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POLICY & ACTION FROM CONSUMER REPORTS

November 22, 2017

Acting Secretary Eric D. Hargan
Department of Health and Human Services
Attention: CMS-9930-P
PO Box 8016
Baltimore, MD 21244-8016

Submitted via https://www.regulations.gov

Re: CMS-9930-P - Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Acting Secretary Hargan,

Consumers Union, the policy and mobilization division of Consumer Reports,[1] submits these comments on the changes proposed in the Notice of Benefit and Payment Parameters (NBPP) for 2019. We appreciate the opportunity to explain our deep concerns with many of the changes both standing alone and reviewed as a whole.

Among the many consumer protections in the Affordable Care Act (ACA) are health insurance rate review, the medical loss ratio (MLR), and essential health benefits (EHBs). These programs work in concert to ensure that consumers who purchase health insurance will get at least a baseline value from their insurance. Considered as a system, rate review seeks to protect consumers from being overcharged, MLR corrects the balance if consumers are overcharged, and the EHB standard guarantees that consumers get high quality insurance coverage. It is a delicate balance, and if one of these components is eroded, the system does not work. It is therefore troubling that the changes proposed in this NPRM would make it easier for carriers to overcharge consumers, free carriers from the obligation to repay consumers they overcharged, and make the quality of coverage dependent upon the state where a consumer lives.

Many of the changes proposed in the NBPP are coupled with promises of increased flexibility and reduced regulatory burdens. However, we believe that these burdens will not be eliminated; instead, they will be shifted onto consumers. Taken as a whole, the proposed changes would:

[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 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.

1. diminish the value of health insurance offered to consumers on the individual and small group markets.
2. make purchasing insurance in the individual and small group markets more complicated for consumers seeking to make the most appropriate purchasing decision for themselves and their families.

Our section-by-section comments, in chronological order, are as follows.

Part 154 - Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

The changes proposed to the Rate Review sections would allow carriers to raise rates unchecked up to 15 percent each year. Comprehensive review of rate filing justifications (RFJs) plays a key role in ensuring that consumers pay a fair price for their health insurance coverage. This process is a key consumer protection. We urge the states and HHS to use the rate review process *more* to protect insurance enrollees, not *less*.

The proposal in this NPRM, to raise the rate review threshold from 10 percent to 15 percent, would normalize excessive rate increases,[2] which we strongly oppose. The justification that this change would reduce the burden on the states or on the carriers ignores the fact that this change would allow carriers to finalize exorbitant rate increases without oversight. This, combined with the specter of lowered MLR safeguards, is especially troubling.

- Sec. 154.200(a)(1) - Rate Increases Subject to Review - Consumers Union strongly opposes the proposed change to §154.200(a)(1), in which HHS would raise the rate review threshold from 10 percent to 15 percent. Prior significant rate increases are not a justification for future large and unchecked rate increases. This regulatory change would create a segment of rate increases that would have been reviewed and possibly reduced were it not for this change. For example, for the 2018 plan year in Oregon, a proposed rate increase of 13.1% by Moda was reduced to a 9.2% increase as a result of the rate review process.[3] This reduction will save consumers in Oregon tens of millions of dollars and would not have happened were the threshold for rate review to rise to 15 percent.

  Rather than opening the gates for unchecked rate increases in 2019, we encourage HHS to lower the bar to a threshold more aligned with sustainable rates of health spending growth. According to the National Health Expenditure Projections 2016-2025 released by the Centers for Medicare & Medicaid Services, health spending was projected to grow at an average rate of 5.7 percent per year.[4] Even with a margin for error, long-term annual growth in per capita health spending growth is likely to be well below ten percent. For example, a threshold of 6 percent would be in line with national health expenditures yet still well above the general rate of inflation. It is time to lower, not raise, the review threshold.

[2] As stated by HHS, the threshold change is proposed "in recognition of significant rate increases in the past number of years." Federal Register Vol. 82, No. 211, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019*, at 51079.

[3] Oregon Department of Consumer and Business Services, 2018 Final Rate Decisions, available at http://dfr.oregon.gov/healthrates/Documents/2018-fnl-rates.pdf.

[4] The Office of the Actuary in the Centers for Medicare & Medicaid Services, *NHE Projections 2016-2025*.

- Sec. 154.200(a)(2) - Rate Increases Subject to Review - Consumers Union supports the proposed adjustments to §154.200(a)(2), to allow states to lower the threshold with fewer steps for approval than exist for the process for raising the threshold. Yet, as a national organization, we are concerned about the inequitable impact the lack of adequate rate review poses for insurance enrollees living in states that are less protective of consumers. States have always had the option of lowering the review threshold; while states such as California and Oregon enacted laws giving them authority to review all rates, most states use the federal threshold. It is therefore critical that the federal government set a reasonable standard as the starting point. A 15 percent threshold is far from reasonable. It is also impossible to make recommendations to HHS, regarding which factors states would have to produce to gain approval to raise their threshold above the 15 percent mark, because we firmly believe that a 15 percent threshold is already far too high – there is no sufficient justification for raising the threshold even higher.
- Sec. 154.200(b) - Rate Increases Subject to Review - We question the proposal to eliminate §154.200(b). If finalized, CMS would no longer post information on states where the federal default or a stricter state-specific threshold applies. Instead, CMS would rely on states to communicate information about stricter thresholds (and any other state-specific requirements). HHS fails to explain the reason for implementing this change. At a minimum, the Department should be required to delineate the benefits of proposed changes, and why those changes are proposed at this time. What is proposed here will reduce the accessibility of public information with no clear purpose or benefit. We also are unclear on why HHS has concluded that 154.200(c)(1) is "no longer necessary."
- Sec. 154.215(h)(2) - Submission of Rate Filing Justification - Consumers Union opposes the proposed technical change to §154.215(h)(2) on the basis that there should be no trade secret exemption for any part of the rate filing justification. The trade secret exemption is designed to protect businesses from having key business and manufacturing details revealed to competitors for fear they will be stolen. Rate setting is far different from product development and actuarial calculations are not trade secrets. Several states do not permit carriers to claim "trade secrets" in their rate filings, and thereby shield key information from the public, but instead require public disclosure of the complete justification for rate increases. These states, (for example California, Hawaii, and Oregon), feature robust, competitive health insurance markets. The use of trade secret protections in the context of rate review only protects insurers from public scrutiny, and not from any actual threat from competitors. We need a rate review system that is transparent and open. Ensuring fair health insurance rates and public confidence in them requires transparency and accountability. Furthermore, the new standard for which HHS proposes insurers would be able to withhold records, 45 CFR 5.31(d), is much too broad. Allowing for HHS to suppress information that is "trade secrets and commercial or financial information" could result in major redactions, as we have seen in prior years. Rather than creating a new loophole for carriers to hide key information in their rate filings, HHS should eliminate the loophole altogether.

- Sec. 154.301 - Determinations of Effective Rate Review Programs - Consumers Union supports the proposal to alter the 30-day notification requirement in §154.301(b)(2) to a 5-day notice requirement. This proposal will reduce the burden on states without impacting consumers. We also suggest that HHS add a requirement that states ensure that the public is duly notified of the change.

  As in prior years, we oppose HHS's longstanding allowance for states to defer to HHS's rate review site rather than posting rate filing justifications to state-based sites. We urge the Department to further revise §154.301 to eliminate the option of providing HHS's web address for rate filing information. This information should be available in both locations in order to make the information as accessible to the public as possible, and to ensure that it meets transparency standards in states. This concern is not just theoretical. For example, the rate filing submitted by Anthem Blue Cross to the California Department of Managed Health Care (DMHC) for the 2017 plan year was substantially redacted in its display on HHS's site, but fully displayed on the state-based site. If California had deferred to HHS's rate review site, the public would have no access to this key information.

  Finally, in addition to specifying the minimum timeframe and manner in which states must make information available to the public, we would like to see a standard that calls for providing a meaningful opportunity for public review of the complete filing at least 60 days before rates are approved or before rates go into effect, whichever is earlier. To avoid undermining states that already have strong rate review rules, HHS should set a federal floor with permission for states to build upon that foundation.

Part 155 - Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

- Sec. 155.20 - Standardized Options - Consumers Union opposes eliminating the standardized plan benefit option for Healthcare.gov. We also oppose the decision not to provide differential display for standardized options on HealthCare.gov. This, along with the requirement in §156.298 that a carrier's products exhibit "meaningful differences" (whose elimination we also oppose), makes shopping for insurance coverage easier and more effective. The standardized plan option reflects features from the most popular Qualified Health Plans (QHPs) by enrollment, such as removing emergency care from deductibles and emphasizing copayment cost-sharing rather than coinsurance. Insurers were never required to offer standardized plans, but encouraged to do so by HHS providing differential display of these plans on HealthCare.gov. Standardized designs enable the apples-to-apples comparisons that are essential for sound consumer decision making. For decades, consumers in our country have been confronted with scores of benefit designs that, in the guise of affording options for every possible preference, have obfuscated and made it impossible to determine the true value of plans. The Affordable Care Act promised to change that, and standardizing plans has been an essential step in that direction. Consumer testing has shown that standardizing benefit designs within actuarial value tiers provides great benefit to consumers. Several states have enacted further standardized

designs[5]; the years-long work Covered California, a state-based Marketplace, engaged in on its standardized cost-sharing, for example, has resulted in extremely positive outcomes for consumers and for robust Exchange enrollment.[6] We are more firmly persuaded than ever that a similar approach is the right course for the FFEs and other state-based Exchanges as well as their enrollees.[7]

Standardized benefit design, and the requirement that plans from a given carrier be meaningfully different from each other, are the kinds of innovations that are headed in the right direction: steps that help consumers in the plan selection process and thus encourage them to make the right choices for their needs, as well as encouraging enrollment overall. We, therefore, strongly urge HHS to drop the proposed changes regarding the meaningful difference standard (§156.298) and standardized plan options.

Finally, we view the proposal to use differential display options to promote the availability of high-deductible health plans (HDHPs) that can be paired with a health savings account (HSA) as the *wrong kind* of innovation. High deductibles are an anathema to consumers, causing financial hardship for many and discouraging the use of all kinds of medical care, including appropriate preventive care.[8] For lower income workers, research has shown that high-deductible plans with HSAs are associated with decreased use of office visits, free preventive services and increases in emergency room visits and hospitalizations.[9] Moreover, the complexity of these products, especially for Marketplace enrollees of low-moderate income, makes them far less appropriate than for those with higher incomes who have the extra incentive of the tax-sheltering advantages of HSAs. For these reasons, we urge HHS not to focus its attention on finding ways to encourage insurers to offer HDHPs that can be paired with an HSA, nor on using differential plan display options to promote these products on Healthcare.gov.

- Sec. 155.200(f)(2)(ii) - Elimination of requirement for SBE-FPs to enforce FFE standards for network adequacy - We generally support efforts to streamline monitoring and enforcement of insurance standards between federal and state regulators, especially with respect to qualified health plan (QHP) certification standards. However, we have serious concerns regarding the proposed federal deference to states on network adequacy and essential community providers for the state-based exchanges that use the HealthCare.gov platform. Network adequacy is a key consumer priority, but state regulatory frameworks vary widely from state to state. Twenty-three states and the District of Columbia have no quantitative standards of network adequacy in place, relying instead on a general attestation of adequacy coupled with insurers' articulation of how they choose to determine adequacy. An additional 11 have quantitative standards solely

[5] The Commonwealth Fund, *Realizing Health Reform's Potential What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces*, December 2013.

[6] See Consumers Union, *Healthcare by Design: Consumer-Centric Benefits for California's Individual Market*, July 2017.

[7] Our previous comments on the *Notice of Benefit and Payment Parameters for 2017* are available here: http://consumersunion.org/research/comments-on-patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017.

[8] Rand Health, *High-Deductible Health Plans Cut Spending But Also Reduce Preventive Care*, March 2011.

[9] Employee Benefit Research Institute, *Issue Brief No. 425: The Impact of an HSA-Eligible Health Plan on Health Care Services Use and Spending by Worker Income*, 2016.

for health maintenance organizations, leaving preferred provider organizations to a self-attestation process.[10] The recently updated Health Benefit Plan Network Access and Adequacy Model Act (#74) by the National Association of Insurance Commissioners (NAIC) serves as a foundation which states could adopt or build upon in their regulatory scheme to ensure that plan networks are adequate for their particular consumers and markets. To date, however, few states have moved forward with adopting this Model Act. Clearly, a federal floor is needed. Moreover, a 2014 Survey on State Insurance Standards[11] conducted on behalf of the Consumer Representatives at the National Association of Insurance Commissioners (NAIC) found state oversight is primarily complaint-driven, with few states enforcing their "reasonable access" standard. For example, less than 10 percent of state regulators reported performing "secret shopper" calls to confirm that listed providers were actually in network and accepting new patients, and almost 80 percent of regulators reported taking only one enforcement action in response to network adequacy concerns in the past year.[12]Moreover, states lacking the authority or means to perform their own reviews often rely on private accreditors to oversee network adequacy for the state. Private accreditation, however, typically relies only on self-certification of networks; that is, insurers set and verify their own standards. Private accreditors also have virtually no method of enforcing such standards beyond revoking or suspending an insurer's accredited status.[13]

With oversight so uneven across the states, state network adequacy requirements often only applying in certain circumstances, and most states using qualitative rather than bright-line, quantitative measures, wholly ceding network assessment to the states may result in substantial gaps and disparities in network adequacy. Therefore, strong federal minimum standards – at least as strong as the current ACA standards – should be in place before deferring to state oversight. We raised similar concerns about federal deference to states on network adequacy and essential community providers in our previous comment letters on HHS' market stabilization rule regarding the FFE. We reiterate those concerns regarding the proposal to expand this flexibility for QHP certification to state-based exchanges that use the HealthCare.gov platform. By weakening standards, particularly in states without the means to conduct sufficient reviews for network adequacy and essential community providers, we are concerned that the proposed rule will reduce consumer protection, access to in-network providers, and financial security that network adequacy standards and oversight are meant to provide.

- Sec. 155.200(f)(2)(iv) - Elimination of requirement that QHP issuers in SBE-FPs comply with Federal meaningful difference standard - Consumers Union opposes the proposed elimination of §155.200(f)(2)(iv), in conformance with the elimination of §156.298, for the reasons detailed in that section, *supra*.

[10] Center for Health Policy at Brookings, *A Better Approach to Regulating Provider Network Adequacy*, Sept. 2017.

[11] Health Management Associates, *Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market*, November 2014.

[12] *Id.*

[13] Center on Health Insurance Reforms CHIRBlog, *New Network Adequacy Rules: Less Federal Oversight, More Deference to States*, April 6 2017.

- Sec. 155.210 - Navigator Program Standards - Consumers Union opposes the proposed amendment to §155.210(c)(2), which would eliminate the requirement that consumers have access to community and consumer-focused nonprofit Navigators. The requirement was put in place to ensure that consumers always have access to an unbiased, credible, consumer-focused Navigator who has established relationships with the local community. The proposed changes would eliminate the current standard for navigators, allowing the Exchanges to award grants to a single navigator from any category of navigator grantees - such as trade, industry, and professional associations or chambers of commerce - who are more likely to be motivated by profit or outside interests. In this NPRM, HHS emphasizes the desire to increase flexibility for the Exchanges, but that flexibility must not be at the expense of efficacy and quality. Removing the requirement may reduce the time and effort it takes for the Exchanges to select a Navigator grantee, but it will do so by lowering safeguards for consumers.

  We also oppose the elimination of the §155.210(e)(7) requirement that Navigators maintain a physical presence in the Exchange service area. As HHS notes, "entities with a physical presence and strong relationships in their FFE service areas tend to deliver the most effective outreach and enrollment results." The proposed amendments would allow non-local Navigators to receive grants, and does not even require that the grantee to have relationships with the community; the only requirement would be to show that they *could* "readily establish relationships" with individuals in the community. Access to in-person, local assistance is essential to ensure consumers have the culturally and geographically appropriate information to assist them in getting covered. These minimum standards ensure all consumers will have the necessary assistance, regardless of their location. For the same reason, we oppose the corresponding amendment to §155.215(h).

  We support HHS's decision to not change §155.225(b)(3).

- Sec. § 155.221 - Standards for Third-Party Entities to Perform Audits of Agents, Brokers, and Issuers Participating in Direct Enrollment - Consumers Union opposes the amendment of §155.221, and the conforming edits to §156.1230(b)(2), which would allow insurers, agents, and brokers to select their own third-party entities for conducting annual reviews and audits. Currently, HHS currently reviews and approves these entities, to ensure they meet all of the necessary requirements and to protect against any potential impropriety. While we appreciate that the proposed approach may reduce the administrative burden on HHS, it would in essence allow agents, brokers, and issuers to choose their own oversight, with little to no quality control from HHS. Further, although HHS has proposed to implement a conflict of interest standard, the proposed standard only requires the *disclosure* of financial relationships, and does not prohibit the selection of a financially-interested auditor. We therefore oppose these amendments, and suggest retaining the standards as currently written.

- Sec. 155.305 - Eligibility Standards - Consumers Union opposes the proposed elimination of the direct notice requirement in §155.305. This requirement ensures that consumers receive a notification before the Exchange can discontinue their Advance Premium Tax Credits or Cost-Sharing Reductions for failure to reconcile their taxes, alerting them to the need to address the

discrepancy in order to continue receiving financial assistance. Although consumers are often indirectly notified by HHS of their discontinued eligibility, HHS reports in this NPRM that these notices prompt appropriate action only 60 percent of the time. That is not nearly enough. The severity of the risk of consumers not receiving the notice in time to act, thereby risking the loss of access to financial aid they depend on to be able to afford coverage, demands that direct and specific warnings be sent. A specific, formal notice is required to safeguard these consumers, and to ensure that they are not denied subsidies without adequate notice.

- Sec. 155.320 - Verification Process Related to Eligibility for Insurance Affordability Programs - Consumers Union strongly opposes the proposed addition of an income verification requirement to §155.320. Consumers already face a host of complications and requirements when signing up for coverage, and they depend upon the Advanced Premium Tax Credits and Cost-Sharing Reduction payments to pay for their coverage. Introducing income verification would accomplish little more than to further complicate the application and renewal processes, and increase the possibility that individuals will be denied benefits to which they are entitled. Low-income consumers often struggle to provide accurate documentation of their expected income due to temporary employment, fluctuating hours, and inconsistent income, and are in a better position to estimate their annual earnings than HHS could ever be. Additionally, any danger that consumers might collect more financial assistance than they are entitled to is moot, because individuals are required to repay additional subsidies at tax time. Income verification, therefore, would do little to benefit HHS or the Exchanges, but would likely deter enrollment or leave low-income consumers without affordable access to coverage.
- Sec. 155.605(d) - Hardship Exemptions - Consumers Union supports the suggested change to §155.605(d), which would base the hardship eligibility determination on the lowest cost plan available in the rating area in regions where there is no bronze plan available. This change will ensure that all consumers have the same rights and protections, no matter the plans that are locally available.

Part 156 - Health insurance issuer standards

Consumers Union is a strong proponent of the Essential Health Benefits (EHBs) and has consistently opposed efforts to weaken this part of the ACA. The EHB requirement ensures that millions of consumers have adequate healthcare coverage by mandating that plans sold must cover ten EHB categories. Before the passage of the ACA, many consumers bought insurance plans believing that they covered maternity care, emergency situations, or long hospital stays, for example, only to find out that their insurance did not include this coverage. Additionally, the EHB requirement has made it much easier for consumers to compare different insurance products because they are making apples-to-apples comparisons. Consumers do not want to return to a time where plans are not comprehensive and comparing plans is a difficult and confusing process.

- Sec. 156.111 - State selection of EHB-benchmark plan - We strongly oppose the proposed revision options to the EHB package and urge the Department to leave the current EHB requirement untouched. The proposed revisions will only allow states to reduce the value of insurance plans sold to consumers, resulting in increased purchases of low-value insurance

products. This will hurt consumers and, when paired with other components of this proposed rule, constitutes a giveaway to insurance companies.

The proposed EHB changes will raise costs across the board for consumers, allow insurers to leave out certain benefit categories that many consumers need, and will lead consumers who have complex medical needs and/or pre-existing conditions to pay much more for the care they need or to not even be able to access the services they require.

- Sec. 156.111(a)-(d) - States' EHB-benchmark Plan Options and Requirements for States' EHB-benchmark Plans - Although Consumers Union appreciates that the Department values the role states can play in determining the best benefits for their constituents, we do not believe that the proposed changes will lead to better health insurance options or more affordable care for consumers. In fact, we believe they will do just the opposite.

  The first two proposed options — allowing a state to adopt the EHB benchmark plan that any other state used in 2017 or using their 2017 benchmark plan, but replacing one or more benefit categories with those of other states — would allow states that have more comprehensive and robust EHB packages to limit or drop certain benefits altogether. For example, if a state that has required coverage for hearing aids or fertility treatments opts for the EHB benchmark plan of another state that does not cover these services, insurers in this state will likely drop these benefits because coverage of them will no longer be required. The same scenario holds for the second option, under which states may keep their own general EHB benchmark plan, but can swap one or more benefit categories with those of another state. In both cases, consumers who are in ACA-compliant plans could find themselves unable to access and afford treatment they need. We are especially concerned about the impact this could have on the most vulnerable consumers, those who need access to quality treatment because of chronic illnesses, or those whose care is likely to be dropped under this scenario, such as treatment for opioid addiction.

  Under the third proposed option, states would be allowed to create an entirely new benchmark plan from scratch. This is the most radical option and presents the greatest potential risk for consumers. Although any new EHB benchmark plan will have to contain the 10 statutorily mandated benefit categories, services within these categories could be pared down greatly.

  We must emphasize our deep concern with the Department's proposed definition for a typical employer plan as this would serve as the benchmark plan under the third option. While we support the Department's goal of including a large number of consumers as part of the definition of a typical employer plan, we do not believe this is sufficient. For example, a state could pick a group plan with 5,000 enrollees that limits the number of hospital days or does not provide prescription drug coverage beyond generics. States would only have to supplement plans if they do not cover entire categories of EHBs, meaning that a state could pick as a typical employer plan a product that offers very limited benefits within a category. This will leave consumers in this state on the hook for potentially large, frequently unexpected, out-of-pocket costs, with needed services inaccessible to them. We strongly oppose this option and again urge HHS not to finalize the proposed changes to how EHBs are set, and to set aside the question of defining "typicality."

