

On behalf of the NY State of Health, New York’s Official Health Plan Marketplace and the New York State Department of Financial Services we appreciate the opportunity to comment on the proposed regulations for 45 CFR Parts 147, 155 and 156; Patient Protection and Affordable Care Act; Market Stabilization [CMS-9929-P].

III. Provisions of the Proposed Rule

Naturally, New York agrees that it is important to ensure the integrity of the enrollment process; however, since Marketplaces achieve this purpose through different mechanisms, a single approach to achieving this end should not be adopted. New York is unique in that we offer consumers an integrated health insurance platform adjudicating eligibility and enrollment for Medicaid, the Children’s Health Insurance Program, the Basic Health Program, Qualified Health Plans, Advance Premium Tax Credits and Cost-Sharing Reductions in a single system. We have noted in the specific sections below where state flexibility should be promoted.

A. Part 147 Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

- 1. Guaranteed availability of coverage (§147.104)
 - The proposed rule seeks to eliminate the guaranteed availability of coverage requirement when a consumer seeks to enroll in coverage with an issuer and has outstanding debt for non-payment of premiums in the past 12 months with that same issuer.

New York has the following comments:

First, we urge that the final rule define the meaning of “non-payment of premium”. Below we present three “real-life” scenarios under which a consumer may not make premium payment. We urge that the rule be interpreted to allow the insurer to apply current premium to past coverage months only when the issuer has accepted liability for covered services for that month as is the case in the third scenario.

Scenario 1: Enrollee A stops paying monthly premiums in June because they began a job which provides coverage. Enrollee A does not notify the issuer or the Marketplace that she is terminating coverage. Enrollee A does not seek payment for services from the issuer for the remainder of the plan year. Clarification is needed to determine what, if any, non-payment of premium A is liable for. Would the issuer be allowed to prohibit A’s enrollment in one of their plans during the next open enrollment period because of non-payment of premium? If the issuer is allowed to prohibit A’s enrollment unless A pays outstanding premium, are we correct in our understanding that if A is retroactively terminated to the date premiums were last paid, there would be no outstanding premium due?

Scenario 2: Enrollee B enrolls in a plan during open enrollment in 2017, but does not pay her initial (binder) premium to effectuate coverage. Are we correct in our understanding that since B never paid the initial premium, B's coverage was never effectuated and thus, if B enrolled at a later date, no outstanding premium would be due? If not, please clarify what outstanding premium would be due.

Scenario 3: Enrollee C enrolls during open enrollment for 2017 and is found eligible for Advance Premium Tax Credits (APTC). In June 2017, Enrollee C stops paying monthly premium and the 90-day grace period begins. Enrollee C incurs claims during the initial 30-day period which are paid by the issuer. Enrollee C does not make any additional premium payments for the 2017 plan year, but seeks to reenroll with the same issuer during the 2018 open enrollment period. Could the issuer determine that C had an outstanding premium obligation for 2017 and require payment before allowing enrollment in one of their plans for 2018? Are we correct in our understanding that since APTC was paid in the month claims were accrued that only one month of C's portion of the premium is owed to the insurer?

Should HHS finalize these rules, we suggest that insurers be required to provide clear and timely notice of their policy around outstanding debt to their enrollees. In addition, we suggest there be clear standards to ensure that insurers who opt to require re-payment of outstanding debt apply this standard consistently across all of their enrollees.

B. Part 155 Exchange Establishment Standards and Other Related Standards under the ACA

- 1. Initial and annual open enrollment periods (§155.410)
 - The proposed rule seeks comments on modifying paragraph (e) of §155.410 to change the open enrollment period for plan year 2018 so that it begins on November 1, 2017 and ends on December 15, 2017 rather than ending on January 31, 2018.

New York has the following comments:

Shortening the Open Enrollment Period Could Have a Negative Impact on the Individual Risk Pool. More than 135,000 individuals enrolled in Marketplace coverage in the final month of 2017 open enrollment. We analyzed the NY State of Health's enrollment data to determine the relative risk of those individuals who enroll in later weeks of the open enrollment period compared to those individuals who enroll in the earlier weeks. Using age as a proxy for risk, we found that younger, likely healthier, enrollees comprise a higher share of total enrollment at the end of January than they do at earlier points in the open enrollment period. Conversely, prior to January, enrollees age 55 to 64 comprise a larger share of QHP enrollees.

Consistent with these findings, New York's data also indicate that a greater share of QHP enrollees in Platinum and Gold level plans enroll prior to the December 15th deadline versus the end of open enrollment, when Bronze and Silver enrollment reach their relative peaks.

These findings raise significant concerns that shortening the enrollment period will have a negative impact on the individual market risk pool as older individuals with higher medical needs enroll early, while younger persons with lower medical needs enroll at the end of the period.

Shortening the Open Enrollment Period is Not Operationally Feasible.

More than 3.6 million New Yorkers have coverage through the NY State of Health as of the end of open enrollment, January 31, 2017. With an estimated 400,000 households going through renewal during annual open enrollment, reducing the enrollment period will place demands on the customer service function and in-person assistor capacity that simply cannot be met.

To illustrate the magnitude of this concern, during the 2017 Open Enrollment Period, NY State of Health's Customer Service Center handled nearly 2 million calls, evenly distributed with 1 million calls during the period November 1 through December 15, and 1 million calls between December 16 and January 31. Daily average call volume was fairly consistent across the entire open enrollment period with an average volume of between 32,000 and 34,000 calls daily. Taking into consideration the expected increase in the number of renewal households for 2018 given increases in enrollment, limiting the open enrollment period to November 1 through December 15 would result in a daily call volume of over 60,000 calls. Based on experience, expected call wait times would increase to far exceed the current 5-minute performance standard to no less than 15 minutes on non-peak days and more than 2 hours on peak days. Such delays would likely negatively impact enrollment.

For these reasons, New York urges HHS to maintain the current open enrollment dates of November 1 through January 31 through the 2018 plan year and for the 2019 plan year as well. Changes being debated at the national level have already confused consumers who are accustomed to a longer enrollment period. Such uncertainty would likely negatively impact enrollment and the risk pool of enrollees. Should HHS finalize the proposed change to shorten the 2018 open enrollment period, state-based Marketplaces must be provided with the flexibility to set their own open enrollment period. Clearly, there is no consensus among Marketplaces or issuers on this issue and meeting the needs of state markets far outweighs any benefit of a consistent rule across states.

- 2. Special Enrollment Periods (SEPs) (§155.420)

- The proposed rule seeks comments on whether state based exchanges should be required to conduct pre-enrollment verification for SEPs.

New York has the following comments:

New York supports efforts to reduce adverse selection in the individual insurance market, while minimizing unnecessary administrative burdens on consumers. However, we oppose a one-size fits all requirement to verify 100 percent of SEP requests for the reasons explained below.

New York's Marketplace currently requires applicants seeking a SEP to answer detailed questions during the application process. As an integrated eligibility platform, NY State of Health independently verifies loss of minimum essential coverage (MEC) for persons previously covered by Medicaid, the Basic Health Program (called the Essential Plan in New York), the Children's Health Insurance Program (called Child Health Plus in New York) and through the Small Business Marketplace. In detailed analyses of SEP applications, New York found that it could deem more than half of the requests legitimate without the need to delay the application, burden the consumers with document requests and incur costs for document review and processing.

Given the unique nature of each state Marketplace, New York strongly encourages HHS to allow states the flexibility to establish systems in collaboration with the state's insurers that will ensure the integrity of the SEP application process and meet the needs of their consumers. Moreover, as acknowledged in the proposed regulation with respect to the federal Marketplace, imposing a 100 percent verification requirement on state-based Marketplaces would result in significant unfunded costs, especially in the absence of evidence that misuse of the SEP is widespread and where targeted reviews may prove more effective and less disruptive for consumers.

C. Part 156 Health Insurance Issuer Standards under the ACA, Including Standards Related to Exchanges

- 1. Levels of coverage (actuarial value) §156.140
 - The proposed rule seeks to amend the definition of de minimis included in §156.140(c) from +/- 2 to +2/-4 for all non-grandfathered individual and small group market plans that are required to comply with actuarial values for the plan year 2018. The proposed rule seeks comment on whether the Bronze de minimis range should be further expanded to +5/-4 percentage points to align with a prior rule change of +5/-2.

New York has the following comments:

We understand that HHS is making this proposed change in response to claims that lowering the floor of the AV will result in lower premiums. While New York supports efforts to reduce premiums, having saved consumers an estimated \$302 million in 2017 through the NYS Department of Financial Services prior approval reviews of premium rates, the effect of allowing lower AV of plans in the individual and small group markets would have other unintended consequences.

First, because Advance Premium Tax Credit (APTC) amounts are based on the Second Lowest Cost Silver Plan available to consumers, lowering the allowable AV would reduce premiums and thereby reduce APTC available to consumers. Our data show that consumers offered less APTC are less likely to enroll in any coverage.

Second, lowering the AV will result in higher out-of-pocket costs for consumers. Out-of-pocket costs are a major criticism of current plan designs and a significant concern from consumers who would see increases in deductibles, copayments and other cost-sharing in 2018 as a result of this proposed rule change.

Third, under the proposed rule, the differential between some metal tiers will be as low as one percentage point. As a result, there may not be meaningful differences between metal tiers and consumers might have difficulty comparing plans.

We urge HHS not to adopt this change. However, if it is adopted, it should not be construed in any way to preclude state based Marketplaces from requiring issuers to offer standard plan designs or from setting acceptable AV levels by contract between the Marketplace and issuers as long as they fall within the permissible range.

- 2. Network Adequacy (§156.230)
 - The proposed rule provides that, in states that meet “reasonable access standards”, no federal review would take place. In other states, CMS-CCIIO would rely on the issuer’s accreditation. Unaccredited plans would be required to submit an access plan consistent with the NAIC model.

New York has the following comment:

New York supports leaving network adequacy review to states with reasonable access standards as reliance on issuer accreditation may not be sufficient to protect consumers.

New York appreciates HHS' consideration of these comments and looks forward to continuing to work with our federal partners to refine the proposed regulations.