



THE AIDS INSTITUTE

March 7, 2017

The Honorable Tom Price
Secretary of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: *RIN 0938-AT14 Patient Protection and Affordable Care Act; Market Stabilization*

Dear Secretary Price:

The AIDS Institute, a national nonprofit organization that focuses on public policy, research, advocacy and education, is dedicated to ensuring that people living with HIV, hepatitis, and other chronic conditions have access to quality and affordable health care. We appreciate the opportunity to provide comments to the Department of Health and Human Services (HHS) on the [*Patient Protection and Affordable Care Act; Market Stabilization*](#) proposed rule.

Overall, the Patient Protection and Affordable Care Act (ACA) and the regulations that the Department of Health and Human Services (HHS) have crafted to implement the law continue to benefit individuals living with HIV, hepatitis, and other chronic and serious conditions. Offering coverage that many were previously excluded from, guaranteeing an essential set of benefits, eliminating annual and lifetime coverage limits, and providing many other groundbreaking patient protections have all been beneficial to the communities we represent.

Although there is more work to be done to realize the full promise of quality, affordable health care for individuals who rely on the health plans offered in the ACA marketplaces, the ACA's solid foundation makes that work possible. As we move forward in the new Administration, The AIDS Institute remains committed to preserving the patient protections and essential health benefits available through the health plans offered in the ACA marketplaces. We will continue to advocate for predictable, lower patient cost-sharing; rigorous enforcement of nondiscrimination and other patient protections; and increased transparency so that individuals living with HIV, hepatitis, and other chronic and serious conditions can have meaningful access to quality, affordable health care.

We believe that more can and should be done to ensure a strong marketplace that makes quality, affordable coverage available to all consumers. However, we are concerned that the proposed rule is focused on improving the business concerns of issuers while not considering its impacts on consumers.

We recognize that the current health policy debate in Congress may have implications for the stability of the individual health insurance market in many states and support federal and state efforts to allay uncertainty among both issuers and consumers and to increase robust competition in the Marketplaces for the 2018 plan year. However, we believe that protecting consumers' access to comprehensive coverage and care should be the top priority and are concerned that the proposed rule responds to insurance issuers' business concerns while curbing vital consumer protections regarding affordability and access. Particularly, we are apprehensive about several of the proposals because HHS states that it drafted this proposed rule on the assumption that individuals are choosing to enroll "only after they discover they require services." Without evidence of this alleged abuse or an understanding of the impact of the proposed changes, we believe that this approach is not the way to improve stability and will, in fact, serve to limit enrollment and competition in the individual market, thereby harming consumers who depend on the marketplace for coverage. To provide meaningful access to care for people living with chronic and serious conditions and to promote robust enrollment and competition in the individual health insurance market, we urge HHS to consider the recommendations and comments detailed below.

OPEN ENROLLMENT PERIOD LENGTH

We recognize that eventually moving to an open enrollment period that does not cross two plan years will be administratively simpler. However, we are concerned that the 2018 plan year is too soon to dramatically shorten the open enrollment period and will result in individuals missing out on the critical open enrollment period. We urge HHS to maintain the existing open enrollment period, or at least allow open enrollment until December 31, 2017. If HHS decides to move forward with a shortened open enrollment period for the 2018 plan year, we strongly urge additional consumer outreach and education activities to ensure consumers understand the new timeline and the importance of enrolling in coverage. This includes additional resources for Health Insurance Navigators and other assisters as well as a robust educational campaign to promote enrollment.

SPECIAL ENROLLMENT PERIODS

Many of the changes that are proposed to the Special Enrollment Periods (SEPs) seem to stem from allegation of abuse; however, data has not been presented to demonstrate abuse or to justify the narrowing of SEPs. We urge HHS to maintain the current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, to avoid creating barriers for individuals who have, in fact, had a qualifying life event.

We also oppose prohibiting individuals from changing metal levels mid-year when they experience a qualifying life event and adding continuous coverage requirements as a pre-condition of SEP availability in certain instances. Changes in life circumstances often necessitate different levels of coverage and can lead to unavoidable gaps in coverage, particularly for lower income individuals. Such gaps should not preclude individuals from being able to enroll through an SEP when they meet all other criteria. Individuals who need care but are denied coverage

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due to “lockouts” and waiting periods are more likely to forgo early treatment and prevention and risk needing more expensive, uncompensated care later. Therefore, we urge HHS not to limit the availability of SEPs, which are vital to ensuring that everyone has access to health coverage.

