



WHITMAN-WALKER HEALTH

Mailing Address:

Elizabeth Taylor Medical Center
1701 14th St., NW
Washington, DC 20009

March 7, 2017

Submitted Electronically

Patrick Conway, Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Acting Administrator Conway,

Whitman-Walker Health (WWH) is pleased to offer these comments to the Department of Health and Human Services (HHS) on the Centers for Medicare Medicaid Services' (CMS) proposed rule as it relates to regulations related to the Patient Protection and Affordable Care Act; Market Stabilization, available at: 82 Fed. Reg. 10980 (proposed Feb. 17, 2017) (to be codified at 45 C.F.R. pts. 147, 155, and 156).

We commend CMS's determination to stabilize the individual and small group markets, as well as its attempts to enroll uninsured individuals well in advance of catastrophic health care needs. As a health care center, as well as a certified enrollment center for the District of Columbia's Health Exchange, we strongly support CMS's determinedness to ensure consumers' access to essential health benefits. CMS incorrectly asserts however that many of the proposed changes issued in the February 17, 2017 are necessary to stabilize the insurance marketplace as well as to eliminate "opportunities" for individuals to "game" the system. We are concerned that many of the proposed measures will create major barriers to accessing insurance given that CMS

has been unable to provide any data regarding alleged enrollment abuse by individuals against issuers.

We encourage CMS to incorporate our feedback and revise its proposed rules to encourage individuals to enroll in health insurance and to work with issuers to maintain access to and affordable care for all enrollees.

Interest and Expertise of Whitman-Walker Health

WWH is a nonprofit, Federally Qualified Health Center located in Washington, DC and serves individuals from across the region. We offer primary medical for all individuals, including those living with HIV; LGBT primary and specialty care, including transgender care; dental care; mental health care and addictions counseling and treatment; nurse care management; HIV education, prevention, and testing services; other community health services; insurance navigation and enrollment; and legal services.

WWH Legal Services has been very involved in the implementation of the Affordable Care Act in the District of Columbia. Since 2007, our Public Benefits Unit, which has been recognized as a model for other DC community health clinics, has screened all uninsured WWH patients for public medical program eligibility, including Medicaid, Medicare, DC Healthcare Alliance and the AIDS Drug Assistance Program; enrolled eligible individuals; and assisted with timely recertification to avoid any lapse in coverage. Since 2010, that unit has expanded to a Public Benefits and Insurance Navigation Unit, and additional staff has been hired to help uninsured and under-insured DC residents understand their insurance options and patient protections under the Affordable Care Act and through DC's State-based Exchange DC Health Link. Whitman-Walker Health is one of four DC Health Link Enrollment Centers and has a team of over one dozen trained public benefits insurance navigators who act as certified DC Health Link Assisters. Whitman-Walker Legal Services was selected by the DC Health Benefit Exchange Authority to provide the training for all of the organizations who received funding to serve as In-Person Assisters and Navigators in the District.

As an enrollment center, we are uniquely positioned to provide feedback about the enrollment process and to identify needs of the program. In addition to acting as an enrollment center, WWH's insurance navigators, with the support of our legal team, assist individuals with escalated issues as they arise. As one of the oldest medical-legal partnerships in the country, WWH has substantial experience with the interrelationships between health care and the law. For many years, Whitman-Walker medical and mental health providers have worked alongside lawyers to serve persons living with HIV/AIDS and the LGBT community, each of which continue to experience barriers to adequate health care due to under-insurance and discrimination. Further, these communities suffer continuing health disparities. Lawyers are part of the integrated care team working to address social determinants of health, specifically health-harming legal problems that create barriers to health care access.

For the reasons discussed below, we are concerned about the proposed changes and oppose the shortened initial and annual open enrollment periods, the new evidentiary requirement for a special enrollment period as well as the limited plan selection during special enrollment periods, and overly burdensome continuous coverage rules. Further, we oppose the proposed change in actuarial value as it would reduce the value of coverage to the consumer and lead to more out-of-pocket expenses and financial risks to consumers. Finally, we express great apprehension regarding reducing the percentage of Essential Community Providers (ECPs) that issuers must contract with on a yearly basis. These changes lack legal or policy justification and undermine the goals of access to health care, patient protections, and expanded coverage options, all of which are key components of the ACA.

Shortening Annual Open Enrollment Period Creates Capacity Concerns

We praise CMS's goal of achieving a full year of insurance coverage for individuals who enroll in coverage before December 15, 2017; however, we have major concerns that shortening the enrollment period by a month and a half will prevent otherwise interested individuals from obtaining insurance. Since the first open enrollment in November 2013, the Federal Marketplace, as well as the State-based Exchanges have made major improvements to make enrollment more accessible. We know that individuals still have problems, however, accessing enrollment counselors and enrollment events due to capacity issues. The Federal Marketplace and State-

based Exchanges have been flexible in adjusting the enrollment period and offering extensions when high user volume causes technical issues. Eliminating six weeks of open enrollment would be detrimental to consumers and create unmanageable capacity issues at enrollment centers and at enrollment events. Further, eliminating the last six weeks of open enrollment undermines enrollment patterns.

Historically, enrollment trends show significant reliance on the latter part of open enrollment. Enrollment peaks in mid-December for individuals to be insured by January 1 of the following year. In 2015, Healthcare.gov extended the December 15 deadline (for January 1 coverage) to December 17. Likewise, in 2016, Healthcare.gov extended the deadline to December 19 for January 1 coverage due to high user volume. In addition to a mid-December peak, exchanges normally see high traffic during the last week of the open enrollment period. For example, during the second open enrollment (November 15, 2014 through February 15, 2015), DC Health Link experienced a surge in last minute shopping; this resulted in long lines at enrollment centers, higher call volume at the Contact Center, and increased traffic on DCHealthLink.com. As a result the enrollment period was extended. Nationally, this trend has continued and on January 31, 2017 Healthcare.gov announced it was experiencing heavy traffic and long enrollment delays. Individuals who were in line, either at enrollment centers or online, were counseled that they would be granted an extension.

Limiting the open enrollment period will greatly reduce the number of enrollment events that State-based Exchanges and the Federally Facilitated Marketplace will be able to host and will undoubtedly increase wait times at enrollment centers and the State-based Exchanges. Further, insurance carriers are also at peak call volume during the open enrollment period as many issuers are also working with Medicare Part D products and employer-based products, all of which have overlapping open enrollment periods. Continuing the ACA open enrollment period until after Medicare Part D's open enrollment and after the majority of employer-based open enrollment periods have ended allows consumers time to connect with issuers. It also provides an opportunity for a change in insurance if the employer-based option no longer meets the consumer's needs and allows true comparison and evaluation of these options in order to select the best insurance option.

With the continued discussions in the media about repealing and replacing the ACA, consumers will have many questions and concerns during the next open enrollment period. We observed that during the first open enrollment period in 2013 that nearly half of all consumers who enrolled in a plan met three or more times with certified Assistants to get comfortable with the options and consider enrolling.¹ We expect that this will occur during the next open enrollment period, as much uncertainty exists surrounding Congressional and Presidential efforts to implement significant cuts and changes to ACA. In light of this uncertainty, consumers will need more time to weigh their options and to understand how any changes may impact their enrollment options and health care.

We strongly support continuing the open enrollment period until January 31, 2018 and suggest that CMS review data about enrollment trends to determine if a shorter enrollment window is appropriate for coverage year 2019.

Pre-enrollment Verification for Special Enrollment Period Impacts Consumers'

Ability to Obtain Coverage

The proposed changes seek to curb alleged abuses of special enrollment periods (SEPs) by requiring individuals to provide evidentiary proof and seek to limit enrollment by restricting SEPs. We believe these changes undermine the intent of the Affordable Care Act by restricting access to insurance coverage. Currently, it is widely accepted that self-attestation is a reliable standard. CMS argues in its proposed rules that relying on self-attestation without verifying documents allows applicants to obtain coverage for which they do not qualify and therefore a pre-enrollment verification of eligibility is warranted. This pre-enrollment verification would be required in advance of making a plan selection. There is no data to support that there have been any fraudulent applications submitted through SEPs. Further, very few individuals who are eligible to enroll for coverage using a SEP actually enroll in coverage through this process. Assistants believe this is because individuals do not know about SEPs or do not realize they may be eligible for a SEP. In 2015, approximately 5% of individuals eligible for a SEP used one to

¹ Enroll America, Key Findings: Maximizing Enrollment through Digital Best Practices and Testing, (April 30, 2014), <http://www.enrollamerica.org/blog/2014/04/stateofenrollment-key-findingsmaximizing-enrollment-through-digital-best-practicesand-testing/>.

obtain insurance coverage.² Because so few individuals are using SEPs, we strongly disagree that a pre-enrollment verification system is needed to prevent fraud.

