March 7, 2017

Patrick Conway, M.D.
Acting Administrator
Centers for Medicare and Medicaid Services
Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-9929-P

Submitted Electronically Via Regulations.Gov

Dear Dr. Conway,

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 benefit specialists nationally. We are pleased to have the opportunity to provide comment on the proposed rule titled "Patient Protection and Affordable Care Act; Market Stabilization" that was published in the *Federal Register* on February 17, 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 Patient Protection and Affordable Care Act (ACA), our members have worked directly and tirelessly with millions of individuals and employers of all sizes to help them obtain new coverage, including coverage through both the individual and Small Business Health Options Program (SHOP) marketplaces. NAHU members also work directly with individuals and employers to help them implement health-plan changes related to the ACA.

Ensuring 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 proposed regulation and believe many of its provisions will do a great deal to provide needed stability to both the private individual and small-group markets in the year ahead. NAHU agents and brokers do have some thoughts about how these regulatory changes could be enhanced to better serve consumers and provide even greater marketplace certainty. For your convenience, we have broken our comments out by topic to correspond with the provisions of the proposed rule.

Open-Enrollment Period
Current CMS rules have set the individual-market open-enrollment period dates for the 2018 coverage year as November 1, 2017-January 31, 2018. The proposed rule would change the 2018 coverage year open-enrollment dates to November 1-December 15, 2017. This proposed change would not only reduce the enrollment time by half, but also make the period overlap significantly with the Medicare annual enrollment period, as well as with open-enrollment time for the many employer-sponsored plans that operate on a calendar-year renewal cycle. The reasoning for this planned change is to reduce adverse selection and provide a greater assurance of 12 months of continuous coverage for consumers, both things that will help with needed market stability.

NAHU supports these goals and recognizes the advantages of some overlap in open-enrollment periods across the individual, Medicare and employer market sectors, particularly for lower-income working individuals who may not have access to group coverage that meets the ACA affordability test. However, health insurance consumers in each of these three distinct markets segments all need and deserve sufficient enrollment support, and the proposed change will definitely have an impact on resources available. Our members have expressed concern that these shorter and virtually simultaneous open-enrollment windows present a huge challenge to provide the level of service needed to ensure that customers get the advice and support they need to make the best choice of coverage.

Due to the current volatility of the individual market, NAHU recognizes that the proposed shorter open timeframe may lead to the market stability needed for the 2018 plan year specifically. However, we urge CMS to accompany this proposed change with early outreach and education to consumers to make them aware of the shortened enrollment dates, including enhanced resources and support for the agent and broker community. Furthermore, we stress that final rules should promote better communication between consumers and issuers before enrollment/reenrollment. Once the market is stabilized, in the out-years we would support lengthening the open-enrollment period again or, at minimum, providing a greater degree of separation between the three distinct open-enrollment windows to give health insurance consumers in each of the three distinct market segments the customer service support they all need and deserve. Finally, in order get the full market stability benefits from this proposed 2018 enrollment year change, NAHU requests that state-based exchanges and all off-exchange individual-market issuers be required to align with the federal individual-market open-enrollment dates as well. Unless open-enrollment dates are consistent in every state and for all individual-market purchasing options, the possibility of destabilizing anti-selection exists.

Special Enrollment Period Changes

NAHU believes that the goal of requiring greater verification of SEP eligibility for the most common enrollment situations is a sound policy and we commend CMS for proposing to expand the eligibility-verification process to all federally facilitated marketplace applicants beginning in June of 2017. In order to maintain a national level playing field in the entire individual market, NAHU suggests that CMS also require the new verification standards and timeframe not just to the federally facilitated marketplace (FFM), but also to state-based exchanges and individual-market carriers offering products to consumers independent of the exchange marketplaces**.** Given that the ACA mandates limiting enrollment for the entire private individual health insurance marketplace to just during the annual open-enrollment period or during a special enrollment period for qualified individuals, it is critical that all individuals who are seeking coverage outside of the annual open-enrollment period have a legitimate reason for doing so. Just as we noted with regard to the proposed open-enrollment dates, NAHU also believes that unless there is consistency of special enrollment period criteria across states and individual-market purchasing options, the possibility of destabilizing anti-selection exists.

NAHU also supports the proposal to require appropriate documentation of SEP-qualifying status to be submitted by a consumer to the marketplace prior to the effectuation of coverage, as well as the proposed 30-day timeframe for document submission. However, NAHU members believe that it is important for CMS to recognize that there will always be extraordinary cases where individuals cannot obtain official documents or cannot meet allowable timeframes due to circumstances beyond their control. The FFM has a robust appeals process already in place. NAHU suggests that the final rule explicitly specify that all special-circumstance cases will be routed through the

appeals process, including individuals who cannot obtain official documentation and individuals whose ability to obtain the documents eclipsed the 30 days allowed by the proposed rule.

With regard to the proposed changes to SEP qualification and verification requirements relative to marriage, permanent moves and nonpayment of premiums, NAHU is generally supportive of the proposed new standards. However, we note that the additional verification criteria the proposed rule would require of newly married couples (which limits SEP eligibility so that it only is available if at least one partner had minimum essential coverage or lived outside the United States or in a United States territory for one or more days during the previous 60 days) is an entirely different verification standard than what is used in the private individual market generally. It is also not the normal standard used by employer-sponsored plans when determining if an individual and his or her new spouse meet the standard of the marriage qualifying event to elect or make changes to group coverage. As is our view with SEP verification criteria generally, NAHU believes that CMS should take care to ensure consistency in what constitutes a qualifying event, as well as what qualifies as appropriate eligibility documentation requirements for all markets and purchasing options, otherwise the possibility of destabilizing anti-selection exists.

Finally, in addition to the proposed changes to SEP qualification and verification requirements in the proposed rule, NAHU believes that CMS could also impose better verification standards on another common SEP: involuntary loss of eligibility for minimum essential coverage (MEC). An individual's eligibility for an SEP related to the loss of MEC eligibility can be tricky for a consumer to understand and tricky to document. Based on both the complexity of the SEP criteria and extensive marketplace observation, NAHU members believe that this SEP is commonly claimed inappropriately by consumers, and often inadvertently. To address this issue, NAHU feels that it is crucial that CMS reexamine its approach to the SEP and that your required coverage documentation accurately reflects an individual's status. Qualification for this SEP is specifically predicated upon involuntary loss of eligibility for MEC. Qualification is not necessarily related to if the person had and lost prior coverage; rather, it is the loss of eligibility that is important. For example, if an individual consumer had prior individual coverage and dropped it voluntarily, he or she would not be truly eligible for an SEP even though proof would be available that indicated a coverage loss. However, an individual who previously had access to group coverage through an employer but chose not to enroll, and then lost such eligibility mid-year due to a discontinuation of the employer group plan, would have SEP rights even though there was no actual coverage loss to document.

Given that qualification for an SEP based on this situation is both complicated and ACA-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 documents that may or may not truly indicate their eligibility, for consistency purposes, NAHU members suggest that CMS develop an official template letter/form that individuals could provide to their former source of MEC eligibility to certify their current SEP eligibility status. This form could have several variations to accommodate the various different 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 clear notification of the consequences of a false certification and that CMS reserves the right to contact the source of prior MEC eligibility to verify that eligibility has been involuntarily lost.

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

Additional Suggestions
Beyond the market reforms outlined in the proposed rule, the membership of NAHU believes there are several other areas where regulatory changes initiated by CMS could bring greater stabilization to both the individual and small-group health insurance markets nationally. These include:

Additional "Grandmothered" Plan Relief
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, we note that when this relief expires at the end of 2018, unless significant changes have been made to the underlying federal health reform statutes and those changes have been fully implemented, then the millions of individual consumers and employees of small businesses who are covered by these 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 the uncertainty of future plan options and potential for significant price increases ahead is weighing on individual and small-businesses 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 will not be rescinded until ACA statutory improvements are signed into law and can be fully implemented.

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 prior to their insurance coverage being terminated. 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. In order to maintain consistency with existing state policies for other coverage, and also 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.

Adjustments to the Age Rating Requirements
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 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 ACA 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 fully 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 individual 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-ACA 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.

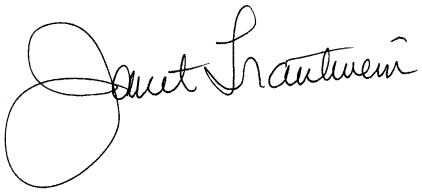
Unfortunately, the ACA age rules as currently structured have virtually eliminated the ability for insurers and employers to set small-group composite rates and instead require individual age-based rating for every single beneficiary on the group plan. For example, under current ACA rules in most states, a small employer with 10 employees and 25 dependents on its plan now has to deal with 35 premium rate variations and rates can changes further throughout the year if any member of the group experiences a family life event like a birth or a 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 state-based age-rating variations to allow for the return of small-group composite rates.

Medical Loss Ratio (MLR) Calculation Changes

NAHU strongly recommends that in the final market-stabilization rule, or in additional rulemaking to follow, CMS allow for health insurance agent and broker commissions, as well as issuer fraud-prevention measures, be exempted from an issuer's MLR calculation. Alternatively, we propose that CMS revise existing rules so that issuers may consider agent and broker commissions and fraud-prevention measures as quality-improvement expenses and not administrative expenses. These changes, which are supported by current state insurance commissioners and have been the topic of a resolution of support from the National Association of Insurance Commissioners, would help agents and brokers provide additional and market-stabilizing services to individual and small-group customers. Greater customer enrollment support and plan servicing throughout the year will reduce the number of potential SEP enrollments and help eliminate inappropriate SEP applicants. Allowing carriers to consider fraud- and abuse-prevention expenditures as a health quality expense exempt from the MLR will also lead to lower-cost health plan premiums due to reduced fraud and abuse.

NAHU is grateful for the opportunity to provide comments on the proposed rule. If you have any questions or need additional information, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,



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