likely that young and healthy people sign up for coverage, could cause uninsured or underinsured individuals to miss the deadline to select a plan, or might result in individuals and families that currently have coverage being auto-enrolled into plans that no longer meet their needs.

The AOA supports CMS' efforts to expand targeted outreach and education efforts. Raising public awareness about the law and providing information about financial assistance, the accessibility of enrollment help, and the availability of a variety of coverage options will continue to play a key role in growing enrollment, improving the risk pool, and stabilizing the individual market as we look towards the next open enrollment period.

Special Enrollment Periods (§ 155.420)
We appreciate CMS' intent to stabilize the market through changes to special enrollment periods (SEPs). We offer our comments on pre-enrollment verification, metal-level upgrades, eligibility limits, and exceptional circumstances.

First, on pre-enrollment verification, we are concerned that the proposal to require pre-enrollment verification of all new applicants starting in June 2017 will not necessarily result in market stabilizing effects. In fact, the additional upfront paperwork may be a disincentive for some populations that

QHPs may seek to cover, such as young people or healthy individuals who lose employer coverage. We believe that a staggered approach to increasing pre-enrollment verification, such as by ramping up the demonstration project, will better inform the effects of pre-enrollment verification on the marketplace. This approach will also provide an opportunity for federal regulators and issuers to test processing systems and ensure that additional volume can be reasonably managed through HealthCare.gov. In addition, we support the CMS proposal that eligibility should be confirmed via electronic means to speed up the process, and to further encourage younger individuals to enroll who are much more likely to participate in a process that only requires their electronic interaction versus postal mail, telephone, or the like. We further suggest that the verification process should be capped at no more than 30 days, once the applicant has submitted all relevant documentation to the QHP. Finally, we support the proposed rule's provision that coverage would be retroactive to the date of plan selection, once the applicant is approved.

Second, regarding metal-level coverage upgrades, we support the proposed option to switch metal-levels if additional people are added to the plan through birth or marriage. This will enable consumers to get sufficient coverage for their health care needs as a family.

Third, regarding eligibility limits, we caution against the proposal to restrict eligibility for consumers who lost coverage for non-payment of premiums unless the applicant pays past-due premiums for previous coverage. This proposed policy would lock out applicants in need of coverage. Closing the door on these populations, who may be more vulnerable than others, is a disservice to them and the physicians who provide their care. Further, this proposal undermines the intent of the ACA to increase coverage to vulnerable populations. Applicants that fell on hard times and were unable to make premium payments should not face further obstacles to securing new coverage. Thirty-two percent of counties in the United States will have one QHP issuer in 2017[1]—therefore under the proposed rule, consumers who are terminated for non-payment will effectively be shut out from being able to secure any coverage at all during the next open-enrollment period. A sudden medical issue can very quickly leave a consumer too incapacitated to work (even just temporarily) and earn the income necessary to pay their premiums. Should they then be terminated from coverage, even once they have regained the ability to earn sufficient income to afford premium payments, it can take much longer for them to be able to build up the funds necessary to pay off their past-due amounts in time for the next open enrollment period. This leaves a very likely scenario that many consumers in areas with only one QHP issuer will be unable to obtain coverage. We would ask CMS to instead explore alternatives to this proposed change that still would hold consumers to their payment responsibilities, but not completely shut them out of coverage. For example, demonstrated adherence to a repayment plan could be one such alternative, at least in these single-issuer areas.

Fourth, regarding limits to exceptional circumstances, we urge CMS to use caution in limiting these circumstances to ensure that applicants are not unfairly prevented from securing coverage. We appreciate the desire to limit exceptional circumstances to those that are "truly exceptional" but question how CMS will set these limits in a verifiable way that can reflect the needs of multiple consumers. We urge flexibility that is sufficient for consumers with exceptional circumstances to be able to enroll in a timely manner.

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[1] Kaiser Family Foundation. *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces.* October 24, 2016, updated November 1, 2016. Available online: http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/

Continuous Coverage
The AOA agrees with CMS that the advancement of policies that promote continuous enrollment in health insurance coverage and discourage individuals from waiting until illness occurs to become enrolled are critically important to achieving a more stable and sustainable marketplace. With that said, the AOA does not support adoption of continuous coverage standards that would create additional barriers to access for consumers. The AOA believes that the imposition of pre-existing condition exclusions, health status underwriting allowances, waiting periods, and/or enrollment penalties as contemplated under a continuous coverage approach would conflict with CMS' stated goal of expanding access and encouraging uninsured individuals to enroll in coverage.

Actuarial Value (§ 156.140)
The AOA supports CMS' efforts to reduce costs, but we oppose the proposed expansion of the *de minimis* variation in actuarial values as a means to achieve a reduction in premiums. Actuarial value refers to the percentage of total average costs for covered benefits that a plan will cover and, by law, all non-grandfathered, single risk pool compliant individual and small group health plans are currently tiered by four base actuarial value levels: 60 percent (bronze), 70 percent (silver), 80 percent (gold) and 90 percent (platinum). Current rules allow a *de minimis* variation of -/+ 2 percentage points to account for differences in actuarial estimates and calculations. Pursuant to the Notice of Benefit and Payment Parameters for 2018 final rule, certain "expanded" bronze plans (i.e., those that cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan) may have actuarial values ranging from 58 percent to 65 percent starting next year. Under the proposed rule, CMS would expand the *de minimis* range to - 4/+ 2 percentage points for all other base plans required to comply with actuarial value standards.

Pursuant to the ACA, the value of each enrollee's APTC is determined by subtracting the maximum payable amount for the second-lowest cost silver plan available through a state's Exchange from the total premium of the second-lowest-priced silver plan (i.e., the benchmark plan). The AOA cautions that finalization of the standards in the proposed rule could result in the selection of benchmark plans with an actuarial value of 66 percent, which would almost certainly reduce the amount of financial assistance, in the form of APTCs, available to millions of individuals and families utilize to purchase coverage. Consumers would be forced to choose between paying more for premiums or more on cost-sharing to account for selection of a plan with a lower actuarial value.

CMS acknowledges in the preamble of the proposed rule the inherent risk that an expansion of the *de minimis* range for base plans poses, stating: "A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government;" and "The proposed change could reduce the value of coverage for 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."

Thus, the AOA recommends that CMS maintain the current *de minimis* AV requirements of -2/+5 percentage points for expanded bronze plans and -/+2 percentage points for all other base plans. In the event CMS' proposal regarding actuarial value is finalized, the AOA recommends that rulemaking establish guidance requiring a state's benchmark plan to have an actuarial value of no less than 70 percent.

Network Adequacy (§ 156.230)

We understand CMS' goal to reduce the cost of operating QHPs, but stress that proposals to minimize or substantively redefine requirements on network adequacy will adversely impact beneficiaries and physicians. Networks within some QHPs are already too narrow and limited to offer necessary care to beneficiaries, especially for lowest cost-sharing tiers in which there are insufficient numbers or specialties of providers to offer consumers adequate access to covered services. Further, providers in narrow networks are challenged to coordinate patient care and are forced to take on more responsibility for the patient due to lack of other providers in network. This provides a disincentive for physicians to contract with QHPs that have narrow networks to begin with, potentially creating an increasingly downward spiral. As such, the proposed rule may provide incentives for QHPs to stay in the marketplace, but does not provide incentives for physicians to contract with those QHPs, thus generating access issues of a different nature for beneficiaries. We encourage CMS to strengthen networks, rather than erode them, and offer the following suggestions to meet those aims:

First, we believe it is the QHP issuer's responsibility to provide accurate information regarding its plans to ensure that beneficiaries, particularly those in underserved areas, have access to physicians and care they need without disruptions or delays. The importance of having access to accurate directories cannot be overstated. Accurate physician directories are necessary for properly overseeing the adequacy of the health plans and for patients who rely on these listings to evaluate their health plan options during open enrollment. Incorrect or out-of-date information diminishes the transparency of the program, and patients are left confused over whether or not a physician is participating in a given plan. When changes are made, provider directories should be updated within 15 days. A provider directory will be considered easily accessible when the general public is able to view all of the current providers for a plan on the plan's public website through a clearly identifiable link or tab, without having to create or access an account or enter a policy number. As well, if the plan issuer maintains multiple networks and plans, the general public should be able to easily discern which providers participate in which plan(s) and provider network(s). Further, CMS has provided on Healthcare.gov a rating of some QHP's relative network coverage. We support including such a rating system on the website for all plans which could help an enrollee select a plan that best meets his or her needs.

Second, while we support states' ability to regulate their insurance market, wide variation exists on how network adequacy is determined. We believe that consistency is important, and suggest that CMS maintain a minimum standard and allow more stringent requirements to prevail in states where they have been adopted. We support current approaches of determining network adequacy including time and distance, and wait-times. This should be established by CMS as a baseline test for assuring network adequacy. Using both time and distance will factor in the challenges patients face depending on where they live, access to transportation, and socioeconomic conditions. For example, the amount of time it takes to go a doctor's appointment may take longer for a person who is dependent on public transportation versus a person who drives a car. Time and distance are also important factors for complex chronically ill patients in need of specialty care. Such patients may have limited capabilities, therefore extended time and distance for travel to an appointment for treatment could be prohibitive. Using wait-times for scheduled appointments further indicates the presence of challenges to obtaining access to needed care. A wait-time measure should be an option under permissible state standards and should give particular attention to rural and underserved areas.

Third, if states want to adopt a more sophisticated method of determining network adequacy, standards provided in the National Association of Insurance Commissioners (NAIC) model act is a fair starting point. However, we remain concerned with a provision that would allow state regulators to use telemedicine/telehealth as a means for meeting network adequacy standards. Not all services can be safely and appropriately delivered using telemedicine, and therefore cannot and should not be used in network adequacy determinations.

We continue to support the progress made by the NAIC in defining tiered networks and movement away from using accreditation as meeting regulatory standards. If CMS continues down the path proposed, we suggest clarification on the standards used to evaluate plans that lack accreditation and are sold in states that fail to have a defined mechanism for assuring network adequacy in place. We recommend that the NAIC language on tiered networks be incorporated into the proposed rule. While the current language infers that the proposed rule adopts the network adequacy language (Section 5) of the NAIC model act as a whole, the tiered network definition or related language are not found in the proposed rule. We believe it is necessary to clarify this section by specifically mentioning tiered networks and their relationship with network adequacy standards as referenced in the NAIC model act.

Finally, it is important that networks support continuous and coordinated care, and that instability is mitigated. We suggest that enrollees should be notified of changes to the network on a timely basis as they need accurate information about which providers are in-network to ensure that they can optimize their health insurance coverage and access the care they need to remain healthy. Therefore, we believe enrollees should receive written notification of a discontinued provider at least 45 days prior to the effective date of the change to maximize their chance of coordinated care. Further, the QHP should work with the provider to obtain the list of affected patients or use claims data to identify the enrollees. We also recommend that QHPs be required to notify the enrollee of other comparable in-network providers in the enrollee's service area, provide information on how an enrollee could access the plan's continuity of care coverage, and to have the enrollee contact the plan with any questions. We believe this will maintain access and continuity of care as well as help ensure up-to-date provider directories. Additionally, we believe when a provider's contract is non-renewed, it should be considered as a termination without cause under section 156.230(e)(1). We also recommend that enrollees should be allowed to continue treatment until the treatment is complete or for 90 days (whichever comes first) regardless of the grounds for termination of the contract, unless the contract is terminated due to quality concerns that could pose jeopardy to patient health and safety.

Essential Community Providers (§ 156.235)
We are opposed to CMS' proposal to roll back the required Essential Community Providers' (ECP) threshold from 30 percent to 20 percent. This policy would restrict access to basic health care, including from physicians that serve predominately low-income, medically underserved communities. We understand that previous challenges with identifying ECPs due to late lists may have restricted QHPs meeting the 30 percent mark, but we are confident that lower standards are not the solution.

Truncated Public Comment Period
The AOA respectfully objects to the truncated public comment period provided by CMS under this proposed rule. The proposed rule was published in the *Federal Register* on February 17. 2017,

allowing less than three weeks for stakeholders to review CMS' proposals and respond by the established deadline of March 7, 2017. In the future, the AOA requests that CMS provide a public comment period of no less than 30 days from the time a proposed rule is published in the *Federal Register*. We believe that 30 days is the minimum amount of time that should be made available for stakeholders to read, digest, assess, draft, and electronically file or mail meaningful comments on a proposed rule.

We appreciate that the current system may not provide sufficient incentives for insurers to remain in the Exchanges, and appreciate CMS' effort to create more stability. However, these proposed adjustments to the current system should not reduce coverage or access for people in the US, especially those who already have coverage through the Exchanges. We appreciate the opportunity to advance this effort and would be pleased to provide additional insight as you complete rulemaking. To do so, or for additional information, please contact Laura Wooster, Senior Vice President for Public Policy, at lwooster@osteopathic.org, or (202) 349-8747.

Sincerely,

Boyd R. Buser, DO
President