



November 27, 2017

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Submitted electronically via [www.regulations.gov](http://www.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. We are pleased to have the opportunity to provide comments in response to the proposed rule titled "Patient Protection and Affordable Care Act: Notice of Benefit and Payment Parameters for 2019."

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 our top goals. NAHU greatly appreciates the willingness of HHS and CMS to hear from stakeholders on this important regulation, which covers such a wide array of these health-policy issues. Our comments reflect the views of experts who fully understand the needs and interests of today's individual and group health insurance consumers.

NAHU has elected to organize the body of our comment letter by policy issue as the topics appear in the proposed rule. However, we want to stress that the issues of greatest importance to our membership are those that would directly impact the ability of health insurance agents and brokers to serve their clients, including medical loss ratio requirement changes, exchange enrollment changes and issues, changes to the SHOP exchange, alterations to navigator requirements, changes to the web-broker program, and tax credit eligibility-verification issues.



## **Risk Adjustment**

To improve the accuracy of the risk-adjustment formula, HHS outlines a number of changes to its existing risk-adjustment model and methodology for 2019, including a proposed change to the data source blend used to create the model. The current employer-based claims database would be used to provide 2014 and 2015 data, but the 2016 data draw would come from HHS servers to reflect current individual-market claims. State regulators would be allowed to request risk-percentage adjustments for risk-adjustment transfer amounts calculations used for their state's small-group markets if they can meet specific criteria. Also, risk-adjustment data provided by insurers must be audited and, to reduce the regulatory burden and cost of these audits, HHS is proposing many changes to the audit process. Finally, the 2019 risk-adjustment model formula would be adjusted to remove two prescription drug classifications, since enrollee use of the drugs didn't correlate with more risk in 2018.

NAHU supports these changes generally, particularly the concepts of using more accurate claims data in the application of the risk-adjustment formula and providing more flexibility to state regulators. However, since our organization represents independent health insurance agents, brokers and consultants, we feel that detailed comments about these proposals are far more appropriate from state regulators, actuaries and issuers, as they can provide far more accurate assessments of how the specific proposed changes could impact state regulations as well as issuer operations and financial solvency.

NAHU does want to point out that the adequacy of risk adjustment in a guaranteed-issue marketplace cannot be compromised without the risk of grave insurance market instability, including higher costs and fewer choices for individual health coverage consumers, small-business owners and the self-employed. The risk-adjustment program as it exists currently has already created much market instability. By assessing charges against plans with lower-risk beneficiaries and claims costs to make payments to plans with higher-risk individuals, HHS has unfairly penalized many smaller and more innovative plans. The inadequacy of the existing adjustment formula is a reason that many issuers, including national plans and smaller entities, have cited as to why they can no longer serve the individual and small-group exchange marketplaces. Accordingly, NAHU urges HHS to evaluate the views of all issuers, regulators and actuaries that provide commentary on the proposed risk-adjustment formula changes carefully, and to heed advice that will improve the adequacy of the methodology, issuer solvency and competition.

## **Expanded Role for States**

The proposed rule generally would extend the role of states regarding rate review, qualified health plan (QHP) certification and network adequacy designation. NAHU has long supported such changes and supports their inclusion in the proposed rule.

## **Standardized Options**

Section 155.20 of the proposed rule would eliminate the standardized option plans on healthcare.gov and web-brokers would be relieved of their obligation to differentially display these plan options. NAHU



supports this proposed change and notes that our members who work with individual consumers routinely on their purchase decisions report that standardized plans are not needed in the marketplace. In fact, consumers should not be limited in their choices but instead should have transparency in the marketplace and access to licensed professional brokers to help them pick the coverage that suits their specific need.