GUARANTEED AVAILABILITY

The proposal to allow insurers to withhold services to enrollees who failed to pay some of last year’s premiums is both contrary to the ACA’s guaranteed issue provisions and has the potential to severely curtail access to care for enrollees. We believe healthier individuals, especially those with limited incomes, could be dissuaded from enrolling if they fear they will be locked out of coverage for missing a payment that they cannot afford. Instead, we recommend allowing issuers to recoup unpaid premiums through an installment plan while maintaining enrollment and collecting past-due premiums the following coverage year.

ACTUARIAL VALUE DE MINIMIS VARIATION

We oppose the proposed expansion of the de minimis actuarial value variations. While we strongly support lowering cost-sharing and premiums for consumers, we do not believe this is the appropriate strategy to accomplish this goal. The law specifically allowed limited actuarial variation “to account for difference in actuarial estimates” – not to encourage competition in the market or put downward pressure on premium costs, which are the goals HHS stated in the proposed rule summary.

This proposal will also harm lower income individuals by lowering the subsidies they receive to purchase health insurance coverage and further discourage enrollment, especially of healthier individuals. Lower premium tax credits would have a particularly detrimental impact on people living with chronic illnesses and disabilities who depend on access to plans with a higher actuarial value to defray high cost sharing. Therefore, if this proposal is adopted, we encourage HHS to require that the advance premium tax credit be calculated based on the second lowest cost silver plan in the Marketplace with an actuarial value of 70 percent or greater.

The current rules surrounding actuarial value of plans are important to ensure that the metal classifications are useful guides for individuals when choosing plans and seeking a subsidy. We strongly support greater plan transparency and clear descriptions of plan details for individuals to make informed choices when comparing and selecting plans. The plan metal levels play a role in helping individuals navigate the ACA marketplaces. HHS should more closely consider the impact of these proposals, by engaging the diverse stakeholders that rely on the ACA marketplace plans for health care coverage, beyond this comment period before making changes to actuarial values of metal levels.

NETWORK ADEQUACY

We are concerned that the proposed rule will erode critical network adequacy standards and jeopardize access to providers with the appropriate experience and expertise to treat people

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living chronic illnesses and disabilities. While we support efficient and non-duplicative monitoring and enforcement of insurance standards between state and federal regulators, we do not support using accreditation as a substitute for regulator enforcement. Because accreditation standards are not readily accessible, it will be impossible to determine adequate compliance with the ACA's network adequacy requirements with the only requirement being that plans have been accredited.

In states with robust network adequacy standards and review processes that are at least as protective as the ACA's federal standards and the National Association of Insurance Commissioners (NAIC) *Managed Care Plan Network Adequacy Model Act* (#74), we support deference to the state regulatory process. This must include quantitative time and distance standards. However, absent evidence of robust state monitoring and enforcement of network adequacy, HHS must step in to review plan justification of compliance with federal standards.

ESSENTIAL COMMUNITY PROVIDERS

We are concerned with the proposal to weaken standards for plan networks to include Essential Community Providers (ECPs), who are critical to caring for low income and medically underserved individuals. We believe that the proposed reduction in ECP coverage would harm consumers through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally appropriate care providers. Many consumers who use ECPs have long-standing relationships with these providers who are key components of successful management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause consumers to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

We also urge HHS to implement continuity of care requirements for consumers whose providers, particularly ECPs, are not included in the 2018 network provided by the same plan. Without this protection, issuers may attempt to shed enrollees with high-cost chronic conditions and discourage such consumers from enrolling by eliminating ECPs from the provider network.

COMPRESSED PUBLIC COMMENT PERIOD

Finally, we would like to express concern that the public comment period for this proposed rule was so compressed. Because the comment period was only 20 days, consumers, providers, and other stakeholders did not have the opportunity to meaningfully comment on the significant proposals included in the rule. We believe that a comment period of at least 30 days is necessary to meet the notice and comment requirements of the Administrative Procedures Act.

Thank you, again, for the opportunity to comment on Market Stabilization Proposed Rule. We urge HHS to continue its commitment to ensuring that all consumers, especially those with HIV, hepatitis, and other chronic and serious conditions, have access to the affordable care and treatment they rely on. Please contact Carl Schmid at cschmid@theaidsinstitute.org or 202-462-3042, with any questions or concerns.

Sincerely,

A handwritten signature in blue ink that reads "Michael Ruppal". The signature is fluid and cursive, with the first name "Michael" being larger and more prominent than the last name "Ruppal".

Michael Ruppal
Executive Director
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