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January 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicaid and Medicaid Services
Department of Health and Human Services
Attention: CMS–9906–P
PO Box 8016
Baltimore, MD 21244-8016

Submitted Electronically to stateinnovationwaivers@cms.hhs.gov

RE: [CMS-9911-P] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to provide comments on the proposals included in the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023." As a state-based public policy organization in Minnesota, Center of the American Experiment has a particular interest in how this rule will impact insurance affordability and a state's flexibility to address unique challenges facing its insurance markets under the Patient Protection and Affordable Care Act (ACA). The rule includes several sensible proposals to improve the risk adjustment program and better protect consumers. However, overall, we hold strong concerns that the proposed rule will substantially limit state flexibility, harm insurance market risk pools, and result in higher, less affordable premiums. In fact, the combined premium impact from major policy proposals—including proposals on past due premiums, the Exchange user fee, network adequacy, and pre-enrollment special enrollment period (SEP) verification—could easily amount to a 10 to 20 percent premium increase when fully implemented.

Past Due Premiums

HHS proposes to re-interpret Public Health Service Act section 2702 (guaranteed availability) to require issuers to accept re-enrollment from individuals who have failed to stay current on their premium payments from the same issuer for the prior year. HHS states that the policy, which is

intended to encourage individuals to stay current on their premiums, has a disproportionate impact on low-income people and creates a barrier to accessing health coverage.

The preamble's argument that the requirement, which encourages individuals to pay their legally owed share of premiums erects a "barrier" to accessing care fails for several reasons. First, Congress has provided for generous, taxpayer-subsidized premium credits for low-income individuals to lower their premiums, to the point that many low-income individuals qualify for zero-dollar premiums. Second, not only are there premium subsidies available but, as the preamble points out, Congress has also provided for a three-month grace period for non-payment of premium for subsidized individuals. This grace period is significantly longer than the thirty-day grace period provided by most states for unsubsidized individuals. Combined, these provisions provide ample protection for low-income and underserved people to assist them in affording and maintaining coverage as well as accessing health care. Third, HHS's justification ignores the fact that reversing the requirement and allowing individuals to not pay their premiums and still remain covered will have the effect of increasing premiums and reducing choice, including premiums paid by low- and middle-income families, making coverage less affordable and potentially increasing the number of uninsured. It is also incongruous to suggest, as HHS does in the preamble, that the prospect of having to pay past-due premiums at the end of the year could somehow disincentivize individuals to take up health insurance enrollment at an earlier point in the year while simultaneously claiming that gaming or abuse is not a factor.

The same arguments HHS makes for reverting to the prior policy could be made to argue that no one should be required to pay premiums at all, since having to pay any premiums could theoretically be construed as erecting a "barrier" to accessing care. This wrongheaded approach clearly reflects either a deep misunderstanding of health insurance basics or a willful effort to ignore the facts. Along with the proposal to roll back pre-enrollment verification for special enrollment periods discussed later and other similar policies that increase adverse selection, this proposal represents the same failed approach that led premiums to spike and issuers to flee the individual market from 2014-2018. Instead of pursuing policies that impose higher costs and encourage individuals not to pay their premiums, HHS should focus on policies that lower premiums and make coverage more affordable.

HHS Risk Adjustment

Risk adjustment is an important part of any insurance market that guarantees coverage to people with pre-existing conditions. Risk adjustment provides payments to issuer that attract a higher risk, sicker pool of people. Without risk adjustment, issuers would have strong incentives to avoid the sick and attract the healthy. But risk adjustment across every health insurance market where it is used, included the individual insurance market, is far from perfect. That means there is always room to improve the predictive power of a risk adjustment methodology. To that end, HHS proposes improvements to the HHS risk adjustment model in each annual Payment Notice.

HHS proposes to use plan year risk adjustment data from 2017, 2018 and 2019 to recalibrate the risk adjustment model and, considering the impact of COVID-19, requests comments on using 2020 data to recalibrate the model for 2024, 2025, and 2026 plan years. HHS notes they have not analyzed the 2020 risk adjustment data. Without any analysis of this data, as well as 2021

data, it is hard to comment on whether the data should be used. HHS should issue a technical paper discussing the impact of both 2020 and 2021. That said, it's reasonable to assume that 2020 will be an outlier year considering the reductions in elective procedures during that time.

HHS also reproposes the three updates to the risk adjustment model that were included in the proposed 2022 Payment Notice. This includes adding a two-stage weighted model specific to the adult and child models to improve the underprediction of plan liability for the lowest-risk enrollees, adding an interacted hierarchical condition categories (HCCs) model specification to the adult and child models to address the underprediction of liability for the highest-risk enrollees, and replacing the current enrollment duration factors with duration factors that better account for the way people with HCCs drive the increase in per member per month expenditures for partial year enrollees. All of these changes appear to be sensible efforts to improve the predictive power of the risk adjustment model. The fact that they were proposed under the prior administration and are now being reproposed after further consideration suggests these highly technical updates have been fully vetted and are ready to finalize.

HHS is also proposing several other reasonable adjustments to the risk adjustment model, including pricing adjustment for the hepatitis C drugs to account for price changes from the introduction new generic drugs and technical changes to prescription drug categories (RXCs) for recalibration.

In addition, HHS proposes to collect and extract new data elements on ZIP codes, race, ethnicity, subsidy, and Individual Coverage Health Reimbursement Arrangements (ICHRAs) through the EDGE servers. While we generally support the goal of collecting additional data on these topics to inform and improve future policy proposals, we oppose this proposal to use the EDGE servers to extract the data because it would further erode the original, fundamental purpose for which the EDGE servers were created. EDGE servers were created in 2013 for the primary purpose of implementing the HHS risk adjustment program, and should not be expanded beyond this purpose.

In the 2019 Payment Notice, HHS provided states with flexibility to reduce risk adjustment transfers between issuers in both the individual and small group markets by up to 50 percent. The purpose was to give states flexibility to help attract and retain insurers, and to more precisely account for relative risk differences in state markets. HHS granted this flexibility to Alabama for its small group market. HHS now proposes to withdraw this flexibility, with an exception to allow Alabama to continue using the flexibility in 2024 and future benefit years. To support this change, HHS cites prior comments claiming the policy could create incentives for issuers to avoid high risk enrollees. HHS also cites the change in Administration priorities and the directive from Executive Order 14009 to strengthen the ACA.

We oppose this proposal because there has been nothing to indicate the policy resulted in the problems critics warned about prior to being provided to Alabama. In fact, in the preamble discussion, HHS justifies the proposal to retain flexibility for Alabama to reduce risk adjustment transfers in that state while eliminating the flexibility in other states due to the state's unique characteristics and the presence of a dominant issuer and several small competitors that produces imprecise results under the HHS risk adjustment methodology (because it is calibrated using a

national dataset). HHS also states that this flexibility helped to maximize participation in the state's market. This is more than enough justification for HHS to retain this flexibility for all states. Markets change over time, and it is possible that in the future a state will face similar circumstances as Alabama continues to face in its market. However, by taking away state flexibility to make changes to transfer payments, it will leave states with fewer options to address dynamics in their markets and, even if HHS later tried to grant additional states this flexibility, it could be too late.

Moreover, the policy strengthens the ACA by giving states the flexibility to exercise control over risk adjustment. The ACA establishes a risk adjustment program to be administered by HHS "in consultation with States."[1] This flexibility implements this portion of the ACA and it's removal would therefore weaken the ACA.

Web Broker Requirements

HHS proposes to prohibit web-brokers from preferentially displaying QHPs for which they have an appointment as well as to prohibit QHP advertising on web-broker cites. We oppose this policy because not allowing web brokers to preferentially display plans for which they receive a commission lessens the incentive for web-brokers to participate in the market and to continue to innovate.

Through enhanced direct enrollment (EDE), web-brokers have become an indispensable partner in enrolling individuals in QHPs, including during the public health emergency and the COVID SEP. However, because EDE is still in its early phases, it is crucial to keep barriers to entry as low as possible, including by allowing preferential display of plans. At a minimum, HHS should continue to allow the preferred placement but require web-brokers to display a disclaimer indicating that the issuer is paying a fee for the placement. This will provide transparency for consumers while still providing the web-broker ongoing incentives to develop and innovate.

Reflecting the importance of this pathway, HHS should also commit to publishing and regularly updating data on web brokers including the number of plan selections received via EDE and Direct Enrollment as well as data on new enrollments, metal level, average premium, and average age as compared with these data for HealthCare.gov.

Prorate the calculation of APTCs

HHS currently requires FFEs and SBE-FPs to prorate the calculation of premiums for individual market policies and the calculation of APTC when the consumer is enrolled for less than a full coverage month. The purpose is to protect consumers from overpayment of APTCs that they will otherwise be required to pay when the file their taxes. HHS now proposes to extend this requirement to SBEs. This is a sensible proposal that should be finalized to better protect consumers.

[1] PPACA § 1343(b).

Standard of Conduct for Agents and Brokers

HHS proposes to require agents and brokers to provide correct information to the FFEs, including correct emails, telephone numbers, and mailing addresses for the consumer. This includes requiring agents and brokers to only enter an email address that is secure, not disposable, and belongs to the consumer. In addition, agents and brokers would need to gain the consumer's or their representative's consent to enter the email on an application. HHS also proposes to require agents and brokers to not engage in scripting and other automations of interactions with HHS unless they gain prior approval, only use an identity that belongs to the consumer when identify proofing the consumer's account on HealthCare.gov, and obtain authorization from the consumer before requesting a determination of eligibility for a SEP.

Unfortunately, we are aware that there are a few bad apples in the agent and broker community who have used their personal emails on applications and engaged in other practices to enroll consumers without keeping the consumer full engaged and informed. Some have even engaged in entirely fraudulent enrollments. Some consumers have been unknowingly enrolled only to find they owe the IRS excess advance premium tax credit (APTC) payments that the Department of the Treasury paid to insurers on their behalf. These are entirely sensible proposals to include with current requirements on agents and brokers to better protect consumers and protect the federal taxpayer from excess premium tax credit payments.

Pre-enrollment SEP Verifications

The ACA establishes an annual open enrollment period which is intended to be a brief period when anyone can freely enroll in the individual health insurance market. The law also establishes special enrollment periods (SEPs) that allow people to enroll at any time during the year if they experience certain life events, like the loss of job-based coverage or a marriage. These enrollment periods play an important role in the overall structure of the ACA to mitigate adverse selection and protect the risk pool.

When HealthCare.gov initially launched in 2014, people could enroll through SEPs by simply attesting to meeting the qualifications. In 2016, understanding attestation could be open to abuse, HHS began requiring people to provide documentation to confirm their eligibility for the most common SEPs after they enrolled. As the stability of the insurance market continued to deteriorate, HHS implemented the Market Stabilization Rule in 2017 which required pre-enrollment verification for several SEPs. HHS now proposes to stop pre-enrollment verification for all but one SEP. We oppose this policy because it would harm the risk pool and, as a result, raise premiums by making it easier for people to abuse SEPs to wait to enroll until they need care.

As explained in the Market Stabilization Rule, HHS finalized pre-enrollment verification based on "strong issuer feedback."[2] As HHS summarized, issuers consistently communicated that "pre-enrollment verification of special enrollment periods is critical to promote continuous coverage, protect the risk pool, and stabilize rates." The policy worked. Rates peaked in 2018 and have been stable ever since.

[2] 82 FR 18346, at18356.

HHS provides little to no evidence to support this reversal in policy in the proposed rule. The proposal only explains that pre-enrollment verification can deter some people from enrolling because document verification can be a barrier. The proposal asserts that younger, often healthier people submit verification documents at lower rates which can negatively impact the risk pool. In addition, it claims that in the experience of the agency pre-enrollment SEP verification "disproportionately negatively impacts Black and African American consumers" who successfully submit verifications at lower rates than White consumers.

