July 12, 2017

Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

Attention: CMS-9928-NC
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Request for Information: Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare choices to Empower Patients

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments to the Department of Health and Human Services (the "Department" or "HHS") in response to the Request for Information on reducing regulatory burdens imposed by the Patient Protection and Affordable Care Act and improving health care choices to empower patients ("RFI"). This RFI was published in the Federal Register on June 12, 2017 by HHS.[1] Through our comments, the Chamber hopes to inform the Department's ongoing efforts to create a more patient-centered health care system that adhere to the key principles of affordability, accessibility, quality, innovation and empowerment. We commend the Secretary's endeavors to achieve the aim of the Executive Order 13765, "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal." Further, we appreciate the Department's commitment and interest, as expressed with this RFI, to empower patients and promote consumer choice, stabilize the individual and small group health insurance markets, enhance affordability, and affirm the traditional authority of the States in regulating the business of health insurance. These are four laudable and worthy goals.

INTRODUCTION

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business

[1] Request for Information, 82 Fed. Reg. 26,885-26,887. (June 12, 2017) (to be codified at 42 C.F.R. Chapter IV and 45 C.F.R. Subtitle A) [hereinafter referred to as the "RFI"] https://www.gpo.gov/fdsys/pkg/FR-2017-06-12/pdf/2017-12130.pdf

community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – is represented.

The Chamber is committed to working with the administration and members of Congress to strengthen and further reform our nation's health care system through regulatory and legislative action. With input from our members, we have identified a series of legislative and regulatory changes that could provide significant assistance to businesses that offer health insurance products in the individual and small group markets, as well as businesses that offer health coverage to their employees and their employees' families as an employment benefit.

OVERVIEW

This comment letter highlights changes to existing regulations and sub-regulatory guidance, as well as other actions within HHS's authority to further the four specific goals as solicited by the RFI. Our comments in this letter are focused on responding to the particular questions posed by the RFI. However, in addition to this letter, we encourage you to also review and consider the contents of three other items submitted with this comment letter:

- 5-page chart on "Health Care Regulatory Work";
- 10-page chart on "Important Regulatory Steps;" and
- 21-page document on "2017 Health Care Policy Recommendations."

These three documents detail in several different ways the extensive regulatory and legislative changes that we believe are necessary to improve our current health care system. This may be informative as you delve further into the substance of prior rules and look for ways to alleviate burdens.

The 5-page chart on "Health Care Regulatory Work" includes hyperlinks to the litany of comment letters that we have submitted as regulations were being promulgated by the past administration. As you also pursue efforts to roll back problematic and improper regulations, we encourage you review these comment letters detailing our substantive and procedural concerns.

The "Regulatory Changes" chart details specific regulatory changes that we believe will help achieve several of the RFI's goals. The recommendations in this chart are divided into three categories based on our priorities and the critical outcomes that we believe the proposed changes can accomplish: stabilize insurance markets, provide relief to employers, and return regulatory authority to the states.

The "Health Policy Recommendations" document includes a thorough discussion of several Affordable Care Act (ACA) provisions and non-ACA policy priorities along with our "steps requested." While the document is comprised of four sections, we call your attention to the first two sections which detail opportunities to correct bad policy and flawed ACA reforms, and promote private sector innovation, respectively.

RECOMMENDATIONS

The Chamber shares the Department's priorities and goals of empowering patients and promoting consumer choice, stabilizing the individual and small group health insurance markets, enhancing affordability and affirming the traditional authority of the States in regulating the business of health insurance. There are many ways to answer the RFI's specific questions as to how to advance these goals, and many changes that could prove fruitful. The Chamber suggested some recommendations and changes to advance these goals in our March 7th, 2017 response to HHS's Market Stabilization Proposed Rule. While it is not our intent to be duplicative, we hope this comment letter will remind the Department of the litany of opportunities to advance each of the outlines goals.

Empowering Patients and Promoting Consumer Choice

- What activities would best inform consumers and help them choose a plan that best meets their needs?

  - ***Provide Employers a Summary of Benefit and Coverage and Uniform Glossary (SBC) Safe Harbor.*** By allowing employers to provide customized plan materials to employees, we can better inform consumers and help them choose a plan that best meets their needs.

    Recommendation: HHS should provide an SBC safe harbor to avoid confusion caused by the one-size-fits-all template.

    Discussion: We encourage the Department to provide a safe harbor from the ACA's SBC requirement to employers that provide information through the Summary Plan Description (SPD) in conformance with Employee Retirement Income and Security Act (ERISA) requirements and other summary materials.

    Before the ACA, employers, health insurance issuers and other groups sponsoring group health plans already provided SPD as required by the ERISA, as well as benefit summaries that are customized to provide information in the format preferred by their employee population. Other highly-customized tools and information were also provided to employees and individuals when they enrolled during open enrollment periods or otherwise.

    Unfortunately, the prior administration failed to appreciate the value of the information that employers had previously provided as well as the enormity of the cost to comply with this new duplicative SBC notice requirement and its highly prescriptive format.

    The SBC's rigid format imposes wording and formatting rules that are confusing and often misleading to employees. The format fails to reflect the highly customized benefits common in large employer and union health programs. The format doesn't support the description of newly designed multi-level network plans, non-traditional deductible programs or any number of other items. For these reasons, we urge the

Department to allow issuers and employers to provide summaries as they were able (and required) to before the ACA.

- Which regulations currently reduce consumer choice of how to finance their health care and health insurance needs?

  - ***Properly classify Health Reimbursement Arrangements (HRAs)***: The improper classification of HRAs reduces choice.

    Recommendation: HHS should clarify that an HRA is not a group health plan per se.

    Discussion: While HRAs are categorized as a group health plan in the Internal Revenue Code, they do not provide coverage like a typical group health plan. There is not a "network" of providers associated with an HRA whereby an individual who sees an "out-of-network" provider must pay more. There are no "copayments, coinsurances" or other divided reimbursement schema dictated by a contractual agreement between an insurer and a provider for services obtained by an individual "covered" by an HRA. In fact, HRAs can be offered and elected alongside a major medical group health plan. There are few other scenarios where an employer could offer and an employee could elect to enroll in two different group health insurance plans simultaneously. To be clear, HRAs are a financing mechanism. Clarifying the role and designation of an HRA as "not a group health plan" would better inform consumers and allow these arrangements to be more broadly available as a financing option that could be elected more freely.

  - ***Re-examine Short-Term Limited Duration Plans***. After the ACA passed, the sale of short-term, limited duration policies increased. In 2016, the Obama Administration imposed new limitations on these short-term, limited duration plans due to concerns with the risks pools in the individual market.

    Recommendation: HHS should reassess the appropriate role of these short-term, limited duration policies, mindful that the individual insurance markets are already facing significant challenges.

    Discussion: Historically, short-term coverage has provided an important option for consumers who may need to bridge a gap that may occur during a coverage transition such as those aging into Medicare and other situations. However, the Chamber recognizes that the individual markets have experienced significant upheaval in the last several years, and will likely continue to do so. HHS should examine any potential impact that loosening restrictions on short-term policies could have in terms of the stability of these markets as healthier individuals may choose these plans. Congress is currently grappling with these issues and may soon pass legislation that impacts these markets, further changing the rules of the road. Any reconsideration of the rules relating to these short-term policies should be made in conjunction with the changing landscape.

- ***Extend Transition Policies.*** Customers should be able to continue to elect coverage under transition plans or "grandmothered" plans some of which are set to expire at the end of 2017. Consumers should also be able to keep the plans that they had which were given "grandfathered-plan" status.

  Recommendations: HHS should immediately extend indefinitely the transition plans for "grandmothered" coverage and allow more flexibility to issuers to make necessary changes to pre-ACA plans while maintaining "grandfathered" status.

  Discussion: Over 1 million individuals in many states are still in "grandfathered" and "grandmothered" plans that allowed individuals and groups to keep many of the pre-ACA benefits and rules. Allowing these individuals to keep these plans will maintain stability in coverage and affordable premiums.

- ***Facilitate Workplace Wellness Programs***. Employers should have one set of clear and consistent rules as to how they may vary premiums and provide financial rewards to employees for participation and engagement in workplace wellness programs.

  Recommendations: Workplace wellness programs that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) should be deemed to be in-compliance with the Americans with Disabilities Act (ADA) and the Genetic Information and Non-discrimination Act (GINA). HHS should:
  - Provide a safe harbor when programs comply with limits under current law.
  - Remove the 30% cap on incentives for participatory programs.
  - Exclude nominal awards from all incentives caps.

  Discussion: The final ADA and GINA rules issued by the Equal Employment Opportunity Commission (EEOC) contradict both the text of the ACA and the Tri-Agency regulations on HIPAA compliant workplace wellness programs making it harder for employers to offer these programs which improve health and provide financial rewards that reduce premiums for coverage. The final ADA and GINA rules undercut the full promise of wellness programs and hinder the ability of employers to implement and facilitate employee access to programs that improve the health of American employees and can start to reduce spiraling health care cost increases. The EEOC went beyond current law and established rules by HHS, Treasury, and Labor by imposing new limits on incentive amounts in programs that give awards for simply participating. Wellness programs often include nominal awards which have low value and should not count in incentive caps, as consistent with the IRS exemption of nominal value benefits as gross income. Without these programs, coverage is more expensive for employees and employers alike.

- ***Permit Broader Use of Excepted Benefits***. Excepted benefits should be permitted to be sold and offered in conjunction with an employer-sponsored health plan, including a high-deductible health plan.

  Recommendation: HHS should clarify that excepted benefits may be sold alongside other major medical insurance.

Discussion: Excepted benefit plans have historically been available in the marketplace as valued options. Consistent with the statutory provision that refers to benefits payable with respect "to an event," the Department should clarify in guidance or regulation that hospital indemnity or other fixed indemnity insurance pays benefits in a fixed dollar amount per specified event, such as a period of hospitalization or illness and/or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. Similar clarifying changes should be made by HHS to the individual market rules. This change will provide clarity and conform the rules in the individual and group markets.

- ***Work to discontinue unnecessary reporting***. The ACA included two different reporting provisions intended to facilitate the enforcement of the individual and the employer mandates as well as to ensure that premium tax credits were properly awarded to individuals without an offering of affordable, minimum value employer-sponsored coverage. These reporting schemas have been exceedingly complicated, costly and difficult to satisfy.

  Recommendation: HHS should work with the Internal Revenue Service (IRS) and the Department of Treasury (Treasury) to quickly release guidance relieving individuals and entities required to report under Section 6055 and 6056 from the requirements that are overly burdensome or rendered moot by Congressional action.

  Discussion: Given that Congress is currently considering legislation that would materially change or eliminate much of the reporting required under Sections 6055 and 6056, and that the administration may be considering additional relief for individuals and employers from the mandates, waiving this costly administrative obligation would reduce this unnecessary cost for businesses. Employers should be furnished with reporting forms that require only the information necessary to ensure individual market consumers do not receive an advance premium tax credit (APTC) if they have an offer of employer-sponsored insurance. We ask that HHS and Treasury issuing guidance stating that the existing individual and employer mandate reporting forms (i.e., those required by Sections 6055 & 6056) will not be enforced, but replaced with less onerous requirements.

- ***Direct the Office of Civil Rights ("OCR") to revise the scope of the Section 1557 rules and reduce notice burdens.*** On May 18, 2016, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) issued a final rule on the ACA's Section 1557 which prohibits "covered entities" from discriminating on the basis of race, national origin, sex, age, or disability in any health programs or activities receiving federal financial assistance. However, the OCR's interpretation of the statute and the regulations issued far exceed the protections delineated.

  Recommendations: HHS should:
  - Specify that for 1557 Nondiscrimination rules to apply to a plan or coverage,

there must be a direct nexus between the employer-sponsored health plan or coverage and the receipt of federal funds. A Third Party Administrator (TPA) should not be considered a covered entity "by association" merely because it is operated by an entity that offers an insurance product in the exchange.

- Only require the notices to be provided on an annual basis – as part of open-enrollment (or special enrollment periods).
- Allow notices to include an icon indicating that language assistance is available, which would limit the need to translate the tagline informing consumers of this assistance into 15 different languages.

Discussion: While the Chamber supports the goals of Section 1557, the final rule is not only excessive in scope and application but is also burdensome with regard to the mandated frequency and length of the notice. With regard to scope, the OCR's overly broad interpretation of "covered entities" subjects TPAs of self-funded plans to these requirements if the TPA is operated by an entity that also offers individual health care coverage on the ACA's exchange. With regard to frequency, OCR's regulations implementing Section 1557 require voluminous notice and taglines to be provided with every "significant" document, a term that OCR has interpreted broadly. The result is that consumers receive numerous duplicative notices; notices that are often longer than the "significant" information that an entity is trying to provide. Health insurance issuers should only be required to provide the notice and taglines annually and to post the notice and taglines online.

With regard to length, the final rule requires covered entities to post a notice of consumer rights providing information about communication assistance; and post taglines in the top 15 languages spoken by individuals with limited English proficiency (LEP) nationally, indicating the availability of such assistance. The expense of having to provide translations into 15 different languages and to provide multiple notices of these protections is significant and outweighs the benefit to consumers.

- ***Ease the current restrictions on the use of Health Savings Accounts (HSAs)***. The current rules unnecessarily restrict plan and benefit design flexibility as to what preventive services can be covered on pre-deductible, zero dollar cost sharing basis.

  Recommendations: HHS should allow employers and plan-sponsors the flexibility to provide more robust coverage with regard to pre-deductible zero dollar-cost sharing for preventive services under a High Deductible Health Plan (HDHP). If an employer or plan sponsor chooses to offer a HDHP that covers additional preventive services, HHS should enable this coverage by expanding the definition of HSA qualifying preventative care services and prescriptions under an HSA-qualified High Deductible Health Plan.

  Discussion: HSA-HDHPs, like other health plans, must cover certain preventive services (such as those given an "A" or "B" recommendation by the U.S. Preventive Services Task Force) on a pre-deductible basis with zero-dollar-cost-sharing. Coverage of these services on a pre-deductible basis is permitted as they fall within a

"safe harbor," allowing HSA-HDHPs to cover certain preventive care prior to the deductible being met. Beyond the preventive services that must be covered on a pre-deductible basis by all plans, current interpretation of the scope of the HSA-HDHP preventive care safe harbor is narrow and, from the prism of modern health reform efforts, increasingly problematic and disconnected. Generally, plans lack the regulatory flexibility to cover additional services that help patients manage chronic conditions because of pre-ACA sub-regulatory guidance which states that the preventive service safe harbor does not apply to benefits or services meant to treat "an existing illness, injury or condition." This guidance can most easily be read as suggesting that management of chronic medical problems is not "preventive" within the meaning of the safe harbor because it relates to an "existing" condition. Such a reading, however, severely restricts HDHPs from implementing benefit designs that encourage the use of evidence-based, high-value services recommended by an increasing number of public health organizations. This interpretation fails to reflect the importance of prevention, which in addition to improving outcomes and enhancing productivity, prevents adverse, costly, and often avoidable acute exacerbations.

Stabilizing the Individual and Small Group Health Insurance Markets

- What changes would bring stability to the risk pool, promote continuous coverage, increase the number of younger and healthier consumers purchasing plans, reduce uncertainty and volatility and encourage uninsured individuals to buy coverage?

  - ***Make Cost Sharing Reduction (CSR) Payments***. The federal government must fulfill its commitment to holding individuals below 250% of federal poverty line for cost sharing amounts. The uncertainty as to whether and for how long the government will make these CSR payments is creating tremendous volatility in the individual insurance market, which is causing premiums to further increase and insurers to withdraw from the individual market.

    Recommendation: HHS should make a firm commitment to pay the CSRs until additional legislative relief can provide necessary certainty.

    Discussion: Millions of Americans do not receive health insurance through an employer, Medicare or Medicaid. The individual market is their only option for getting coverage. Unless CSRs are funded, carriers are going to continue to have to increase premiums and/or exit the individual markets which will ultimately force a tremendous number of Americans to go without coverage and move to the ranks of the uninsured. This threatens not just the health and financial stability of these individuals, but also the economic stability of their communities. We urge the Department to commit to paying the cost-sharing reductions.

  - ***Verify Special Enrollment Period (SEP) Eligibility***. HHS must prevent improper and inappropriate abuse of SEPs and stop allowing individuals to enroll in exchange coverage only when and for the length of time that they needed health care services, instead of during open enrollment.

Recommendations: HHS should verify the eligibility of individuals attempting to qualify for all categories of special enrollment periods. Additionally, HHS should reduce the number of SEP categories to align more closely with Medicare Advantage/the employer market.

Discussion: Under the new insurance reform rules in the ACA, individuals are able to obtain health insurance regardless of preexisting conditions. While this is an important reform that the Chamber supports generally, other necessary protections and requirements must continue to be enforced. As a variety of provisions in the ACA intended to do, it is critical that individuals maintain continuous coverage and not simply enroll and retain health insurance when they need health care services. Current rules allow some people to misuse special enrollment and grace periods to purchase coverage only when they need medical care.

In order to truly address improper manipulation of the SEPs, the Department must develop a pre-enrollment verification process. Without pre-enrollment verification, the current guaranteed issue requirement will continue to force carriers to enroll individuals who choose to wait to buy health insurance until they need services – driving up premiums for everyone and destabilizing risk pools and markets. The Chamber urges the Department to adopt an SEP verification process similar to the process used for Medicare enrollees.

- ***Prevent Third Party Premium Payers***. HHS must curtail self-serving third party premium payers from improperly and inappropriately steering individuals from public programs into the individual market insurance exchange plans to boost reimbursement payments for covered services.

  Recommendations: HHS should revise regulations to:
  - Prohibit third parties with financial interests, such as providers and groups receiving funding from providers, from steering individuals who are eligible for Medicaid and Medicare into exchange coverage.
  - Clarify that health plans may deny any third party payments that are outside the federal requirements and that these requirements supersede any state guidance to the contrary.
  - Provide explicitly that individuals cannot enroll in an individual health plan if they are eligible for Medicare and/or enrolled in Medicare.
  - Amend regulations to limit guaranteed renewability and guaranteed availability to only individual members that can demonstrate denied eligibility for Medicare and those eligible for end stage renal disease (ESRD) programs but in a waiting period.

  Discussion: Individuals who are eligible for and should be enrolled in Medicare and/or Medicaid are being enrolled with financial assistance from third party entities into the individual market in order to improve reimbursements for services rendered. Limiting this practice is critical if efforts to stabilize the individual markets are to be realized. This practice is also harming individuals who may not be adequately

informed of the consequences of enrolling in these programs in lieu of publically subsidized programs.

- ***Permit Recoupment of Unpaid Premiums***: HHS must allow carriers to collect past due and unpaid premiums from individuals who are manipulating the ACA's grace-period and consumer protections to avoid having to make payments.

  Recommendations: HHS should:
  - Require individuals with outstanding premiums with a given issuer to pay their balance before re-enrolling.
  - Not obligate plans to pay for claims in a new coverage year if the consumer has not paid January premiums.
  - Provide issuers with greater flexibility in setting minimum premium payment policies including tolerance and thresholds.

  Discussion: The ACA created a problematic federal 90-day grace period for subsidized enrollees which individuals are manipulating to take advantage of the rule. In many instances, individuals are not paying premiums for 90 days and are still accessing/obtaining covered services because insurers cannot hold/pend claims from being paid in case the consumer never pays. Consumers are currently able to stop paying towards the end of the plan year with no consequence because insurers are not allowed to use consumer payments for the next year's coverage to satisfy prior debts.

Enhancing Affordability

- What steps can HHS take to enhance the affordability of coverage for individual consumers and small businesses?

  - ***Revise Maximum Out-of-pocket (MOOP) Limit Interpretation.*** HHS could enhance affordability by rolling back improper regulatory interpretations that limit choice in plan design

    Recommendations: HHS should modify the sub-regulatory language that previously and incorrectly interpreted this embedded limit requirement in order to facilitate greater variety of plan options, benefit designs and affordable premiums. Plans should have the option of embedding an individual maximum out-of-pocket limit when coverage is other than self-only coverage but should not be required to do so unilaterally.

    Discussion: ACA regulatory guidance improperly and unnecessarily requires employers and plans to embed the individual MOOP limit and apply this lower limit to individuals covered in non-individual plans. This means that plans and employers must pay 100% of costs at a lower threshold which will force plans and employers to increase premiums. This limits plan variety and options.

Affirming the Traditional Authority of the States in Regulating the Business of Health Insurance

- Which HHS regulations or policies have impeded or unnecessarily interfered with States' primary role in regulating the health insurance markets they know best?

    - ***Federal Network Adequacy Requirements***. Federal network adequacy requirements have unnecessarily interfered with states role in regulating health insurance markets.

      Recommendation: HHS should defer to states for network adequacy determinations.

      Discussion: Given the variation in geography and population density within states, state insurance regulators are best able to determine network adequacy standards. States are most familiar with their market dynamics and are in the best position to ensure issuer offerings—including narrow networks and innovative plan designs such as Accountable Care Organizations ("ACOs")—also provide consumers with adequate provider networks. We urge HHS to roll back federal network adequacy standards and reinstate a commitment to deferring to state network adequacy determinations for fully insured plans.

CONCLUSION

The Chamber appreciates the ongoing work of the Department, the administration and Congress in exploring and implementing steps to empower patients and promote consumer choice, stabilize the health insurance markets, enhance affordability and affirm states' traditional health insurance regulatory authority. There are many opportunities to roll back guidance and modify existing regulations as further detailed in the regulatory chart and policy recommendations document. To the extent that regulatory changes alone are not sufficient, we hope that you will join us in calling on Congress to make additional legislative changes quickly to preserve the private markets and restore choice and plan variety for consumers.

Sincerely,

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