



November 27, 2017

The Honorable Seema Verma
Administrator
Center for Medicare & Medicaid Services

The Honorable Eric D. Hargan
Acting Secretary
U.S. Department of Health and Human Services

Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Young Invincibles' Comments on HHS Proposed 2019 Notice of Benefit and Payment Parameters Rule (Reference Number: CMS-9930-P)

Dear Administrator Verma & Acting Secretary Hargan:

Young Invincibles (YI) is a non-profit, non-partisan organization committed to expanding economic opportunity for young adults ages 18 to 34, including access to health care. As one of the leading organizations focused on educating and enrolling young adults in health coverage, we write to share our thoughts on the recent proposed rule issued by the U.S. Department of Health and Human Services (HHS) on the 2019 Notice of Benefit and Payment Parameters

Although we are concerned about many other proposals in the rule, these comments focus on proposed changes to the essential health benefits standards, eligibility and enrollment, student health plans, rate review, medical loss ratio, navigators, qualified health plan certification standards, plan selection issues, and special enrollment periods.

We are also disturbed by this proposed rule's comment period being the latest, and perhaps most egregious, example of HHS and the Centers for Medicare & Medicaid Services (CMS) limiting the period of public review and comment. This 365-page proposed rule was published in the Federal Register on November 2, 2017, straining our organization's ability to meet the agency's self-designated November 27, 2017 deadline to provide feedback. Regulations pertaining to the public's access to health coverage deserve scrutiny, and a 17-work day period makes it difficult for the public to thoroughly vet such a substantial proposal.

I. ESSENTIAL HEALTH BENEFITS (45 CFR § 156.100 to § 156.115)

We are concerned that HHS's proposed changes to EHB standards could be especially harmful to the 31 million young adults (ages 18 to 34) living with a pre-existing condition and who

benefit from access to comprehensive health insurance.¹ Specifically, we are concerned that changes to the EHB-benchmark process, expanding EHB benefit substitution among categories, and undermining state flexibility could subject young consumers to paying more out-of-pocket for services no longer covered or covered less comprehensively. This is particularly concerning given that the services young adults value and utilize most, like mental health services, maternity care, and preventive services, are services covered by the ACA's EHB requirements.²

Among all marketplace enrollees, at least two-thirds — 65 percent or more—reported satisfaction with their qualified health plan (QHP) in 2014 through 2016 in three separate national surveys.³ To improve their coverage, most enrollees want policymakers to lower the cost of prescription drugs, to ensure that benefits are comprehensive, and to improve network adequacy.⁴ Over two-thirds of consumers—67 percent—believe that the top health care priority should be to lower, not increase, consumer out-of-pocket costs.⁵ Young adults enrolled on the individual market earn a median income of \$26,000, while uninsured young workers earn a median income of \$20,000 per year,⁶ so this cash-strapped cohort is ill-prepared to shoulder greater cost sharing liabilities.⁷

We fear that the proposed changes to EHBs will do exactly the opposite of what we know consumers want and need. The current EHB standards already appropriately balance the need for a minimum federal benefit standard with deference to existing state laws, regulatory standards, and market needs. Impaired access to coverage for EHBs might cause young adults to see less value in getting covered, which could blunt their enrollment, further destabilize the insurance markets, and ultimately lead to higher costs for all marketplace shoppers.

We are also concerned that the proposed changes would create additional regulatory uncertainty and an administrative burden for insurers (who will soon be designing their plans and rates for 2019 and beyond) and state regulators (who would need to undertake a comprehensive review and analysis of potential EHB-benchmark plan options to the extent a state opts not to maintain its current benchmark plan).

¹ Office of the Assistant Secretary for Planning and Evaluation, [Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act](#), U.S. Department of Health and Human Services (2017).

² Erin Hemlin, *What's Happened to Millennials since the ACA? Unprecedented Coverage & Improved Access to Benefits* (Washington, DC: Young Invincibles, 2017), 3, <http://younginvincibles.org/wp-content/uploads/2017/05/YI-Health-Care-Brief-2017.pdf>

³ U.S. Government Accountability Office, *Most Enrollees Reported Satisfaction with their Health Plans, Although Some Concerns Exist*: GAO-16-761, (Sept. 2016), <https://www.gao.gov/assets/680/679673.pdf>.

⁴ Drew Altman, "[The Health Care Plan Trump Voters Really Want](#)," *New York Times* (Jan. 5, 2017); Ashley Kirzinger et al., [Kaiser Health Tracking Poll: Health Care Priorities for 2017](#), Kaiser Family Foundation (2017); Jennifer Tolbert & Larisa Antonisse, [Listening to Trump Voters with ACA Coverage: What They Want in a Health Care Plan](#), Kaiser Family Foundation (2017).

⁵ Ibid.

⁶ Testimony of Christina Postolowski, US Senate HELP Committee, *Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: Health Care Stakeholders*, September 14, 2017, <https://www.help.senate.gov/imo/media/doc/Postolowski.pdf>.

⁷ Diana Farrell and Fiona Greig, "Coping with Medical Costs through Life." JPMorgan Chase Institute, 2017

a. Skimpier Benefits and Discriminatory Benefit Design. We are concerned that the proposed changes to the EHB-benchmark process will reduce the comprehensiveness of coverage for consumers. HHS readily admits that its proposal could result in consumers being left without access to coverage for certain services (depending on their state's EHB-benchmark decision). We are particularly concerned that scaling back EHB coverage may significantly raise out-of-pocket costs for beneficiaries with health conditions without significantly reducing overall premiums. Some of the benefits most often targeted for proposed cutbacks (such as rehabilitative services and maternity care) account for a relatively small portion of the overall premium.⁸ Yet scaling back coverage of these benefits, which are highly utilized by young adults,⁹ would raise out-of-pocket costs significantly for the people who need them. For instance, CMS estimates that treatment for drug dependence could cost a young enrollee \$20,450 without access to comprehensive rehabilitation coverage.¹⁰ Further, slashing coverage of more commonly used benefits, such as prescription drugs, might help bring down premium costs, but could raise insurers' costs in other areas over time if enrollees forgo or delay needed care resulting in the need for other expensive services such as hospitalization.¹¹

Under the proposed rule, states would have many more EHB-benchmark plan options. States could maintain their current EHB-benchmark plan, adopt another state's 2017 EHB-benchmark plan or one or more benefit categories from another state's 2017 benchmark plan, or design a new EHB-benchmark from scratch. We are concerned that these changes would allow states to drop or limit the benefits that are currently covered in their state, give insurers more latitude to deviate from a state's EHB standard, and weaken consumer protections against catastrophic out-of-pocket costs in large employer plans. These changes would disproportionately impact people with pre-existing medical conditions who could face reduced access to the services they need and higher out-of-pocket costs.¹²

We are particularly concerned that the proposed rule would allow states to select an EHB-benchmark plan with benefits that are less generous than current ACA-compliant plans. Under the proposed rule, a state with an EHB-benchmark that currently includes coverage of autism services, hearing aids, infertility treatment, or transplant-related travel costs could select another state's EHB-benchmark plan or benefit category that does not include one or all of these benefits. This would result in the loss of coverage of critical services that consumers have come to expect and rely upon over the past three years.

These concerns are exacerbated by the proposal to allow states to design a new EHB-benchmark plan from scratch. Although the benchmark plan would have to include coverage of

⁸ Linda J. Blumberg & John Holahan, [The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums under the ACA](#), Urban Institute (Jul. 2017).

⁹ *Ibid.*

¹⁰ Sam Berger & Emily Gee, [Senate Health Care Bill Could Drive Up Coverage Costs for Maternity Care and Mental Health and Substance Use Disorder Treatment](#), CAP (June 2017).

¹¹ Blumberg et al., *supra* note 8.

¹² Berger & Gee, *supra* note 10.

the 10 statutorily prescribed EHB categories, states could select a benchmark plan that would significantly scale back coverage relative to current ACA plans. We are deeply concerned that the proposed definition of a typical employer plan—any group plan, including a self-insured group health plan, with enrollment of at least 5,000 enrollees—could enable states to select a benchmark plan that, for instance, sharply limits the number of hospital days or doctor visits available each year, covers only generic medications, or offers only preventive services.¹³ Although states would have to supplement such plans to ensure that all 10 EHB categories are covered, states would only have to do so if the benchmark did not cover any items or services in that EHB category. This would mean that EHB-benchmark plans would either include a very low EHB standard from an employer plan with minimal coverage, or states would have no point of comparison for the benefits covered in each of those added categories, which states could choose to slim down relative to current benefit packages.

We also expect that it will be difficult for states to identify or develop a new EHB-benchmark plan that fully meets federal EHB requirements. States would, for instance, need to ensure that a new EHB-benchmark plan provides benefits for diverse segments of the population (such as women, children, and people with disabilities) and is not unduly weighted towards any of the 10 EHB categories. States would also want to consider the impact of federal and state protections against discriminatory benefit design, such as Section 1557 and 45 C.F.R. 156.125, which prohibits discrimination in benefit design (and the implementation of benefit design) on the basis of race, age, disability, sex, gender identity, sexual orientation, expected length of life, disability, quality of life, and medical condition. In the past, some state regulators have reported challenges in defining and implementing some of these broad nondiscrimination standards, such as discrimination based on “quality of life,” without further guidance from federal regulators.¹⁴ The proposed rule would do little to illuminate these standards while granting even more responsibility to states to ensure that EHB-benchmark plans and insurer implementation of these plans comply with sweeping nondiscrimination protections. Allowing discriminatory benefit design under the guise of a new EHB-benchmark plan process could also open insurers up to future litigation and increase the volume of consumer complaints at state insurance departments.

Further, these changes would impact consumers in every market. Because the ACA’s ban on annual and lifetime benefit limits and the annual out-of-pocket maximum are linked to the definition of EHB, state-level changes could be widely felt. A benefit that is no longer an EHB would no longer be included in these protections, resulting in skimpier benefits and higher out-of-pocket costs for consumers in group coverage.¹⁵ This is especially concerning because large employer plans can currently select from any state’s 10 EHB-benchmark plan options. Under

¹³ Sarah Lueck, [Administration’s Proposed Changes to Essential Health Benefits Seriously Threaten Comprehensive Coverage](#), Center on Budget and Policy Priorities (Nov. 2017).

¹⁴ Katie Keith et al., [Nondiscrimination under the Affordable Care Act](#), Georgetown University Center on Health Insurance Reforms (Jul. 2013).

