November 27, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9930-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019 [CMS-9930-P]

Dear Administrator Verma:

This letter includes comments on the provisions of the proposed Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2019 that contribute to the Trump Administration's sabotage of the Affordable Care Act (ACA). "Sabotage" is defined here as actions that undermine rather than sustain the reformed individual and small group markets. Such actions undermine markets by driving out low-cost enrollees and driving in high-cost enrollees. The consequence is disproportionately costly enrollees, high health insurance premiums, reduced insurer participation, and, in some cases, increased costs to taxpayers – which President Trump said is "great politically" since, as a result, "Democrats will come and beg for us to do something" to repeal the ACA. [1]

This letter first describes the specific provisions of proposed Notice (CMS-9930-P) that could undermine insurance markets. Second, the letter provides background on concerns about sabotage that the notice, if finalized unchanged, would exacerbate. This letter does not address proposals like changing essential health benefit standards which directly reduce consumer protections for all enrollees rather than destabilize markets; they, too, are critical to address as other comment letters surely explain.

I urge you to change the policies described below in the final notice to preserve and improve private insurance enrollment and affordability.

PROVISIONS IN THE PROPOSED NOTICE THAT COULD CONTRIBUTE TO SABOTAGE

Rolls back Navigator requirements: The ACA requires all Exchanges (or Marketplaces) to have Navigators, which must maintain a current understanding of available health insurance options, conduct public education and awareness campaigns, help consumers understand their choices, facilitate their health insurance decisions, and ensure their access to consumer protections.[2] The proposed notice would remove the requirements that two Navigators serve each Marketplace,

and that one be a community and consumer-focused group. It also would end the requirement that Navigators have a physical presence in service areas, potentially leaving residents in parts of the country without this statutorily required service. This will likely lead to lower enrollment, particularly of low-income and healthy people who may not sign up without such help. Compared to other shoppers, people who receive in-person assistance are nearly 40 percent more likely to enroll in coverage.[3] This proposal also raises serious questions about whether Navigators would be able to meet their statutorily required duties, such as providing information "in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges." The Administration should not finalize these proposals.

Increases verification for enrollment of low-income people: Because program integrity is primarily targeted at people claiming premium tax credits that are too high rather than too low, documentation from applicants is required when reported income is lower than that reflected in data from the Internal Revenue Service and other sources. The proposed notice changes this to require applicants reporting income between 100 and 400 percent of poverty whose records show income below 100 percent of poverty to document their income. People with low incomes tend to have variable employment – multiple part-time jobs, part-year jobs, or variable hour jobs – that makes providing paper documentation particularly difficult. In addition, the process may be overly confusing for affected consumers. As such, this would likely discourage eligible and likely relatively healthy people not to enroll due to lack of sufficient paperwork to get coverage. This proposal should not be finalized.

Limits price competition: Standardizing plans' cost sharing designs encourages competing insurers to focus on lowering premiums and increasing quality. "Simple choice plans" with standardized deductibles and copays were implemented as an option for HealthCare.gov insurers in 2017 and will be offered in 2018 as well. The proposed notice would end them, along with a requirement that a single insurer's plans must be "meaningfully different" from each other. Both changes would create confusion and make it less likely that consumers make the best choice. It could also lead to benefit designs aimed to attract healthy enrollees and repel sick ones. The final notice should continue, evaluate and, if successful, expand these provisions designed to lower premiums and increase consumers' ability to make informed choices.

Promotes direct enrollment: The proposed notice would further promote direct enrollment by agents, brokers, and insurers who want to steer healthy applicants to non-ACA compliant plans, undermining the risk pool. It would do so by allowing greater use of their private websites and letting them select their own auditors, weakening oversight. The final notice should instead ensure that these entities provide fair, unbiased information about ACA-compliant coverage and available subsidies to all consumers, as the Exchanges (or Marketplaces) for which direct enrollment entities are acting as a proxy would do. In addition, the federal government should maintain strong oversight of direct enrollment entities and their websites to ensure shoppers are presented with their full range of options and are not steered into non-ACA compliant coverage.

