

March 7, 2017

Patrick Conway, MD  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Acting Administrator Conway:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on market stabilization. While the AMA recognizes that a stable individual health insurance market is necessary to ensure health insurer participation and competition, we are concerned about the potential impact that this proposed rule could have on patients and their physicians. If finalized as proposed, the rule would raise premiums, out-of-pocket costs, or both for millions of moderate-income families and would make it more difficult for eligible individuals to enroll in health insurance coverage and access needed care. The AMA's concerns are detailed further below.

#### Guaranteed Availability of Coverage

CMS proposes to change the rules related to guaranteed availability of coverage in situations where a consumer owes a debt to an insurer for a previous year's coverage and is trying to reenroll with the insurer. Under current regulations, individuals cannot be denied coverage simply because they owe a debt to an insurer for a previous year's coverage as long as the consumer is not reenrolling in the same product from which the consumer was terminated for nonpayment. Now, CMS is proposing that an insurer can condition coverage for a new enrollment period under the same or a different product on payment of the amount due by the consumer. The insurer could refuse to enroll a consumer—as long as state law does not prohibit such action—until an individual has paid all past due premiums owed to that insurer. CMS states that this change in approach would not be considered in violation of the guaranteed availability requirement in the Affordable Care Act (ACA).

This proposed change involves the three-month grace period, under which a consumer who is receiving advance premium tax credits and falls behind on premium payments cannot be terminated from coverage until the end of the grace period. During the first month the insurer will pay provider claims, but will pend claims for the second and third months. If the enrollee does not pay the owed premium, the insurer may terminate coverage as of the end of the first month and not pay any claims for the second and third months. Now, CMS is proposing to make an insurer who is owed past premiums whole. We believe if this change is finalized, then physicians who have treated an enrollee under these circumstances should

also be paid for any services provided during a grace period for which the enrollee owes premium payments. We urge CMS to require any insurer who is owed premium payments from an enrollee who was terminated from coverage for non-payment of such premiums and who subsequently pays the insurer such past debt in order to reenroll with the insurer, to reimburse physicians for any claims submitted during the second and third months of the grace period which were pended by the insurer.

### Open Enrollment for 2018 and Beyond

Since the first year that the ACA marketplaces began operating, the open enrollment period has declined from six months to three months. The U.S. Department of Health and Human Services (HHS) had earlier proposed that the open enrollment period for 2018 would be from November 1 to January 31; beginning with 2019, the open enrollment period would be cut to 45 days and would run from November 1 to December 15. CMS now proposes moving that change up a year by reducing the open enrollment period for 2018 to 45 days. We recognize that this change might better align with open enrollment periods for employment-based coverage as well as for Medicare and could simplify operational processes for insurers and the marketplaces. However, a six-week open enrollment period that may coincide with holiday distractions simply may not be enough time for consumers, especially young adults, to focus on and understand their health insurance options and enroll. We recommend that CMS consider either delaying this change or consider moving the open enrollment period so that it begins in October. If CMS moves ahead with its current proposal, we strongly agree with the need to engage in extensive outreach and education to ensure that all consumers are informed about the shorter time frame to enroll in coverage and that they understand the consequences of failing to do so during this period. We also recognize that it will be critical for CMS to have the necessary resources to undertake such an outreach and education effort, and that if such resources are not available, CMS should consider lengthening the open enrollment period.

### Special Enrollment Periods

CMS is proposing several changes to tighten up special enrollment periods (SEPs), both to discourage inappropriate use of SEPs and adverse selection, and to encourage consumers to maintain continuous coverage. While we recognize that the risk pools need to be balanced between healthier and sicker individuals, the AMA is concerned that these proposed changes could instead create barriers that would make it more difficult for enrollees who are currently eligible for SEPs to successfully enroll in coverage. SEPs are key to ensuring that consumers have access to health insurance and can make changes in such coverage following certain life events, such as marriage, adoption or birth of a baby, or after circumstances that might have been unanticipated during open enrollment, such as the loss of employment-sponsored coverage. Despite complaints by insurers that ineligible consumers have been enrolling in coverage through SEPs, thereby increasing claims and decreasing revenues for insurers, there is some evidence that the real problem is not that too many consumers are inappropriately using SEPs, but that too few are. According to a study by the Urban Institute last year, only an estimated five percent of those eligible for coverage under SEPs are enrolling.

CMS already took a number of steps in 2016 to either tighten up or eliminate some SEPs, including requiring documentation for some SEPs and modifying the risk adjustment formula to recognize higher plan costs for partial year enrollees. CMS also announced that it would begin a pilot program in June of 2017 to require pre-enrollment eligibility verification for half of new SEP applications and test whether this would affect the risk pool. Now, however, CMS is proposing to move forward with pre-enrollment verification of eligibility for all SEP categories for all new applicants in states using the HealthCare.gov

platform. CMS already has some data about what happens with increased documentation requirements: in 2016, after extra documentation was required for SEPs, there was a 20 percent decrease in SEP enrollments. Of particular note, younger consumers were much less likely to finish the verification process than older consumers—only 55 percent of those aged 18 to 24 completed the process compared to 73 percent of those aged 55 to 64. We recommend that instead of expanding pre-enrollment eligibility verification as proposed, CMS should instead proceed with the pilot program so that it can gather and assess data on how the risk pool is actually impacted, and then move forward with any policy changes based on that evidence.

CMS also proposes to limit metal level plan changes during SEPs or require evidence of continuous coverage for certain SEPs. For example, following marriage or the birth of a child, an individual enrolled in coverage would be eligible for an SEP. Under the proposed rule, however, the enrollee would not be able to choose a new plan with a different metal level but would be limited to adding the spouse or child to the current enrollee's plan with some minor exceptions. Enrollees would also be banned from changing metal levels for most other SEPs, including after a permanent move. In addition, CMS is proposing to require continuous coverage under the marriage SEP and the permanent move SEP. We are concerned that these limitations will make it more difficult for consumers to understand their options for making changes in their coverage after life-changing events, and that the continuous coverage changes might undermine guaranteed issue protections.

#### Continuous Coverage

In the preamble to the proposed rule, CMS asks for comments on adopting policies that promote continuous enrollment in health coverage and to discourage consumers from waiting until they are sick to enroll in coverage. To encourage healthy consumers to maintain coverage and protect against adverse selection, the ACA chose an individual mandate rather than a continuous coverage requirement. The AMA continues to believe that an individual mandate remains the best way to maximize coverage gains, as well as help ensure healthy individuals enroll in coverage and stay covered. The AMA also supports continued health insurance coverage for patients with pre-existing medical conditions who are transitioning between health plans. It is unclear how well individuals will understand the consequences of a "continuous coverage" requirement, nor how such a requirement would impact those with complex health problems, unstable employment and/or limited income. We could not support denying guaranteed issue or pre-existing condition coverage limitations because someone has an unforeseen gap in coverage.

#### Actuarial Value

The proposed rule would modify the current de minimus variations allowed in actuarial value (AV), from the current +/-2 to -4/+2 percentage points for the four metal levels of plans offered through the exchanges (except for bronze plans, which could vary from -4 to +5 percentage points). While at first glance the proposed changes appear minor, upon closer review they are problematic. The changes would allow insurers to offer plans with higher deductibles and other out-of-pocket costs, but with slightly lower premiums. Healthy, higher income individuals might be interested in such plans. However, we are concerned that this change would, in turn, reduce the value of the advanced premium tax credits, which are determined based on the second lowest cost silver plan premium. Consumers with moderate incomes would be confronted with higher out-of-pocket costs, either through premiums or cost-sharing. This would mean that for consumers who wanted to keep the same coverage they currently have, tax credits

would cover less of the cost. Either way, patients will end up paying higher premiums or opting for worse coverage.

### Network Adequacy

The AMA is concerned that the proposed rule would undo progress made toward ensuring adequacy of provider networks, and, as a result, will impede access to care for patients. In efforts to reduce premiums, insurers are increasingly narrowing their provider networks. As a result, strong network adequacy requirements and regulations are more important than ever. Unfortunately, at this critical time, this proposed rule unravels many of the positive changes CMS has taken to address patient access in narrow networks.

The proposed rule essentially lays out three pathways through which networks could be regulated—state oversight, accreditation, or health insurer attestation to meeting access plan provisions in the National Association of Insurance Commissioners’ (NAIC) Health Benefit Plan Network Access and Adequacy Model Act (NAIC Model Act). The AMA is concerned about all three of these vehicles for regulation.

While many states have network adequacy requirements in place, most are insufficient to address the needs of patients in this new “narrow network” environment. This insufficiency has lead regulators, including the NAIC, legislators, patient groups, provider organizations, and many other stakeholders to push for changes to network adequacy requirements in the states. While some states have been successful in making meaningful changes to address narrower networks (e.g., Maryland, Connecticut), most states have not acted. Thankfully, CMS recognized the immediate need for stronger requirements and established a minimum federal standard for network adequacy that included quantitative, measurable standards. CMS’ current proposal would remove that floor. The AMA believes that state regulators should have flexibility to regulate their provider networks, but we also believe there is a critical need for a minimum federal network adequacy standard that includes quantifiable standards, especially in light of inaction in many states to update network adequacy requirements. We urge CMS to maintain a federal minimum standard and to move forward in further developing it.

Additionally, the AMA strongly opposes the idea that accreditation could serve as a substitute for network adequacy regulation and is deeply concerned about the impact that this alternative would have on patient access to care. There is great value in accreditation, and as noted in the proposed rule, all health plans in the marketplace have been accredited by a federally-approved accrediting organization. However, accreditation, as a substitute for active oversight, is a concept previously rejected by the nation’s insurance commissioners in the NAIC’s Model Act and by HHS itself. Accreditation standards are not available to the public, accreditors do not have regulatory authority over plans, and these organizations are not in a position to monitor network adequacy via consumer complaints or other such commonly used means. We strongly urge CMS to recognize accreditation as an important complement to active regulation of provider networks, but not as a substitute.

Finally, while the AMA views many of the network adequacy proposals in the NAIC Model Act as good starting points to build strong network adequacy legislation, the model is meant to be just that—a starting point for legislation. It is a document filled with drafting notes and options for state legislators to consider and on which to reach consensus, and was not drafted as a polished regulatory tool. We believe there are many provisions of the NAIC Model Act that could inform excellent network adequacy regulation, specifically those that prevent reliance on accreditation by regulators and encourage active

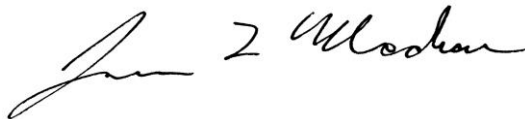
regulation of provider networks using quantitative standards. We encourage the adoption of these specific proposals by state regulators and CMS.

Essential Community Providers

The AMA is very concerned that a reduction of the minimum essential community provider (ECP) requirement from 30 percent to 20 percent would result in serious access issues for some of the nation's most vulnerable patients. ECPs include those that care for individuals in low-income and/or medically underserved communities, often the same patients that are negatively impacted by inadequate networks. The current ECP requirement is an important protection from discriminatory network designs and network structures that leave out providers that care for these underserved patients. On its own, this proposal to reduce the ECP requirement would have a very negative impact on vulnerable populations, and combined with the network adequacy proposals could be devastating for many patients. Moreover, the analysis of the hardship on insurers associated with the current ECP requirement shows minimal administrative impact at best. We strongly oppose going forward with a proposal that would threaten patient access to care in the name of a minimal paperwork reduction on a handful of insurers.

Thank you for considering our comments. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at 202-789-7409 or [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org).

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD