American Heart Association | American Stroke Association

December 21, 2012

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-9972-P
PO Box 8012
Baltimore, MD 21244-1850

RE: File Code CMS-9972-P (Health Insurance Market Rules)

Dear Secretary Sebelius:

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 the opportunity to submit comments on the Affordable Care Act (ACA) health insurance market rules. In general, the AHA/ASA strongly supports these rules that provide critically important protections for patients with pre-existing medical conditions who often struggle to access affordable, quality health insurance coverage today. When implemented on January 1, 2014, these regulations will have a significant positive impact on Americans with or at-risk for heart disease and stroke by insuring that no one is denied coverage or charged higher premiums simply because they have a pre-existing condition.

An estimated 7.3 million Americans under age 65 with heart disease or stroke are uninsured, and many of these individuals are denied coverage because of their pre-existing condition or are unable to afford coverage because the premiums are prohibitively expensive. The burden of cardiovascular disease (CVD) and stroke is especially difficult for individuals without health insurance, and even those with insurance can face significant barriers to accessing medically necessary health care due to costly insurance premiums, pre-existing condition limitations, and high out-of-pocket costs. These individuals are far less likely than their well-insured counterparts to receive appropriate and timely medical care, and as a consequence, have poorer medical outcomes. The uninsured with stroke have higher mortality rates, poorer blood pressure control, greater neurological impairments and longer post-stroke hospital stays than their insured counterparts. People who lack health insurance also experience a 24-56 percent higher risk of death from stroke than those who are insured.

Following are more specific comments on the health insurance market rules:

§147.102 Fair health insurance premiums

As required under the ACA, these rules prohibit health insurers from charging individuals, families, and small employers higher premiums due to health status,

claims experience, gender, and other factors, and instead provides that premium rates in the individual and small group markets can only vary due to family size, geography, and age and tobacco use within limits. We enthusiastically support the implementation of modified community rating rules, and agree with the provisions of the proposed rule requiring standardized rating methodologies across and within states. As proposed, the regulation establishes clear rules and procedures for how issuers will establish premiums in each state and will assure a level playing field and limit the risk of adverse selection against the exchanges.

HHS also specifically requests comments "regarding additional strategies consistent with the ACA that (they) or states might deploy to avoid or minimize disruption of rates in the current market and encourage timely enrollment in coverage in 2014." In general, we believe this rule does a good job of balancing the need for affordability with ensuring that the essential consumer protections of the ACA live up to their full promise. A number of features of the ACA, including the availability of premium tax credits, the availability of catastrophic plans for young people or people for whom other coverage is unaffordable, and the ability of young people to stay on their parents' plan until age 26, will further help ensure that premiums are affordable for consumers. As discussed elsewhere, AHA/ASA also supports instituting the same enrollment periods inside and outside of exchanges (as proposed in this rule) and allowing states to continue their high risk pools beyond 2014 as a means of easing the transition.

With respect to the rating areas for geography, AHA/ASA supports allowing each state to establish the rating areas within the state and the proposed maximum of seven rating areas per state based on defined geographic divisions. As a general rule, we agree that fewer rating areas are desirable to ensure that they cover a sufficient number of individuals and to minimize consumer confusion.

Footnote 20 in the preamble of the rule indicates that age, tobacco use, and geographic rating factors are multiplicative. We believe that rating for age and tobacco use in particular should instead be additive. In other words, premium rate variation for an older adult who smokes should be limited to a 3:1 ratio, rather than to a 4.5:1 ratio. Without this further limitation, premiums for older tobacco users will be prohibitively expensive. According to the CDC, more than one in five adults' ages 45 to 64 were current cigarette smokers in 2011. These are the very individuals most likely to need access to health care services, including tobacco cessation services.

Age Rating

The proposed rule provides that premiums in both the individual and small group markets can vary by age but by no more than a 3:1 ratio. Among Americans ages 45-64, nearly half (47 percent), have some form of cardiovascular disease, and the limitation on age rating (as well as the ban on health status rating) will be beneficial to middle-aged Americans who are trying to manage their cardiovascular disease yet struggle today to find affordable coverage.