If HHS does pursue defining a "typical employer plan," the Department must create more specific standards for defining plan typicality and that they should put consumers' bests interests first. By definition, the typical plan should not only be required to have a minimum of 5,000 enrollees, but also be required to meet minimum benefit standards that ensure insurance products provide adequate coverage.

We are deeply concerned and strongly oppose the provision that allows insurers to swap benefits across categories and not only within a particular category. An insurer could reduce coverage of hospital care or maternity care and increase benefits in another category — outpatient visits or urgent care, for instance. This is a dangerous game and will leave many consumers without the care they need or facing larger and more unaffordable health care bills. We do not believe that certain benefits, even if they are equivalent in terms of actuarial value, should be allowed to be substituted for each other. Consumers who need maternity care or inpatient hospital care will find themselves in plans that do not cover these services and they will be left holding full responsibility for covering these costs.

Overall, these proposed changes to state benchmark EHB plans will allow insurers to scale back on benefits and coverage, shifting more risk and more costs onto consumers. This is exactly the opposite of what consumers want and need.

Furthermore, this will not just affect consumers who purchase plans through their state Marketplaces, but will impact all consumers through the annual and lifetime caps on benefits. Currently, plans cannot limit care that is part of the EHBs on an annual or lifetime basis. By allowing states to pick and choose their benchmark plans and remove services from within EHB categories, out-of-pocket costs associated with those services will no longer be capped. If states opt to modify their EHB benchmark plans to effectively include fewer benefits in the EHB package, ***all*** consumers will be liable for higher cost-sharing and greater out-of-pocket costs.

A burden on the States and insurers

We are also concerned that the proposed changes to allow states to swap out an EHB category, to choose the benchmark plan of another state, or to create their own, new benchmark plan from scratch will increase the amount of options state regulators will have to review. If states make changes to their benchmark plans on a yearly basis, this will greatly increase the amount and burden of state regulatory oversight. All of this makes oversight more difficult and increases the chances that consumers won't be adequately protected.

According to the proposed rule, changing the EHB benchmark plan would require reasonable opportunity for public comment and notice. We believe this should include public hearings that include the solicitation of input from consumer advocates, necessary data and analysis, and a sufficient comment period.

In addition to the increased work this places on state regulators, insurers will need adequate time to understand, review, and analyze proposed changes, and to create or adapt their products if necessary. The administrative burden this would pose could make selling individual products unattractive for some carriers. Furthermore, the potential for constant fluctuations in

the benchmark would hamper the ability of navigators and brokers to fully educate consumers about their options.

Finally, we strongly oppose the proposal, in §156.111(a), which would require states to defray the costs of benefits mandated after December 31, 2011, even if the source of the new mandate is a new EHB-benchmark plan. We believe this policy would have a chilling effect on states that want to improve the value of insurance products for their citizens, or that want to improve consumer protections. Because of the requirement to defray costs, states with less comprehensive benefit standards as of 2011 would be condemned to always lag behind other states or pay what could amount to substantial sums to defray the cost of making up for decisions made years earlier.

- Sec. 156 - Essential Health Benefits Package - Consumers Union supports the current EHB standards and urges the Department to make no further changes. Ideally, we support a federal EHB package that would standardize benefits across states, and bring states with less comprehensive benefits up to the level of the most consumer-friendly states. However, the content of this NPRM suggests that a federal EHB package, and/or a national benchmark plan standard for prescription drugs, would likely be less generous than what states have adopted since 2014. This would set consumers back from the guarantee of coverage from which they currently benefit. Furthermore, a change to the current EHB framework would contribute to uncertainty felt by consumers, insurers, and state regulators, and could further destabilize the market.

- Sec. 156.298 - Elimination of meaningful difference standard for QHP in the Federally-facilitated Exchanges - Consumers Union opposes eliminating the "meaningful difference standard" for products sold on Healthcare.gov. The current provision makes shopping for health insurance a more informed and less difficult endeavor for consumers. The meaningful difference standard requires plans wishing to be certified as Qualified Health Plans (QHPs) to show that a reasonable consumer would be able to identify one or more material differences among five key characteristics between the plan and other plans offered by the same issuer. It helps ensure that Marketplace plans reflect substantive distinctions among benefit design features, such as cost-sharing levels, to allow for meaningful consumer choices, rather than simply a bewildering array of similar options by the same issuer.

  The meaningful difference standard rests on the clear evidence from social science, economics and health policy research, including consumer testing, that too many choices, without meaningful, clear distinctions are confounding and can lead to sub-optimal choices – or the inability to decide at all.[14] Thus, in the world of complex health insurance products, having too many options can even cause consumers not to enroll at all. Instead, having a reasonable number of curated, consumer-friendly, distinguishable designs creates a secure foundation for plan selection – especially if they have standardized, easily comparable benefits and cost-sharing.

[14] Consumers Union, *Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making*, November 2012.

- Other considerations[15] - Regarding the Notice's request for comments on value-based benefit design, we note that the most prevalent such design, embodied in the ACA, is the offering of specified preventive services for free – with no cost-sharing and outside the deductible. In addition, in the individual market as many as one-third of policies sold on the federally-facilitated Marketplaces go beyond free preventive care to take certain other services outside the deductible such as primary care visits and generic drugs.[16] Covered California created standardized benefit designs that removed nearly all outpatient services from the deductible.[17] This simple benefit design step – removing key services from the deductible – allows consumers to get necessary services and has been found to work within the constraints of the actuarial value calculator. Many of these features are contained in the optional standardized design found in current §156.298 of the HHS regulations, the continuation of which we advocate for above.

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

The changes proposed to the Medical Loss Ratio (MLR) sections would allow carriers to spend more premium dollars on profit and salaries without improving the quality of plans. Currently, the MLR and the rate review process work in tandem to protect consumers from being overcharged for their health insurer. Simultaneously lowering the guardrails for these protections will raise costs for consumers, with increased profits for carriers. By changing how quality improvement is calculated, the new rule would reduce the incentive for carriers to improve the quality of their products and of the care consumers receive.

Altogether, these changes would reduce the value of health insurance products, increase the likelihood of consumers being overcharged, and leave markets unstable. Over the past year, most insurance carriers remaining in the individual and small group markets enjoyed improved finances, with increases in revenue, underwriting profit, and net profits.[18] Whether that upward trend continues through the 2019 plan year has nothing to do with the size of their MLR, and more to do with whether cost-sharing (CSR) subsidies are paid, the individual mandate is upheld and enforced, and misinformation and confusion continues to be prevalent.

- Sec. 158.162 - Reporting of Federal and State Taxes - Consumers Union disagrees with the fundamentals laid out by HHS in its statement, "in light of the changes in the market landscape since §158.162 was amended in early 2015, HHS is considering whether revising the decision on the treatment of employment taxes may help improve market stability." How federal and state taxes are included in the MLR calculation has no meaningful bearing on market stability. Rather, we suggest that market instability is caused, in large part, by layer upon layer of uncertainty thrust at the individual and small group markets. Changing the MLR calculation will not solve that problem; rather, it will introduce a new element of unnecessary change. We therefore

[15] This refers to the section titled "e. Other Considerations," located on page 51111 of the proposed rule.

[16] Urban Institute, *State Efforts to Lower Cost-Sharing Barriers to Health Care for the Privately Insured, Urban Institute*, 2017.

[17] See Consumers Union, *Healthcare By Design: Consumer-Centric Benefits for California's Individual Market*, July 2017.

[18] FitchRatings Special Report, *Blue Cross and Blue Shield Companies: Credit Overview*, November 6, 2017, as reported by Axios, *Blue Cross Blue Shield Insurers are Still Doing Well*, November 7, 2017.

recommend that HHS maintain the reporting requirement for these taxes as they have been in recent years.

- Sec. 158.170 - Allocation of Expenses - The quality improvement expenses in the numerator of the MLR calculation plays an important role in motivating insurers to allocate a percentage of expenses to quality improvement activities that benefit consumers. The "quality improvement" definition recommended by NAIC for medical-loss ratios (MLRs) and adopted by HHS in 2010 was designed to ensure that insurers only classify as quality improving expenditures those that improve healthcare quality. At the time, consumer groups and advocates urged HHS to "develop a definition for 'quality improving activities' that is not so broad that issuers may improperly classify administrative activities as improving quality."[19] Ensuring that this ratio is calculated appropriately has been an ongoing battle ever since. The newly proposed paragraph §158.221(b)(8) would erode the backbone of the MLR and is contrary to the recent recommendation of NAIC that no changes be made to existing rules. We therefore strongly oppose this proposal.

  Insurers have historically applied the "quality improvement" classification very broadly, categorizing some activities as "medical" that were not. Even in California, where details of quality improvement efforts are a required component of the rate filing justification,[20] insurers regularly fail to demonstrate that the expenditures are legitimate quality improvement expenses. In some cases, carriers explicitly apply the "quality improvement" classification to expenses that are surely not, such as ICD-10 conversion. Often the reviewer is left guessing the amount the carrier is claiming in quality improvement expenses.