¹⁵ Matt Fiedler, [Allowing States to Define “Essential Health Benefits” Could Weaken ACA Protections Against Catastrophic Costs for People with Employer Coverage Nationwide](#), Brookings Institution (May 2017).

the proposed rule, the number of EHB-benchmark plan options would increase and vary dramatically. As a result, these changes could significantly weaken protections against catastrophic costs for millions of consumers with large employer coverage as well.

HHS readily admits that its proposal could result in consumers being left without access to coverage for certain services (depending on their state's EHB-benchmark decision). We are particularly concerned that scaling back EHB coverage may significantly raise out-of-pocket costs for beneficiaries with health conditions without significantly reducing overall premiums. Some of the benefits most often targeted for proposed cutbacks (such as rehabilitative services and maternity care) account for a relatively small portion of the overall premium.¹⁶ Yet scaling back coverage of these benefits would raise out-of-pocket costs significantly for the people who need them. Further, slashing coverage of more commonly used benefits, such as prescription drugs, might help bring down premium costs, but could raise insurers' costs in other areas over time if enrollees forgo or delay needed care resulting in the need for other expensive services such as hospitalization.¹⁷

b. Expanding Benefit Substitution. Aside from the proposed EHB-benchmark plan process, we are concerned that the proposal would allow benefits to be substituted between different statutorily required EHB categories. This approach was rejected by the Obama administration, which allowed benefit substitution within an EHB category, but not between categories.¹⁸ Benefit substitution across categories might permit an insurer to, for example, scale back coverage of hospital care or rehabilitative services while increasing the coverage of outpatient physician visits and urgent care so long as the substitution is actuarially equivalent. The result of this policy is that consumers in need of costly hospital care or rehabilitation could end up with large gaps in coverage and higher out-of-pocket costs.

Benefit substitution across EHB categories would also make it more difficult for consumers to accurately compare their plan options and make informed pre-enrollment decisions. Young adults already have lower rates of health insurance literacy and subsequently face more challenges in navigating the enrollment process,¹⁹ so it would be misguided for HHS to make it more difficult for young consumers to make apples-to-apples plan comparisons and know that the plan they select is one that balances their financial condition and health needs.

For instance, less generous maternity coverage in exchange for more generous prescription drug and laboratory service benefits could force an expecting mother to assume a substantial burden in paying for pregnancy care and delivery, which on average is about \$17,000.²⁰ For

¹⁶ Blumberg et al., *supra* note 8.

¹⁷ Blumberg et al., *supra* note 8.

¹⁸ PPACA; HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 55 (November 2, 2017). *Federal Register: The Daily Journal of the United States*. Web. 20 November 2017.

¹⁹ Yang, Law, "Young Adults' Attitudes and Perceptions on Health Insurance and their Health Insurance Literacy Levels" (2016). All Theses, Dissertations, and Other Capstone Projects. Paper 617.

²⁰ Congressional Budget Office Cost Estimate, "H.R. 1628 Better Care Reconciliation Act of 2017," May 24, 2017, 26, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf>.

many consumers, these changes could prove unaffordable, as a recent analysis of consumer finance data found that, for young people, an extraordinary medical payment amounted to \$1,406.²¹

c. Limits on State Flexibility. We are concerned that the draft rule proposes to continue its policy on state-mandated benefits even while proposing to change many of the underlying standards regarding the EHB-benchmark plan. Under this policy, a state does not have to defray the cost of a benefit mandated prior to or on December 31, 2011, but must defray the costs of benefits mandated after that date. This policy was adopted when states were largely limited to selecting an EHB-benchmark plan option that already existed in their state and, for the most part, reflected many of the state's existing mandates.

Under the proposed rule, states would still be required to defray the cost of any benefits included in a state's EHB-benchmark plan that exceeds state benefit standards in place through December 31, 2011. The result of this policy has been to deter states from adopting new benefit mandates that exceed their EHB-benchmark plan and limit state flexibility in responding to the coverage needs of their communities and populations. We are concerned that this policy—combined with the potential for states to select a less comprehensive EHB-benchmark plan—would result in far less coverage for consumers relative to current ACA-compliant plans. We are also concerned about the impact of this policy if HHS were to, as it suggests, adopt a federal EHB package in the future and possibly require states to defray the costs of benefits that exceed this federal EHB package.

For example, if HHS were to adopt a federal EHB package that did not cover mental health services, states could be pressed to discontinue coverage for the treatment of mental health diagnoses. That could leave consumers living in such states and who struggle from depression paying \$8,490 more for the treatment they need. We are especially concerned about what a lack of access to coverage for mental health treatment could mean for college-age young adults, who are the most likely age group to have serious thoughts about suicide.²²

II. ELIGIBILITY AND ENROLLMENT (45 CFR § 154.103)

We are concerned about the changes that HHS proposes to make to the eligibility and enrollment process for HealthCare.gov. These changes will introduce new burdens on consumers, particularly young and low-income consumers, and will make it more difficult to enroll in and maintain coverage each year. Many young adults shopping on the marketplace are doing so for the first time; young adults who age off their parents plan at 26, age off of Medicaid or CHIP, or transition from a school-based plan to the marketplace are likely shopping for individual health insurance for the first time. Additional barriers to coverage are likely to deter young adults from enrolling in coverage, hampering market stability. We oppose the

²¹ Farrell et al., *supra* note 7.

²² Center for Disease Control, Division of Violence Prevention, [Suicide: Facts at a glance](#), (Washington, DC: 2015).

proposed changes because these changes may deter enrollment, leave consumers without access to coverage, and ultimately hurt the risk pool.

First, HHS proposes to require income verification for consumers who attest that their income is over 100 percent of the federal poverty level (FPL)—about \$12,000 for 2017—but whose federal income data indicates that past income is below this level. Consumers in this situation would have to submit additional information to HHS to verify their attested income; for those who fail to do so, their eligibility for premium tax credits and cost-sharing reductions would likely be discontinued.

Although HHS cites concerns about program integrity, they offer no data or other justification as to how often this situation—where consumers attest that their income is higher than it is and receive subsidies—occurs or why it is of such critical importance at this time. The change is very concerning for low-income consumers whose income often fluctuates and where a minor change in income—such as a few extra shifts at work—can increase income above the 100 percent FPL threshold. Furthermore, because many of these consumers have less stable employment or income streams, obtaining documentation of income may be extremely challenging, potentially leaving consumers who are eligible for subsidies out in the cold for an entire year if they do not know they are eligible for an SEP. We are also concerned that requiring employees to verify their income for public benefits purposes could be humiliating to employees and be difficult for them to raise with their employer. Consumers are also already disincentivized from overstating their income because consumers who do so are liable for the repayment of subsidies. Finally, this proposal is deeply unfair; it explicitly targets consumers who have experienced poverty at some point for harsher requirements, which will have a disparate impact on people of color who are far more likely to have experienced poverty.²³ For these reasons, we think this policy is ill-advised and will significantly deter enrollment or otherwise leave low-income consumers without access to coverage.

Second, HHS proposes to eliminate the requirement to provide direct notice to consumers before the marketplace can discontinue an individual's premium tax credits and cost-sharing reductions for failure to reconcile their taxes. This requirement was adopted in the 2018 payment rule in response to ongoing challenges with tax reconciliation where HHS noted that "targeted and detailed messaging to tax filers that highlights the specific requirement to file an income tax return and reconcile [advance premium tax credit] paid on their behalf—and the potential adverse impact on APTC eligibility for future coverage years—is essential."²⁴

Although HHS states that it will continue to notify noncompliant tax filers and households similar to previous years, this process has been somewhat ineffective and resulted in only 60 percent of households taking appropriate action to file a tax return to reconcile their premium

²³ U.S. Census Bureau; *Income and Poverty in the United States: 2016*

²⁴ PPACA; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 67 (December 22, 2016). *Federal Register: The Daily Journal of the United States*. Web. 20 November 2017.

tax credit.²⁵ We are very concerned about eliminating this formal notice requirement and note that this change also likely implicates other federal rules, such as due process protections, that prohibit the marketplace from denying consumer subsidies without adequate notice.

Third, HHS requests comment on ongoing eligibility determinations, suggesting that the agency is considering additional changes to require consumers to report additional information to the marketplace on more of an ongoing basis. HHS also asks for comment on whether it should reduce the current five-year term during which enrollees can authorize the marketplace to obtain updated tax return information to help facilitate annual eligibility redeterminations and reenrollment. Additional changes in these areas would increase burdens on consumers by requiring them to submit additional documentation, visit HealthCare.gov on a regular basis, or otherwise take steps that could needlessly jeopardize their coverage. Such changes, if adopted, would disproportionately impact low-income consumers, those with limited English proficiency, and those living in rural areas who may be more likely to lack internet access.

Fourth, HHS proposes to let QHP insurers, agents, and brokers participating in direct enrollment to select their own third-party entities for annual reviews and audits. This is a considerable shift away from current rules where HHS planned to select approved third-party entities. We are concerned about this change because it reduces federal oversight at the same time that HHS is giving more prominence to direct enrollment and allowing insurers, brokers, and agents to access more and more consumer personal and financial information. We oppose this change, in favor of ongoing federal oversight of direct enrollment, and encourage HHS to promote policies that states could adopt, such as requiring the disclosure of consumers' rights and ensuring that complaints are coded to identify issues and concerns with direct enrollment.²⁶

Overall, we are concerned about each of these proposals to change eligibility and enrollment procedures, as well as their combined effect, which we believe would ultimately deter and reduce enrollment and reenrollment by consumers who qualify for, and are thus entitled to, coverage and subsidies under federal law.

III. STUDENT HEALTH INSURANCE COVERAGE (45 CFR § 154.103)

As of 2010, approximately one million college students received health insurance through a school-sponsored plan -- with annual premiums for individual coverage for these policies ranging from \$100 to \$2,500 a year.²⁷ A nationwide investigation by then-New York Attorney General Andrew Cuomo found that many of these plans had frequent limitations and exclusions

²⁵ See *supra* note 18.

²⁶ JoAnn Volk, [State Options Blog Series: Streamlined, Direct Marketplace Enrollment Has Risks, Benefits, but Much Depends on State Oversight](#), CHIRblog (Nov. 8, 2017); Sabrina Corlette et al., [Stepping Into the Breach: State Options to Protect Consumers and Stabilize Markets in the Wake of Federal Changes to the Affordable Care Act](#), Georgetown University Center on Health Insurance Reforms (Aug. 2017).

²⁷ [Attorney General Cuomo Finds College Students Nationwide May Be At Risk Due To Inferior Health Insurance Plans](#), Office of the Attorney General of New York (April 8, 2010).

that made students financially vulnerable. For instance, some plans had exclusions for consumers with pre-existing conditions, while others set annual limits or failed to offer basic coverage like a prescription drug benefit.²⁸ The investigation also found “conflicting relationships between insurers and agents... [that] created incentives to work against the best interests of the students and persuade schools into offering overly costly plans.”²⁹ Another 2010 study in Massachusetts found that, despite offering less comprehensive coverage, student health plans generated far greater profits for insurers than private insurance plans sold in the Commonwealth,³⁰ and that the greatest per member profits were generated at the institutions most students attend -- community and public colleges.³¹ Put simply, prior to the ACA, student health plans left many students with inadequate yet expensive coverage.

Since then, tremendous progress has been made to expand consumer protections for students and better regulate student health plans. HHS’s 2012 regulatory guidance on college health plans cemented what the agency had previously suggested in various statements: that college health plans that span a 12-month coverage period are not short-term health plans and should be treated as individual health insurance.³² This ensured that students covered through student health plans were entitled to the ACA’s benefits and protections for those enrolled on the individual market, including a ban on annual and lifetime limits, providing preventive care without cost sharing, and accepting students with pre-existing conditions.³³

We are concerned that the proposed rule would scale back this progress by exempting student health insurance plans, which have been found to overcharge consumers, from federal rate review guidelines. This explicitly conflicts with the Department’s 2012 guidance that clarified student health plans should be treated as individual insurance.

HHS argues that student health insurance plans should not be subject to rate review requirements because higher education institutions are well informed and have purchasing power,³⁴ but this misses the point. Students have few, if any, choices in picking a student health plan once they select a school, because institutions typically offer students one or very few plan options. Without rate review, students could see their premiums skyrocket and insurers could be incentivized to generate higher profits on products requiring less transparency. We fear many consumers would find plans unaffordable under this proposal, leading some students to drop their insurance altogether. Students remaining uninsured would be exposed to catastrophic medical costs in the event of a health emergency, which could imperil their financial security and prevent them from finishing their degrees and entering the workforce.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Student Health Program Academic Year 2008-2009 Annual Report, Massachusetts Division of Health Care Policy & Finance, December 2010.

³¹ Ibid.

³² PPACA; Student Health Insurance Coverage, 77 Fed. Reg. 55 (March 21, 2012). *Federal Register: The Daily Journal of the United States*. Web. 20 November 2017.

³³ Jonathan Dame, [“Student health plans forced to adapt to ACA requirements,”](#) *USA Today*, (Jan. 11, 2014).

³⁴ *Supra* note 18, at 98.

IV. RATE REVIEW (45 CFR § 154.301) AND MEDICAL LOSS RATIO (45 CFR § 158.170 et seq.)

HHS proposes to raise the threshold for review of “unreasonable” premium increases from the current 10 percent to 15 percent and to exempt student health insurance rates from review beginning in 2019. We strongly urge HHS to maintain the rate review threshold at 10 percent and, as referenced above, to continue to require the review of student health insurance rates. Maintaining strong, consistent regulatory review over all plans seeing double-digit rate increases and all student health plans is vital to ensuring that marketplace consumers and students have access to affordable health insurance. This is especially critical at a time when HHS and Congress continue to consider changes that may increase premiums.

HHS also proposes to substantially relax MLR standards which we worry will further increase premiums for consumers, who should be able to see how insurers are spending their premium dollars. Easing MLR standards would force consumers to foot the bill for their insurer’s expenses like marketing, executive salaries, and bonuses.

Specifically, HHS proposes to allow insurers to exclude employment taxes from premiums in calculating their MLR, and to automatically claim 0.8 percent of earned premium as quality improvement expense. The employment taxes were previously considered to be employment costs (rather than taxes that the ACA intended to exclude from premiums). Further, many insurers do not currently report quality improvement activities. Allowing companies to automatically claim 0.8 percent of premiums as quality improvement will automatically increase the MLR for most insurers with no guarantee that quality improvement efforts are actually being undertaken.

HHS also proposes to simplify the process for states to apply for a reduction in their MLR, which would allow states to adjust the MLR from 80 percent in the individual market to as low as 70 percent. Although we support state flexibility, we are concerned that HHS has overly simplified this process by no longer requiring information or data on, for instance, the state’s MLR formula for assessing compliance, detailed individual market enrollment and premium data, or a justification as to how their adjustment was determined or how it would affect rebates. States would only have to submit total premium, total agent and broker commissions, and risk-based capital information for insurers with more than 1,000 enrollees in a state and would no longer have to report net underwriting profit and total after-tax profit for insurers doing business in the state. We believe these standards are inadequate: the MLR is a critical consumer protection that we do not believe should be adjusted without detailed information and data that fully justifies this request.

Aside from these specific changes, we disagree with HHS’ premise that allowing insurers to reduce their MLRs to 70 or 75 percent addresses instability in the individual market in some states. Instead of reducing the value of coverage by changing the MLR, HHS could better help stabilize the individual market by funding cost-sharing reduction payments, engaging in robust outreach and enrollment and advertising efforts, settling risk corridor litigation, supporting

state reinsurance programs, improving (not reducing) the value of coverage for consumers, and enforcing the individual mandate. For these reasons, we oppose these changes.

