ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

July 28, 2014

Center for Medicare and Medicaid Services
Department of Health and Human Services,
Attention: CMS-9941-P
P.O. Box 8012
Baltimore, Maryland 21244-1850

Submitted via www.regulations.gov

Re: **Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges**

Dear Secretary Burwell,

Consumers Union, the policy and advocacy division of Consumer Reports,[1] thanks you for releasing these important proposed rules.

Under section 2703 of the Public Health Services Act (PHS), as added by the Affordable Care Act, health insurance issuers in the group and individual markets must guarantee the renewability of coverage unless an exception applies. The process currently established in regulation allows an individual who is enrolled in a QHP through the Exchange and whose QHP remains available to renew coverage for the following year without reapplying or having to take other actions.

HHS has asked for comments on the proposed rules for auto-renewing consumers into coverage.

We recognize the benefit of instituting a streamlined auto-renewal system, but also see substantial risks to consumers. Enrollees may end up with an inaccurate calculation of their tax credit subsidies if auto-enrollment is based on stale data. Further, consumers may find themselves in a plan outside the exchange that does not allow them to receive any subsidies and thus is unaffordable; or may continue in a plan they did not realize they could change. Our comments below reflect our concerns. We hope that CMS will work to revise these regulations to ensure an appropriate balance between guaranteed renewability and accurate information to ensure that consumers in all Marketplaces remain enrolled in

[1] Founded in 1936, *Consumer Reports* is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. Using its more than 50 labs, auto test center, and survey research center, the nonprofit rates thousands of products and services annually. Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its policy and advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and the marketplace. This division employs a dedicated staff of policy analysts, lobbyists, grassroots organizers, and outreach specialists who work with the organization's more than 1million online activists to change legislation and the marketplace in favor of the consumer interest.

2015 and do so in the plan that makes most sense to them in terms of affordability and comprehensiveness of coverage. To ensure accurate information is provided to consumers, we strongly recommend the Marketplace recalculate tax subsidies and cost-sharing assistance annually for *all* individuals and families purchasing or renewing products through the Exchange and provide that information to enrollees and QHP issuers so that the required consumer notice information about tax credits and net premiums is accurate for the 2015 enrollment period.

§155.330(b)(4) and §155.335(e)(2), Reporting changes by mail

HHS proposes to end the requirement that Exchanges allow enrollees and applicants to report changes via mail. We understand that the FFM will eliminate the ability to make mail-in changes altogether, providing state-based Exchanges the option, but removing the requirement, to continue accepting mail-in changes.

Consumers Union **opposes** eliminating, and making optional for State Marketplaces, change reporting by mail. We recognize that encouraging use of the telephone option promotes administrative efficiency, since a call center representative can use the dynamic application to ask the qualified individual any follow-up questions that may arise from the change report. We also recognize that many of the Exchanges have had to deal with challenges of processing paper information, scanning it in, and tagging it to a consumer's electronic files.

However, not all applicants have access to the internet or in-person assisters. Call centers will be inundated with millions of new applicants during the open enrollment period. Eliminating the mail-in option for people renewing at the same time that new people will be signing up for coverage creates a high risk of long phone wait times. Additionally, some states continue to struggle with call center performance.[2] While we agree that other methods should be emphasized over mail as a method of reporting changes, we believe that individuals renewing their eligibility should be provided the same methods for reporting changes as are offered during the original application process.

Given the ACA promise of a single, streamlined application and enrollment process, and the continued commitment to allow individuals enrolled in Medicaid to respond to annual redeterminations via mail, we strongly believe that individuals renewing through Exchanges should be afforded the mail-in option for annual renewal. Consumers Union thus urges HHS to continue to require renewal by mail as an option available to *all* consumers.

§155.335 Annual Eligibility Redetermination

Paragraph (e): Consumers Union strongly believes that consumers need consistent messages about reporting changes in income. Currently, exchanges may establish a threshold below which enrollees are not required to report changes in income. In the interest of consistency, Consumers Union thus **disagrees** with HHS' elimination of the minimum threshold for reporting income changes for re-determinations. In keeping with HHS's desire to foster administrative simplicity and consistency, we recommend maintaining a threshold below which income changes are not required to be reported as

[2] http://www.governing.com/news/headlines/minnesotas-health-insurance-marketplace-has-some-big-call-center-problems.html ; http://kff.org/report-section/survey-of-health-insurance-marketplace-assister-programs-section-6/

part of a redetermination, thus aligning with the treatment under §155.330 describing the reporting requirement during the benefit year .

We, therefore, recommend adding language that permits Exchanges to establish a threshold for changes in income, so as not to inundate the website and the call center with small changes that have no impact on eligibility, language such as:

> (e) (3) The Exchange may establish a reasonable threshold for *Di minimis* changes in income, such that an enrollee who experiences a change in income that is below the threshold is not required to report such change.

Moreover, th**e** regulatory language needs to make clear that the obligation to report income changes at open enrollment relates to *projected income for the upcoming plan year*. Many consumers will be providing this information for re-determinations in 2014, and may find it unclear whether they should be updating their present circumstance or reporting their expectations for 2015. To optimize the accuracy of subsidy calculations, Exchanges need to do all they can to inform consumers of exactly what data they are seeking and for what time frame.

Paragraph (e)(1): We support the proposed change that the Exchange would <u>not</u> be permitted to require a qualified individual to report changes that affect eligibility for insurance affordability programs if that person did not request an eligibility determination for insurance affordability programs.

Paragraph (j) We recognize the need to address the different situations that might arise from changes in the plan and product offerings on the Exchange. Defaults assignments have the benefit of avoiding gaps in coverage. However, as we discuss below, we are concerned that the proposed rules for re-enrollment may enroll consumers in a plan that does not make sense for them.

Before getting into specific scenarios, we propose the following overarching recommendations.

(1) Given the tremendous confusion that exists between "plans" and "products," we recommend that HHS include a reference to their definition in the final rule.[3]
(2) Given fluctuating premiums, the availability of new product offerings and changes in personal family circumstances, it is likely that consumers would be far better off shopping before re-enrolling in the same plan. Strong consumer communication about important changes is essential to ensure that consumers get the plan that is best for them. **We recommend stronger rules and model notices**[4] for issuers, so that enrollees are encouraged to shop for the best value. As described in more detail below, model notices should be upgraded to prominently remind enrollees to check to ensure the new plan still includes their drugs on the formulary and includes their doctor(s) in the network. Further, we recommend pro-active outreach by the Exchange.

[3] These terms defined in the original 2010 healthcare.gov rule and in the 2015 exchange rule.
[4] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Bulletin-on-Renewal-and-Termination-Notices-FINAL.pdf

In several cases, we recommend HHS adopt a more exact procedure and more precise language for cases when an individual's plan is no longer offered on the Exchange and, thus, cannot be renewed.

Paragraph (j) (1)(ii) We recommend that HHS clarify that this reference to "a plan at the same metal level" is intended to mean with the same insurer/same product, as we believe that is HHS's intent.

Paragraph (j) (1)(iii) The proposal to enroll individuals in a different metal level when their "product" no longer includes their current metal level is problematic for several reasons.

First, and most concerning, enrollees eligible for cost-sharing reductions will lose this financial protection if they are auto-renewed into a non-Silver plan with the same QHP issuer. **We strongly recommend** HHS protect enrollees enrolled in silver level plans who receive cost-sharing reductions to ensure they do not lose this financial support. HHS could consider auto-enrolling these individuals in the Silver Plan (regardless of carrier) that is most similar to the plan they have now but that plan might not include their current providers and/or the formulary might not cover their drugs. The best outcome is for these individuals to pro-actively shop for coverage with the help of an assister or a customer service representative. The model dis-continuation notices[5] do not sufficiently protect consumers facing this circumstance and **must be upgraded**. For this group, notices should be mailed multiple times and phone contact attempted. The headline message on the notice should be that the enrollee must shop for coverage due to the discontinuation of their plan in order to preserve both their cost-sharing reductions, ensure their providers are in the network and their drugs are covered by the formulary.

Second, for the enrollees not eligible for cost-sharing reductions, HHS offers too little guidance on whether the substitute plan should be at a higher or lower metal level when both are available. **We recommend** HHS develop additional guidelines for how to proceed in the case that an enrollee's current QHP is not available and the enrollee's product no longer includes a plan at the same metal level as the enrollee's current QHP. Additional clarification is needed for how an insurer will decide, in a manner that is not arbitrary, whether to enroll an individual in a plan of a higher or a lower metal value. This decision has important implications for the consumer, both in terms of premium and cost-sharing tradeoffs. We do not support an approach that merely seeks to identify the closest premium, as this disregards cost-sharing considerations. For similar reasons, we do not think preference should be given to the plan with the lowest metal level. A better approach would be a "total cost" approach,[6] whereby the expected annual out-of-pocket cost for the average enrollee of that age is added to the premium and compared across the plan alternatives. The enrollee should be auto-renewed into the "best value" using the total cost approach, as long as the approach does not make them ineligible for cost-sharing reductions. Again, notice requirements must be updated to ensure that they check to see if their providers are still in the network and the formulary covers their drugs.

[5] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Bulletin-on-Renewal-and-Termination-Notices-FINAL.pdf

[6] The estimation of "total cost" is explained in more detail in this Consumers Checkbook publication: http://www.checkbook.org/exchange/Health%20plan%20comparison%20tool--best%20practices%20recommendations.pdf

Paragraph (j) (1)(iv) We have the same concerns as expressed in (j)(1)(iii) with respect to individuals who lose access to cost-sharing reductions due to being auto-enrolled in a non-Silver plan and the insufficient nature of current notice requirements.

Paragraph (j) (2) (ii) and (iii) We have the same concerns as expressed in (j)(1)(iii) with respect to individuals who lose access to cost-sharing reductions due to being auto-enrolled in a non-Silver plan and the insufficient nature of current notice requirements.

Paragraph (j) (2)(iv) In the case that the issuer does not offer any plan through the Exchange in which the enrollee is eligible to enroll, **we strongly oppose HHS' proposal** to allow QHPs to auto-enroll enrollees in plans outside the Exchange. Under the proposed rule, enrollees would not be able to use tax credits and therefore would lose an important benefit that makes health insurance more affordable. If feasible, we recommend that the Exchange auto-renew enrollees into the most similar Marketplace product from another carrier. However, this default Exchange plan might not include their current providers and/or the formulary might not cover their drugs. Hence, the best outcome is for these individuals to pro-actively shop for coverage with the help of an assister or call center representative. Rather than have the regulations permit auto-enrollment outside the Marketplace and risk loss of tax credits, the rules should require affirmative outreach to these specific enrollees. The Exchanges should be required to make multiple attempts to reach the enrollees through the telephone, e-mail and mail. Only when multiple contacts are tried and fail, should the enrollees be auto-enrolled in a different QHP.

The model dis-continuation notices[7] do not sufficiently protect consumers facing this circumstance and **must be upgraded**. For this group, these notices should be mailed multiple times and phone contact attempted. The bold headline message on the notice should be that the enrollee must shop for coverage due to the discontinuation of their plan in order to preserve their tax credits (and possibly cost-sharing reductions), ensure their providers are in the network and ensure their drugs are covered by the formulary. The rules should require affirmative action by a customer service representative or assister to ensure that the enrollee is sufficiently informed before the default takes place..

§156.1255 Renewal and re-enrollment notices

HHS proposes to require insurers to include certain information in the renewal or discontinuation notices.

Paragraph (a): We **support** the portion of the proposed rule that requires QHP issuers to provide premium and premium tax credit information sufficient to inform consumers of their expected monthly premium payment under renewed coverage. We are concerned, however, about the disconnect between the proposed language, namely that the tax credit information be "sufficient" to understand their expected monthly premium payment and the June 26 Insurance Standards Bulletin series "Draft Standard Notices," where this requirement was clarified to be the 2014 APTC amount.

[7] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Bulletin-on-Renewal-and-Termination-Notices-FINAL.pdf

If the notice rules do not require updated tax credit eligibility, but rather default to tax credit information used for the enrollee's 2014 determination, the tax credit information provided by the QHP issuer will almost certainly be inaccurate because the notice will not reflect changes in the premium charged by the second lowest cost Silver plan, changes in family income or changes in family size.

We strongly recommend the Marketplace recalculate tax subsidies and cost-sharing assistance annually for *all* individuals and families purchasing or renewing products through the Exchange and provide that information to enrollees and QHP issuers so that the required information about tax credit and net premium is accurate for the 2015 enrollment period. In instances where the enrollee did not provide advance permission to access their tax return information for renewal purposes, we recommend the Exchange proactively reach out, requesting that the enrollee initiate a re-determination.[8]

While the model notices[9] (but not the proposed rule) include language encouraging enrollees to have their tax credit amounts re-determined, this requirement needs to be added to the rules for re-determination notices. Hence, **we recommend** new language:

> (a)(i) The renewal or discontinuation notice must include a redetermined APTC amount for the plan year, if possible. If updated information on family size and income is not available, the APTC must at least reflect the premium for the second lowest cost Silver plan for that marketplace and enrollee-type. The notice must make it clear how the tax credit amount in the notice differs from the enrollee's actual 2015 APTC, if at all.

Paragraph (d): We strongly support the requirement that notices include information on the possible loss of cost-sharing reductions due to auto-renewal into a non-Silver plan. We recommend that HHS strengthen the rule language to make this more prominent. We recommend the following change to this paragraph (new/altered text underlined):

> (d) For all renewal notices for plans at all metal tiers, a prominent notice on page 1 that explains that in order to access cost-sharing reductions, they must be enrolled in a Marketplace plan that is at the silver-level, otherwise they will not be able to get lower out-of-pocket costs.

New Paragraph (e): In keeping with our concerns expressed above about being auto-enrolled from a Marketplace plan to a plan outside the Exchange, **we renew our opposition to that provision.** If it continues, **we strongly support** adding a requirement that notices include information on the possible loss of tax credits and cost-sharing reductions if enrollees are auto-renewed into a non-Marketplace plan. We recommend a new paragraph be added such as:

> (e) For enrollees that are being defaulted from Marketplace plans to non-Marketplace plans, a prominent notice on page 1 that explains that unless the enrollee buys a plan in the Marketplace, they will not be eligible for tax credits and/or cost-sharing reductions. The notice

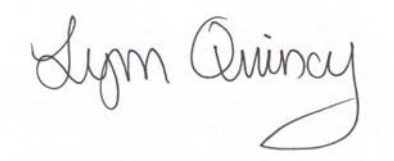
[8] We understand from CCIIO that they estimate only 1% of current enrollees in the FFM did not provide such permission.
[9] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Bulletin-on-Renewal-and-Termination-Notices-FINAL.pdf

should make it clear that families must be below certain income thresholds and meet other requirements to qualify for a tax credit, in addition to purchasing a plan from the Marketplace.

After strengthening the model notices per our recommendations, we recommend that carriers be required to use the model notices.

On behalf of Consumers Union, I thank you for the opportunity to comment on this important rule-making and would be happy to answer any questions.

Sincerely,



Lynn Quincy
Associate Director, Health Reform Policy
Consumers Union
202-462-6262