July 12, 2017

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: CMS–9928-NC

Submitted Electronically Via Regulations.Gov

Dear Ms. Verma,

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists nationally. We are pleased to have the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS) request for information about reducing regulatory burdens imposed by the Patient Protection and Affordable Care Act (PPACA) and improving healthcare choices to empower patients, which was published in the Federal Register on June 12, 2017.

The members of NAHU work on a daily basis to help millions of individuals and employers purchase, administer and utilize health insurance coverage. Over the past seven years, since the passage of the PPACA, our members have worked directly and tirelessly with millions of individuals and employers of all sizes to help them obtain new coverage necessitated by the PPACA and to assist them with the many health reform implementation and compliance changes the PPACA has required. Ensuring private health insurance market stability and competition as well as improving health coverage affordability are among NAHU's top goals. As such, we truly appreciate the intent of this request for information and believe that there is much the Trump Administration can achieve to serve consumers better, lower costs and create greater private health insurance market stability via regulatory changes, new sub-regulatory guidance and reframed strategies regarding PPACA implementation policies.

To ensure our response to your request was both thorough and reflective of the real-world experiences and views of insurance agents and brokers and their individual and employer clients, NAHU convened a working group of members from around the country. Members included those who sell and service health insurance coverage to individual and business consumers and experts who specialize in health reform compliance. The group reviewed all of NAHU's past comment letters to the Obama and Trump Administrations about PPACA-related regulatory issues and noted how these matters have or have not

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been handled to date by the federal Department of Health and Human Services (HHS) or other federal departments or agencies. They also discussed how private health insurance markets and consumers have been affected by specific PPACA regulatory provisions to-date, and whether making changes to specific in-force requirements would still have a beneficial impact. Our group identified common real-world concerns and cost-drivers related to the PPACA that have not been adequately addressed by HHS. These discussions formed the basis for NAHU's detailed suggestions, as did the direct observations of experts in the fields of health insurance plan administration and consumer service.

Additionally, we note that while this request for information originated from HHS, HHS promulgated most PPACA-related regulations issued between 2010 and 2016 jointly with the Departments of Labor and Treasury. The Departments of Labor or Treasury acting singularly both also promulgated some very burdensome PPACA-related regulations. Since the effects of the PPACA and all of its related regulations impact all three departments, and to provide the most comprehensive suggestions possible, NAHU has purposefully elected to include information about some problematic policies or requirements that may fall more squarely under the jurisdiction of either the Departments of Labor or Treasury. NAHU trusts that as the lead agency in this information-gathering effort, CMS will be able to deliver health reform improvement suggestions that may be more applicable to other departments appropriately. Wherever possible, we have identified within our specific comment text if we believe that a particular recommendation might be of significant interest to another federal department or agency and referenced that entity.

Finally, as you requested, we have grouped our suggestions by topic to correspond with the four questions outlined in the solicitation of public comments.

Question # 1 - Recommendations to Empower Patients and Promote Consumer Choice

CMS has requested suggestions about activities it could promote that would best inform consumers and help them choose health plans that best meet their needs as well as information about which regulations currently reduce consumer choice regarding health insurance financing and health coverage requirements.

NAHU believes that the best action CMS could take to provide health insurance consumers with more direct information and better support is to fully embrace the licensed independent health insurance agent and broker community. If there is one thing seven years of PPACA implementation has taught us, it is that health insurance consumers, at the individual, business and direct employee level, all need personalized assistance with their coverage needs. Websites, call centers, calculators, apps, data and increased choices have all provided improvements, but individual people, as well as small and large institutions, routinely call on licensed specialists to help them navigate the healthcare financing system.

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This assistance has value and the industry designed to provide it should be embraced and supported, including financially.

Independent health insurance agents help individual and business consumers find the right health plan and navigate the healthcare system throughout the term of their health insurance policy. They advocate on consumers' behalf year-round when problems arise, identify cost-saving opportunities and keep consumers informed of new products and changes to the industry that may impact them. Independent agents and brokers do not work for health insurance carriers. Instead, they run their own businesses and hire their own support staff. They choose which insurance carriers they will represent and receive appointments from many different insurance carriers based on their state license, maintenance of liability insurance and confirmation of their knowledge of the carrier's product offerings.

Unfortunately, HHS and other federal departments have not always fully utilized the services of independent health insurance agent and brokers about PPACA implementation. Furthermore, some PPACA-related regulations and HHS policies have had an adverse impact on the ability of licensed health insurance agents and brokers to serve their clients, particularly those who wish to purchase individual insurance coverage. As such, NAHU has several specific suggestions for actions that HHS could take immediately to help consumers have better access to health insurance agents and brokers. In addition to the suggestions directly related to health insurance agents and brokers, NAHU also has many other ideas to help HHS promote informing consumers and allow people to more easily choose health plans that best meet their needs. For your convenience, we have broken these suggestions down by topic below.

Review of all HHS-Sponsored Consumer Assistance Services
The PPACA requires the use of navigators to provide health insurance exchange consumers with information and enrollment assistance about both coverage and subsidies. HHS has also created, via regulation, additional categories of consumer helpers, including assisters, application counselors and call center personnel. HHS rules regarding navigators and other assisters virtually preclude health insurance agents and brokers from serving the navigator role, due to conflict of interest requirements that would essentially prevent an agent from obtaining revenue from any other source. Also, Obama Administration HHS rules and guidance prohibit navigators and other assisters from engaging in meaningful collaboration with agents and brokers in many instances.

The individuals who fill the HHS-created consumer assistance roles are largely not subject to uniform state-level licensing laws that otherwise apply to all people who "sell, solicit, or negotiate" health insurance coverage. Unlike agents, they are also not subject to federal-level consumer protection and financial and health privacy laws, like the Gramm-Leach-Bliley Act, Health Insurance Portability and Accountability Act, Health Information Technology for Economic and Clinical Health (HITECH) Act and their related privacy and data security requirements. Furthermore, they are subject to different CMS

training and certification requirements than independent agents, and the flow of information and level of internal support and assistance provided to each of these groups by CMS is disparate.

NAHU understands that many types of consumer support personnel will play a role in an efficient health coverage system. It is not our point-of-view that independent health insurance agents should in any way replace other groups. However, we suggest that CMS thoroughly review all of its policies about consumer assistance for individual market health insurance exchange consumers provided by agents, navigators, assisters, application counselors, call center personnel and any other outward-facing support groups. We suggest much more uniform treatment of such groups by CMS and that CMS embrace collaboration amongst the various support roles, rather than shunning it. Finally, we urge CMS to evaluate all of its existing programs with an eye towards cost, effectiveness and potential duplication of services.

Medical Loss Ratio Requirements

The part of the health reform law that most quickly, directly and negatively impacted health insurance agents and brokers was the medical loss ratio (MLR) requirements. The MLR requirements were designed to limit the amount that a health insurance company can spend on administrative costs. Unfortunately, the rules crafted by HHS to implement this requirement classified independent agent and broker compensation as an administrative expense. In practice, health insurance agent and broker commissions are pass-through fees folded into insurance premiums as a consumer convenience and as a means of complying with state tax and consumer-protection laws; they have never been any part of the insurer's bottom line. As a direct result of the MLR requirements, many agents that primarily serve the individual and small-employer health insurance markets suffered significant revenue losses. Some have reduced services to clients and laid off employees. In many states, health insurance carriers now do not compensate independent health insurance agents for their work with individual market health insurance consumers at all, drastically reducing the ability of agents to support these clients.

NAHU strongly recommends that HHS exempt health insurance agent and broker commissions from an issuer's MLR calculation. Alternatively, we propose that CMS revise existing rules so that issuers may consider agent and broker commissions as quality-improvement expenses and not administrative costs. These changes, which are supported by many current state insurance commissioners and have been the topic of a past resolution of support from the National Association of Insurance Commissioners (NAIC), would help agents and brokers provide additional and market-stabilizing services to individual and small-group customers.

Year-Round Commission Stability

In addition to our recommendations regarding the MLR regulation, NAHU believes that CMS should require that health insurance issuers who offer to pay independent agents a commission for their work at the beginning of a plan year may not eliminate or reduce that commission mid-year. During the past two years, issuers in multiple states implemented mid-year commission changes for the individual market

even though they included commission costs in their product filings and they did not correspondingly reduce premiums once they eliminated commission payments. NAHU is very concerned about the impact this continued practice is having on consumers and believes that it is within CMS's authority to address it with issuers on several fronts.

While CMS has been clear that it does not require or regulate broker compensation for marketplace products, CMS does stipulate that if an issuer provides broker compensation, then it must be the same for all substantially similar qualified health plan (QHP) products. This is the requirement regardless if products are sold via the exchange marketplace or in the off-exchange marketplace. The reasoning for this requirement is CMS's direct authority to both enforce the PPACA's guaranteed issue requirement and to ensure stability in the exchange marketplace. If the compensation environment is not kept level for substantially similar products on- or off-exchange, then the guaranteed-issue provisions of the law are undermined. Individuals might not have access to all products from their brokers and people may be unknowingly directed to one market or another, creating an unlevel market playing field and consumer harm.

The same threats to the PPACA's guaranteed issue requirements and market stability protections apply to a mid-year commission policy change by an issuer. If an issuer provides brokers with one commission rate during open enrollment then reduces rates for the remainder of the plan year during the special enrollment period (SEP), it will diminish an individual's access to coverage and exposure to all channels of consumer assistance. When issuers impose commission changes following the open enrollment season, consumer harm from decreased service availability is the greatest SEP since consumers with SEP rights often need the most help taking advantage of their special status. Furthermore, by reducing their rate to a noncompetitive level midway through the plan year, an issuer may be able to inappropriately shift risk to other issuers in the marketplace, causing instability for all. If an issuer reduces its commission rate to zero after the open-enrollment process ends, then the issuer can unfairly shift almost all of its potential SEP risk, and certainly all broker-driven risk, to other issuers.

NAHU believes that CMS has the responsibility and authority through the QHP-certification processes to ensure that issuers maintain the services that they promise via filed and approved rates throughout the plan year. Much like CMS stipulates that issuers may not leave the marketplace mid-plan year, we believe it would be appropriate to specify that the services promised as part of approved rates, not be eliminated part way through a given plan year. Access to the purchasing services and plan year and renewal consumer support offered by a licensed health insurance agent or brokers would fall under that clarification. Otherwise, customer services promised as part of the approved rates of the policy may be reduced and the consumer would see no corresponding premium reduction.

NAHU requests that CMS stipulate via guidance that issuers who file premium rates that include broker compensation may not alter the general compensation rate for agents for the duration of that plan year

and still maintain QHP certification. Such a requirement should not preclude an issuer from suspending broker compensation in the case of individual agent misconduct.

Availability of Plan Information

Even though health insurance issuers must commit to participating in the health insurance marketplaces at the end of each spring, and they must file and have their QHP products approved by the states and federal marketplace each summer, plan information, pricing and technical details are not made available to health insurance agents and brokers ahead of open enrollment. Every year, brokers have to spend the first few precious weeks of open enrollment learning all the ins and outs of plan options to explain them to clients and help recommend appropriate choices. This flow of information is not standard practice in the rest of the private health insurance markets, where agents get volumes of advance information about the products they will be able to offer in the plan year ahead. Especially given the marketplace's shortened open enrollment window, NAHU suggests that HHS stipulate that everyone (particularly agents) should have access to plan pricing, tax credits product designs and technical details at least two weeks before open enrollment. Ideally, issuers and the marketplace should provide an even longer lead-time to certified and licensed professionals.

Redeterminations and Reenrollment

NAHU urges CMS to reconsider its policies on marketplace redeterminations and reenrollments and strongly suggests that auto-reenrollments be prohibited. While NAHU recognizes the need to keep people continuously enrolled in coverage to prevent adverse selection, we do not think that reenrollment in coverage should be at the expense of an individual's choice in coverage options. We question the appropriateness of HHS's current practice of reassigning people into new binding insurance contracts, particularly when this can involve significant cost and tax consequences for the enrollee. If an individual's current coverage option is no longer available through the marketplace, then we believe that HHS should make direct contact with the consumer and obtain consent before passively placing the individual in a new health insurance coverage option. The decision about what is most important to a customer regarding coverage choices—metal level, carrier, provider network, premium prices, cost-sharing expenses, tax credit implications, etc.—is highly personal. What a customer desires or what is most appropriate for the consumer could change from year-to-year. It is not suitable for the federal government to make health plan decisions on a customer's behalf, even if the marketplace ascertained "preferences" for such a decision ahead of time, such as during the initial exchange enrollment process. A wide range of studies show that individual exchange consumers would likely be better off if they shopped annually for a new policy or at least actively reviewed their coverage options with a professional, but they often do not do so. HHS has been perpetuating this problem by placing consumers into new policies based on a government-designed hierarchy with no guarantee that it yields the best or even an appropriate coverage choice for the consumer. In fact, NAHU members report that consumers that have been auto-reenrolled represent the single greatest source of coverage errors that independent agents see. Reenrolled consumers often turn to independent agents in desperation for help and resolving the

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confusion auto-enrollments and redeterminations cause wastes tremendous amounts of time. It also often ends with an uninsured person for the rest of the year. If HHS decides to retain the policy of reenrolling individuals in exchange policies and/or making coverage redeterminations for people, then NAHU requests that the broker of record associated with that marketplace account be notified of the reenrollment and/or redetermination at the same time as the consumer, so that the agent can proactively address any issues.

Open Enrollment Period

For each of the past four years that the PPACA exchanges have been operational, the open enrollment period dates for individuals purchasing individual marketplace coverage have been different and the length of time people have had to enroll has also varied. Each year, NAHU members have observed pros and cons with the dates chosen, as well as the length of the open enrollment window, and our association does not believe that HHS has found the perfect formula yet. This coming coverage year (2018), the open enrollment window will be the shortest yet, with the goal of preventing adverse selection and stabilizing the individual insurance market.

Before finalizing the open enrollment window for 2019 and beyond, NAHU encourages HHS to spend time reviewing data from the preceding five open enrollment cycles to determine what works and what does not. Then, when setting future open enrollment period dates, we encourage HHS to keep a few important points in mind. For open enrollment to experience long-term success, the timeframe needs to be consistent from year to year, so that the dates penetrate the public psyche. Every American adult can tell you that federal personal income taxes are due on April 15 and every Medicare-eligible individual can tell you that its annual enrollment season lasts from October 7 to December 15 every year. HHS should strive for something similar for its long-term individual market open enrollment policy.

Consistency is the most important factor, even more than the date window itself. However, NAHU does believe when picking the future open enrollment date window, CMS should not be afraid to think outside the box and perhaps carve out a distinct time of year for individual market enrollment. In particular, NAHU believes that the individual market open enrollment period should not be identical to the Medicare open enrollment period and the very traditional employer plan renewal dates of December 1st and January 1st. While we recognize the advantages of some overlap, attempting to create identical open enrollment periods for these three market sectors creates a tremendous workload for the thousands of agents and brokers who service customers in two or three of these areas. It also creates a challenging workload for insurance carriers and their support personnel who operate in multiple markets. Plus, multiple holidays occur during this time and mail service and other infrastructures are often already strained. As a result, consumers may suffer from decreased customer service resources.

We also want to point out that while December and January are frequent plan renewal dates, just as many employers operate non-calendar year plans, so there will never be perfect alignment of the individual

open enrollment period with the employer group marketplace. Therefore, to give all health insurance consumers in each of the three distinct market segments the customer service support they all need and deserve, we encourage HHS to maintain at least some separation between the three open enrollment periods, as is achieved with the current proposed dates of November 1-January 31.

Finally, NAHU believes that if HHS requires detailed plan information and pricing to be made publicly available at least two weeks before open enrollment starts, and if automatic reenrollments and redeterminations are prohibited, then a shorter open enrollment period may be appropriate. Without those two market changes, the very short open enrollment period, as has been proposed for 2018, could be problematic in 2019 and beyond.

Exchange Coverage and Subsidy Eligibility and Enrollment Issues

NAHU has had longstanding concerns about how individual consumers understand and how HHS has treated complicated PPACA rules regarding eligibility for coverage and subsidies versus the ability to enroll in such coverage and obtain related subsidies. Most PPACA rules involve complex eligibility standards, not simple enrollment or loss of prior coverage. However, varying interpretations and implementation of these standards and terms, by consumers, issuers, HHS, and various consumer support functions and persons associated with both the state and federal marketplaces, have caused confusion. Unfortunately, NAHU believes this confusion has resulted in many uninsured individuals. It has also created a class of people who have obtained access to SEPs and subsidies that they might not truly be eligible for due to their eligibility for other coverage. In many cases, we believe that inappropriate subsidy awards have occurred due to confusion, misinformation, inadequate training and inappropriate policies (like auto-reenrollments in coverage) rather than due to any improper intent on behalf of the consumer. To address these issues, NAHU suggests a complete review of the use and application of the terms eligibility, loss of coverage and enrollment by HHS, as well as an internal review of call center procedures and how to improve upfront attempts by HHS of employer coverage eligibility verification.

An Adjustment to the 90-Day Grace Period

Existing health reform market rules provide recipients of Advanced Premium Tax Credits (APTC) a 90-day grace period to make past-due premium payments before their insurance coverage terminates. Additionally, issuers must pay provider claims incurred during the first 30 days of non-payment. This policy is inconsistent with most state laws, which either allow insurers to terminate unpaid coverage without advance notice or require insurers to offer a 30-day grace period before termination. Further, state laws generally do not require issuers to pay claims on policies for which premiums are not up-to-date. To maintain consistency with existing state policies for other coverage and prevent the risk-pool instability that results when individuals sign up for coverage, receive care and incur claims but do not ultimately make premium payments, NAHU urges CMS to change the grace period length for APTC recipients from 90 to 30 days.

Exchange Notice
The PPACA contains a statutory requirement that most employers must provide employees with a notice that explains exchange and subsidy eligibility rules and information about if their offer of employer coverage might disqualify them from subsidy eligibility. HHS prepared a model notice that most companies use and provide to new employees, but it has not been updated since 2013 and now contains inaccurate information. Furthermore, the text is confusing and the notice content keeps on expiring and being renewed by HHS with no changes. Employers do not have to use this model text, but most do not realize it. NAHU urges HHS to review this document, make appropriate changes and provide it to employers along with education and guidelines for distribution. Further, HHS should specify that the form will be updated no more frequently than annually and that the update will occur well in advance of each year's open enrollment period.

Enrollment/Disenrollment Concerns
Individuals who have lost group coverage and need to obtain health insurance through the individual market often approach NAHU members for help. These consumers may be trying to get coverage during the open enrollment period or have legitimate SEP eligibility due to their loss of eligibility for employer-sponsored coverage. Based on the day their employer coverage is terminated, or they lose group plan eligibility, it can be impossible or close to impossible for an individual to obtain continuous individual market coverage under current CMS policies, even if the issuer retroactively awards coverage. For example, consider the case of a person who loses a job on June 27 and the employer terminates health coverage immediately (which is common, particularly in self-funded plans, but could happen with any group plan depending on circumstance). If the individual completes the process to obtain new individual market coverage by June 30, then the individual could have their coverage date retroactively applied and have seamless insurance protection. However, if that same person did not complete their application process until July 1, then coverage could not be retroactively issued and the new individual policy would not become active until August 1, leaving the person with a gap in coverage. NAHU members most commonly see this issue arise in the case of sudden and involuntary job loss.

Individuals who lose eligibility for their employer group coverage also frequently do not understand how the election of Consolidated Omnibus Budget Reconciliation Act of 1983 (COBRA) coverage and early discontinuation of COBRA coverage may impact their ability to qualify for a health insurance marketplace SEP, which can also result in unintended gaps in coverage.

To solve these problems, NAHU recommends CMS require individual market insurers to allow retroactive coverage that dates back either to the day of SEP qualification or 30 days from the date of application finalization, whichever is less and not just the previous days of the month in which the application is

finalized. NAHU also encourages CMS to consider rescinding its regulatory guidance that allowed employers and issuers to cease providing individuals who terminate coverage with a certificate of creditable coverage as was required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While CMS deemed this document superfluous now that the PPACA ensures that all coverage is guaranteed issue, NAHU has long thought that creditable coverage certificates have been and could still be used for purposes other than what was originally intended. An updated creditable coverage template could include the documentation issuers need to retroactively issue individual coverage when involuntary loss of eligibility for an employer group plan warrants it.

Special Enrollment Period Eligibility Documentation

Given that qualification for a SEP based on the loss of minimum essential coverage (MEC) eligibility is both complicated and PPACA-specific, NAHU believes that the best means of documenting eligibility would be through the completion of a CMS-developed document. Rather than consumers being required to procure materials from past employers or other sources that may not truly indicate their eligibility, for consistency purposes, NAHU members suggest that CMS develop an official template letter/form. Individuals could provide the form to their former source of MEC eligibility to certify their current SEP eligibility status. This form could have several variations to accommodate the various potential sources of MEC, such as employer-based coverage, a school plan, Medicaid/CHIP, etc. It would need to include eligibility loss dates and sections to be completed and signed by both the consumer and the appropriate MEC plan administrator. Furthermore, NAHU would suggest that such a form include explicit notification of the consequences of a false certification and that CMS reserves the right to contact the source of prior MEC eligibility to verify involuntarily lost eligibility. If CMS agrees to our previous recommendation that it restore the HIPAA certificate of creditable coverage requirement, the template for this form could be revised to include these data elements.

The onus for obtaining the form and ensuring its completion should always be on the consumer seeking to enroll in FFM-based coverage during a SEP. However, NAHU believes that if CMS made this form readily and publicly available, specific group plans and particularly government sources of coverage might automatically begin to adopt its use when an individual loses eligibility.

Marketplace Issues Related to Medicare

Potentially Medicare-eligible individuals create a unique problem for health insurance exchanges and the people who provide individual market consumer support. Since there are such significant potential financial consequences for Medicare-eligible individuals who do not enroll in Medicare on a timely basis, we suggest much stronger coordination between CMS's marketplace operations and the Medicare program. First of all, regardless of any actions you take on exchange reenrollment and redeterminations generally, NAHU strongly suggests disallowing passive reenrollment for individuals whose birthdate indicates that they are likely Medicare-eligible. Perhaps a six-month time window could be used since that timeframe would coincide with the requirement that contributions to HSAs cease). For individuals in

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this age range, personal contact and written consent should be a requirement for marketplace enrollment. Second, concerning all online exchange systems, we suggest a pop-up notification based on an individual's birthday if they were attempting to enroll or reenroll in exchange coverage options. We also recommend online notification for consumers potentially eligible for Medicare due to a disability. Finally, we believe that CMS should develop an internal system so that enrollment in Medicare would automatically trigger a disenrollment from an individual PPACA plan offered through any health insurance exchange.

General Exchange Improvements
NAHU believes that much could be done to improve the consumer exchange experience and that HHS should engage in a thorough review of existing systems and communications. NAHU would be happy to assist with detailed "focus group" type testing of operations and communications and could also provide HHS with direct access to willing health insurance exchange consumers who could provide detailed and helpful "real-world" feedback. A particular area where NAHU members report that their clients often have trouble, and feel like they waste time and effort, is the federal call center and phone-based marketplace system. In addition, NAHU suggests directing any exchange-based consumer communications to the individual's health insurance agent or broker too as an additional means of notification. Concerning marketplace applications, it would make the system much more efficient if only one application for each social security number (SSN) could be active for each year. When an enrollee completes an enrollment, the marketplace should automatically delete all other applications from their file. Finally, NAHU members who work with exchange clients regularly report that the concept of the marketplace "account" is cumbersome, problematic and unnecessary. Only using the "Application ID" is a far more useful method.

Question # 2 - Stabilizing the Individual, Small Group and Non-traditional Health Insurance Markets

CMS has inquired what changes would bring stability to health insurance risk pools, promote continuous coverage, increase the number of younger and healthier consumers purchasing plans, reduce health insurance market uncertainty and volatility, and encourage uninsured individuals to buy coverage. NAHU members have many suggestions that fall into this general category, which we have broken down by topic for your convenience.

"Grandmothered" Plans
NAHU truly appreciates the recent guidance from CMS extending transitional relief for "grandmothered" plans through the end of 2018. We believe it will be helpful for small group market consumers in many states. While an additional year of relief is most welcome, this relief expires at the end of 2018. Unless Congress changes all of the underlying federal health reform statutes concerning market requirements and HHS fully implements all those changes by then, the millions of individual consumers and employees of small businesses who are covered by grandmothered plans will be unable to renew policies that are

serving them well. These individual and business consumers will also likely face massive premium rate increases when they go to purchase alternative coverage. If uncertainty regarding plan options and the potential for significant price increases ahead are weighing on individual and small business consumers of health insurance, it may cause even more market instability. To prevent this, NAHU recommends that CMS build on its recent extension of "grandmothered plan" relief and formally state that the federal transition policy will remain in effect until further notice and the Trump Administration will not rescind it until comprehensive PPACA statutory improvements are both law and fully implemented.

Actuarial Value Calculator

Every year since 2014, HHS has made significant tweaks to the actuarial value calculator QHPs use to determine where individual and small group plan designs stand relative to the PPACA metal levels. NAHU members that work directly for health insurance issuers report that regular changes to the actuarial value calculator have significantly hindered the development and finalization of plan design choices. Issuers are often fairly far along in the product development process when the have to abandon or substantially modify plan designs due to alterations HHS makes to the actuarial value calculator. This HHS practice both limits the options consumers have to choose from and also wastes resources and likely increases overall product development costs. Accordingly, NAHU urges HHS to attempt for actuarial value calculator consistency in the coming years. We also propose that HHS allow issuers to use either the preceding year's calculator or the upcoming year's calculator when submitting their QHP plan designs for approval.

Guaranteed Availability of Coverage Issues

NAHU members routinely work with business owners of all sizes to develop and implement health-coverage options for employees. Accordingly, our members have had the opportunity to observe how the intricacies of PPACA requirements can impact business owners and human resource professionals on a day-to-day basis as they work to ensure that their employees have access to affordable and high-quality coverage options. While NAHU does not believe that employers should be legally required to offer health insurance to their employees or fined if they do not do so, we do believe that if a company wants to provide group health insurance benefits, then the policies of the federal government should not be a barrier to entry. Accordingly, we would welcome additional regulatory action or guidance from CMS to help employers and issuers resolve a series of guaranteed availability of coverage issues that NAHU members have observed while helping companies implement the employer shared responsibility requirements outlined in IRC §4980H.

Many of these issues concern CFR §147.104, which establishes that small employers purchasing coverage, either through the traditional small group market or the SHOP exchange, must meet state and issuer employee participation requirements, except for a one-month annual plan participation requirement holiday, which falls between November 15 and December 15. Large group plans may purchase new coverage at any time of the year without having to meet participation standards to ensure

that such employers can also meet IRC §4980H obligations. However, an issuer may impose participation requirements upon renewal and issuers may also impose a premium surcharge if a large group does not comply with an issuer's or state's specific participation requirements.

First of all, NAHU members report that in many states issuers are applying differing standards to count eligible employees and determine if a group is eligible to participate in either the large or small group markets. Different criteria issuers use includes state small group law definitions, the applicable large employer (ALE) count standard and the federal Small Business Health Options Program (SHOP) exchange participation standard. In some cases issuers appear to be creating their own standards, with varying ways of treating the eligibility of part-time and variable employees. In the experience of NAHU members, these practices are employed for risk-selection and business purposes that are rarely, if ever, in the best interest of the employer group and its participants. These practices can also be destabilizing to the small group insurance market. While NAHU generally favors state insurance market and issuer flexibility as means of driving down costs and best serving the needs of distinct geographic populations, in this case, we believe that there is a direct need for a national employee counting standard. It is the only way to fairly apply the PPACA's small group and large group guaranteed availability of coverage protections across states and issuers.

NAHU suggests that CMS issue regulatory guidance to require all issuers to utilize the IRC §4980H applicability standard for the purposes of determining which employer group market a group may enter and which participation standards to apply. This is already a standard measure since all businesses nationally must use it to count their employees and determine if they are an ALE. In states that have expanded their small group market limit to 99 eligible employees, the company could still complete the ALE applicability formula using their larger workforce, and small group issuers would have to accept any employers whose score was less than 99 employees. Smaller business entities that are part of a controlled group and thereby ALEs, but who maintain a distinct health plan, would also complete the ALE applicability calculation using the employee data for just their separate company. In addition to requiring that all issuers accept the IRC §4980H applicability standard for purposes related to the guaranteed availability of coverage, NAHU proposes that CMS create and maintain a standard online certification program for employers and issuers to use for employee counting purposes so that every issuer and employer is documenting their eligibility using the same system.

Also, given that the majority of states have elected to keep the size of their small group markets as 2-50 employees, many small businesses are subject to IRC §4980H because they employ many part-time employees or could be part of a controlled group. Many American companies that are subject to the IRC §4980H requirements already must buy coverage through the small group market, and many could still be required to purchase health insurance coverage through their state's small group marketplace using the proposed national employee counting standard NAHU delineated above. To make sure that these groups can never be subject to barriers to entering and staying in the group health insurance market,

NAHU recommends that HHS, at minimum, amend §147.104. HHS should exempt any employer that can document that it is subject to IRC §4980H regardless of employee count from having to meet small-group participation requirements at any time during that plan year.

Concerning the small and large-group participation requirements HHS imposes under §147.104 specifically, NAHU members have identified several more problems that we believe regulatory guidance from CMS could solve. First, just as there needs to be a common standard for insurers and issuers to use to determine group size for purchasing and participation requirement purposes, there needs to be a standard way that employers and issuers calculate participation itself. Currently, there is no universal number that issuers use nationally or even within most states to signify that a sufficient number of employees have joined the employer's group plan. Depending on the state, issuer and company's size, numbers can vary from 50-90 percent participation. Second, issuers use wildly different standards to calculate what constitutes a valid plan "participant." Obviously, if an employee enrolls in the coverage offered, all insurers and employers count that employee towards the group's participation total. However, many issuers give employers some form of credit for employees that have other coverage, such as coverage through a different coverage option offered by the employer, or a spouse's plan or coverage through Medicare, and they all use their own formulas. A few states have dictated what constitutes a "valid waiver of coverage" for participation requirements, but most do not and the variation in participation standards nationwide and amongst competing issuers can lead to adverse selection and cherry picking of groups by issuers. To solve this issue, NAHU recommends that CMS establish a standard percentage of covered employees that signifies significant small group market participation and clarify that if an employee attests that he/she has other MEC in place, then that employee must count towards the business' total employee participation number. Finally, we ask that HHS develop a model waiver of coverage form that employers and issuers can use to document an employee's attestation to having another form of MEC.

Another concern relative to small group participation requirements is that the November 15-December 15-participation requirement-free window for small group health plans is exceedingly short. Given other PPACA-related market changes, this requirement is becoming less and less relevant and, as it stands now, the window dates essentially force many small employers to maintain a January 1 plan renewal date, which may not be desirable for their businesses. Also, if a small business suddenly loses their ability to meet participation requirements and has a different annual renewal date, then they can be forced to discontinue their group plan for months, harming both the employer and all covered employees. To address these issues, NAHU suggests that HHS consider either eliminating the small group window created by §147.104 entirely or widening it to at least three months out of the year.

Additionally, particularly in some areas of the country, health plans increase rates for large groups that cannot meet traditional participation standards. In some cases, these premium surcharges are as high as 250%, so they effectively act as a denial of coverage. NAHU requests that CMS develop a reasonable

national ceiling for premium adjustments based on low-employee participation. NAHU recognizes that issuers need to protect themselves from adverse selection, but they also should not be allowed to use low participation as a means of market manipulation.

Similarly, while large employers purchasing fully insured coverage in the large group market do not have to meet participation thresholds when they buy new coverage, existing rules allow carriers to impose participation standards on renewal in some cases. Small groups also may need to meet participation standards again each year when their plan renews or face a loss of coverage. NAHU members have reported incidents of carriers imposing participation audits at renewal unevenly, arbitrarily, and sometimes following significant health claims. Particular issuers have been observed electing to rate up certain groups that cannot meet participation standards but not others, refusing to continue coverage for undesirable groups and allowing healthier groups to continue coverage without any penalty. All of this inconsistency and unfairness has caused coverage instability in both the large and small group markets and has forced many employers to switch health insurance carriers needlessly. NAHU would appreciate clarification from CMS that issuers may only impose renewal-participation requirements on business groups subject to IRC §4980H if state law requires a minimum participation standard for such employers.

A related issue concerns large groups with variable-hour employees. This issue impacts both large companies that are purchasing fully insured coverage and those operating self-funded plans and purchasing stop-loss coverage. IRC §4980H requirements are quite clear that employers must treat employees who are determined to be full-time for health coverage purposes during a measurement period as full-time employees for health coverage purposes during the entire duration of the subsequent stability period, regardless of the number of hours worked. However, there is no corresponding requirement for the issuers that provide such employers with either fully insured health coverage or stop-loss coverage for a self-funded plan. NAHU members are reporting cases of issuers imposing participation/hours worked audits on large employer plans and then denying claims and coverage, particularly following the review of high-cost claims. The business can wind up with absolutely no recourse relative to its coverage offer requirements and can be forced to absorb high claims costs to ensure coverage for such employees. As IRC §4980H implementation has moved forward, this is becoming an increasingly common issue. It is also one that NAHU believes is an unintended consequence of the way the Obama Administration implemented the PPACA that runs afoul of statutory intent. As such, we are requesting that CMS specify that all issuers, including stop-loss plans providing coverage to employer-sponsored health benefit plans, treat all individuals offered coverage based on their hours worked/full-time status during the employer's measurement period as full-time for coverage participation requirements in the subsequent stability period, regardless of their actual hours worked during the stability period.

Finally, guidance is needed to ensure that carriers accommodate individual enrollments of newly eligible employees based on satisfaction of either the monthly measurement or look-back measurement method.

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Many insurer systems cannot accommodate these new rules, resulting in individuals being classified as late enrollees and denied coverage until the next open enrollment. Employers have no means of preventing these issues and have no recourse against IRC §4980H excise penalties in all of these cases. Furthermore, individual employee coverage is disrupted or not provided, in conflict with the intention of the PPACA statute. It is imperative that these consumer and employer protection issues be addressed by CMS as soon as possible.

HSA Embedded Deductible Confusion

Under federal law, a prerequisite for a taxpayer to contribute to a Health Savings Accounts is their coverage through a High Deductible Health Plan (HDHP) as defined in IRC § 223(c)(2). That statutory requirement states that an individual's deductible and maximum out-of-pocket costs must be two times the amount of self-only coverage. However, during the Obama Administration, HHS, along with the Departments of Labor and Treasury, released guidance known as PPACA FAQ 27 questions 1-3, which prohibited application of that statutory requirement. The result has been market confusion as to what constitutes a HDHP on the part of regulators, employers and insurers. The inconsistent and confusing implementation of this FAQ by issuers has created the very cumbersome market phenomenon known as an "embedded deductible" and made HDHPs combined with HSAs a much less consumer-friendly market choice. It has also negatively impacted the cost paid by consumers for these plans. NAHU recommends that HHS and the Departments of Labor and Treasury rescind the guidance contained in FAQ 27 questions 1-3, and that the Trump Administration encourage Congress to address the gap between the HDHP requirements and the PPACA's mandates for out-of-pocket limits.

Question # 3 - Enhancing Affordability

HHS has asked what steps the Trump Administration can take to enhance the affordability of coverage for individual consumers and small businesses. Since business size is defined differently by different aspects of the PPACA, and since business owners of all sizes have been affected by the PPACA both in terms of direct healthcare cost impact and also by increased compliance burdens and regulatory and market uncertainty, NAHU has included suggestions for regulatory improvement that may help large as well as small businesses and their employees. Additionally, in this section, we have identified some issues that the Departments of Labor and Treasury could resolve.

Rating Issues

Changes to the way health insurance premium rates are determined and also implemented have had a significant cost impact on the individual market and small group health insurance coverage. NAHU urges CMS to use whatever discretion it has to expand the current age rating bands of 3:1 in the individual and small group markets. Widening of the current bands will provide needed price relief to individual and small-business owners. Tight age bands have caused individual and small-group premium rates to rise

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substantially over the past three years, and NAHU believes high prices are keeping younger and healthier individuals from both purchasing and maintaining coverage, which is, in turn, damaging to the risk pool.

NAHU recognizes that the PPACA statute mandates the 3:1 bands so CMS may be limited in its discretion in this area. However, our members have some regulatory relief suggestions that we believe fall entirely within the authority of CMS. The first would be to encourage CMS to rescind planned changes to the age rating rules for children age 15 and older finalized in the Notice of Benefit and Payment Parameters for 2018. Under the current age-rating rules, employers may use a single rate for dependent non-adult children on group plans. The new rule, which has not yet been implemented, would require special rates for all children age 15 and older, a very burdensome prospect for both issuers and small employers. Furthermore, this proposal would have a detrimental cost impact on families with older children, even though older children consume less medical care services than their younger counterparts on average. To help reduce costs for families and reduce the administrative burden on small-employer group plans, NAHU strongly recommends that CMS maintain the existing age-rating structure for children.

NAHU also urges CMS to quickly take whatever steps it can to make it simpler for issuers, employers and states to allow for small-group market composite rates. Additionally, we urge you to allow for more state-based variations under the existing age-rating regulatory program. The pre-PPACA norm for all group plans was to charge uniform premiums across four categories of enrollment—employee only, employee plus spouse, employee plus children and family coverage, which included the employee, any spouse, and any other qualified dependent. While the actual premiums charged reflected all of the ages of the people enrolled in the group plan, the premiums were averaged and set for the whole group for each category. This structure is commonly referred to as composite rating and it had numerous benefits for employers and employees alike.

Unfortunately, the PPACA age rules, as currently structured, have virtually eliminated the ability of insurers and employers to set small-group composite rates in most states and instead requires individual age-based rating for every single beneficiary on the group plan. For example, under current PPACA rules in most states, a small employer with 10 employees and 25 dependents on its plan now has to deal with 35 premium rate variations. Plus rates can changes further throughout the year if any member of the group experiences a family life event like a birth, death or divorce. This makes group insurance very complicated for small employers to administer, can cause human resource problems in determining fair employer contributions to premiums and can lead to age discrimination or allegations of age discrimination. To fix these problems, NAHU urges CMS to use its discretionary authority and ability to grant more state-based age-rating variations to allow for the return of small-group composite rates. The Obama Administration did grant some waivers, but virtually all states could benefit from increased discretion in this area.

Nondiscrimination in Health Programs and Activities

On May 18, 2016, the Obama Administration finalized a regulation implementing the prohibition of discrimination under §1557 of the PPACA. This rule imposes significant costs and mandates on health plan design. Even though not all employers are affected by the rule, since most smaller business groups get their coverage through a health insurance carrier or work with a TPA that is covered by the new rule, the construction of the health insurance policies most employer groups must buy are now affected. Therefore the application of the rule can be confusing to employers and costly. Also, a legal challenge to the regulation has put a temporary injunction on some of the related mandated benefits, but most employers and health insurers had already made benefit adjustments for the 2017 plan year before the action of the federal court. Uncertainty about the case and its impact on 2018 benefits is causing costly uncertainty amongst affected business consumers of health insurance. NAHU recommends that HHS revise the final rule so that only entities directly under the control of HHS must comply with these new requirements. NAHU also recommends that HHS develop a clear communication strategy for affected employer groups. Many of them are uncertain about the applicability of the rule to them, the status of the legal challenge and how the injunction might impact their 2018 benefit offerings and options, and their legal obligations to maintain compliant health insurance benefit plans. For these cases and others, clear communication from HHS about what to expect would be helpful.

Essential Health Benefits
The PPACA establishes the 10 essential health benefit (EHB) categories and, without congressional action, those categories cannot change. However, as a means of encouraging plan design innovation and reducing premium costs, NAHU recommends that HHS explore means of providing individual states with greater authority relative to EHB subcategories and plan design approval.

Additionally, NAHU believes several specific immediate policy changes by HHS would reduce costs and help improve consumers relative to the pediatric dental essential benefit category. Before the PPACA, dental coverage, particularly for children, was rarely included in a comprehensive group major medical plan design. Instead, employers offered their employees dental coverage through stand-alone excepted benefit plans. When the Obama Administration HHS issued the EHB plan rules, they did allow for stand-alone dental plan coverage to continue and most employers still favor that option, since the coverage is more specialized and usually a better and less expensive choice. However, small group comprehensive major medical plans still need to include pediatric dental benefits in their plan offerings, and most do so with a separate premium surcharge for that coverage.

To help reduce employer and employee premiums, NAHU recommends that HHS issue guidance preventing QHP issuers from charging employers for pediatric dental benefits if the employer can certify that they have a stand-alone dental policy in place to cover all children on the plan. The certification would ensure that no one on the group major medical plan will be using its pediatric dental benefits. Additionally, NAHU requests that HHS prevent QHP issuers from applying their pediatric dental coverage surcharge to tiers of coverage that do not include children. So, for example, an employer's family and

employer+child rating tiers could include a pediatric dental surcharge, but the single employee and employee+spouse rating categories could not. Finally, NAHU requests that HHS clarify that stand-alone dental plans can have annual and/or lifetime limits as part of their plan design, provided that these plans meet the standard of excepted benefit according to HIPAA.

Transparency

Since private insurers and government programs pay the vast majority of medical care expenses in the United States, most Americans have no idea what the healthcare they receive costs and they have been conditioned not to ask. The ability for consumers to compare prices and quality when making decisions about their healthcare has been virtually eliminated in our national healthcare delivery and financing system. This paradigm needs to shift and NAHU believes that HHS could and should take a leading role in doing so.

Making informed healthcare decisions helps us understand that medical care is expensive, but not all treatments and providers are necessarily better in value or quality. NAHU calls on HHS to encourage the principles of transparency, consumerism, health and wellbeing wherever possible by exposing more quality and price information in all programs under its jurisdiction, including Medicare, Medicaid, the Children's Health Insurance Program and health insurance exchanges. HHS can do this by prioritizing providing Americans with more informative, consumer-friendly healthcare cost and quality data and tools. They can also publicly disclose the prices they pay to providers, hospitals and health insurers for all programs and prioritize the public disclosure of all plan network and prescription drug formulary information before the start of open enrollment each year.

Wellness Program Rules

On May 17, 2016, the Equal Employment Opportunity Commission (EEOC) published final rules on wellness programs under the Americans with Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA). These rules are intended to complement existing HHS rules on wellness programs and to provide clarity about how employers can operate wellness programs and not run afoul of either the ADA or GINA. These rules were proposed and finalized after the EEOC initiated three lawsuits against high-profile employers for allegedly committing ADA violations in the administration of their wellness programs, which have so far all been decided in favor of the employers.

The finalized EEOC rules have already been implemented by employer-sponsored wellness plans, but NAHU believes that they can be improved and better integrated by HHS with its existing wellness program rules. First, the wellness program standards imposed by the EEOC only impact limited aspects of employer wellness programs and it is complicated for employers to determine if they apply to their specific plan. Plus, the standards the EEOC rules create are different and, in some cases, more extensive than the preexisting HIPAA and PPACA wellness program rules issued by HHS. Concerning the value of the wellness incentives, the EEOC standard actually conflicts with, and reduces, the discount specifically

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allowed by the PPACA and by HHS rules. The PPACA allows for wellness program premium variations of up to 50 percent based on the overall premium rate. HHS rules promulgated to implement this requirement to allow for individuals to receive up to a 30 percent overall premium discount for wellness program participation and allow for an addition 20 percent variation for involvement in a smoking cessation program. The HHS rules base the value of this incentive on the total amount of each employee's premium based on the coverage option elected by the employee. So, if the employee chooses single coverage, the wellness program premium discount is 30 percent of the single employee premium, but if the employee picks family coverage, then the value of the discount for that employee is 30 percent of the more expensive family premium. The EEOC rules relative to the ADA limit the value of the incentive to 30 percent of the single employee premium regardless of what type of coverage the employee elects. The EEOC rules relative to GINA allow spouses that participate in certain types of wellness programs to obtain an additional 30 percent discount based on the single employee premium rate of their own. However, even these two single discounts stacked together is often less than a 30 percent discount on an overall family premium, as is allowable under HHS rules.

In short, the EEOC wellness rules create two problems for businesses and their employees. They make wellness program discounts tricky to administer and they reduce the value of wellness program incentives for many employees. NAHU recommends that HHS reopen its wellness program rules to integrate them with the EEOC requirements. In doing so, NAHU suggests that HHS allow consistency in the application of wellness program discounts by basing all discount values on the cost of the premium of the policy elected by a participating employee. Furthermore, NAHU recommends that HHS consider expanding upon its existing PPACA wellness rules and allowing premium variation discounts of up to 50 percent simply for wellness program participation, as is permitted by statute.

Proposed Revision of 5500 Annual Information Returns and Report

The Obama Administration proposed an enormous overhaul and expansion of the 5500 annual information returns and reports most employer-sponsored group benefit and retirement plans must submit annually to the Departments of Labor and Treasury. Not only would the rule require entities that currently have to comply with reporting requirements to drastically expand the amount of information they provide annually to the federal government, but it would also expand health plan reporting obligations to more than 2 million new small businesses. The proposed reporting expansion will be extremely expensive and complicated for employers of all sizes to implement. Furthermore, it is unclear what the Departments of Labor and Treasury will even do with the voluminous new data they proposed to collect. Comments were due on this proposed rule on December 5, 2016, but the Obama Administration did not finalize it.

Closure on the Form 5500 proposed rule would be very helpful to employers of all sizes that offer group benefits and group retirement plans. To provide more certainty to these businesses, NAHU suggests that HHS urge the Departments of Labor and Treasury to finalize this proposed rule with vast modifications.

With regard to health benefit plans, NAHU urges the Trump Administration, in the strongest of terms, to eliminate the new proposed "Schedule J" reporting in a final rule and also restore the reporting exemption for small welfare plans (i.e., fewer than 100 participants) that provide group health benefits. Additionally, we encourage you to allow a reporting exemption for health plans that qualify for the small plan exception (e.g. retiree medical plans) and those that are excepted benefits under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (e.g., dental, vision, and health flexible spending accounts). Such exemption should apply even when such a health or welfare plan is part of a wrap plan with a group health plan.

Information Reporting Requirements
The PPACA requires ALEs and health insurance issuers to report extensive health coverage information to the federal government annually to effectively enforce the law's individual and employer mandates and also help verify individual eligibility for health insurance premium tax credit subsidies. The Department of Treasury is the primary regulator of the IRC §§6055-56 requirements and related regulations, forms, systems, and guidance, but HHS is also very much impacted by these reporting requirements as they relate to the health insurance marketplace, subsidy eligibility and employer mandate penalty enforcement.

NAHU believes that the IRC §§6055-56 reporting process could be substantially improved to the benefit of both employers and issuers, the administration and affected health insurance consumers. Changes could reduce costs for employers and issuers and also make subsidy administration and verification much simpler and more effective. NAHU urges the Trump Administration to allow for a voluntary certification system that complements the PPACA's information reporting requirements under IRC §§6055-56 so that employers could prospectively report to the Internal Revenue Service (IRS) that they are offering PPACA-compliant coverage to full-time employees. Under such a system, employers could confidentially attest that they offer coverage that meets the PPACA's employer shared-responsibility provisions and could certify that they offer at least one plan that meets one of the affordability safe harbors that the Treasury Department provided in the final rules under IRC §4980H. HHS could amend its data-sharing agreement with the IRS to allow state-based exchanges and the FFM to access such information in helping to make accurate eligibility determinations for premium tax credits and cost-sharing reductions.

Additionally, NAHU asks HHS to urge the Department of Treasury to extend the IRC §§6055-56 regulatory deadline permanently for issuers and employers to distribute Forms 1095 B and C to individuals to March 1 of each year and to submit them to the IRS to March 31 annually. Originally the Obama Administration IRS specified via regulatory guidance that these forms must be distributed by January 31 of each year, but for the reporting years 2015 and 2016 they later revised these deadlines and issued a delay for employers and issuers midway through the reporting season. NAHU believes employers and the administration need greater certainty in deadlines and that the originally proposed

January 31 deadline is unrealistic as businesses and the IRS are already under deadlines for W-2s and other end of year reporting. A declaration of permanent March deadlines would provide sufficient time for both employers and the administration and be a welcome relief for everyone.

Providing Education and Relief to Employer Sponsored Plans

Over the past seven years of PPACA implementation, one area where the Obama Administration was very inconsistent, and NAHU feels the Trump Administration could easily achieve improvement, is in providing compliance education and support to employer-sponsored health plans. While HHS and the Departments of Labor and Treasury did provide some instructional materials and resources to group plans, they often were lengthy and confusing and hard to interpret. NAHU feels that HHS would do well to focus on helping employers and issuers comply with the PPACA's myriad of requirements, by providing reasonable deadlines, lengthy transition periods, ample time for public comment, and utilizing a good faith compliance enforcement standard with employers and health plans whenever possible. Additionally, as the PPACA changes and evolves, we hope that you will focus on educating the public about any plan changes they need to make, including always providing detailed public information support, model documents and extensive compliance examples.

Just one example of how the Obama Administration could have easily provided more information and assistance to group health plans is Michelle's Law, which predated the PPACA. This measure established that an employer group benefit plan couldn't terminate a child's coverage for loss of full-time student status if the dependent child was on a "medically necessary leave of absence" from school and the law includes a notice requirement for plan participants. The PPACA's dependent coverage to age 26 provisions has rendered Michelle Law's provisions essentially moot for all PPACA-compliant plans (non-grandfathered plans), as they do not condition dependent coverage on full-time student status. However, even though Michelle's Law is now obsolete, the Obama Administration did nothing to communicate to employers about how their old compliance responsibilities relative to that law may have been affected by the PPACA. Many employers, in an abundance of caution, continue to provide participants with Michelle's Law notices, even though they are irrelevant and could create consumer confusion. NAHU would urge the Trump Administration, in this case and in every similar case, to review the facts and circumstances of the employer health plan compliance burden and make every effort to reduce and simplify this load for employers of all sizes.

Eliminate Separate PCORI Fee for HRAs

The PPACA established that all employers that sponsor self-insured health plans by commercial group health insurance issuers pay an annual fee to fund the Patient-Centered Outcomes Research Institute (PCORI fee) through 2019. Obama Administration rules require that health reimbursement arrangements (HRAs) offered by employers pay this fee too, separate from the fee paid by the employer or issuer on behalf of the group major medical plan. The HRA fee must be determined using distinct and complicated calculation rules for companies that offer HRAs. Many smaller employers use the HRA framework as part

of their health coverage offerings, and this policy imposes an unneeded compliance and cost burdens on small businesses and the individuals who work for small companies. NAHU suggests that HHS communicate with the Department of Treasury about how this policy is increasing the cost and compliance burden and urge them to discontinue the practice of requiring HRAs to calculate and pay PCORI fees separately.

Health Insurance Providers Fee (HIT Tax)
NAHU members and their employer clients have had longstanding and significant concerns about the health insurance fee imposed by the PPACA on all individual and fully insured group health insurance policies sold in this country from 2014 to 2016, and it is scheduled for reinstatement beginning on January 1, 2018. It technically falls on health insurers but, as the Congressional Budget Office (CBO) predicted when Congress was debating the PPACA, it is “largely passed through to consumers in the form of higher premiums for private coverage.” It has disproportionately impacted small-business owners and the employees of small businesses, and it has increased the cost of healthcare coverage for consumers and employers in every state. NAHU members know all too well that any requirement that increases the cost of health insurance for small-business owners and the self-employed makes offering affordable coverage, or any coverage at all, to employees more cumbersome.

To help reduce the economic impact this fee is having on individuals and small-business owners, NAHU urges HHS to ask the Department of Treasury to make a critical modification to the way the fee amount is calculated. We propose a clarification that health insurance providers’ fee collections will no longer be considered as taxable business revenue of issuers. Under the PPACA statute, the annual fee on health insurance providers is treated, for tax purposes, as a nondeductible excise tax and the PPACA specifically referenced the concept of deductibility as it relates to the treatment of the tax. When Congress was considering the PPACA statute, the CBO recognized and informed Congress and the president that a large portion of these fees would be passed through to policyholders in the form of higher premiums and that prediction was borne out when the tax was levied during 2014-2016. When the Obama Administration was promulgating the regulations to effectuate the health insurance provider fee in 2013, NAHU and many other stakeholders argued that, based on long-standing federal income tax principles, final regulations should permit any fees recovered from policyholders to be excluded from the health insurance companies’ gross income if the conditions of the tax policy and rules are met. Instead, the Obama Administration, via the final Health Insurance Premium tax rules promulgated in 2013, chose to “tax the tax” and applied federal income tax to the health insurance provider fee premiums that insurers collect and then forward to the IRS. This excess taxation represents around one-third of the total premium impact of the tax and is not required under the statute.