V. NAVIGATORS (45 CFR § 155.210 and § 155.215)

We are deeply concerned about the proposed rule's changes to scale back the navigator program. Navigators and CAC programs provide consumers with critical, unbiased guidance throughout the application process. Navigators and CACs are crucial in guiding consumers through the application process, and ensuring consumers understand eligibility for financial assistance, accurately report income, and apply for APTCs and CSRs. Past research has shown more than 7 in 10 uninsured consumers want one on one help enrolling in a plan;³⁵ furthermore, those who did seek in-person help were twice as likely to complete enrollment.³⁶ Continued investment in the navigator and certified application counselor programs is critical to promoting a healthy risk pool and ensuring that consumers, especially those who are low-income, enroll in a plan that best suits their needs.

Young adult marketplace shoppers tend to have lower incomes compared to their older counterparts and are therefore more likely to qualify for tax subsidies to help lower their premiums.³⁷ However, young adults historically have been less likely to be aware of the existence of financial help on the marketplace.³⁸ Young adults who work with Navigators and CACs are better equipped to make the most of APTCs and CSRs, enroll in appropriate plans based on their health and financial status, and maintain coverage throughout the year, thereby helping to ensure an overall healthy risk pool. Scaling back the navigator program will make it harder for young adults to understand their plan choices, and enroll in coverage that will meet their needs.

To ensure that consumers have continued access to the mode of assistance they have come to rely on, we oppose the proposed changes to the navigator program. In particular, we oppose changes that would eliminate the requirements that there be at least two navigator entities in each state, that at least one of these entities be a community and consumer-focused nonprofit group, and that navigators maintain a physical presence in the service area to provide in-person outreach and enrollment support.

Grants to more than one navigator entity and at least one community and consumer-focused nonprofit entity are critical to helping the consumers we serve, many of whom may not be reached by only one navigator entity. We share HHS' stated goal of ensuring that the strongest

³⁵ *Understanding the Uninsured Now*, PerryUndem Research (June 2015). Accessed November 20, 2017.

<https://www.rwjf.org/en/library/research/2015/06/understanding-the-uninsured-now.html>

³⁶ *In-Person Assistance Maximizes Enrollment Success*, Enroll America (Mar. 2014). Accessed November 20, 2017.

<https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf>

³⁷ *Supra* note 2.

³⁸ *Young Adults and Health Insurance: Not Invincibles but Perhaps Convincible. Findings from the Deloitte 2014 Survey of Young Adults and Health Insurance*. Deloitte. 2014. <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-chs-young-adults-and-health-insurance.pdf>

applicants are selected to serve as navigators, but our experience over the past four years is that groups that have strong community ties and are physically present in the community and thus able to provide face to face assistance provide the best support to consumers and are necessary to the enrollment process. In the midst of the fifth open enrollment period, we cannot overstate the value and importance of supporting and working with trusted community nonprofit organizations—such as food banks, HIV services organizations, United Way affiliates, and legal aid organizations—who have conducted in-person outreach, educated consumers, and assisted with enrollment since 2013.

HHS is pursuing this proposal while admitting that its changes could result in fewer navigator options and potentially no in-person enrollment assistance from a navigator or certified application counselor. The agency also notes that entities with a physical presence and strong local community relationships “tend to deliver the most effective outreach and enrollment results.” These changes follow a 40 percent cut in funding to navigators, which has limited these organizations’ operations in a number of states for the 2018 plan year.³⁹ In South Carolina, for example, navigator funding was cut by two-thirds for 2018, resulting in the loss of navigator services in about two-thirds of the state’s counties and potentially leaving consumers without access.⁴⁰ In Ohio, funding cuts were so deep that the largest Navigator grantee was forced to exit the navigator program.⁴¹ Given this impact (especially when coupled with navigator funding cuts), we oppose the proposed changes to the navigator program.

Lastly, we urge CMS to provide clarity about what metrics are being used to measure Navigator performance. We further urge CMS to include all aspects of statutorily required activities in any measurements used to assess Navigators’ work moving forward. The ACA statute requires that Navigators perform tasks far and above merely providing enrollment assistance. However, the metrics used by CMS for federally-facilitated marketplace (FFM) Navigators in 2018 were arbitrary and did not include all aspects of Navigator work.⁴² The preamble to this proposed rule mentions providing grants to “high performing” entities as well as the “highest scoring” entities, but it is unclear what these terms mean in practice.

VI. QUALIFIED HEALTH PLAN CERTIFICATION STANDARDS (45 CFR § 156.230 and § 156.235)

We support efforts to streamline monitoring and enforcement of insurance standards between federal and state regulators, especially with respect to qualified health plan (QHP) certification standards. Although nearly all states have adopted some sort of regulatory framework for network adequacy, oversight is uneven across and within states, and state network adequacy

³⁹ [CMS Announcement on ACA Navigator Program and Promotion for Upcoming Open Enrollment Period](#), Center for Consumer Information and Insurance Oversight, (Aug. 31, 2017).

⁴⁰ Alex Olgin, “[Reductions in Federal Funding for Health Law Navigators Cut Unevenly](#),” *NPR* (Oct. 26, 2017).

⁴¹ Ohio Association of Foodbanks Press Release, September 22, 2017. Accessed November 27, 2017.

<http://ohiofoodbanks.org/files/2017-18/Press-Statement-Ohio-Association-of-Foodbanks-Exits-Navigator-Program.pdf>

⁴² *Data Note: Changes in 2017 Federal Navigator Funding*, Kaiser Family Foundation (Washington, DC: Oct. 11, 2017), available online at: <https://www.kff.org/health-reform/issue-brief/data-note-changes-in-2017-federal-navigator-funding/>.

requirements often only apply to certain types of network designs, such as HMOs but not PPOs.⁴³

Given ongoing gaps at the state level, we believe it is appropriate for federal regulators to defer to state oversight but only while maintaining strong minimum federal network adequacy standards that are at least as protective as the current ACA standards. Essential community providers serve predominantly low-income, medically underserved individuals.⁴⁴ There is no patient-centered reason to decrease, rather than increase, the use of ECPs under the ACA. As HHS proposes to expand this flexibility to state-based exchanges that use the HealthCare.gov platform, we would like to reiterate those concerns regarding network adequacy and essential community provider standards for QHP certification. By weakening standards, particularly in states without the authority or means to conduct sufficient reviews for network adequacy and essential community providers, we are concerned that the proposed rule will reduce government oversight in these critical areas and ultimately limit consumer access to providers.

VII. PLAN SELECTION ISSUES (45 CFR § 156.298 and 45 CFR § 155.20)

We are concerned that HHS' proposal to eliminate the meaningful difference standard and standardized plan options on HealthCare.gov will have a detrimental effect on the plan selection process for consumers. The meaningful difference standard and the standardized plan options are designed to facilitate consumer comparison and choice by helping consumers differentiate among plan options.⁴⁵ The meaningful difference standard helps ensure that marketplace plans reflect substantive distinctions between benefit design features, such as cost-sharing levels, while the standardized plan options reflect features from the most popular QHPs by enrollment, such as requiring drug tiers to have copayments rather than coinsurance. These plans also encourage insurers to cover a number of service "pre-deductible," which makes basic care more affordable. Insurers were never required to offer standardized plans, although HHS encouraged them to do so by providing differential display of these plans on HealthCare.gov.

We are particularly concerned that these changes will make the plan selection process much more difficult for consumers, and could inadvertently discourage enrollment. The complexity of sorting through multiple plan options can often immobilize consumers and runs the risk that some people will decide to forgo picking a plan altogether. Studies have shown that young

⁴³ Justin Giovannelli et al., [Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks](#), Commonwealth Fund (Washington, DC: May 2015).

⁴⁴ "Federal and State Standards for Essential Community Providers Under the ACA." Kaiser Family Foundation. (Washington, DC: June 2015). Accessed November 27, 2017. <https://www.kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/>

⁴⁵ Sarah Dash et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges*, Commonwealth Fund. (Washington, DC: Jul. 2013). Accessed November 27, 2017. http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/jul/1696_dash_key_design_decisions_state_based_exchanges.pdf

adults have lower levels of health insurance literacy compared to older adults, are less likely to be familiar with health insurance concepts, and therefore have a harder time comparing plans.⁴⁶

We are also concerned that eliminating the standardized plan options will reduce the incentive for insurers to offer services on a pre-deductible basis, resulting in higher out-of-pocket costs for consumers. To promote consumer choice and access to high-quality health service without cost-sharing, we oppose these changes regarding the meaningful difference standard and standardized plan options.

We are also concerned about HHS' suggestion that they will use differential display options to promote the availability of high-deductible health plans that can be paired with a health savings account (HSA). Many young adult consumers with high deductibles currently struggle to afford health care despite the ACA's protections (including subsidies, minimum actuarial value standards, and caps on out-of-pocket costs), and proposals that incentivize or subsidize high-deductible health plans and HSAs would shift significant costs to consumers at a time when few consumers can afford higher out-of-pocket costs. Young adults in the individual market earn a median income of \$26,000,⁴⁷ an income that leaves little room for savings. According to employer data, even young adult employees with access to HSA accounts tend to contribute less than their older counterparts, making the HSA account ineffective when needed.⁴⁸ Instead of helping the uninsured, HSAs mostly benefit high-income taxpayers who can afford to take advantage of these tax-sheltering accounts.⁴⁹ And, even when low-income people have HSAs, the effect on their use of care is not favorable, resulting in declines in office visits and free preventive care and increases in emergency room visits and hospitalization.⁵⁰

Given their lower incomes and health insurance literacy rates, we are concerned that the complexity of products like HSAs would put young consumers at financial risk. For these reasons, we are very concerned about HHS' proposal to encourage insurers to offer HDHPs that can be paired with an HSA.

VIII. SPECIAL ENROLLMENT PERIODS (45 CFR § 155.420)

⁴⁶ Sharon Long, Genevieve Kenney, Stephen Zuckerman, and Dana Goin. "Low ACA Knowledge and Health Literacy Hinder Young Adult Marketplace Enrollment," Health Affairs Blog, February 12, 2014, <http://healthaffairs.org/blog/2014/02/12/low-aca-knowledge-and-health-literacy-hinder-young-adult-marketplace-enrollment/>

⁴⁷ *Supra* note 6.