Ends SHOP enrollment: As signaled earlier in the year, the Trump Administration is effectively ending the requirement that each Marketplace allow small businesses to buy qualified health plans online through SHOP Exchanges (or Marketplaces). The proposed notice would maintain websites for comparing plans, the SHOP's role in eligibility determination for premium tax credits, and policies such as an annual open enrollment period. But, small businesses would have to return to a system of using agents and brokers or directly signing up with insurers except in states that opt to continue to have SHOP perform those functions. These alternatives may have a financial incentive to help only low-cost small businesses. This final notice should add requirements to ensure that fair and impartial information and enrollment processes are offered by agents, brokers, and insurers in the absence of a SHOP website for enrollment.

BACKGROUND

Reformed Health Insurance Markets Inherited by the Trump Administration

The ACA has increased affordable access to private insurance for all Americans in three major ways. First, it has opened the door to such coverage for people with pre-existing conditions. Insurers offering individual or small group coverage can no longer charge more or deny coverage to avoid high-cost enrollees. Second, it provides financial assistance to uninsured people with too much income to qualify for Medicaid but too little to afford private coverage. And, third, it incentivizes enrollment of uninsured people who can afford coverage but previously didn't think it was worth it through the shared responsibility provision (a.k.a., the mandate). Under this provision, uninsured people who can afford coverage but still don't buy it pay a tax. The ACA also made the process of signing up for coverage much easier than it previously was through Marketplace websites, in-person assistance, reduced paperwork, and government (rather than insurer) marketing.

Republican efforts to sabotage the ACA began on the day it was signed into law, March 23, 2010.[4] Lawsuits filed by that day ended in a Supreme Court decision that made the ACA Medicaid expansion a state option rather than a requirement. In states that have not taken the expansion, individual market premiums are 7 percent higher than in states that expanded Medicaid since this group tends to have higher health needs.[5] The Republican Congress shut down the government over ACA implementation funding in 2013 and blocked the Administration's ability to make risk corridor payments, a type of temporary stabilization program, which contributed significantly to insurers' losses in 2014 and 2015.

Despite this sabotage, the Obama Administration left the Trump Administration stable individual and small group markets.[6] Financial performance improved in 2016. The Centers for Medicare and Medicaid Services (CMS) reported that in 2016 risk scores did not increase in the individual insurance market and dropped by 4 percent in the small-group market, technical evidence that these markets' stability has improved.[7] The previous Administration allowed what most experts agree were one-time price corrections for 2017.[8] Preliminary data for 2017 show that this worked: individual market insurer loss ratios and profits were better for the first half of this year

than any previous year going back to 2011.[9] Had Republicans not escalated their sabotage of the ACA marketplaces, premium increases would have been in the mid- to high single digits for 2018.[10]

The Trump Administration's Intent to Sabotage Reformed Insurance Markets

President Trump has been clear since he launched his campaign that his goal is to repeal the ACA – one way or another. This commitment was in his announcement to run for President.[11] On February 9, 2016, he tweeted, "We will immediately repeal and replace ObamaCare - and nobody can do that like me."[12] On August 8, 2016, Trump stated, "One of my first acts as President will be to repeal and replace disastrous Obamacare…."[13] And after he was elected, he and Congressional Republicans made it their first legislative priority.

President Trump and his Administration have pursued the ACA's repeal through unilateral executive action as well. On his first day in office, President Trump signed Executive Order No. 13,765, "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal,"[14] indicating intent to use executive actions to thwart current law. On January 25, 2017, President Trump stated, "[T]he best thing we could do is nothing for two years, let [the ACA] explode. And then we'll go in and we'll do a new plan and—and the Democrats will vote for it. …. And to do it right, sit back, let it explode and let the Democrats come begging us to help them because it's on them."[15] On October 10, 2017, in advance of issuing Executive Order No. 13,813, President Trump tweeted, "Since Congress can't get its act together on HealthCare, I will be using the power of the pen to give great HealthCare to many people – FAST."[16] And, after his actions (described below) contributed to premium increases, on October 17, 2017, President Trump stated, "Obamacare is virtually dead. At best you could say it's in its final legs. The premiums are going through the roof. The deductibles are so high that people don't get to use it. Obamacare is a disgrace to our nation, and we are solving the problem of Obamacare."[17]

President Trump's agenda, to undermine the law administratively, has been echoed by his senior officials and spokespeople. In June 2017, HHS produced and posted 23 video testimonials "from people who said they had been 'burdened by Obamacare,' including families, health care professionals and small business owners."[18] In responding to press reports about reduced outreach, an HHS spokesperson said, "The American people know a bad deal when they see one and many won't be convinced to sign up for 'Washington-knows-best' health coverage that they can't afford."[19] In October 2017, the same spokesperson said, "The Trump administration is determined to serve the American people instead of trying to sell them a bad deal."[20]

The Trump Administration's Actions on Sabotage to Date

To make these claims a self-fulfilling prophesy, the Trump Administration has taken actions that have (a) raised premiums in the reformed individual and small-group markets, driving out lower risk enrollees; (b) reduced efforts to enroll people in these markets, which affects those who need coverage less since those who need coverage more will seek coverage anyway; and (c) erected

barriers to enrollment, which young and healthy uninsured are less likely to work to overcome than people with pre-existing conditions. A list of specific actions taken is below.