Requiring individuals to have pre-enrollment verification will prevent or significantly delay potential consumers from applying and enrolling in coverage, as often evidence is not readily available. The pre-enrollment process will likely delay coverage and in many cases access to life-sustaining medication and care. Further, individuals who are eligible for a SEP may miss the deadline to select a plan if the pre-enrollment verification process extends past their SEP. For example, an individual who is moving to a new area would need to provide proof of her past address and past coverage, as well as proof of her new address in addition to any other evidence needed to determine eligibility. Depending on a person's circumstances, proof of past address may not be readily available or even safe to access. Young adults and legal immigrants who are eligible for coverage under the ACA move at a much higher rate than others and often have temporary living situations making it difficult to provide proof of a permanent move. Further, if a person loses employer-based coverage, they must obtain a termination of coverage letter from the employer. Often these requests go unanswered or are delayed for many weeks. Individuals who are eligible for a SEP due to their release from prison are not always provided paperwork from the Department of Justice and are often already burdened with many other reentry concerns; adding a pre-enrollment verification step will prevent consumers from accessing life-saving insurance coverage.

Another major concern with CMS's proposed pre-enrollment verification process is that many SEPs clearly state that a QHP must be selected and within 60 days of the life occurring event; if the pre-enrollment verification process requires more than 60 days, an individual may be without coverage. CMS attempts to address this by stating that it will consider having the coverage effectuate retroactively; this does not alleviate our concern that individuals will not have health care access during the pre-enrollment verification process. While waiting for pre-enrollment verification individuals will be uninsured which means many specialty providers will refuse to provide care and individuals will not be able to access medications. A one month

² Dorn, Stan, Helping Special Enrollment Periods Work under the Affordable Care Act, Urban Institute, 1 (June 2016), <http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf>.

supply of HIV medications can easily cost over \$4,000; individuals without insurance will simply not be able to access medications and risk becoming sick as well as developing a drug resistance.

We strongly urge CMS to eliminate the pre-enrollment verification requirement, as it will create delays in accessing new coverage. We believe that HHS should continue to randomly audit individuals to determine if there is a trend of abuse. For SEP periods that do not easily lend themselves to verification other than self-attestation, CMS should accept self-attestation or alternative documents as the proposed changes may disproportionately impact specific demographic groups.

Limiting Metal-Level Coverage Changes is Overly Restrictive

Additionally, CMS's proposed changes include limiting the ability of consumers to change plan metal-levels during the year, despite being eligible for a SEP. Per the proposed rules, if an enrollee qualifies for a SEP due to a new dependent, in most cases that dependent must be added to the current QHP and cannot move to a new plan or new metal-level band. The individual marketplace is a vital resource for individuals who have major life-changing events occur. Commonly, individuals are seeking a SEP because of: a change in household size (either through birth, death, or marriage), or a change in income, or a permanent move; in some cases, it is a combination of two or more of these scenarios. The purpose of the SEP is to allow individuals to be able to select the plan that best meets their needs given the life-changing event that took place. Confining consumers and especially their new dependent(s) to the same metal-level band is overly restrictive and likely to lead to individuals not getting the care they need or being able to afford the care they need.

For example, if a young, healthy individual enrolls in a bronze plan because she does not have the disposable income needed to afford a higher metal-level band and subsequently is married to an individual who is uninsured, the new rule would limit the spouse to the bronze plan. If the couple's new combined income would make it possible for both individuals to afford a platinum level plan, they should be able to select this metal-level option. Likewise, if a married couple is enrolled in a platinum plan and one spouse passes away, subsequently reducing the

household income dramatically, the surviving spouse should be able to select a QHP in a different metal-level band of coverage. Rules that limit individuals from making decisions to invest more in their health coverage seem contrary to public policy and the goal of promoting health overall.

As an enrollment center we assist individuals year-round with enrollment into plans through both Maryland and DC's State-based Exchanges. We rely on SEPs regularly and without such the individuals we serve would be unable to access life-sustaining care.

Restricting SEPs and Requiring Back Payment of Premiums Creates Major
Barriers to Insurance

CMS suggests that issuers be allowed to reject SEP enrollments where the applicant earlier lost coverage for non-payment of premiums unless the previously unpaid premium balance is paid to the issuer by the individual. Further, HHS incorrectly contends that collecting information about an individual's termination is necessary to ensure that people who lose coverage for non-payment do not subsequently regain coverage with a SEP through either the same plan or a new plan option. Additionally, SEPs would be restricted for newly married individuals to include only instances where one spouse was already enrolled in minimum essential coverage.

When an individual is terminated by the issuer due to non-payment, the plan is retroactively terminated back to the date last paid. Any claims that were potentially paid during the enrollee's initial grace period are reconciled and recouped by the issuer. The proposed rule suggests that individuals are "gaming" the system to access care that they have not paid for, when in fact, the individual is fully liable for care during any uninsured period. In addition to being responsible for care received during months not insured, an individual is also responsible for the individual mandate penalty. The ACA created these regulations as a disincentive to "gaming" the system; CMS has provided no data to suggest the current regulations are not effective. The proposed rule indicates that CMS would stop individuals who were terminated within the last sixty days due to non-payment of premiums from enrolling regardless of any other circumstances. We have observed that many individuals are categorized as being terminated due

to non-payment despite their attempts to make payments or to otherwise cancel their policy for reasons such as moving or being eligible for other insurance coverage. CMS's attempt to create a list of individuals who have been terminated due to non-payment is problematic given that issuers are unable to compile accurate information about terminations. This restrictive policy would prevent individuals who are otherwise eligible from obtaining coverage.

Individuals who lose coverage are often mis-categorized by issuers as 'terminated for non-payment.' For example, if an individual loses his job and therefore lacks the income to pay for insurance, he may have a few months where he is unable to pay his premium on time. After missing two payments, he realizes his financial situation is not improving as quickly as he has hoped and he meets with an assister to understand his options. He learns he is now Medicaid eligible. However, strictly speaking, his disenrollment from his QHP lists the reason as failure to pay his premium. In this case, the QHP should have been closed due to becoming Medicaid eligible, but instead shows termination due to non-payment. Given that neither HHS nor the issuer would be able to properly track this information, we find it incredibly problematic to allow the issuer to reject a future enrollment on this basis alone. Further, in many instances we have worked with individuals who have attempted to make a payment to the issuer but the payment was applied to an incorrect account or the issuer refused to generate an invoice, or accept payment, and the individual's coverage was subsequently terminated. Consumers often rely on SEPs to regain access to insurance where dis-enrollment is the result of the issuer's administrative mistake or delay.

Further, we believe CMS's attempt to limit the SEP available at marriage is excessively narrow and does not consider the practical implications that marriage may have on a couple. For instance, if two individuals are both uninsured and then combine households and income, they may then decide they are able to afford insurance or may be newly eligible for advance premium tax credits or the cost-sharing reduction.

Overly Burdensome Continuous Coverage Rules Prevent Coverage

As a health center, we believe in continuous enrollment in health care coverage and always encourage individuals to remain insured. Individuals want continuous coverage as it

assures they have access to the care they need or may need in the future. CMS contends that a “look back period” that would require proof of prior coverage for six to twelve months before issuing coverage is necessary to prevent fraud. If an individual is not able to provide proof of coverage they would be subject to a waiting period of at least ninety days before the plan effectuated or a late enrollment penalty. This policy would undoubtedly provide a disincentive for individuals to even attempt to enroll in coverage and ultimately shifts health care costs onto providers.

Individuals lacking continuous health care coverage are often our most vulnerable patients. These individuals are more likely to be homeless or without a permanent address, sicker, and have an unstable source of income. Individuals lose coverage because they do not receive communications from the plan due to their unstable housing; or they are unable to pay the premium due to an unstable source or income; or in some cases, their health prevents them from being able to manage their insurance premiums. Additionally, when individuals rely on third party payer programs, such as the Ryan White AIDS Drug Assistance Program (ADAP), to pay their premium, they are simply unaware when a payment is not processed correctly or missed. These individuals are often enrolled in numerous public assistance programs due to their socioeconomic and health status and may be simply overwhelmed by the processes of each program. For a number of reasons individuals fall out of a health insurance plan and then need to re-enroll; for many, this is not their fault and they are not trying to “game” the system.

Imposing a waiting period on coverage is similar to the days when insurance carriers had waiting periods for pre-existing conditions and similar to the Health Insurance Portability and Accountability Act (HIPAA) which provided that individuals must maintain credible coverage in order to avoid being subject to pre-existing condition exclusions. The ACA opted for the individual mandate rather than a continuous coverage look-back period. The individual mandate works as a financial incentive to remain insured. As a leader in HIV care, WWH understands the importance of continuous care and worries that a ninety day waiting period—during which an individual would not have coverage for medications, will negatively impact health and greatly increase the number of patients who become drug resistant to HIV medications. HIV drug resistance occurs when an individual is unable to remain adherent to their regimen and often

means that particular medication or families of medications will never work for that individual again.

We believe that a waiting period or a late enrollment penalty is counter to the purpose of the ACA and believe that the individual mandate penalty is already in place to promote continuous coverage. To penalize individuals during their initial attempt to enroll in coverage (through a waiting period, a penalty, or both) and again during the tax reconciliation period is duplicative and presents another major barrier to care.

Proposed Changes to Actuarial Value of Qualified Health Plans

Supports Insurers and Not Individuals

The proposed rule amends the definition of de minimis to a variation of -4/+2 percentage points instead of the +/-2 percentage points currently required to comply with the actuarial value (AV) rules created under the ACA for non-grandfathered plans. CMS states that the intent is to encourage insurance plans to put downward pressure on QHP premiums, but fails to explain that lower premiums will increase deductibles and co-pay/co-insurance costs. Further, increasing the spread in AV will make comparing plans more confusing for individuals as the band levels will blend together much more. Consumers may be attracted to a silver plan with an AV of 66 because of its low premiums not realizing that it offers significantly higher out-of-pocket costs than the silver plan with an AV of 72.

While a plan with a lower monthly premium and higher deductible is often a reasonable solution for young, healthy individuals, we fear that CMS is underestimating the number of high need individuals who rely on the ACA to obtain insurance. Individuals who have benefited the most from the ACA include consumers – like many of our patients – for whom, due to their HIV status or other health conditions, insurance companies refused to sell a plan just 5 years ago. Issuers will be incentivized to create low monthly premiums to remain competitive in the market, but no measures are in place to encourage issuers to enroll individuals into plans with reasonable cost-sharing spread evenly across premiums, deductibles, and co-insurance/co-pays. We fear that by allowing issuers to increase the out-of-pocket costs by lowering the AV, individuals will have fewer options and less access to care.

Reducing Essential Community Providers Leads to Less Choice for Consumers

Whitman-Walker Health serves as an essential community provider. The proposed amendments in this rule would allow for issuers to use a write-in process to identify essential community providers (ECPs) who are not on the HHS list of available ECPs and would lower the ECP standard to 20% rather than the current 30%. We fear that allowing issuers to write-in their own ECPs not on the HHS list will limit care available to the most vulnerable members, as write-ins mean there would be no vetting of the ECP to document or evaluate whether they serve the target populations. ECPs play a unique role as they include providers that serve predominantly low-income and medically underserved individuals, and specifically include providers described in section 340B of the Public Health Service (PHS) Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Their inclusion is critical in medically underserved areas as primary care is one of the foundations of the ACA and often ECPs are the primary source of care in underserved neighborhoods.


We strongly urge CMS to maintain the current 30% standard to provide issuers' most vulnerable members access to care and the ability to continued service at the community health centers which for many years were the only places willing to see them without insurance. Removing ECPs from issuer networks reduces enrollees' ability to access care and remain healthy. As a leading provider of HIV care (as well as LGBT care, and serving consumers who face barriers to care) in Washington DC, we recognize the importance of individuals remaining adherent to their medications, not only for their own personal health benefits, but for the community as a whole. When an HIV positive individual is adherent on their daily medication regimen they often have levels of HIV that are undetectable, meaning their risk of passing the disease to others is eliminated. Health Centers, and more broadly ECPs, such as WWH, play a critical role in access for underserved areas and communities but also play a critical role in improving and protecting public health.


Conclusion

The implications of the proposed changes to these regulations are immense as they affect individuals, issuers, and the community providers. The ACA expanded coverage options and created patient protections. These two hallmarks have made it possible for many of our patients to enroll in insurance when they previously had been denied because of pre-existing conditions. The patient protections in the ACA and 1557 as the non-discrimination regulations for the ACA promoted equality, enhanced access, and saved lives—particularly for those who are most vulnerable. We are deeply concerned that the proposed rules will hurt the progress that has been made and will harm individuals in addition to leading to poor health outcomes, health disparities, and contribute to lower levels of public health across the nation.

In conclusion, Whitman-Walker Health urges CMS to strongly consider our comments as you work towards the final rule. We offer to serve as a resource or provide additional information regarding these comments as necessary.

Respectfully,


Allison Dowling
Staff Attorney
adowling@whitman-walker.org


Erin M. Loubier
Senior Director for Health and Legal Integration and
Payment Innovation
eloubier@whitman-walker.org

WHITMAN-WALKER HEALTH
1701 14th Street NW
Washington, DC 20009
(202) 939-7627
www.whitman-walker.org