### **Navigators**

NAHU has significant concern with the proposed changes to the Navigator program outlined in § 155.210. According to the proposed rule, navigator groups would no longer need to maintain a physical presence in exchange service areas. Also, the requirements that exchanges have at least two Navigator entities per service area, and that one of these entities must be a community nonprofit group, would be eliminated. NAHU notes that the reason why these requirements were added into the federal regulations governing ACA health insurance marketplaces initially were concerns about fraud and the difficulty that states faced concerning oversight of non-community-based navigator groups. By stripping away these requirements, HHS would be making state-based oversight of navigator groups infinitely more difficult.

As long as the ACA remains the law of the land and health insurance marketplaces are in existence as a source of individual-market coverage and health insurance premium tax credit subsidies, health insurance consumers will need help with selecting and managing coverage that best meets their needs. 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 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.

Given these facts, NAHU believes that instead of dismantling consumer protections relative to the navigator program, HHS should embrace state-level navigator program oversight. Furthermore, we suggest that HHS review the rules regarding navigators and other assisters that virtually preclude licensed 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, HHS rules and guidance prohibit navigators and other assisters from engaging in meaningful collaboration with agents and brokers in many instances; these requirements should be eliminated. Finally, NAHU believes that one of the best actions HHS 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. The assistance brokers provide to exchange consumers has value and the industry designed to provide it should be embraced and supported, including financially.



## **Web-Brokers**

NAHU supports the provision in § 155.221 that would allow web-brokers that are engaged in exchange direct-enrollment efforts to hire a third-party auditor of their choosing to provide annual operational readiness review for HHS.

## **Premium Tax Credit Eligibility Verification**

NAHU supports the provision in § 155.320 that would increase data-matching efforts for certain individuals who have reported income inconsistencies. However, our association is concerned that § 155.320 would allow exchanges to keep using an alternative and more limited process to verify if an individual has access to employer-sponsored coverage, which negates exchange subsidy eligibility in most cases. NAHU believes that HHS should take the exact opposite approach. We strongly recommend that HHS improve its efforts and data sources for verifying offers of employer coverage for exchange subsidy-eligibility purposes.

As we have commented many times, NAHU remains very concerned about the workability and effectiveness of the employer-coverage verification, notice and appeals processes as they currently stand with health insurance exchanges. We continue to believe that, in the absence of a comprehensive electronic data source available for exchanges to verify the availability of employer-sponsored coverage, the Administration should allow for a voluntary certification system that complements the ACA's information-reporting requirements under IRC §§ 6055-56 so that employers could prospectively report to the IRS that they are offering ACA-compliant coverage to full-time employees. Under such a system, employers could confidentially attest that they offer coverage that meets the ACA'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 federally facilitated marketplace (FFM) to access such information at the time of an individual's exchange enrollment in order to facilitate more accurate eligibility determinations for tax credits and cost-sharing reductions. NAHU believes that the implementation of these policy changes would not only prevent many individuals from receiving subsidies inappropriately, but would also reduce the ultimate employer mandate enforcement burden for the IRS and employers nationally.

NAHU members also disagree with the proposal in § 155.305 to eliminate the process of directly notifying individuals that they need to file a tax return to continue to receive premium tax credit subsidies and allow for the termination of these subsidies without prior notice. Given that the population involved may be unused to having tax liability and may not need to file a return otherwise, NAHU feels this change is unwarranted.



With regard to your information request concerning providing consumers with better information about the consequences of premium tax eligibility changes that occur mid-year and the importance of notifying exchanges about these changes outlined in § 155.330, NAHU suggests working directly with the individual's broker of record as indicated on the individual's coverage record.

### **Special Enrollment Periods**

NAHU supports the proposed changes that would create a new qualification for a special enrollment period (SEP) for women who lose access to coverage through the Children's Health Insurance Program (CHIP) once they give birth. Our association also supports the new proposed procedures for allowable coverage changes when a dependent qualifies for an SEP, as well as the proposal to eliminate the proof-of-prior-coverage requirement for people who live in bare counties.

### **Exchange Coverage Terminations**

NAHU supports the proposal outlined in § 155.430 that would allow exchange enrollees to request that their exchange coverage be terminated on the same day as their request or on a prospective date rather than having to wait at least 14 days in some cases.

### **SHOP Exchanges**

The proposed rule would eliminate most of the online functionality of the federal small-group SHOP exchange, beginning with the 2018 plan year. Instead, enrollment, premium aggregation and employee eligibility determinations would be handled by carriers offering SHOP policies and health insurance agents certified to sell SHOP products. The proposed changes are intended to make the federal SHOP much leaner and more efficient. However, NAHU cautions that none of these changes are likely to improve SHOP exchange enrollment. Not only do they ignore some of the core reasons that the SHOP exchange continues to be an unattractive purchasing option for most small-employer groups, but they would also put more of the administrative onus of SHOP plans on health insurance brokers and issuers without providing any additional compensation to these entities.

NAHU can understand if HHS has concerns about the long-term viability of the SHOP, but the ACA statute requires its existence. Accordingly, NAHU suggests that HHS recommend to Congress that the program be eliminated, and that improvements be made to the related small-business health insurance tax credit. NAHU believes that small-business consumers should be able to use the tax credit to purchase coverage outside of the SHOP exchange environment. Additionally, we urge a comprehensive review of the United States Government Accountability Office's [2016 recommendations regarding the functionality of the small-business tax credit](#) and suggest legislation to implement the GAO's proposed improvements.

### **Exchange User Fee**

The proposed rule would retain the current exchange user fee of three percent for the federally facilitated marketplace. It also proposed to increase the user fee for state-based exchanges that use federal



exchange services from two to three percent. Given that exchange user fees are ultimately passed on to consumers, NAHU requests that HHS exhibit greater transparency regarding the use of this exchange fee methodology and provide annual justification for proposed fee increases or decreases.

### **Redeterminations and Reenrollment**

NAHU urges HHS 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, 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 resolving the confusion auto-enrollments and redeterminations cause, wasting tremendous amounts of time. It also often ends with an uninsured person for the rest of the year.

NAHU urges HHS to discontinue its policies of reenrollments and redeterminations. 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.

### **Essential Health Benefits**

The proposed rule would give the states the authority to vary their essential health benefit (EHB) benchmark plan design starting with the 2019 plan year. According to the draft regulation, not only



would states be permitted to change their benchmark plan choice each year, but they would also be given substantial flexibility in designing their benchmark standard. States could use other states' standards or swap standards for specific categories of benefits with those used by other states. The ability to make these changes would mostly impact fully insured individual and small-group plans, but since self-funded and large-group plans cannot impose annual or lifetime benefit limits on EHBs if they cover them, this proposal would impact individual purchasers of health insurance as well, as almost all Americans get their health insurance coverage through their workplace.

The ACA authorizes HHS to periodically update the EHBs to address any gaps in access to coverage or changes in medical evidence that are uncovered during its periodic reviews. Given the impact healthcare costs have had on access in recent years, particularly regarding individual-market coverage for the non-subsidized population, NAHU supports the concept of HHS exploring giving the states greater authority relative to EHB subcategories and plan-design approval. However, NAHU cautions that excessive flexibility can lead to market chaos. The proposed rule would allow states to use the 2017 base benchmark plan of another state as their guideline. NAHU believes that extensive guidance will be needed to implement such a proposal and that selection dates and timing will be critical so that health insurance issuers will be able to integrate state-level changes with the product-design and approval process. Additionally, since essential health benefit requirements do impact large-group plan design, particularly with regard to employers with multistate locations, HHS will need to provide clear guidance to these plans and explain how state-based benchmark plan variations may apply to them.

A regulatory change of this magnitude will have a substantial impact on health insurance markets and employer benefit plan choices. It will require a substantial investment of resources at both the state and issuer levels. In the preamble to the proposed rule, HHS suggests that it may ultimately replace state benchmark plan flexibility with a national EHB standard. The preamble acknowledges the many pros and cons of this approach and seeks comment on this potential change. NAHU is not prepared to take a position on a national federal EHB standard versus state-level flexibility without further discussion about the scope and design of a potential federal standard, but we caution HHS about the substantial cost and resource impact that an abrupt regulatory change in this area could have on all segments of the health insurance marketplace.

### **Stand-Alone Dental Plans**

In order to improve the flexibility of stand-alone dental plans and encourage more plan-design innovation in this area, the proposed rule specifies that stand-alone dental plans would no longer have to meet an actuarial value requirement. NAHU supports this proposed change but we believe that HHS should consider several additional immediate policy changes to help reduce costs and help improve coverage relative to the pediatric dental essential benefit category. Before the ACA, 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 allowed 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 it has 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. 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.

### **Minimum Essential Coverage**

HHS proposes to designate state-level CHIP buy-in programs as a form of minimum essential coverage so that individuals who participate in these programs will be deemed compliant with the individual shared responsibility requirements and not be subjected to the individual mandate tax penalty. NAHU supports this expansion of the definition of minimum essential coverage.

### **Individual Mandate Hardship Exemption**

HHS proposes the establishment of a new exemption class for consumers that do not have access to employer coverage and cannot access an affordable bronze plan in their area due to individual-market competition issues. These individuals would be allowed to seek an exemption from the ACA's individual shared responsibility requirements and would not have to pay an individual mandate penalty if they qualified for the exemption. NAHU supports this proposed exemption category, but we note that HHS needs to make a greater effort to ensure that people understand what constitutes an offer of affordable employer coverage and verify that individuals truly have not received an offer of affordable coverage on a prospective basis.

### **Medical Loss Ratio**

NAHU supports the proposed changes to the medical loss ratio (MLR) calculation contained in Part 158 that would allow issuers to account for state and local employment taxes and to make it easier to account dollars they spent on healthcare-quality expenses as part of their medical claims costs calculations. These changes should have a positive impact on premiums over time and encourage quality components in plan design, benefiting all consumers.



NAHU also supports the proposed changes to allow greater flexibility for state regulators to seek waivers regarding MLR requirements for the consumers in their jurisdictions. NAHU has long expressed concern that strict MLR rules have inhibited the number of insurers willing to write health insurance in the individual and small-group markets. These rules have left consumers underserved, reduced competition and caused countless insured individuals to lose coverage. By providing greater rule flexibility for state regulators, hopefully HHS's action will encourage greater small-group and individual-market competition, positively impacting consumers, issuers and the marketplaces in the long run. While this change will not provide immediate market relief, if the waiver process is improved and more relief is granted to states, these changes will ultimately benefit of all health insurance purchasers.

The part of the health-reform law that most quickly, directly and negatively impacted health insurance agents and brokers was the medical loss ratio 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.

Therefore, in addition to proposed changes in the rule, NAHU believes that HHS should alter the MLR calculation to accommodate payments made to independent health insurance producers. HHS could do this by either classifying the commissions paid to agents and brokers as a pass-through fee exempt from the MLR calculation. This mechanism would align with the changes HHS has proposed in this rule relative to the treatment of state and local employment taxes. Alternatively, HHS could adopt the National Association of Insurance Commissioners' December 2011 finding that a significant portion of insurance producer activities are dedicated to consumer advocacy and service and therefore classify an appropriate portion of producer compensation as a healthcare-quality expense for purposes of Section 2718 of the Public Health Services Act.

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, would help agents and brokers provide additional and market-stabilizing services to individual and small-group customers. Additionally, it would support the Administration's goal of ensuring cost-effective enrollment since there is no more cost-effective enrollment than health insurance brokers, as they are paid by the



carrier only when they assist someone to obtain coverage, and the consumer pays no increase in premium by enrolling through an agent or broker.

### **Actuarial Value Calculator**

As part of the proposed rule, HHS has also released the 2019 actuarial calculator QHPs used to determine where individual and small-group plan designs stand relative to the PPACA metal levels. Every year since 2014, HHS has issued a revised version of this calculator. NAHU members who 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 they have to abandon or substantially modify plan designs due to alterations HHS makes to the actuarial value calculator. This HHS practice limits the options consumers have to choose from, 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.

### **Request for Information on How to Improve Consumer Access to Health Savings Accounts**

In the preamble to the proposed rule, information was requested on how HHS could improve access to Health Savings Accounts (HSAs) through regulatory changes. Over the past few years of observing the impact of full implementation of the ACA on the health insurance marketplace, one area NAHU members report ACA rules are having an impact regarding HSAs concerns regulations governing actuarial value requirements. If an employer deposits funds in an employee's HSA under specified conditions, then the value of the HSA may be factored in to the actuarial value of the plan and will impact the metal level of the underlying HSA-qualified high-deductible health plans (HDHPs). Since health insurance issuers must make sure that the actuarial values of the various metal level plans fall in precise percentage windows, an HSA plan that is too generously funded could cause a plan to exceed the specified actuarial value range for the assigned metal tier. Accordingly, NAHU members report that health insurance issuers may limit employer HSA contributions associated with their HSA-qualified HDHP offerings. In order to encourage plan-design flexibility and incent more generous employer contributions to HSAs, NAHU suggests that HHS either separate HSA contributions from the actuarial value calculation or allow for a metal-level accommodation for generously funded HSA accounts.

Another area that NAHU members believe that HHS could improve upon relative to HSAs is confusion concerning embedded deductibles and HSA-qualified HDHPs. Under federal law, a prerequisite for a taxpayer to contribute to a Health Savings Account is their coverage through a 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.

### **Request for Information on Improving Transparency and Value-Based Insurance Design in the Individual and Small-Group Health Insurance Marketplace**

In the preamble to the proposed rule, HHS requested more information about steps the Trump Administration could take to improve healthcare transparency and encourage the use of value-based payment mechanisms in the individual and small-group health insurance markets. NAHU applauds HHS for seeking information about these critical policy areas, and we believe federal action on these fronts is a critical step in bending the healthcare cost curve. We encourage HHS to exercise 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 providing Americans with more informative, consumer-friendly healthcare cost and quality data and tools. HHS could also publicly disclose the prices it pays 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.

With regard to encouraging greater value-based purchasing opportunities in the individual and small-group health insurance markets, NAHU believes that much work can be done in this area. In 2015 and 2016, the NAHU Education Foundation partnered with the Robert Wood Johnson Foundation to create a free educational series for health insurance brokers, small employers, policymakers and other interested stakeholders about what can be done to encourage greater value-based purchasing in the fully insured health insurance markets most frequently accessed by individual and small-employer group purchasers. Information from the educational series can be found at <https://nahueducationfoundation.org/toolkit/index.cfm> and NAHU would be glad to meet with HHS to specifically discuss the results of this year-long effort of working directly with health insurance brokers and small employers on value-based design issues. Specifically, our work focused on how small employers and insurance brokers that work with fully insured insurance products can create demand for health insurance issuers to incorporate value-based design components into “off-the-shelf” health insurance products.

Small employers and individual-market purchasers have little to no health insurance plan design flexibility, as all of those decisions are made at the carrier level. However, in addition to using consumer



demand to create market change, HHS could use its regulatory power to incent insurers to incorporate more value-based design elements into fully insured plan designs. One thing HHS, working with the Department of Treasury, could do would be to update IRS Section 223(c)(2)(C) to allow insurance carriers the flexibility to design HSA-compatible HDHPs that cover services and drugs needed to treat chronic diseases and conditions prior to meeting the plan's deductible.

### **Additional Topics Not Addressed by the Proposed Regulation**

In addition to the topics addressed in the proposed rule, NAHU members have identified a number of other policy issues that we believe that HHS should act on to serve consumers better, lower costs and create greater private health insurance market stability. We believe all of these items could be achieved via regulatory changes, new sub-regulatory guidance and reframed strategies regarding ACA implementation policies. We encourage you to give them due consideration.

