Congress of the United States
House of Representatives
Washington, DC 20515

December 6, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, D.C. 20201

Dear Administrator Verma:

As the Ranking Members of the committees of jurisdiction over health care, we write to express our serious concerns regarding the Centers for Medicare & Medicaid Services (CMS) 2019 Proposed Notice of Benefit and Payment Parameters ("Notice"). The proposed Notice includes a number of troubling provisions that would hurt consumers, raise costs, and undermine protections for individuals with preexisting conditions. These proposed changes go to the heart of the individual and small group market consumer protections and appear to be part of the Administration's ongoing campaign to sabotage the health care system. Of primary concern are changes related to the following critical consumer protections: essential health benefits (EHBs), medical loss ratios (MLRs), rate review, consumer navigators, meaningfully different plan choices, and notification and verification requirements for advanced premium tax credits (APTCs) and cost-sharing reductions (CSRs). We urge you to withdraw these harmful, anti-consumer provisions.

The proposal weakens essential health benefits protections and would harm consumers.

CMS's proposed changes to EHB requirements would gut current protections that ensure consumers have access to needed services, screenings, and treatments regardless of where they live. EHBs guarantee millions of consumers access to 10 categories of needed health care services and treatments including hospital care, prescription drugs, mental health and substance use disorders, and maternity care. Current law protects consumers further by ensuring that these needed services are not subject to lifetime and annual limits. Consumers in the individual market have access to plans that mirror a "benchmark plan," commonly a "typical employer plan" in that state.

The proposed rule would change how a state can define this benchmark plan and how an insurer implements that benchmark, undermining EHB protections fundamental to Congressional intent. The EHBs stabilize and ensure adequate, affordable coverage in the individual and small group markets for everyone, regardless of location or preexisting conditions. Altering how states choose a benchmark plan under the proposed rule would return the individual and small group markets to the days when consumers had to settle for limited benefits at a higher cost. For example, a 2011 U.S. Department of Health and Human Services (HHS) report found that 62 percent of individual market enrollees lacked maternity care coverage and others found that only

12 percent of individual market plans provided maternity coverage.[1-2] That finding indicates that without robust EHB protections, consumers would lack access to comprehensive coverage for needed health care services.[3]

The proposed rule could substantially undermine coverage and increase patient costs, especially for those with high-cost conditions. First, the proposed rule would allow states to select a benchmark plan from another state or substitute a category of benefits for the category as it is sold in another state. Altogether, states could simply choose to piece together a "benchmark" that contains all of the least-comprehensive state benchmarks for each benefit category. Such a practice would harm consumers and undermine the objective of having the EHB benchmark reflect a "typical employer plan" in that state.

Second, the proposed rule allows a state to come up with a benchmark from scratch based on a self-insured group plan or employer plan with at least 5,000 enrollees in the state. This change would allow the state to set a benchmark based on plans far smaller than what Congress intended to be "typical," including plans with extremely limited coverage for common services and treatments like emergency services, doctor's visits, and branded drugs.

Finally, the proposed rule would allow insurers to deviate from the state's EHB standard and substitute benefits across EHB categories. This trend would allow insurers to further dilute benefits to discourage sicker enrollees from signing up, potentially limiting access to those with preexisting conditions. The final result of the above changes would be higher costs for individuals with preexisting conditions and little reduction in overall premiums.[4]

The proposal undermines current law protections that ensure premium dollars go to medical care, not profits.

The proposed rule also includes changes to MLR standards for health plan issuers in the individual market. These changes would allow states to adjust the current standard that requires 80 percent of premium dollars to go toward health care services and quality improvement, permit issuers to deduct federal and state employment taxes for the purposes of MLR calculation, disregard actual incurred quality improvement activity expenses and instead report quality improvement as a fixed percentage of premiums, and reduce additional reporting requirements meant to ensure plans address consumers' needs. While the proposed rule asserts that these changes would improve market stability and competition, there is little reason to believe that these changes would produce the desired effect.

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[1] U.S. Department of Health and Human Services, ASPE. "Essential Health Benefits: Individual Market Coverage." (Dec. 16, 2011), https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage.
[2] National Women's Law Center. "Turning to Fairness: Insurance Discrimination Today and the Affordable Care Act." (March 2012). https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.
[3] Sarah Lueck, "Administration's Proposed Changes to Essential Health Benefits Seriously Threaten Comprehensive Coverage," Center on Budget and Policy Priorities (Nov. 7, 2017), https://www.cbpp.org/research/health/administrations-proposed-changes-to-essential-health-benefits-seriously-threaten.
[4] *Ibid.*

Rolling back MLR standards would not produce meaningful choice, stability, or competition for consumers. Current law ensures that individual market issuers use premium dollars to provide care rather than increase profitability, spend money on marketing, or pay for executive compensation. Issuers have adjusted to the new marketplaces, and premiums now outpace claims to a greater degree than when implementation began.[5] Now is not the time to roll back standards that have helped to ensure that both consumer premiums and federal outlays go toward needed health care rather than insurance industry administrative expenses.

The proposal weakens protections against exorbitant premium increases.

The proposed rule includes changes to current rate review standards. Under current law, insurance companies must explain significant rate increases and provide evidence to justify them—protecting consumers from arbitrary rate increases and increasing transparency. The rate review program has effectively reduced premiums for consumers and employers. According to a December 2015 report from HHS, rate review reduced individual market premiums by a total of $1.1 billion and small group premiums by $418 million in 2015 alone.[6]

The CMS proposed rule would exempt student plans from rate review and increase the reasonableness standard for annual rate increases from the current 10 percent to 15 percent, making it easier for insurers to avoid accountability when raising premiums for consumers. The rule would also expose students to premium increases by exempting student health insurance plans from federal rate review requirements, imposing higher costs on students that could hurt their ability to afford tuition and books. Exempting more plans from this important program and allowing insurers to implement higher premium hikes without transparency will hurt consumers by exposing them to increased costs without accountability.

The proposal harms consumers' ability to shop for and enroll in plans.

Navigators have played an important role in assisting consumers with both marketplace and Medicaid enrollment in recent years. These trusted community partners have been subject to arbitrary cuts, and some navigators have been forced to close down in the wake of more than a 40 percent in nationwide funding cut for 2017. The proposed rule would make this situation worse by reducing the standard for the minimum number of navigators in a market and removing the requirement to have a physical location in a marketplace service area.

Under current law, marketplaces must have at least two navigator entities, one of which must be a consumer-focused nonprofit group. These standards help to ensure that consumers have adequate options when they need assistance with enrollment and that at least one navigator entity has a consumer focus. Without these standards, the entirety of navigator funding for a given marketplace could go to an organization with little interest in consumer protection.

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[5] Ashley Semanskee and Larry Levitt, "Individual Insurance Market Performance in Mid 2017," Kaiser Family Foundation (Oct. 6, 2017), https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2017.

[6] U.S. Department of Health and Human Services, *Rate Review Annual Report: 2015* (Dec. 2015), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf.

Further, the proposed rule seeks to eliminate the requirement that navigators have an actual physical presence in the community. While there are a number of avenues to seek assistance with enrollment, navigators are the primary in-person assistance for many areas. Removing this requirement could mean that communities do not have access to in-person assistance, which is crucial for many consumers who are older, have low incomes, or have lower levels of education and literacy. The Administration's proposed changes seek to undermine the very mission of the navigator program and would undoubtedly reduce enrollment and financial assistance among vulnerable consumers.

The proposal makes comparison shopping more complicated and puts consumers at a disadvantage when buying health coverage.

The proposed rule removes current standards that ensure consumers have access to meaningfully different plan choices in the marketplace. The marketplace substantially reduced barriers to enrollment, including standardized labeling for key affordability metrics, comparable metal tiers across issuers, and online enrollment. The "meaningful difference" standard simplifies the enrollment process for consumers by ensuring that issuers present plan choices that have real differences among them rather than multiple versions of the same general product. In this regard, this policy builds on the experience of Medicare Part D, where consumers were overwhelmed by too many plans without meaningful differences. This excess of choices increased confusion among beneficiaries and resulted in significant barriers to coverage. Removing the meaningful difference standard in the individual market would similarly increase confusion and erect new barriers to enrollment.

The proposal threatens access to APTCs and CSRs.

The proposed rule may undermine access to premium and cost-sharing subsidies for eligible low-income consumers by imposing additional verification requirements and removing important advance notification requirements that alert consumers that subsidies will be revoked.

The Administration proposes to require marketplaces to collect additional data for some consumers to verify their income. Those who fail to provide this paperwork would then have their APTC and CSR eligibility reevaluated and possibly discontinued. Since many individuals and families have complicated employment histories and variable incomes – particularly those with lower incomes – these verification requirements could lead to the revocation of APTCs and CSRs for eligible consumers who need assistance, threatening their ability to access affordable insurance.

The proposed rule would also remove current requirements that marketplaces provide advance notice to consumers who fail to file taxes or reconcile subsidy amounts before revoking their APTCs. By removing this requirement, the Administration is dismantling a backstop that protects consumers who experience variable incomes, such as those with seasonal employment.

The proposal shifts more up-front costs on to consumers.

The proposed rule seeks to increase high deductible health plan offerings. While increased choice is a laudable goal, increasing deductibles for consumers is not the right way to achieve it.

More than 40 percent of adults with coverage report having difficulty affording their deductibles, up from 34 percent in 2015, and outpacing the number of adults with trouble affording their premiums.[7] Increasing high deductible plans would worsen this problem and expose consumers to unexpected costs associated with insufficient coverage for medical care.

In conclusion, the 2019 Proposed Notice of Benefit and Payment Parameters is a systematic effort to undermine health coverage and reduce consumer protections. The changes contained in the proposed Notice run counter to the intent of the law, which was to provide quality, affordable coverage to all. Consumers have benefited greatly from the progress this proposed rule seeks to reverse, and there is no compelling evidence offered to support the claims that these changes would stabilize the marketplace. We urge CMS to withdraw these proposed changes and commit to faithful implementation of the law and policies that improve the quality and cost of coverage for consumers in the final rule.

Sincerely,

The Honorable Richard E. Neal
Ranking Member
House Committee on Ways and Means

The Honorable Ron Wyden
Ranking Member
Finance Committee
U.S. Senate

The Honorable Robert C. "Bobby" Scott
Ranking Member
House Committee on Education and the Workforce

The Honorable Patty Murray
Ranking Member
Health, Education, Labor & Pensions Committee
U.S. Senate

The Honorable Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

[7] Bianca DiJulio et al., "Data Note: Americans' Challenges with Health Care Costs," Kaiser Family Foundation (Mar. 2, 2017), https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs.