American Heart Association | American Stroke Association

April 21, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-9949-P
PO Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-9949-P (Exchange and Insurance Market Standards for 2015 and Beyond)

Dear Administrator Tavenner:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 22 million volunteers and supporters, we appreciate this opportunity to submit comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule, "Exchange and Insurance Market Standards for 2015 and Beyond."

The AHA/ASA has long advocated for all Americans to have access to affordable, quality health insurance coverage. Access to affordable, quality health care is critical to helping the association achieve its ambitious goal to prevent as many heart attacks and strokes as possible, as well as the risk factors for these conditions. Although this proposed CMS rule covers many important topics, we have focused our specific comments below on a number of issues that we believe are particularly critical to people with heart disease or stroke or who need to prevent these conditions:

<u>Fixed Indemnity Insurance in the Individual Health Insurance Market (§ 148.220)</u>

We support the Department's attempt to regulate fixed-dollar indemnity coverage of health care services, often formerly referred to as "mini-med" policies. The Affordable Care Act (ACA) was intended to ensure that, beginning this year of 2104, health insurance coverage would not only be available and affordable but also adequate for consumers to have the health and financial protection they need. The number of people who are underinsured – meaning that their insurance does not provide adequate financial protection when they are sick – has been growing over the last decade. Unfortunately, many consumers with inadequate coverage do not realize the deficiency until they are diagnosed with a serious illness and the bills start rolling in.

It was expected that the ACA would result in the elimination of mini-med products that have in the past appeared to consumers to be major medical coverage but in fact offered their enrollees little protection for health care expenses. While there may be a continuing role for fixed-dollar indemnity products as income replacement insurance supplementing comprehensive medical coverage, issuers must not be allowed to mislead consumers into believing that this fixed-dollar coverage is adequate coverage or a substitute for comprehensive insurance. Issuers must be required to clearly inform consumers that any fixed-dollar coverage does not meet the ACA's minimum coverage requirement and is only supplemental coverage.

We support the restrictions on fixed-dollar coverage found in the proposed rule, particularly the requirements that coverage can only be sold to individuals who otherwise have minimum essential coverage and that consumers be warned that fixed-dollar indemnity coverage is not itself minimum essential coverage or major medical coverage. Issuers should be required to see and keep on file actual proof of minimum essential coverage, such as a copy of an insurance card or policy, before issuing a fixed-dollar coverage policy. This imposes a minimal burden for the issuer but is an important protection for the consumer. We would oppose any effort to weaken these basic consumer protections.

In addition to limiting the sale of fixed-dollar indemnity policies to individuals who have coverage that meets requirements for essential health benefits, we also urge HHS to act in concert with the Departments of Labor and Treasury to expand the definition of excepted benefits to include plans that provide only preventive services. As noted in the preamble, a group health plan providing minimum benefits can be considered minimum essential coverage. A May 2013 article in *The Wall Street Journal* described the use of plans limited to preventive services as a strategy to avoid the employer responsibility requirement. The availability of plans providing such limited benefits not only points to the need to limit the sale of fixed indemnity plans to people who have other coverage that meets the requirements for essential health benefits but also to the need to further define excepted benefits. A plan that provides only preventive services provides no protection against the risk of illness or injury and should not be considered to be minimum essential coverage.

<u>Special Enrollment Periods (§ 155.420)</u>

We support the proposed amendments to this section, which help to provide access to coverage outside of open enrollment periods in certain situations. In particular, we support the clarification that people who know they will lose minimum essential coverage within 60 days have the ability to establish Marketplace coverage ahead of time and minimize or avoid gaps during the transition and that this ability is not limited to just those people losing employer-sponsored coverage.

Along with the changes that have been proposed, we urge HHS to include an additional provision to ensure there is a special enrollment period available to people who experience a change in life circumstances that makes them newly eligible for subsidies. Currently, the rules permit only people already enrolled in a qualified health plan (QHP) or those losing eligible employer-sponsored coverage (that previously barred them from getting subsidies) to qualify for a special enrollment period due to becoming newly eligible for advance premium tax credits (APTCs). However, between April 1 and November 15, 2014, when the 2015 open enrollment period begins, a substantial number of people who did not apply for Marketplace coverage on or before March 31 or who applied and did not enroll because they were denied subsidies and couldn't afford coverage, will experience changes in circumstances that affect their ability to obtain and afford health insurance. Without changes to the regulations, some of these people will be unable to enroll in coverage until November 15, 2014, and their earliest coverage effective date will be January 1, 2015.

We recommend revising §155.420(d)(6) by inserting a new subsection (iii) and making the current (iii) subsection (iv). The new subsection would read as follows:

> "(iii) A qualified individual or his or her dependent has a change in income or tax household composition or tax household size resulting in a determination that he or she is newly eligible for advance payments of the premium tax credit; or"

Changing the policy as we recommend would allow people in the following situations and other situations, including death of a spouse, to qualify for a special enrollment period (SEP):

- *People who would have been eligible for Medicaid but live in states that did not take the Medicaid expansion* and *who become newly eligible during the year for premium tax credits because of an increase in income or a change in household composition or size.* Because of their low incomes, many people in the Medicaid coverage gap will likely remain uninsured in 2014. However, some people may experience an increase in income or a change in household size during the year that would make them eligible for premium tax credits. Under current rules, they would *not* qualify for a SEP unless they had applied for coverage and been denied Medicaid, received an exemption from the shared responsibility payment based on being in the Medicaid coverage gap, and subsequently lost the exemption because of their increased income.

  Guidance that HHS issued in June 2013 states that loss of a hardship exemption, including the exemption for people in the Medicaid coverage gap, triggers a SEP. If people who were in the coverage gap get a job or otherwise have a change in income or household size during 2014 that makes them eligible for premium tax credits, they are unable to qualify for a SEP unless they had obtained a hardship exemption certificate from the Marketplace. Even then, only people whose income rises above 138 percent of the poverty line would actually lose the exemption. Those whose income ends up between 100 and 138 percent of the poverty line would still qualify for an exemption and could not qualify for a SEP, even though they are now eligible for premium tax credits.

- *People who divorce during the year.* Under current rules, divorce itself is *not* a triggering event for a SEP, and some of the changes that divorce can bring — such as a substantial decrease in income and a change in tax filing status, and hence a change in APTC eligibility — trigger the current subsidy-related SEP only for people *currently enrolled* in a QHP. Some people in this situation may get a SEP if they were enrolled in a spouse's employer plan (because of the loss of coverage) or they move after the divorce. But if other such circumstances don't make them eligible for a SEP, they will have to wait until the next open enrollment period — and often will remain uninsured until then.

- *People who have access to employer-sponsored coverage but do not enroll in it because, while it may meet the ACA's technical definition of affordability, it is not affordable in practical terms.* These are people who have an offer of employer-based coverage but have not enrolled in the coverage because they find it too expensive. If such a person loses his or her job and thus loses access to the job-based plan, the individual (and his or her family) could become eligible for Marketplace subsidies because they are no longer subject to the firewall. But the individual may not be able to access a Marketplace plan outside of open enrollment without the change we are recommending, because he or she would not qualify for a SEP related to loss of employer coverage since the individual hadn't enrolled in the employer plan.

- *Victims of domestic abuse that occurs after May 31, 2014.* Guidance issued by the IRS on March 26 allows married survivors of domestic abuse to qualify for premium tax credits in 2014 even though they file their taxes separately from their spouses. The guidance on complex cases gives people in this situation until May 31 to apply and enroll in coverage. Someone who experiences domestic abuse after May 31 would not qualify for a SEP even if they separated from their spouse and knew they would be filing their taxes separately.

Quality Rating System (§155.1400)

It is critically important that consumers have access to quality information related to their QHP options as they make their enrollment decision in order to facilitate their choice of a plan based on high value, not just costs. We support CMS's intention to align the measures used in the Quality Rating System (QRS) with measures currently used by other existing quality reporting programs. We will be submitting separate, more detailed comments on the specific measures being proposed in response to the draft QRS Scoring Specifications released on March 28.

We also support the Department's plan to calculate the quality ratings using validated data submitted by QHP issuers. This will help to ensure that the same underlying methodology is used to the maximum extent possible in calculating quality ratings so that consumers can make "apples-to-apples" comparisons of plans.

With respect to the display of plan quality rating information, it is important that this information be easily seen and understood by consumers in order to be most useful. We therefore support CMS's plan to use a 5-star scale for displaying overall quality ratings, similar to the scale that Medicare Advantage uses today. Consumers should then be able to drill down to get more details for quality and customer service measures of particular importance to them. We do have concerns, however, that the Department is considering allowing state-based exchanges to link to healthcare.gov to provide quality rating information, as opposed to incorporating this information directly into their own exchange websites. Research has found that consumers using web-based health plan chooser tools make their decisions based on the initial default display of information more than 90 percent of the time.[1] This indicates that basic health plan quality information needs to be readily available in the initial display in order for consumers to consider it. Requiring consumers to link elsewhere to find quality information would likely mean that they aren't factoring it into their plan selection decision. Although we understand that technological challenges may make it initially difficult for state-based exchanges to incorporate plan quality ratings directly into their display architecture, this should be the ultimate goal for all exchanges.

Enrollee Satisfaction Survey System (§155.1405)

The enrollee satisfaction survey (ESS) is another important piece of the overall health plan quality rating system, and we generally support CMS's proposal to require QHP issuers to use an approved vendor to conduct the survey and to incorporate ESS data into the overall quality rating for each QHP.

The Department is seeking comment on whether state-based exchanges should have the flexibility to display the ESS 2015 beta test results prior to the scheduled public display of the ESS in the

[1] Consumers Union. "Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices." July 9, 2012. Accessed online at: http://www.consumersunion.org/pdf/Choice_Architecture_Report.pdf.

federally facilitated exchange in 2016. If a particular state believes its data is robust enough to be of value to the consumers of their state, we agree that the state should have the flexibility to provide the information. Allowing states to make this information available in 2015 provides an opportunity to identify best practices as well as lessons learned that may benefit other states and the federal exchange in finalizing the approach to publically displaying the information for 2016.

Prescription Drug Benefits (§156.122)

Currently, QHPs are required to have a procedure in place for enrollees to request and gain access to clinically appropriate drugs that are not covered by the plan. We encourage you to further spell out what this procedure should look like, including providing for an expedited determination for cases involving patients with serious health conditions.

We believe the rights provided to enrollees in Medicare Part D prescription drug plans would serve as a helpful model for patients enrolled in QHPs. Specifically, QHPs should be required to provide a decision on any request to gain access to a non-covered drug within 72 hours and an expedited decision should be available within 24 hours when the consumer is suffering from a serious health condition and waiting could result in a worsening of their condition.

Issuer Use of Premium Revenue: Reporting and Rebate Requirements (Part 158)

The proposed regulations make several small changes in the medical loss ratio (MLR) regulations. While we recognize that many of these changes are temporary and are not unreasonable from a policy perspective, taken collectively they will decrease the pressure that the MLR requirement places on insurers to keep premiums down. Therefore, we urge CMS not to make any additional changes that would undermine the MLR or to further extend the temporary provisions.

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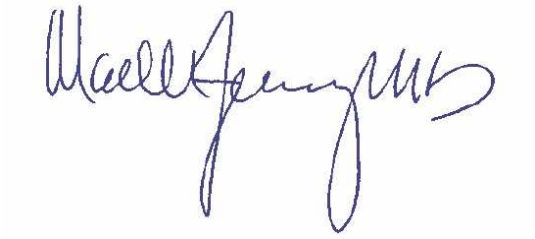
Thank you again for the opportunity to share our comments on these issues related to exchange and insurance market standards. If you have any questions, please feel free to contact Stephanie Mohl, Senior Government Relations Advisor, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,



Mariell Jessup, MD, FAHA
President