### **Open Enrollment Period**

Unlike in past versions of the Notice of Benefit and Payment Parameters covering earlier plan years, in this draft rule, HHS did not establish dates for the 2019 open enrollment season for individual-market coverage. NAHU assumes that by not setting a proposed range of dates in the proposed rule, HHS intends to keep the same date window as in 2018. 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.

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 varied. For this current 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. 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. As such, we urge you to take all five years of open-enrollment experiences into consideration before finalizing 2019 and future year open-enrollment dates.

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. 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 believes that when picking the future open enrollment date window, HHS 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 1 and January 1. 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 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 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 that has been proposed for 2019 and beyond could be problematic.

### **Year-Round Commission Stability**

NAHU requests that HHS stipulate that issuers that file premium rates with the state that include broker compensation and are ultimately certified as a QHP may not alter the general compensation rate for brokers proposed and approved for the duration of that plan year as a condition of their QHP certification. Such a requirement should not preclude an issuer from suspending broker compensation in the case of individual broker proved misconduct, but should prevent an issuer from altering a commission structure included in filed and approved rates for all brokers or a set grouping of brokers (such as appointed brokers) in the midst of the plan year.

Over the past two years, issuers in multiple states implemented mid-year commission changes for the individual market even though rates filed for these products included commissions and the premiums for such policies were not being correspondingly reduced. Commissions are paid as the plan year progresses, either on a monthly or quarterly basis, so a mid-year reduction means an immediate income drop for the health insurance broker. NAHU is very concerned about the impact this practice is having on consumers and believes that it is within HHS's authority to address it with issuers on several fronts. While HHS has been clear that it does not require or regulate broker compensation for marketplace products, HHS does



stipulate that if an issuer provides broker compensation, then the issuer must provide the same level of compensation for all substantially similar QHP products, regardless if they are sold via the exchange marketplace or in the off-exchange marketplace. The reasoning for this requirement is HHS's direct authority to enforce the ACA's guaranteed-issue requirement and to ensure stability in the exchange marketplace. If the compensation environment is not kept level for substantially similar products both on- and off-exchange, then the guaranteed-issue provisions of the law are undermined as individuals might not have access to all products through their brokers.

The same threats to the ACA'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, an individual's access to coverage and exposure to all channels of consumer assistance will be diminished. This is especially true of a commission change that impacts the SEP since consumers with SEP rights often need the most help taking advantage of their special status. Furthermore, by reducing its 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 HHS 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 HHS plans to stipulate in the new § 156.272 that issuers may not leave the marketplace mid-plan-year, we believe it would be appropriate to stipulate that the services promised as part of approved rates, including access to the purchasing services and plan year and renewal consumer support offered by a licensed health insurance agent or broker, not be eliminated partway through a given plan year. Otherwise, consumer services that are promised as part of the approved rates of the policy may be reduced and the consumer would see no corresponding premium reduction.

### **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.

### **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 HHS to change the grace period length for APTC recipients from 90 to 30 days.

### **Exchange Notice**

The ACA 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 HHS 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 his or her coverage date retroactively applied and have seamless insurance protection. However, if that same person did not complete his or her



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 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 HHS 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 HHS 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 HIPAA. While HHS 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.