Actions that Have Raised Premiums

Implied lack of enforcement of the individual mandate: On the day of his inauguration, President Trump signed an Executive Order that indicated an interest in granting exemptions to the individual mandate.[21] Subsequently, on February 14, 2017, the Internal Revenue Service (IRS) cancelled implementation of a policy to improve enforcement of the individual mandate.[22] While the IRS reversed this decision in October, 2017,[23] this was after insurers set their premiums for 2018. Research suggests that uninsured people who sign up due to the mandate have health costs significantly below other enrollees.[24] Preliminary analyses suggest that the lack of commitment to enforcing the individual mandate accounted for up to a 20 percent increase in individual market premiums for 2018.[25] And, while the President continues to urge Congress to repeal the individual mandate as part of tax reform, on November 6, 2017, the press reported that in the face of Congress's unwillingness to pass a bill repealing the individual mandate, the Administration was readying an executive order to attempt to do the same by unilateral executive action.[26]

Ended payments for cost sharing reductions: On October 12, 2017, after repeatedly suggesting he would do so, President Trump ordered an end to making cost sharing reduction (CSR) payments to insurers to offset their costs of lowering deductibles and copayments for low-income enrollees.[27] In 2014, the House of Representatives had sued the Obama Administration over the source of these payments. They did not challenge that insurers are owed this funding, nor whether eligible consumers are guaranteed lower costs as a result of the funding. Instead, the lawsuit was solely based on the claim that the Congress had not appropriated funds for the CSR payment program even though it was mandatory under the ACA. The Trump Administration, after threatening to do so for months, agreed with the House and stopped making such payments effective October 1, 2017. Experts estimate that the end of CSR payments has resulted in premium increases ranging from 7 to 38 percent for silver plans.[28]

Increased premiums for the same coverage by reducing silver plans' actuarial value: The final Market Stabilization rule posted on April 13, 2017 allows insurers offering silver plans in the individual and small group markets to lower the actuarial value (AV) by two percentage points more than previously allowed (to 66 percent).[29] Because the premium tax credits for the Marketplaces are linked to the silver plan with the second lowest cost, this likely means a drop in the value of the premium tax credit as well. For the roughly three million Marketplace enrollees who receive tax credit but not cost sharing reductions, this change means they could have to pay on average $131 per year more for the same level of coverage – or pay the same premium but pay higher deductibles and copays.[30] This backdoor reduction in financial assistance could discourage young and healthy people from signing up for coverage.

Extended transition plans through 2018: On February 23, 2017, the Trump Administration announced it would delay by a year the deadline for insurers to stop selling "transitional" policies.[31] Such policies, if allowed by state authorities, allow insurers to renew plans not in compliance with a number of the ACA's consumer protections. Designed originally as a way to phase in compliant coverage, their extension allows for insurers to cover healthy enrollees in such plans, while sending sicker enrollees to the Marketplace. One actuary estimates that keeping transitional policy enrollees out of the Marketplace raises average risk and costs by 2 to 4 percent, depending on the state.[32]

Slowing down approvals of waiver proposals to lower premiums: The press reported that President Trump personally called CMS Administrator Seema Verma and directed her to deny approval of a waiver request from Iowa after reading an article about its potential benefits.[33] Iowa subsequently withdrew its waiver application. Additionally, Oklahoma Secretary of Health and Human Services Terry Cline stated that CMS's failure to approve Oklahoma's own relatively simple waiver would "prevent thousands of Oklahomans from realizing the benefits of significantly lower insurance premiums in 2018."[34]

Actions that Reduced Education, Outreach, and Enrollment Efforts

Stopped planned ads for the final week of 2017 open enrollment: Under the ACA, Marketplaces must "facilitate[] the purchase of qualified health plans."[35] HHS regulations further specify that Exchanges "must conduct outreach and education activities . . . to educate consumers about the Exchange and insurance affordability programs to encourage participation."[36] Yet, less than a week after inauguration, the Trump Administration announced its cancellation of planned advertisements for the final days of open enrollment for 2017 Marketplace coverage, which ended on January 31, 2017.[37] The former Administration's chief marketing officer estimated that this reduced enrollment by nearly 350,000.[38] A report by the HHS Office of the Inspector General found that this decision resulted in over a million dollars in unrecoupable costs and was made with knowledge that it could worsen the risk pool for the individual market.[39]

Dramatically reduced spending on marketing and Navigators for 2018 open enrollment: On August 31, 2017, the Trump Administration announced a 90 percent reduction in outreach funding and 40 percent reduction in funding consumer enrollment assistance through the statutorily required Navigator program.[40] The outreach cut means no national television campaign this year. And, in response to the funding cuts, 89 percent of Navigator programs reported that they laid off staff and reduced spending on marketing (advertising) and 81 percent reduced the number of activity and events.[41]

Without a sustained indirect and in-person effort, many people will remain unaware of the availability of affordable coverage options and thus remain uninsured. An estimated two in five uninsured adults have not heard about the Marketplaces.[42] In part, this is because the uninsured are a transient group: people aging off coverage, in between jobs, or losing coverage on a family plan. There also is confusion generated by this past year of debate over the future of the ACA.[43]

Past successful practices include tested messages; targeted emails and direct mail; digital, radio, and television advertising; optimized mobile and search tools; and in-person events that generate media coverage. [44] While private efforts have aimed to replace these previously publicly supported efforts, it is unlikely that they will be able to do so. The former CMS chief marketing officer estimates these cuts will reduce enrollment by 1.1 million for 2018.[45]

Ended contracts for in-person consumer assistance: As part of its outreach funding cuts, the Trump Administration ended contracts for in-person assistance in states using HealthCare.gov. This in-person enrollment assistance in 18 cities included enrollment fairs and sign-ups in public libraries.[46]

Barred regional office staff from participating in open enrollment events: In late September, the press reported that HHS ordered its regional office staff to no longer participate in Marketplace enrollment events.[47] In past years, regional office officials not only joined local events but often organized them, coordinating local activities toward the nonpartisan goal of helping people understand their options. While not publicly reported, presumably similar interagency engagement (e.g., Department of Transportation posting educational information on buses; Department of Housing and Urban Development posting information for people applying for housing assistance) has stopped as well.

Stopped coordination with traditional partners: On August 10, 2017, the press reported that HHS will not continue work with the Latino Affordable Care Act Coalition.[48] In each previous open enrollment period, this collaboration helped provide Latinos with the information to sign up for health insurance. One study found that Latinos disproportionately lack information on their ACA coverage options.[49] This is just one example: organizations representing young adults, faith groups, doctors, and women, among others, no longer have been brought in by the Administration to identify ways to collaborate to raise awareness of current-law benefits.[50]

Actions Making It Harder to Sign Up

Shortened the 2018 open enrollment period: The Trump Administration's Marketplace Stabilization Rule cut the number of days for the 2018 open enrollment period in half, to 45 days, compared to 2017.[51] This gives people less time to gather required information, submit their applications, shop for plans, and seek help as needed. This will likely lower enrollment for 2018, especially given the confusion caused by other changes made by the Trump Administration.

Limited access to HealthCare.gov during 2018 open enrollment: Unlike previous years, CMS announced that it plans to shut down HealthCare.gov for maintenance on all but one Sunday morning during the 2018 open enrollment period.[52] If CMS fully utilizes the 12 hours that they announced on each of these days, it is the equivalent of shutting the site down for 2.5 days during the already-shortened open enrollment.[53]

Increased verification for enrollment: The final 2018 Marketplace Stabilization rule also created new pre-enrollment verification requirements for most consumers seeking a special enrollment period (SEP) through HealthCare.gov, replacing a pilot that was assessing its implications.[54] Historically, paperwork burdens have deterred enrollment of people who are less in need of health care, leading to a greater share of enrollees having high risk and thus high cost.[55] Indeed, CMS released early data on the pilot that found only 55 percent of young adults submitted required documents compared to 73 percent of older applicants[56] – suggesting that additional verification would worsen the risk pool and raise premiums.