Fortunately, NAHU sees a legal path for the Department of Treasury and the IRS under the current presidential administration to significantly reduce the financial impact of the fee on American healthcare consumers in the future. Since there is a direct connection between the tax paid to the government by the

insurance companies and the amounts recovered, the payment of the fee and the recovery of the fee amounts should be considered a single integrated transaction. Under the well-established "tax benefit rule," since the fee is not deductible by the insurance company, the Trump Administration would be well within its authority to specify that any future fees recovered from policyholders should not be included in the insurance company's gross income.

Section 105(h) Non-discrimination Provisions Applicable to Insured Group Health Plans
Section 2716 of the PPACA required that existing IRC §105(h) benefit plan non-discrimination requirements and related annual testing requirements that self-funded employer plans must follow, be extended down to all employer-sponsored health benefit plans of all sizes. However, these existing requirements, designed for large employer pension plans, cannot easily be expanded in a way that would make any sense for smaller employer and fully insured group health benefit plans. NAHU analysis, done in 2010 in anticipation of this requirement being imposed on small group benefit plans, showed that up to 80 percent of small group benefit plans of less than 50 employees would fail the current non-discrimination testing imposed on large self-funded plans. These groups would fail simply because too many of their employees have other forms of MEC, such as a spouse's plan. As such, the IRS issued Notice 2011-1 in January of 2011 noting that the Treasury Department and the IRS, as well as the Departments of Labor and HHS, determined that compliance with §2716 should not be required until after regulations or other administrative guidance of general applicability has been issued under §2716. To-date, no regulations have been issued to enforce compliance with this PPACA requirement. NAHU strongly urges the Trump Administration to continue the Obama Administration's policy of not issuing regulations to require expanded compliance with §2716 and to publicly announce its intention to not enforce compliance beyond the requirements currently in force on self-funded employer group plans.

Section 125 Plan Regulations
Almost all small and group health benefits offered in the United States are organized to take advantage of the provisions of IRC §125, which allows employers to offer their employees the benefit of a "cafeteria plan" to pay for their employee benefits on a pre-tax basis. In addition to the governing statute, the IRS proposed regulations to govern §125 plan implementation on August 6, 2007. However, these rules were never finalized, and employers were just left with the instruction to use the proposed rule text as implementation guidance. While the Department of Treasury is the lead agency responsible for this proposed rule, clearly the effect of IRC §125 on group benefit plans impacts both HHS and the Department of Labor, and now we can also see the impact of the PPACA on §125 plans. NAHU recommends that HHS urge the Department of Treasury to consider reviewing, potentially revising and then reissuing the proposed §125 rule in the near-term future, with the goal of finalizing the rule under the Trump Administration. Not only would finalizing these rules provide compliance certainty to employee benefit plans, but also a careful review of the rule might yield opportunities for the Trump Administration to provide employees and group benefit plans with new forms of cost and tax relief.

W-2 Reporting For Smaller Plans
While the PPACA statute requires virtually all employers that offer health insurance coverage to employees to report information about their benefits to employees via the Form W-2, in 2011 the IRS issued Notice 2011-28. This notice made the reporting optional for smaller employers that file fewer than 250 Forms W-2 for the prior calendar year until notice. The IRS has not issued any further guidance mandating reporting for smaller companies, so, for the 2016 tax year, W-2 reporting cycle, which is due to by January 31, 2017, only employers that issue 250 or more Forms W-2 have to comply. NAHU strongly urges the Trump Administration to continue the Obama Administration's policy of not issuing regulations to require expanded compliance with W-2 reporting for smaller employers for at least the next four years and to make that policy publicly known as soon as possible.

Question #4 -Affirming the Traditional Regulatory Authority of the States in Regulating the Business of Health Insurance

HHS has inquired about regulations or policies that have impeded or unnecessarily interfered with the traditional role of states to regulate health insurance markets they know best. NAHU believes that many of the problems we have identified in other sections of this comment letter were pre-PPACA effectively managed and regulated by individual states, including loss ratio requirements, participation standards and age-rating issues. However, given the layering of the PPACA over state laws and authority, as well as the creation of new national programs like the FFM and premium tax credit subsidies, we do recognize that some degree of federal coordination is necessary and can also help facilitate market operations based on a level playing field.

One area where we believe the Obama Administration overstepped its authority and diminished the role of the states involved the proposal of new requirements that supplemental policies, travel insurance and hospital indemnity and other fixed indemnity insurance coverage must meet to maintain their status as excepted benefits. When the PPACA was passed in 2010, it incorporated 42 U.S.C § 201 of the Public Health Service Act's (PHSA) definition of "excepted benefits," which was established by the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This definition expressly includes supplemental policies, travel coverage and fixed indemnity plans that provide limited and fixed medical coverage in its construct, since such plans were never meant to take the place of major medical coverage. Accordingly, NAHU believes that excepted benefit status should be conditional on that statutory definition.

Under the Obama Administration in 2016, HHS and the Departments of Labor and Treasury also created significant new requirements for short-term, limited duration health insurance policies, partly to preserve the health of the individual market risk pool. However, our members have concerns that this regulation made attempts at SEP fraud worse by limiting coverage choices for consumers who used to

buy short-term coverage to meet a gap in their group coverage options and never intended to seek individual market coverage. Furthermore, since the primary responsibility to regulate short-term policies rests within the states, NAHU feels that the Obama Administration exceeded the bounds of its regulatory authority in this area.

While short-term medical policies only represent a small fraction of health insurance policies sold, they always had a clear purpose—to serve as a bridge to other more comprehensive coverage options. Their buyers include not only people seeking individual coverage but also those who have a gap between group coverage options. Agents selling these policies report that at least half of their sales are to people who are transitioning between jobs or have purposely reduced hours or have taken an unpaid leave and cannot afford or do not qualify for COBRA or other group continuation coverage options. Newly retired people who are seeking a temporary bridge to Medicare enrollment, American students studying abroad, individuals temporarily in the United States on VISA programs and undocumented residents all are also common limited duration health policy consumers. People who qualify for an individual mandate hardship exemption, particularly those who fall into a Medicaid coverage gap, also frequently buy short-term policies because it is all they can afford. None of these individuals ever intend to be part of the traditional individual health insurance market, so their inclusion in the limited duration coverage marketplace has no potential impact, positive or negative, on the traditional individual market's risk pool. However, all of these consumers have been detrimentally affected by the 2016 short-term policy rule.

NAHU believes states did an excellent job regulating short-term policies for decades, including by imposing appropriate durational limits. The current federal regulation is inappropriate, unnecessary and is having a very detrimental impact on consumers. Furthermore, the NAIC was in the process of improving model legislation and a model regulation establishing minimum standards for limited duration policies and other types of excepted benefits and other health coverage traditionally under the complete purview of state regulation. The federal action by the Obama Administration on short-term policies only muddled and hindered the collective work of state regulators. NAHU urges HHS to work with the Departments of Labor and Treasury to rescind its joint 2016 efforts to regulate short-term health plans and instead encourage the NAIC to continue its work.

Conclusion

NAHU is grateful for the opportunity to provide information to CMS about changes the Trump Administration could make to further its goals of improving private health insurance markets and creating a more patient-centered healthcare system that adheres to the key principles of affordability, accessibility, quality, innovation and empowerment. The nation's health insurance agents and brokers stand at the ready, willing to provide you with real-world information about the needs and challenges health insurance consumers are experiencing, both at the employer and individual level. We look forward to working with you to improve our nation's healthcare delivery and financing systems.

If you have any questions or need additional information about our suggestions, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters

1212 New York Avenue, NW, Ste. 1100 • Washington, DC 20005 • 202-552-5060 • www.nahu.org