AHA supports the proposal for one-year age bands for adults between the ages of 21 and 63 so that consumers will have stability in their premiums from year to year and will not experience large premium increases when they move from one age band to the next. As written, the proposed rule requires that premium rates be determined based on an enrollee's age at policy issuance or renewal. This policy implies that mid-year premium increases are not permitted due to age, but the final rule should clarify that this is the case.

Tobacco Use Rating

The AHA/ASA continues to be opposed to charging tobacco users higher premiums because we are concerned that such a policy will prevent them from obtaining affordable health insurance coverage and needed health care services, including tobacco cessation therapies. This will be particularly true because we note that, according to footnote 45 of the proposed rule, the tobacco rating surcharge will not be included in the calculation for the premium tax credit. As a result of this policy, we informally estimate that as many as 85 to 90 percent of smokers may be priced out of affordable insurance and therefore may be exempt from the minimum coverage requirement.

People who are currently uninsured smoke at much higher rates than the general population (31.5 percent vs. 21.3 percent respectively), and we are concerned that this policy will further exacerbate the insurance disparity that exists for smokers. There is little evidence that financial incentives or disincentives through insurance premiums change individual behavior. Tobacco rating is an unproven way to improve public health when we have several thoroughly tested, evidence-based interventions that are proven to reduce smoking consumption and prevalence. We do appreciate the acknowledgment in the preamble, however, that states have the ability to prohibit tobacco rating altogether or to require health plans to require a ratio lower than 1.5:1, and we hope that states will take up this option to be more protective of consumers.

The rule specifically seeks comments on how the tobacco rating surcharge could be further coordinated with the wellness provisions under section 2705 of the Public Health Service Act and how the tobacco surcharge in the individual market could be combined with the same type of incentive to promote tobacco cessation that is available in the group market. Under the proposed workplace wellness rules released on November 20, we support that the tobacco surcharge will be waived for anyone who is enrolled in a cessation program and that employers must continue to offer alternative standards for multiple quit attempts.

We appreciate the Administration's recognition that workers who are actively trying to quit smoking should not be charged higher premiums or cost-sharing. We recommend that a parallel policy be put in place in the health insurance market final rules that would allow individuals who don't have access to a workplace wellness program – either because they are purchasing coverage in the individual market or because they work for a small employer that does not offer a wellness program – to similarly avoid the tobacco rating surcharge if they are trying to quit their tobacco use. Specifically, we recommend that the final rule be amended to require that individuals purchasing coverage be given the opportunity upon enrolling or renewing their policy to sign up for tobacco cessation services. Consumers who elect this option should be able to avoid the premium surcharge.

Likewise, small employers offering coverage without a workplace wellness program should be required to make their workers aware of the availability of tobacco cessation services with no cost-sharing, and their workers who use these services should not be charged the surcharge. Moreover, workers who participate in stand-alone cessation programs, such as community-based cessation programs, should be able to avoid the tobacco surcharge. Community-based cessation programs may be best for some consumers, and they should not be required to participate in their employer's program to get the exemption. In other words, the ability of a tobacco user to forego the surtax should not be directly linked to participation in a cessation program offered through a wellness program. Enrollees should be allowed to use a cessation program offered through an employer's or insurer's wellness program, but enrollees should also have the option of participating in any evidence-based cessation program that they choose.

In addition, employers or insurers holding employees or enrollees accountable for their tobacco use should offer a comprehensive cessation program that includes both pharmacotherapy and counseling. The programs should be designed to help smokers as well as smokeless tobacco, e-cigarette, and other tobacco product users to quit. While all individual and small group health plans are required to offer tobacco cessation services which have received an "A" recommendation from the U.S. Preventive Services Task Force with no cost-sharing, current health plan coverage of these services is still uneven. Currently, tobacco cessation programs are designed for smokers. Tobacco users vary in what type of tobacco product(s) they use, how much, how often, and in what coexisting medical conditions they may have. When quitting, they need access to a range of treatments, both medication and counseling, to find the most effective tools that work for them.

The proposed rule also requests comments on possible definitions of "tobacco use." Because of the adverse consequences to patients and consumers of being charged the tobacco surcharge – including the likelihood that a significant percentage of individuals subject to higher premiums could be exempt from the insurance mandate and remain uninsured – we believe that tobacco use should be precisely and narrowly defined when it comes to applying tobacco rating. When defining "tobacco use," it is important to determine how "use" will be assessed (self-report vs. cotinine test), what tobacco products are to be included in the definition (cigarette, cigar, smokeless tobacco, e-cigarette, etc.), and the amount of tobacco use that meets the threshold for use. We will address each of these three issues separately. The goal of defining tobacco use should be to provide a simple and precise assessment of the individual's tobacco use status that minimizes misunderstandings or potential false reporting and accounts for changing trends in tobacco products and uses.

First, with respect to how use will be assessed, we support requiring insurers to rely on self-reporting of tobacco use by the enrollee at the time they are purchasing or renewing the policy. Each of the potential methods for assessing tobacco use – self reporting and cotinine testing – have weaknesses. However, we believe cotinine testing for tobacco use poses greater disadvantages than self-reporting. Cotinine testing is burdensome for insurers, employers, and individuals. In addition, non-smokers can test positive if they have been exposed to second-hand smoke, and these tests also cannot differentiate between a tobacco product and a cessation aid. Moreover, it is our understanding that self-reporting is the most common method of assessing tobacco use among insurers and employers today.

Self-identification as tobacco users is also not without problems. Inaccurate self-reporting on the part of individuals could expose them to paying the surcharge unnecessarily, to a significant financial liability, or even to future accusations of fraud that could subject them to policy rescission by the insurer. For these reasons, HHS should clarify that if there has been a misrepresentation, intentionally or unintentionally, the insurer can only collect the surcharge that should have been paid for one year.

Because of the potential adverse consequences of inaccurate self-reporting, it is critically important that the question be posed to enrollees in a simple, straightforward, precise way that will result in a precise and unambiguous answer. For example, an individual who smokes the occasional cigarette or cigar in social situations may not consider themselves to be a "tobacco user" and such an individual may answer no to a question about whether they regularly smoke. Similarly, someone who uses a tobacco product such as dip or chew may not consider themselves a smoker or tobacco user. These individuals should not unknowingly subject themselves to accusations of fraud because of ambiguities in the question. Because of the complexity of defining tobacco use, HHS should therefore spell out in the final rule exactly how insurers will ask enrollees whether they use tobacco

so that there is a standardized process for applying the tobacco rating across all insurers, just as there is with respect to other rating factors.

Second, as we have already alluded to, determining what tobacco products are to be included in the definition of "tobacco use" can be very complicated. There is no uniform, widely used definition of tobacco use today. Moreover, the issue is becoming more complicated as the tobacco industry continues to introduce new products to expand its market (for example, e-cigarettes, dissolvable tobacco, etc.). While we generally believe that a definition of tobacco use should include the most common tobacco products, not just cigarettes, including a long list of tobacco products – such as the FDA's comprehensive definition of tobacco products – could be confusing and misunderstood by consumers, resulting in the types of ambiguity that should be avoided.

Finally, determining what amount of tobacco constitutes "use" is also complicated. While there is no "safe" amount of tobacco use, there is also no consistent standard for what constitutes regular tobacco use among health plans and health status surveys. Again with respect to this question, it is very critical that, whatever amount of tobacco is considered, that it be a standard that is as precise and unambiguous as possible.

Because there is currently no standard definition of tobacco use and defining this is enormously complicated and has major ramifications for consumers, HHS should use its planned consumer testing program of the uniform enrollment application to test various language, questions, and definitions of tobacco. After evaluating the results, HHS should apply whichever protocol equates to the most reliable and consistent measure of actual tobacco use. There are a number of different examples that HHS could consider for testing. For instance, the World Health Organization (WHO) uses a fairly simple and straightforward definition of tobacco use: the WHO considers someone a "regular" tobacco user if they use at least one tobacco product a day. HHS could test variations of this definition that lists specific tobacco products and includes a 30-day look-back timeframe to assess which definition results in the most accurate and reliable responses from consumers.

§147.104 Guaranteed availability of coverage

AHA strongly supports the guaranteed availability of coverage provisions of this proposed rule, requiring issuers to accept every individual or employer who applies for coverage in the individual or group market regardless of health status, risk, or medical claims and cost, subject to certain exceptions (for example, limits on network capacity). More specifically, we support the requirement that issuers in the individual or group market must offer to any individual or employer in the state all products that are approved for sale in the applicable market, including "closed blocks" of business, and must accept any individual or employer that applies for any of those products as long as the individual or employer meets all of the eligibility requirements.

AHA applauds HHS for aligning the initial and annual open enrollment periods for purchasing coverage in the individual market with the exchange open enrollment periods to make it easier for consumers to understand and navigate the open enrollment process inside or outside the exchange. We also support aligning the effective dates of such coverage with the exchange standards, which will help ensure that individuals are not subject to unreasonable delays before their coverage becomes effective. Consistency in these policies inside and outside of exchanges is also important to curb adverse selection.

The rule also proposes an additional special enrollment period for individuals who experience certain "qualifying events" that could result in loss of coverage, such as termination of employment or divorce. We urge HHS to use its discretion under the law to ensure that qualifying events for

special enrollment periods in the individual and small group markets outside of an exchange are consistent with those that are required inside of exchanges. This is necessary for two main reasons: Consumers would benefit from market-wide rules that are as consistent as possible so that they will more easily understand when they may enroll in coverage or change their plan, and insurance exchanges should be protected as much as possible from the risk of adverse selection from plans offered in the outside markets. We support the proposal to apply the special enrollment periods for qualifying events (as defined under section 603 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended) to the individual and small group markets.

HHS also requested comments on using a 60-day calendar standard, generally consistent with the exchanges, for special enrollments, instead of the proposed a 30-day special enrollment period for qualifying events in the group and individual markets. AHA supports a 60-day calendar standard for special enrollments in order to be consistent with the exchanges and to reduce the potential for adverse selection. The proposed rule also seeks comments on whether health insurance issuers in the individual market should provide to enrollees in their products a notice of special enrollment rights similar to what is currently provided to enrollees in group health plans. Since qualifying events associated with the special enrollment period typically occurs during difficult and confusing times in consumers' lives, we believe requiring issuers to provide clear and prominent notice of their enrollment rights will be particularly important and helpful.

State insurance departments are playing a critical role in the successful implementation of the ACA and will also have an important role in enforcing the insurance market reforms in this proposed rule both inside and outside the exchange. AHA supports HHS's policy intent of having states continue their traditional role of regulating the marketing activities of issuers, consistent with the requirements for qualified health plans in the exchanges. HHS's decision to apply a minimum proposed marketing standard to the entire marketplace will ensure consistency in the marketing of plans inside and outside of the exchanges, leverage existing state oversight mechanisms, make it easier for consumers to understand their coverage options, and help ensure that the marketing practices of issuers will not be used to discourage the enrollment of individuals with significant health needs in qualified health plans.

These provisions are similar to regulations already in force in many or all states and appear to be a reasonable approach to assuring consistency in federal and state regulations. The proposed rule notes that the NAIC's model act and regulation include comprehensive marketing standards for issues that have already been adopted by the vast majority of states, and AHA supports incorporating these standards in the proposed rule to minimize the potential for adverse selection and assure a level playing field for plans sold inside and outside of the Exchange. We note, however, that as proposed, the marketing standard only applies with respect to "individuals with special health needs." The final rule should clarify that under the non-discrimination requirements of section 1557 of the ACA, insurers also cannot discriminate against people based on race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or health conditions.

HHS also requested "comments on possible ways to discourage consumers from abusing guaranteed availability rights (for example, by ensuring enrollees cannot use open and special enrollment periods to facilitate such abuses) while ensuring consumers are guaranteed the protections afforded to them under the law." We do not agree with the premise behind this question since the vast majority of consumers want the financial security and peace of mind that health insurance provides. Rather than manipulating the rules in their favor, it is far more likely that consumers will be confused about when and how to enroll in coverage and what plan to select. In any event, the combination of the minimum coverage requirement and a single annual open

enrollment period should be sufficient to prevent consumers from "gaming" the system by waiting until they are on the way to the hospital to buy coverage.

Under the proposed rule, it appears that states have the option (but are not required) to prohibit issuers in the individual market inside and outside the exchanges from enrolling anyone outside of open and special enrollment periods, a move that could help minimize adverse selection concerns but that could harm consumer access, particularly in the initial years when consumers are still becoming familiar with their rights and responsibilities under the ACA. However, if a state does not take actions to create uniform rules across issuers, we are concerned about the variation that could exist in issuers' practices and that selective issuance and marketing practices could be used to attract lower-cost enrollees or avoid those who are sick and cost more to cover. For example, one issuer in a state might decide not to issue any policies in the individual market between enrollment periods, while another might decide to heavily market catastrophic plans in May in college towns, in order to increase enrollment by younger people in its products in a selective way outside of regular enrollment periods. HHS should ensure, in the final rule and in future guidance, that there are clear federal standards that require each issuer to apply consistent rules for how and when policies will be issued outside of open enrollment periods.

We understand that some states may be looking at other options, such as whether carriers may enroll individuals outside of an open enrollment period and what sorts of underwriting activities would be permissible outside the enrollment periods, if any. These states that may be considering allowing enrollment outside of open enrollment periods also seem to be considering whether waiting periods or late enrollment penalties could be imposed for those that have had a significant break in creditable coverage or who are significantly increasing benefits. Some of these strategies appear to be contrary to the guaranteed issue and rating rules of the ACA, and we encourage HHS to provide clear guidance to the states on whether these strategies are permissible under the statute.

§147.106 Guaranteed renewability of coverage

AHA supports requiring health insurance issuers to renew all coverage in the individual and group markets, subject to certain reasonable exceptions (such as for non-payment of premiums or fraud).

§156.80 Single risk pool

We support the proposed rule's creation of single risk pools for the individual and small group markets both inside and outside the exchange. As permitted under the ACA, the rule also gives states the authority to merge their individual and small group pools into a combined pool. AHA supports the single risk pool requirement, which will help to spread risk over larger populations and stabilize premium rates across all of an issuer's plans. We also support the inclusion of student health plans and catastrophic plans as part of the single risk pool, as proposed. The single risk pool requirement will help establish a more level playing field for issuers, both inside and outside of an exchange, and will lead to more competitive and functional marketplaces that will benefit consumers.

§156.155 Enrollment in catastrophic plans

The ACA allows individuals younger than age 30 and individuals who cannot afford minimum essential coverage or who are eligible for a hardship exemption to enroll in catastrophic plans. We support the rule's proposal to allow an individual enrolled in a catastrophic plan who reaches the age of 30 during a plan year to remain enrolled for the remainder of the year. We also support

codifying in the rules that catastrophic plans must cover preventive services without cost-sharing, including without regard to whether they've reached the cost-sharing maximum requirement.

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Thank you again for the opportunity to share our comments on these issues related to implementation of the 2014 health insurance market reforms. If you have any questions, please feel free to contact Stephanie Mohl, Government Relations Manager, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,

Donna K. Arnett, PhD, BSN, FAHA
President