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POLICY & ACTION FROM CONSUMER REPORTS

March 7, 2017

Tom Price, Secretary
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attn: CMS-9929-P
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-9929-P: Patient Protection and Affordable Care Act; Market Stabilization

Dear Secretary Price,

Consumers Union, the policy and mobilization arm of Consumer Reports,[1] has long advocated for access to high quality, affordable, healthcare and health coverage. Over the past seven years alone, Consumers Union provided feedback to HHS on the many of the proposed rules associated with the Patient Protection and Affordable Care Act (ACA).

The Congressional Budget Office estimates that for 2017, 31 million people under 65 will have obtained coverage under the ACA: 12 million through the Medicaid expansion, 10 million through non-group coverage from Marketplaces, 8 million through non-group coverage off the Marketplaces, and 1 million through the Basic Health Plan.[2] Thus, a large proportion of those who obtained coverage did so by accessing comprehensive benefits through the individual market -- making it a true lifeline. This lifeline depends upon stability in the insurance marketplace. Yet we believe that the current assertions of instability in the non-group market arise in large part from the uncertainty created by the current efforts to repeal the ACA. Furthermore, as explained below, we have concerns that many aspects of this proposed rule -- rather than enhancing stability -- will further deteriorate it.

We believe the NPRM will not achieve its stated purpose, which is as follows:

> *The provisions in this proposed rule aim to improve the health and stability of the Exchanges. They provide additional flexibility to issuers for plan designs, reduce regulatory burden, seek to improve the risk pool and lower premiums by reducing gaming and adverse selection and incentivize consumers to maintain continuous coverage. Issuers would experience a reduction in costs related to network adequacy reviews. Through the*

[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 more than 50 labs, its auto test center, and survey research center, the non-profit organization rates thousands of products and services annually. Consumer Reports has over 7 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 1 million online activists to change legislation and the marketplace in favor of the consumer interest.

[2] The Congressional Budget Office, *Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage*, Jan. 2017, available at https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf.

reduction in financial uncertainty for issuers and increased affordability for consumers, these proposed provisions are expected to increase access to affordable health coverage. Although there is some uncertainty regarding the net effect on enrollment, premiums and total premium tax credit payments by the government, we anticipate that the provisions of this proposed rule would help further HHS's goal of ensuring that all consumers have quality, affordable health care and that markets are stable and that Exchanges operate smoothly.

In fact, we believe the rule will have the contrary effect. The cost reductions and regulatory simplifications set forth in this proposed rule accrue mainly to the benefit of issuers, while the bulk of the costs and impediments to access will be borne by consumers. The stated purpose acknowledges "some uncertainty regarding the net effect on enrollment, but all signs in fact point to reduced enrollment in the Exchanges due to additional hurdles for consumers, including both healthy ones and those who know they need care. We detail our concerns below.

Initial and Annual Open Enrollment Periods (45 CFR §155.410(e))

In its prior rulemaking, HHS established an open enrollment period for 2018 that mirrors the current 2017 open enrollment period of 92 days (November 1 through January 31). In this proposed rule, HHS suggests cutting that period in half, shortening it to just 45 days, for open enrollment for the 2018 benefit year (November 1 to December 15, 2017). Consumers Union respectfully opposes this change, as described below, due to its likely harm to consumers and reduction in the number of people enrolling; the harm it will do to the quality of the risk mix, and thus to premiums; and the damage it would do to the operational functions of exchanges and insurers in this time of uncertainty for both consumers and the individual market.

As changes to the ACA are debated, we urge HHS to maintain the current open enrollment time frame of November 1 through January 31 for the 2018 benefit year. Moreover, due to the current dynamic policy environment, Consumers Union also urges HHS to revisit its prior decision to shorten the open enrollment period beginning with the 2019 plan year. Careful analysis should be performed to better understand the potential impact for individual market enrollment and risk mix of any transition to a shorter open enrollment period, and to balance it against any perceived benefits to shortening the enrollment period.

The proposal does damage to the risk mix, enrollment levels, and premiums: There is substantial evidence that shortening the enrollment period would negatively impact consumers' ability to enroll; overall enrollment numbers; the health of the risk mix; and premiums.

A healthy risk mix is essential to the stability of the individual market and to minimizing premium increases. A shorter open enrollment period would have an especially strong, adverse impact on enrollment of the most sought-after healthy cohort of consumers, including young adults, as illustrated below. Reducing their enrollment numbers would create a less healthy risk mix in the individual market and higher premiums for all enrollees. In many exchanges, a significant share of total open enrollment sign-ups occur in the *last month* of open enrollment.

The experience in California, a state in which Consumers Union has a strong presence and history working on behalf of consumers, is instructive. At that state's Exchange Covered California during open

enrollment for plan year 2017, **39 percent of new enrollments came in January 2017**. The share of **young adults increased as a percent of total plan selections from 35 percent in the first week to 41 percent in the final week**. Moreover, younger enrollees (ages 18-34), who constitute a critical demographic for ensuring a healthy risk mix, tend to have risk scores well below the average. The data from Covered California's 2016 open enrollment period (11/1/2015-2/6/2016) indicate that there was a steady **increase in the health status of enrollees throughout the open enrollment period**. For example, during the first three weeks of the 2016 open enrollment period, the average risk score was 1.02 and **in the final three weeks of the 2016 open enrollment period, the average risk score fell to .93**. Those with lower risk scores have a lower propensity to use medical care.

Thus, continuing the longer enrollment period through January 31 would help ensure a healthier risk mix and lower medical costs, which would tend to suppress premiums for 2018. Conversely, shortening the period to December 15, would damage the risk mix and lead to increased premiums for all.

The proposal would add to both consumer confusion and financial burden: While the preamble states HHS' belief that issuers and exchanges are ready for a transition to a shorter open enrollment period, we believe that consumers are not. Consumers still tend to be confused about open enrollment as a concept and about the precise timing.[3] Thus, the longer current time period is important to allow time for intensive outreach and education.

Moreover, Consumers Union believes that shortening open enrollment to end it on December 15 would put an intensive financial burden on consumers. Affordability is the number one concern of potential enrollees. End of year and holiday expenses will mean that new enrollees may have trouble making their first premium payment in December for January coverage during the season when family finances are tightest. This could lead to lower enrollment by forcing potential enrollees to decide between immediate, family needs and a health insurance premium for the coming year. Many consumers will likely opt for the former.

The experience at Covered California, for example, shows that enrollment tends to slow down in December, with many consumers preoccupied with holiday planning, travel and family gatherings. In contrast, as noted above, Covered California has experienced a *surge* in enrollment in the final days of open enrollment in January.

The operational implications of abbreviating the enrollment period are problematic: While there may be some operational benefits for issuers in shortening the open enrollment prior to the beginning of the plan year, Consumers Union believes those benefits are far outweighed by the operational risks of the very abbreviated proposed 45-day period. This shortened period will seriously destabilize the market as enrollees are confused by the process and fail to obtain coverage by the deadline. In addition, operational complications for consumers, as well as exchanges and agencies on the federal and state levels, will likely result if the open enrollment period is shortened, such as:

[3] Bianca DiJulio, Jamie Firth, Ashley Kirzinger, and Mollyann Brodie, *Kaiser Health Tracking Poll: January* 2016, The Henry J. Kaiser Family Foundation, Jan. 28, 2016, available at http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-january-2016/ (according to the January 2016 poll, just 15 percent of the uninsured could state the correct open enrollment deadline. The majority (57 percent) of the uninsured said they don't know the deadline and small shares incorrectly believed the deadline was some other time in 2016 than it actually was (16 percent)).

- Longer wait times at call centers as consumers struggle to get information; this will compound the drop-off of healthier individuals, who are the least motivated to persevere in seeking coverage since they lack the urgency of felt medical needs.
- Slowdowns in eligibility and data verification capacity in such a condensed time period.
- Enrollment assistance shortages as community-based assisters and agents alike will be busy with Medicare open-enrollment during this same timeframe, as well as with small businesses that have short year-end open-enrollment periods.

There should be additional flexibility for States: If HHS does finalize the abbreviated proposed rule on the open enrollment period, Consumers Union strongly urges HHS to provide state-based Marketplaces the flexibility to set their own open enrollment periods as long as they span, at minimum, the federal open enrollment period. Covered California, for example, has successfully operationalized the current November 1-January 31 open enrollment period. Changes to it would cause confusion for California consumers and assisters, and administrative burden for all stakeholders. We thus urge you to allow states that wish to establish longer enrollment periods than any federal floor to do so.

Special Enrollment Periods (45 CFR §155.420)

As the preamble notes, Section 1311(c)(6)(C) of the Affordable Care Act states that the Secretary is to provide for special enrollment periods (SEPs) specified in section 9801 of the Code and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Act. Section 2702(b)(3) of the PHS Act also directs the Secretary to provide for market-wide special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. Special enrollment periods are also a longstanding feature of employer-based coverage. Specified qualifying events under the ACA for enrollment in Marketplace plans, and changes of plan, outside of the annual Open Enrollment Period include significant life events such as divorce or marriage; birth or adoption of a child; permanent moves to a new region; and loss of minimum coverage, including loss of Medicaid eligibility.

Pre-enrollment verification requirements: The preamble notes that the proposed regulation would impose new pre-enrollment verification requirements of special enrollment qualifying events starting in June 2017, in response to strong issuer requests. HHS estimates that this rule would result in pre-enrollment verification for an additional 650,000 individuals. For some time, insurers have claimed that consumers are abusing current SEPs, but they have provided no evidence to support their claims. Insurers allege that many people using SEPs are either ineligible for Marketplace coverage, or that they use SEPs to enroll only when they know they need costly medical care, then obtain expensive care and drop coverage once the care is received.

While it is important to guard against adverse enrollment--people enrolling only when they are sick--it is also crucial to remember that the individual market is a residual one, the place people go when they have gaps in coverage, whether from job loss, becoming ineligible for Medicaid, or through other changes in life circumstance, such as divorce. The individual market, thus, has always been subject to short-term,

churning enrollment.[4] It is, and has always been, "gap coverage" for people transitioning into and out of other sources of coverage, such as job-based plans and Medicaid.[5] Since life changes that result in loss of coverage are often unpredictable, it makes sense that they often occur outside the narrow window of open enrollment.

There is reason to believe that the real problem regarding SEPs is not over-use, but under-use. According to Urban Institute estimates, fewer than *15 percent of those eligible* for SEPs enroll using them.[6] That means the people using SEPs are likely those most motivated to get coverage — those with medical conditions or who know they'll need medical services in the near future. This explains the higher claims costs among SEP enrollees, not misuse of the system or gaming the documentation rules. Therefore, for a robust risk mix, rather than narrowing the number of people attaining coverage during SEPs, a wiser goal would be broadening the number of people accessing coverage to bring in healthier consumers less motivated to scale documentation hurdles.

Moreover, there is also no validated evidence that SEP enrollees are dropping coverage inappropriately after receiving care. Nor is there data proving that the SEP enrollees who drop their plans soon after enrolling were originally ineligible or have the highest health claims and then become uninsured, as opposed to their simply obtaining other coverage.

CMS' pilot in 2016 tightening documentation requirements for 50% of consumers enrolling in the federal Marketplace during SEPs resulted in a drop in enrollment of 20% over 2015. Notably, younger, presumably healthier, consumers were disproportionately less likely to complete the verification process than older applicants: 73% of applicants age 55-64 completed the process, but only 55% of those 18 to 24.[7] The approach proposed here, further tightening that used in the pilot and applying it to all SEP applicants, thus risks deterring eligible people from enrolling. If, for example, they can't readily obtain needed documentation, they will be left uninsured and without needed health care. Those sturdy enough to overcome the more onerous documentation hurdles and verification process are likely to be even sicker and higher-cost—the most highly motivated to get coverage—contributing to a less healthy pool of enrollees.

The preamble states that HHS will "make every effort" to verify an individual's eligibility through electronic means, for example when there is a birth or when a person was denied Medicaid. We strongly support that effort. Due to the low probability of ineligibility in these cases—as validated by insurers—we urge that these applicants be given immediate coverage, and not have their applications pended as proposed. Instead, their self-attestation should continue to be accepted to ensure prompt, continuous access to health care and coverage. Furthermore, any SEP verification should continue to be done by

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[4] Miranda Dietz, Dave Graham-Squire, and Ken Jacobs, *The Ongoing Importance of Enrollment: Churn in Covered California and Medi-Cal*, The UC Berkeley Labor Center, April 2, 2014, available at http://laborcenter.berkeley.edu/the-ongoing-importance-of-enrollment-churn-in-covered-california-and-medi-cal/.

[5] Laurel Lucia, *How Do We Make Special Enrollment Periods Work?*, Health Affairs Blog, Feb. 16, 2016, available at http://healthaffairs.org/blog/2016/02/16/how-do-we-make-special-enrollment-periods-work/.

[6] Matthew Buettgens, Stan Dorn, and Hannah Recht, *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods*, The Urban Institute, Nov. 2015, available at http://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf.

[7] Timothy Jost, *Unpacking The Trump Administration's Market Stabilization Proposed Rule*, Health Affairs Blog, Feb. 16, 2017, available at http://healthaffairs.org/blog/2017/02/16/unpacking-the-trump-administrations-market-stabilization-proposed-rule/.

Marketplaces, not issuers, consistent with the ACA statute. As noted below (under "State flexibility urged"), some states are further along in using or establishing electronic verification systems; they should not be impaired in their ability to do so, for the benefit of their residents.

We appreciate that the Administration is seeking comment on strategies that would increase the chances of consumers completing the overall verification process and urge explicitly prioritizing that goal. One strategy is to proactively reach out via emails and phone calls to consumers who start, but not complete, the process. Another strategy would be for the federal government to again require certificates of creditable coverage from employers (which used to be required under HIPAA) so there is a reasonable way for people to obtain the proof of eligibility. Currently, there is no assurance that individuals will be able to documentary proof of such coverage, much less in the time frame suggested; in some cases, particularly for low-wage workers, applicants' former employers have not provided it upon request. Yet, under the proposed rule, coverage would be delayed and possibly denied for failure to submit such proof.

In summary, the preamble notes that, "it is possible that the additional steps required to verify eligibility might discourage some eligible individuals from obtaining coverage, and reduce access to health care for those individuals, increasing their exposure to financial risk. If it deters younger and healthier individuals from obtaining coverage, it could also worsen the risk pool." Consumers Union believes the evidence strongly points to those as likely outcomes of the intensive documentation proposed for an HHS -- estimated 650,000 consumers-- and, therefore, urge HHS not to move forward with this proposal. Rather, we urge you to closely examine the results of your pilot and consult with state Marketplaces about their efforts to glean how to craft a more tailored policy going forward.

Metal tier coverage changes limitations: The proposed rule also suggests limitations on consumers who already have Marketplace coverage from switching metal levels during SEPs. When an enrollee marries or has a child, for example, the enrollee and new spouse or child qualify for an SEP. Under the proposed rule, the enrollee would have to add the new dependent to the enrollee's QHP, or, if that was not possible, to another QHP in the same metal level (or in an adjacent metal level, if no QHP in the same metal level was available). If an enrollee was not enrolled in a silver-level plan, however, and adding the dependent would make the family eligible for cost-sharing reductions, the enrollee could move to a silver-level plan. The complexity imposed by this proposal will make for enormous confusion for enrollees. Moreover, there are circumstances, such as a consumer having an increase in income simultaneous to qualifying for an SEP, in which he may receive a reduced premium credit or lose access to cost-sharing reductions. This warrants the chance to change metal levels if the enrollee chooses. The very triggers that qualify an individual for an SEP—such as marriage or birth of a child—by definition signal major life changes that carry financial as well as medical implications that warrant allowing metal level changes.

Eligibility limitations: The proposed rule also would impose several new limitations on eligibility for SEPs, limitations we believe are unwarranted and would harm consumers. The preamble suggests, for example, allowing issuers to reject SEP enrollments for loss of minimum essential coverage where the applicant *earlier* lost coverage for non-payment of premiums. The consumers who seek coverage in Exchanges are primarily at the lower end of the income scale, with little disposable income. A slip-up in a month's premium payment resulting in loss of coverage does not necessarily foretell behavior on future payments, but may simply be due to an unexpectedly high utility bill. We oppose excluding such individuals from obtaining coverage through an SEP.

The rule also proposes to require that those seeking an SEP based on a marriage prove that one of the partners previously had minimum essential coverage for one or more of the prior 60 days. This is more onerous than the employer market and creates a catch-22, where only those with insurance would be qualified to buy insurance. This proposal may also exceed the statutory requirements.

The rule also proposes a much more rigorous test for future uses of the "exceptional circumstances" SEP, including requiring supporting documentation. There may be situations that cannot be anticipated and for which a remedy allowing consumers an SEP opportunity is justified. The exceptional circumstance category allows State Marketplaces leeway on a case-by-case basis to allow for medical coverage if warranted by unusual facts that do not fit any pre-determined category. We believe the Marketplaces have already shown proper restraint in approving exceptional circumstances cases, and any further tightening of the standard would be inappropriately excessive.

State flexibility urged: At the least, states should be permitted the flexibility to devise their own solutions for verifying SEP eligibility. Some states, such as California, have spent several years intensively meeting with stakeholders, probing the evidence on issuers' assertions about SEP abuses, and developing new protocols and solutions for verifying eligibility. For example, Covered California is conducting a random, statistically significant sampling of the SEP categories issuers claim to be most subject to abuse: loss of minimum essential coverage and permanent moves. And it is making solid progress on electronic verification measures to simplify the verification process. As discussed above, using electronic sources to verify special enrollment qualifying events can streamline the process and avoid the need to rely on outmoded, cumbersome, and prolonged paper document retrieval. Local resources for electronic or other forms of verification may vary greatly; it makes sense to push down to the states the option to use the verification resources at their disposal in order to ensure timely coverage for their residents.

Continuous coverage: The preamble notes that HHS is actively exploring additional policies in the individual market that would promote continuous coverage and seeks input on which policies would effectively do so consistent with existing legal authorities. Policies mentioned include, with respect to SEPs that require evidence of prior coverage, policies for the individual market that would require that individuals show evidence of prior coverage for a longer "look back" period, such as 6 to 12 months. Also mentioned for consideration are HIPAA policies requiring maintenance of continuous, creditable coverage without a 63-day break on penalty of pre-existing condition exclusions and waiting periods. Consumers Union urges HHS not to pursue such policies as they would impede people from getting needed coverage, overburden consumers, and conflict with current law.

Under the ACA, issuers generally "must accept every employer and individual in the State that applies for coverage" during open enrollment and SEPs-- the "guaranteed availability" provision. There is no legal basis for allowing issuers to deny coverage to people who have been uninsured or have experienced gaps in coverage. People who go without coverage for longer than a very short time are already subject to a financial penalty through the ACA's individual mandate. Imposing additional penalties on consumers would be both unfair and contrary to law.

Of course, it is in consumers' interest to maintain coverage. But the reality is that gaps in coverage commonly occur. According to the Commonwealth Fund, more than one-a third of American ages 4-64 went without insurance coverage for at least a month between 2004 and 2007, and about one-quarter lost

coverage more than once.[8] This has lead researchers to counsel that "the uninsured" should not be considered a static cohort, but rather that we should think of uninsurance as a fluid state in which gaps occur for many.[9] The ACA recognizes this by aiming to create a system for continuous coverage with an accessible, residual individual market, while protecting against adverse selection through various steps including open and special enrollment periods and the individual mandate penalty. The best way to foster continuous coverage is not by placing further financial and other penalties and complex rules on consumers, steps that impose greater hardships on consumers, but to create as seamless a process as possible that will allow for smooth transitions to avoid gaps.

Levels of Coverage (Actuarial Value) (45 CFR §156.140)

Consumers Union opposes the proposed changes to the actuarial value (AV) of the metal levels, which would be harmful to consumers. De minimis variations permitted to date have been defined as +/- 2 percent--leeway aimed at recognizing that with a wide variety of plans and underlying cost variability, it is difficult to hit precise actuarial numbers for each of the metal tiers. The stated aim of the proposed re-definition of de minimis variation as -4/+2 percentage points (for all metal level plans except for bronze plans which could vary from -4/+5), is to lower premiums. Our concern is that it would result in products with a lower premium, but higher cost-sharing. Moreover, it would result in more variation amongst products in a given metal tier, making it difficult for consumers to compare plans within the same metal level.

This adjustment in de minimis variations could also adversely affect advanced premium tax credits (APTCs), creating a "race to the bottom" if silver plans adopt a 66%, rather than 70%, AV. Since the APTC is calculated using the difference between the second lowest cost silver plan premium and the applicable percentage of the enrollee's income, allowing issuers to offer a less generous silver plan would reduce the value of the APTCs. Almost 90% of enrollees rely on APTC's to afford their coverage. Consumers would be forced to choose between a plan with lower premiums but higher out-of-pocket costs, such as a Bronze plan, or a plan with higher premiums and lower out-of-pocket costs. Either way, the consumer would pay more out-of-pocket (either through premiums or cost-sharing). For example, the Center on Budget and Policy Priorities found that a family of four with an income of $65,000 would either pay $327 more a year in premiums or face a $550 increase in their deductible if they chose a 66 percent AV plan.[10]

The preamble of the proposed rule plainly acknowledges the harm that many consumers will experience under this rule,stating: "A reduction in premiums would likely reduce the benchmark premium for

[8] Pamela Farley Short, Deborah R. Graefe, Katherine Swartz, and Namrata Uberoi, *New Estimates of Gaps and Transitions in Health Insurance*, The Commonwealth Fund, Aug. 3, 2012, available at http://www.commonwealthfund.org/publications/in-the-literature/2012/aug/gaps-and-transitions-in-health-insurance; *see also*, Joseph Sudano and David Baker, "Intermittent Lack of Health Insurance Coverage and Use of Preventive Services," *American Journal of Public Health*, Volume 93, Number 1 (2003).
[9] Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Volume 22, Number 6 (2003).
[10] Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions Of Moderate-Income Families*, The Center for Budget and Policy Priorities, Feb. 15, 2017, available at http://www.cbpp.org/sites/default/files/atoms/files/2-15-17health.pdf.

purposes of the premium tax credit, leading to a transfer from credit recipients to the government, " and "The proposed change could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of- pocket expenses, thus increasing their exposure to financial risk associated with high medical costs."

The Administration must not adopt such a policy that would increase out-of- pocket costs and erode financial assistance for lower- and moderate-income consumers. We strongly recommend that the current de minimis actuarial value requirement of -2/+2 percent be maintained for all metal levels. We believe that a broader level of variation is no longer de minimis and conflicts with the purpose of the metal levels, which is to make it easier for consumers to compare plan options and also to place some boundaries on cost-sharing charges that issuers may include in their plan designs.

Consumers already have access to plans at a wide variety of price points in the exchanges. Therefore, there are no gains for consumers to counteract the consumer harm from reducing the certainty associated with metal tier coverage and the threat to their critical tax credit subsidies.

Network Adequacy (45 CFR §156.230)

Consumers Union opposes the proposal to revert to the pre-2014 standard of reliance on state oversight. The standard currently set forth in Section 156.230(a)(2) provides a simple but sound floor for provider networks: it requires a QHP issuer to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all covered services will be accessible without unreasonable delay. The current federal standard was created largely to respond to persistent concerns about narrow network plans. To regress to the earlier standard would be to purposefully backtrack on advances in consumers' access to healthcare providers.

Currently, nearly half the states have no network adequacy standards and state network adequacy requirements often only apply to certain types of network designs, such as HMOs but not PPOs..[11] This rule would diminish the protections HHS currently uses to identify and improve the most egregious of inadequate insurer networks and instead allows states without sufficient metrics to maintain authority for provider network review. Relying on an issuer's accreditation by an external entity - typically self-attestation that networks are adequate -- is not comparable to government oversight. To wit, study after study has found error rates in provider directories of up to 50%[12]; in some health plans in Texas, up to 50% of in-network hospitals are not served by *any* in-network emergency room doctors (thus guaranteeing a surprise out-of-network bill).[13]

By weakening federal network adequacy standards, particularly in the majority of states lacking either the authority or capacity to conduct sufficient network adequacy reviews, we are concerned that the proposed

[11] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks*, The Commonwealth Fund, May 2015, available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.
[12] Consumers Union Healthcare Value Hub, *Network Adequacy: Resources for Advocates*, available at http://www.healthcarevaluehub.org/events/network-adequacy-webinar-resources/#ProviderDirectory (last visited Mar. 7, 2017) (contains a list of studies detailing problems in current Provider Directories).
[13] Stacey Pogue, *A Texas-Sized Problem: How to Limit Out-of-Control Surprise Medical Billing*, The Center for Public Policy Priorities, Feb. 2017, available at http://forabettertexas.org/surprisebills/img/2017_HW_SurpriseMedBill.pdf.

rule will ultimately limit consumer access to providers and prevent consumers from meaningfully distinguishing among plan networks at the point of plan shopping.

The preamble recognizes the uncertainty for consumers created by this rule stating, "Issuers could potentially use network designs to encourage enrollment into certain plans, exacerbating selection pressures. The net effect on consumers is uncertain." We believe the effect is certain given our nation's significant experience with often inadequate state oversight of plan networks. Consumers Union urges HHS to maintain the implementation of §156.230 as it stands now in order to provide a strong floor of protection for consumers and to ensure timely access to providers so as to receive covered benefits.. The ongoing gaps in standards at the state level and prior experience, relying on accreditors would jeopardize the health care and financial security of consumers. We urge HHS to reject this proposed change in oversight.

Essential Community Providers (45 CFR §156.235)

Consumers Union urges HHS to maintain the current requirement that a plan's provider network contain at least 30% of available essential community providers (ECPs), rather than the proposed reduction to 20%. Reducing the minimum ECP requirement from 30% to 20% will result in decreased consumer access to ECPs, which include providers who serve predominantly low-income, medically underserved individuals and those who predominantly provide specialty services (such as children's hospitals). Even under the existing 30% standard, consumers struggle to access ECPs; reducing the ECP requirement will exacerbate this problem.

The preamble acknowledges that consumers' access to care will suffer under this rule, so that insurers can avoid contracting with ECPs:

> *Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision.*

It further states that the rule would result in "decreased quality of medical services (for example, reductions in continuity of care due to lower ECP threshold)." In addition to the negative impact on consumers' care, the proposed change appears to be unnecessary. In the preamble, HHS notes that only six percent of issuers failed to meet the 30% ECP threshold for the 2017 plan year and, of these, all were able to justify why they failed to meet this threshold. Lowering the threshold would encourage the 94% who currently meet the standard to lower their inclusiveness. Since the vast majority of issuers—94%—were able to meet the current ECP standard for 2017, this change is unnecessary and unjustified. We urge that current 30 percent standard be maintained.

On behalf of Consumers Union, I appreciate this opportunity to provide input on this proposed regulation. We look forward to working with the Administration to develop steps that will truly create a health risk pool, stabilize the market, and ensure full access to affordable coverage and care for all Americans.

Sincerely,

Elizabeth M. Imholz

Director of Special Projects

Consumers Union