Required payment of past premiums prior to starting coverage: Starting in June 2017, thanks to the Marketplace Stabilization rule, insurers can deny or delay issuing coverage to a person who has prior premium debt with that insurer – a change in the ACA's guaranteed availability provision.[57] This is likely to deter enrollment of eligible low-income people who may not be able to make such a back payment. It could also lead to inadvertent coverage loss for consumers who do not owe past premiums but are told they do, or who have no other choice of insurer in their area. As with related policies, people with pre-existing conditions will be more motivated than those with low health care needs to make such repayments, resulting in fewer healthy enrollees.

Results to Date: Higher 2018 Premiums

Despite being handed a Marketplace whose stability was improving, the Trump Administration's actions have resulted in an open enrollment period with higher unsubsidized premiums and fewer choices than any of the four previous open enrollment periods. Rather than being in the single digits, 2018 premium increases average 37 percent for states using HealthCare.gov.[58] And, rather than there being more choices, there are fewer. In 2017, 56 percent of enrollees had a choice of three or more insurers; in 2018, this has dropped to 45 percent of enrollees.[59]

Future Actions that Could Contribute to Sabotage

On October 12, 2017, President Trump signed Executive Order No. 13,813 directing changes in rules because the ACA "has severely limited the choice of healthcare options available to many Americans and has produced large premium increases in many State individual markets for health insurance." The Order directs the agencies to "prioritize three areas for improvement in the near term: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs)."[60] Expanded access to each of these kinds of policies has the potential to further undermine reformed health insurance markets.

Expand short-term limited-duration insurance: In 2016, final rules were issued to limit a type of insurance called short-term limited-duration plans to last less than 90 days since these plans do not comply with other ACA reforms and were increasingly being marketed for sale for as long as 364 days.[61] Such plans are not considered minimum essential coverage and thus people enrolled in them would have to pay a shared responsibility penalty. If the Trump Administration revokes these rules, short-term limited-duration plans could be marketed and sold to people as their

primary form of health coverage. These plans can discriminate against people with pre-existing conditions; charge women more than men; impose annual and lifetime limits; exclude coverage for services; rescind coverage if they find an undisclosed health problem; and charge older Americans significantly more than others. One analysis of short-term plans sold on eHealth found that the best-selling plans excluded coverage for prescription drugs, maternity care, mental health and substance use disorder treatment, and prevention.[62] Such coverage also has relatively low value: the same study found that in 2016, the largest insurer selling such plans spent less than half of premium revenue on medical claims.[63] By attracting healthy people into these plans through low premiums, the premiums for those remaining in the individual market would increase drastically.

Expand Association Health Plans: AHPs have a history of selling cheap insurance to small businesses, but not paying claims when employees need health care, with some owners being charged with embezzlement and conspiracy.[64] To ensure adequate oversight of such plans, the health coverage bought by small businesses through AHPs is treated like any other small group health plan and subject to state oversight. Should the Trump Administration treat AHPs like large groups, small businesses with particularly healthy employees could band together and leave the small group insurance market, driving up premiums for small businesses with less-healthy workers remaining in the small group market.[65] The harm to small businesses enrolled in AHPs would be greater if the AHPs were allowed to self-insure and thus no longer be subject to state oversight.

Expand Health Reimbursement Arrangements: HRAs are accounts set up with employer funding for medical care expenses. They are considered group health plans and thus an employer's contribution is excluded from employees' income for taxes. The ACA's requirement that group health plans, starting in 2014, have no annual limit put the future of these accounts into question. In 2013, the Administration issued guidance that HRAs may be offered if integrated with a non-HRA group health plan that complies with the new rules. It prohibited employers from establishing HRAs that their workers or dependents could use to purchase coverage in the individual market.[66] The 21st Century Cures Act which was signed into law in 2016 allows small business to create stand-alone "qualified small employer" or QSEHRAs for individual market coverage subject to certain rules (e.g., upper limit on the value of QSEHRA, reduction of any premium tax credit by the QSEHRA amount).[67] Should the Trump Administration allow HRAs to be used by large employers for individual market coverage, employers could use such accounts to move their less healthy employees into the individual insurance market, lowering their own health plan's costs while increasing premium costs for those in the individual market.

Sincerely,

Andrew M. Slavitt

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[35] 42 U.S.C. § 18031(b)(1)(a).

[36] 45 C.F.R. § 155.205(e).

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