⁴⁸ "Health Savings Accounts in the Individual Market." Deloitte Center for Health Solutions. 3. (2017). Accessed on November 27, 2017. <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-health-savings-accounts-in-the-individual-market.pdf>

⁴⁹ Edwin Park, *Trump, House GOP Health Savings Account Proposals Would Mostly Help Wealthy, Not Uninsured*, Center on Budget and Policy Priorities (Washington, DC: 2016).

⁵⁰ Paul Fronstin & M. Christopher Roebuck, *The Impact of an HSA-Eligible Health Plan on Health Care Services Use and Spending by Worker Income*, Employee Benefit Research Institute No. 425, (Aug. 2016).

As we have raised in many previous comments to HHS, we are concerned about HHS' continued efforts to limit the availability and accessibility of special enrollment period (SEP) opportunities for consumers. SEPs are a key part of the overall mission of the marketplace to help consumers navigate important life transitions with the peace of mind that they can still access affordable health coverage. Young adults are disproportionately likely to experience a life-changing event that triggers an SEP, such as turning 26 and aging off of a parent's plan, getting married, having a baby, moving to a new state, or changing jobs and losing employer-sponsored coverage.⁵¹

We do, however, support some of the changes that HHS proposes that would increase access to SEPs. This includes allowing a woman who loses access to pregnancy-related CHIP coverage ("CHIP coverage for unborn children") to qualify for a 60-day SEP. This would provide a pathway to coverage for women in 17 states where the CHIP program covers pregnancy-related services who would otherwise be left without the option to enroll in a QHP and align with current regulations that already recognize a similar SEP opportunity for the termination of pregnancy-related Medicaid coverage. We are encouraged to see HHS considering this positive step forward to help young mothers.

Currently, young adults are more likely to qualify for, but less likely to know about, SEPs. In 2014, YI published a report estimating the number of young adults that year who would experience the type of life changes that might qualify them to enroll in or change health plans through special enrollment.⁵² YI found that young adults were more likely than older adults to experience all but one (i.e., gaining a new immigration status) of the major events that may trigger an SEP. Specifically, YI found:

- Young adults are almost twice as likely to lose coverage during the year;
- Young people change jobs every two years;
- Young people move at twice the national rate;
- The median age for marriage in the US is 28 for men and 26 for women
- Half of the people released from incarceration in 2012 were between the ages of 18 and 34
- 83 percent of new moms are between the ages of 18 and 34
- Finally, 100 percent of those turning 26 and losing dependent coverage are young adults

Unfortunately, while young adults are more likely to qualify for SEPs, they may be less likely to know about SEPs than older adults. Particularly telling is new data from the U.S. Census Bureau, which shows that 26-year-olds had the highest uninsured rate of all ages in 2015 and were uninsured at a rate one-and-a-quarter times higher than that of 25-year-olds.⁵³ This data suggests young adults may be experiencing gaps in coverage after they age off of their parent's

⁵¹ *Young Adults More Likely to Qualify for Special Enrollment*, Young Invincibles, (Washington, DC: 2014), accessed February 23, 2017, <http://younginvincibles.org/wp-content/uploads/2014/04/Young-Adults-and-Special-Enrollment-FINAL.pdf>.

⁵² Ibid.

⁵³ Sara R. Collins, Munira Z. Gunja and Sophie Beutel, "New U.S. Census Data Show the Number of Uninsured Americans Dropped by 4 Million, with Young Adults Making Big Gains," Commonwealth Fund, (Washington, DC: Sept. 2016), <http://www.commonwealthfund.org/publications/blog/2016/sep/2015-census-data-insurance>

health plan, perhaps because they did not know about or could not navigate what was then an even simpler SEP enrollment process; for example, a 2015 study by the Urban League found that just 15 percent of those who qualified for an SEP actually enrolled in coverage.⁵⁴

Life changing events like those listed above happen to millions of young adults every year, and these changes warrant allowing consumers to enroll in coverage or change plans. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market upon which consumers in the nongroup market should be able to equally depend. We believe, moreover, that having too few consumers enroll in coverage through SEPs is a greater threat to stability than having too many enroll.

Although we continue to oppose the addition of continuous coverage requirements as a precondition of SEP availability, we support HHS's proposal to create an exemption to this policy for individuals living in a bare county. Fortunately, there are no bare counties for the 2018 plan year, but this requirement would ensure consumers are not harmed in future years if those circumstances arise.

COMPRESSED PUBLIC COMMENT PERIOD

We are concerned about the compression of the public comment period to less than 30 days from the date of publication in the Federal Register. Given this short period, stakeholders may not have been able to offer meaningful comments on the significant proposals included in the rule. We urge HHS to adopt a comment period of at least 30 days from rule publication and to fully comply with notice-and-comment requirements under the Administrative Procedure Act.

CONCLUSION

Thank you in advance for your consideration. We share HHS's goal of expanding access to quality coverage for all consumers through the health insurance marketplace. If you have any questions about the content of this letter, please contact Erin Hemlin (erin.hemlin@younginvincibles.org) or Colin Seeberger (colin.seeberger@younginvincibles.org).

Sincerely,

Young Invincibles

⁵⁴ Matthew Buettgens, Stan Dorn, Hannah Recht. "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods." Urban League. November 2015. Accessed November 27, 2017. <https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>