### **Guaranteed Availability of Coverage Issues**

NAHU members routinely work with business owners of all sizes to design and implement health-coverage options for employees. Accordingly, our members have had the opportunity to observe how the intricacies of ACA 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. Over the past several years of helping employers implement the employer shared responsibility requirements outlined in IRC § 4980H, NAHU members have noticed several market concerns relative to guaranteed availability of coverage and we would welcome additional regulatory action or guidance from HHS to help employers and issuers address these issues. First, HHS has already established via existing regulation that large employers purchasing fully insured coverage in the large-group market do not have to meet participation thresholds when coverage is issued to ensure that such employers can also meet their IRC § 4980H obligations. However, the existing rules allow for carriers to impose participation standards on renewal in certain instances, which has been forcing carrier switches and causing coverage instability. NAHU members have reported cases of carriers imposing participation audits on large-group cases, and they report that some issuers have imposed large-group renewal-participation requirements unevenly and arbitrarily, choosing to rate-up certain groups that cannot meet participation standards, refusing to continue coverage for other groups or allowing groups to continue coverage without any type of penalty. NAHU would appreciate clarification that the carriers may only



impose renewal-participation requirements on employer groups subject to IRC § 4980H if state law requires a minimum participation standard for such employers.

Also, given that the majority of states have elected to keep the size of their small-group markets as two to 50 employees and there are many small businesses that are subject to IRC § 4980H because they employ many part-time employees or could be part of a controlled group, many American businesses that are subject to the IRC § 4980H requirements are also required to buy health insurance coverage through their state's small-group marketplace. These groups can also struggle with the imposition of participation requirements on renewal and participation requirements when they purchase coverage. As such, NAHU recommends that HHS, at minimum, amend § 147.104 to 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 the year.

A related issue concerns large groups with variable-hour employees. This issue impacts both large employers 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 employees for the purposes of the health coverage offer requirements during a measurement period as full-time employees for the purposes of health coverage for the entire duration of the subsequent stability period, regardless of the number of hours worked. However, there is no related 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 employer can be left with absolutely no recourse relative to its coverage offer requirements and can be forced to absorb quite high costs and difficulties to ensure that coverage may be offered to such employees. As IRC § 4980H implementation has moved forward, this is becoming an increasingly common issue, one that NAHU believes is an unintended consequence of the way the law has been implemented that runs afoul of statutory intent. As such, we are requesting that the final rule state 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 in the employer's measurement period as full-time for coverage-participation requirements in the subsequent stability period, regardless of their actual hours worked in 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. Many carrier 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 ACA statute. It is imperative that these consumer- and employer-protection issues be addressed by HHS as soon as possible.

### **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 HHS 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 individuals 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 HHS 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 HHS.

The first would be to encourage HHS 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 of insurers and employers to set small-group composite rates in most states 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. Rates can also change 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 HHS 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.



NAHU also has significant concerns about the recent change to stagger age-band rate increases annually for children ages 15 and older, and raise the base rate used to calculate premium prices for all children covered by fully insured individual and small-group policies nationally. We encourage HHS to rescind the 2018 rules and return to the age-rating structure for children that existed in plan years 2014-2017. Under prior ACA rules, unless a state petitioned to use a different formula, all children up to age 20 covered by fully insured small-group and individual private health plans were charged 63.5% of the premium that applied to a 21-year-old. This rule was changed for 2018 to smooth the significant increase in price individuals used to endure when they turned 21. However, the effect of this change has been to extend the composite rate dilemma for employers down to the children covered through the group benefit plan. In the small-group market, employers are no longer able to charge families a standard rate for adding children to the plan. Instead, premium rates and employee premium cost-sharing need to be calculated on a family-by-family basis according to the age of the children, which has greatly increased the coverage confusion and administrative burden for small employers.

The other effect of this change has been the overall price increase for child coverage. Now the cost for all children is at least 76.5% of the base rate (a 13% hike). Prices for children age 15 and older are now slightly higher than that for each year of the child's age. This is a significant price increase for the employees of small businesses who are also parents. Those people with children ages 15-18 are feeling the effects of the increase the most, even though older children consume less medical care services than their younger counterparts on average. NAHU recommends that HHS repeal the current age-rating scheme for older children and return to the age-rating structure for children that existed before the 2018 coverage year.

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](mailto:jtrautwein@nahu.org).

Sincerely,

A handwritten signature in black ink, reading "Janet Stokes Trautwein". The signature is written in a cursive style with a large, looping initial "J".

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