  Yielding to the carriers a default quality improvement rate for the MLR calculation amounts to a reward for bad behavior, especially where the default matches the average percentage of premium reportedly spent on QIA over the most recent three year period. No doubt, providing this information does require effort on the part of the carriers. But imputing that quality improvement has happened when it actually may not have, or may not have to that same degree, is misguided. The purpose of the *quality improvement* part of the MLR calculation is to improve patient outcomes. The cost of this default provision will be borne by enrollees, whose MLR rebates will be calculated with a weighted scale, and whose carriers will be less inclined to pursue strategies that improve quality.

  Therefore, based on carriers' application of the classification to date, it is apparent that the reigns need to be tightened, not loosened as proposed here. If there must be a default quality improvement rate for the MLR calculation, where carriers fail to provide data themselves, this default should be 0.00.

- Sec. 158.301 - Standard for Adjustments to the Medical Loss Ratio - Consumers Union strongly opposes encouraging states to lower the MLR standard, and making it easier to do so, as well as the assertion that lowering the threshold is the appropriate solution to "help stabilize the

[19] Comments submitted in response to the Interim final rule with requests for comments, 45 CFR Part 158, Federal Register Vol. 75, No. 230 (December 1, 2010).
[20] California Health and Safety Code §1385.03(c)(3) and Insurance Code §10181.3(c)(3).

individual market" in the states. Rather, we firmly believe that easing the process for states to lower the MLR is likely to raise already-high premiums for consumers; HHS itself states that MLR adjustments during the first year would cut MLR rebates of up to $64 million. Those $64 million would come straight out of the pockets of consumers and into the profits of carriers.

The MLR threshold is neither unreasonably high nor a tough bar to meet.. In fact, a GAO analysis of NAIC data for 2010 found that over-three quarters of credible insurers in the large group market met or exceeded MLR standards just prior to the ACA. At that time, before a national MLR standard was implemented for the individual market, the U.S. Government Accountability Office (GAO) estimated that fewer than half of carriers in that market met that standard. There is a reason MLR was included in the ACA: because in many places across the country, carrier profits were booming while uninsurance and underinsurance rates grew. The evidence indicates that it worked. Within the first three years under the ACA MLR rule, the MLR requirement saved consumers over $5 billion, either through consumer rebates or reduced health plan spending on overhead.[21] During that same time, the size of the MLR rebate went down, indicating much greater compliance with the MLR rule.[22] Following the inaugural years of the ACA, the option to adjust the MLR threshold existed but no state sought to do so.

This NPRM claims that lowering the bar for MLR will stabilize the market but provides no evidence that MLR is either linked to carriers leaving the market or carriers setting high premiums. Carriers are leaving the market for reasons unrelated to the MLR: (1) smaller and younger carriers were unable to compete with larger more established carriers, especially after key features of the "3R" programs[23] were not implemented as designed, and (2) compounding political unknowns about the viability of ACA as a whole, along with continued implementation of key provisions of the ACA (such as the individual mandate and payment of cost sharing reductions). None of these has to do with the MLR and each could be addressed via other avenues that are not proposed in this NPRM.

- Sec. 158.322 and 158.330 - Proposal for Adjusted Medical Loss Ratio and Criteria for Assessing Request for Adjustment to the Medical Loss Ratio - Consumers Union reiterates strong opposition to any new rule permitting states to lower the MLR standard. We also oppose the proposals in §158.322 and §158.330 that would reduce the burden of proof on states that seek such a reduction, and reduce the rigor of review before requests are approved.

  Ostensibly, the changes proposed in §158.322 are intended to reduce the burden on the states. We question whether this burden actually exists and, if so, whether loosening that burden is worth lowering the protections it provides for consumers. We also question whether HHS has the capacity to step in for the states in order to estimate rebates that would be paid with and without an adjustment, or if that would pose an overwhelming burden on HHS.

[21] Commonwealth Fund, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3*, March 2015.
[22] *Id*.
[23] The "3R" programs are *Risk Adjustment*, *Risk Corridors*, and *Reinsurance*.

Finally, we firmly oppose easing the criteria for assessing states' requests for adjustment to the MLR. If the review process is to be at all modified, we recommend even more rigorous criteria for assessing whether a state's request to lower the MLR will stabilize the market.

On behalf of Consumers Union, thank you for the opportunity to comment on this important rulemaking. We look to you to reconsider proposals in this NPRM that, if effectuated, would pose a very real threat to the value of health insurance available to consumers on the individual market, and on consumers' ability to make safe and informed shopping choices for themselves and their families.

Sincerely,

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