While there is no data provided to support these assertions, CMS did publish data in a 2016 report on what happened when they began requiring people to provide documentation. They found 73 percent of consumers aged 55 to 64 submitted documentation after initial outreach while, by comparison, 55 percent of consumers aged 18 to 24 submitted documentation.[3] If this is the data they're relying on, this is based on a different verification process and was considered before the implementation of pre-enrollment SEP verification.

Data that does exist shows the SEP verification process works and does not impose a substantial burden. CMS issued a report in 2018 reviewing the experience from the first year of implementing pre-enrollment verification.[4] The report found that CMS averaged 1 to 3 days to review documentation and that 90 percent of SEP applications that required document verification satisfied the requirements. It also found a substantial drop in the use of exceptional circumstance SEPs, suggesting fewer people were, in fact, abusing this more open-ended SEP. Finally, the report found the average age of SEP enrollees in 2017 was 34, younger than the average age of OEP enrollees at 41. In fact, the majority of people enrolling through SEPs in 2017 were younger than 35, which strongly suggests younger people were not having trouble with the pre-enrollment SEP verification.

Another data point suggesting that pre-enrollment SEP verification is working is the declining impact of partial year enrollment on risk adjustment. In the 2018 Payment Notice, HHS added partial year enrollment factors to the risk adjustment model for plan year 2017 after receiving feedback that some issuers were experiencing higher than expected claims costs for partial year enrollees.[5] These are the enrollees who either enroll mid-year through an SEP or drop out mid-year after enrolling through the OEP. Either circumstance presents the possibility of someone timing coverage to when care is needed and so it is not surprising that partial year enrollees incur higher claims per member per month. HHS analysis of risk adjustment data for plan years 2017 and 2018 found that people with one or more chronic conditions—i.e., people with a hierarchical condition category (HCC) coding—drive the increase in per member per month expenditures for

[3] Centers for Medicare & Medicaid Services, Pre-Enrollment Verification for Special Enrollment Periods (https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf
[4] Centers for Medicare & Medicaid Services, The Exchanges Trends Report (July 2, 2018), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf.
[5] 81 FR 94058, at 94072; and Centers for Medicare & Medicaid Services, "March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper," March 24, 2016, at 35-39, available at https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf.

partial year enrollees.[6] Intuitively, this makes sense. Because people with chronic conditions are more likely to be aware of their health care needs and have more expensive care needs, they hold better knowledge and stronger incentives to time coverage to care needs. Thus, risk adjustment data strongly suggests that people with chronic conditions are abusing SEPs to time enrollment to care needs.

From plan year 2017 to 2022, the coefficients for this duration factor have dropped substantially. For instance, the coefficient for 1 month duration in a silver plan dropped from .396 in 2017 to .209 in 2022.[7] The coefficient for 1 month duration in a platinum plan dropped from .515 in 2017 to .281 in 2022. While the data sources used to recalibrate the risk adjustment models changed during this time, this still suggests partial year enrollees are imposing less risk. A likely factor is that fewer people are abusing SEPs to wait to get coverage until they need care due to pre-enrollment SEP verification. At the very least, this demonstrates that HHS should carefully analyze the risk adjustment data to better understand the role of pre-enrollment SEP verification before finalizing the proposed changes.

The market stabilization that occurred soon after the pre-enrollment SEP verification began, the early performance of the policy, and falling impact of shorter enrollment durations on the risk adjustment model all suggest that pre-enrollment SEP verification is working as intended. As a result, if finalized, the proposed policy will only open opportunities to abuse SEPs, harming the risk pool and ultimately raising premiums. Because the program appears to be working without imposing an undue barrier on younger people or anyone else, there is no rationale basis to end pre-enrollment SEP verification. Moreover, the fact that premium rates have remained stable since 2018—the first plan year issuers could set rates lower based on this change—suggests premiums could have been substantially higher without the policy and, therefore, may rise substantially if HHS stops broadly applying pre-enrollment SEP verification. While speculative, doing so could eventually increase premiums rates by upwards of 10 percent.

User Fee

When HealthCare.gov launched, HHS originally set the FFE user fee rate at 3.5 percent. HHS then lowered the rate to 3.0 percent for the 2020 and 2021 plan years. In the proposed 2022 Payment Notice, HHS proposed to lower the rate to 2.25 percent for the 2022 plan year and ended up finalizing the rate at 2.75 percent. HHS also finalized a SBE-FP rate at 2.25 percent. HHS now proposes to set the same rates for plan year 2023. We opposed finalizing the higher than proposed rate for plan year 2022 and continue to oppose maintaining these higher rates into 2023.

As we explained in our prior comments, a higher user fee will raise premiums and is unnecessary because excess collections can cover any spending in excess of user fee revenue. Because the user fee is fully passed on in higher premiums by regulation, maintaining the higher user fee than originally proposed in the 2022 Payment Notice ensures that premium rates will be 0.5 percent

[6] 85 FR at 78585.
[7] 81 FR 94058, at 94088; and Centers for Medicare & Medicaid Services, "Updated 2022 Benefit Year Final HHS Risk Adjustment Model Coefficients," July 19, 2021, available at https://www.cms.gov/files/document/updated-2022-benefit-year-final-hhs-risk-adjustment-model-coefficients-clean-version-508.pdf.

higher. There is no evidence the budget situation has changed even with the additional spending applied to the Navigator program and outreach to justify this higher premium. We further warned in our prior comments that not drawing down the excess collections to an appropriate level may violate the law.

With the ongoing loss of states from participating in the FFE—Kentucky, Maine, and New Mexico all transitioned this year—the user fee rates are clearly not competitive, and states are realizing they can get a better deal if the create their own Exchange. Pennsylvania used a portion of their user fee savings to begin funding a reinsurance program last. HHS should be striving to provide a competitive rate and it has the capacity to do so by drawing down excess funds and driving toward more efficient operations.

As HHS has noted in prior Payment Notices, HHS asserts that "[a]ctivities performed by the federal government that do not provide issuers participating in an FFE with a special benefit are not covered by the FFE user fee." However, as in prior Payment Notices, HHS provides an itemized list of federal activities that provide special benefits and never acknowledges that many of these activities also provide public benefits, the portion of which cannot be funded a user fee. The Exchange program primarily exists to administer a public welfare program that provides premium subsidy support to low-income people. Consumer assistance tools, consumer outreach and education, eligibility determinations, and enrollment processes are all key activities that support this public welfare program to help low-income people. Yet, HHS appears to be using the user fee collections to fully fund these activities. If so, these user fee collections are unlawful. To justify the user fee rate, HHS should more clearly itemize the Exchange budget by activity and differentiate what portion of each activity is funded by the user fee versus other revenue sources.

Removing State Flexibility in the Provision of EHB

HHS proposes to roll back flexibility given to states in 2019 to allow issuers to make benefit substitutions across EHB categories. This policy is intended to give states greater flexibility to allow for innovative plan designs and to offer consumers greater choice and affordability in their coverage options.

HHS justifies its proposal to remove this flexibility for states in part due to the fact that no state has yet requested to use it. However, this is not a well-founded justification. HHS acknowledges that several states have either utilized or requested to utilize other flexibilities given them by HHS in 2019 to make changes to their EHB benchmarks. This demonstrates state interest in flexibility, and the mere fact that states have not yet had time to fully digest and take advantage of a particular flexibility does not mean that HHS should automatically take it away due to the specter of some theoretical, unsubstantiated harm that could result from it. Furthermore, HHS fails to take into account the impact of the pandemic on states' abilities to make significant changes to their markets. States, like the federal government, have been overwhelmed due to the impact of the COVID-19 epidemic, which has limited their ability to tackle complex, but worthy, issues affecting their markets. Rather than penalizing states in the future for failing to take up EHB flexibility during a pandemic, HHS should leave the flexibility in place and work with

states to use it in the way it was intended, that is, to increase innovation, choice, and affordability of coverage.

Standardized Plan Options

HHS originally established a set of standardized qualified health plan (QHP) options in the 2017 Payment Notice. These options established a standardized cost-sharing structure for the bronze, silver, and gold metal tiers based on the most popular QHPs in the market. Issuers were not required to offer these plans, but if they did, the standardized options were given preferential display on HealthCare.gov. HHS stopped specifying standardized plan options in the 2019 payment notice. However, a federal district judge vacated this rule in March 2021. While it's likely the Department of Justice would have won if they appealed the vacatur—the judge's opinion failed to acknowledge the clear discretion HHS holds on this policy—they did not appeal after the Biden administration took office.

HHS now proposes to reintroduce standardized options and, instead of making them voluntary, make them required for every metal tier, including each of the three income-based silver cost sharing reduction plans. Standardized options from the beginning were a flawed policy and should never have been introduced and it is a mistake to bring them back now even after the court's vacatur. In response to the vacatur, HHS should issue a new rule with a more thorough explanation than they provided in the 2019 Payment Notice for why standardized options will do more harm than good for consumers.

The government is not well suited to designing products and services for consumers in any industry, and health insurance is no exception. While the government regulates certain aspects of products and services in other industries, to my knowledge there is no industry where the federal government actually designs the main features to ensure each company sells the same product. Even when there is good reason to standardize certain product characteristics like pipe fittings, consumers still have a wide range of options in materials (brass, copper, chrome, PVC, etc.) and type of fitting (compression, insert, screw-on, soldered, etc). In these cases, standardization is used to ensure products from different companies work together, not to simply choices for consumers.

CMS has an incredibly talented staff who time and again demonstrate the highest levels of expertise, dedication, and professionalism in their work. But their work of implementing and overseeing federal law is all consuming and does provide the time or the tools CMS staff need to develop and continuously improve a health plan design that best fits the wants and needs of a consumer. Because CMS does sell directly to a consumer, they do not have a direct connection to consumers to discern what works best like private health plans do. This direct and daily consumer connection is critical to product development and improvement.

By requiring standardized options and giving them preferential display, the proposed rule would undermine and crowd out private options. Ultimately this will discourage issuers from offering coverage and those that do will have less incentive to innovate better plan designs. That's exactly why HHS chose to stop specifying plan options in the 2019 Payment Notice. Specifically, HHS concluded "that not specifying standardized options for the 2019 plan year will remove

disincentives for issuers to offer coverage with innovative plan designs" and "that issuers are in the best position to design and offer innovative plan designs."[8]

HHS argues the increase in the number plan options since HHS stopped specifying standardized options in 2019 justifies their resumption. HHS then asserts standardized options will help enhance the consumer experience, increase consumer understanding, simplify the plan selection process, combat discriminatory benefit designs that disproportionately impact disadvantaged populations, and advance health equity. By discouraging issuers from offering and innovating new plans, the proposed rule will do the exact opposite.

HHS seems to be most concerned about the dangers of choice overload, which could lead to consumers to make poorer decisions or no decision at all and not buy coverage at all. But consumers generally welcome more choices. Grocery stores stock dozens of types and brands of pasta sauce precisely because consumers buy them. Research tends to show that when stores offer more choices for a product they sell more of the product.[9]

To the extent choice overload might exist for more complex products like health insurance, choice architecture can address those issues without reducing the choices available. For instance, sorting options into smaller subgroups and narrowing choices to selected subgroup has been shown to give consumers the benefits of fewer choices without reducing the number of choices.[10] Healthcare.gov already does this in many respects by allowing consumer to sort health plans by metal tier and plan type (e.g., PPO vs. HMO). Agents, brokers, and web brokers also provide decision support tools that help narrow choices when helpful.

HHS noted that commenters said standardized options could help consumers avoid discriminatory plan designs and HHS appears to agree. Yet, federal law and regulations already bar discriminatory plan designs targeted at people with significant health needs.[11] If HHS agrees standardized options will help, then they are admitting they are failing to enforce the law. However, there is no specific evidence that plans are offering discriminatory plan designs and, therefore, this rationale does support the proposal.

If HHS decides to resume specifying standardized options, then offering these plans should continue to be voluntary as before. HHS should also refrain from providing differential and preferential display to avoid inappropriately steering consumers and crowding out other plan options.

Network Adequacy

In the draft rule, HHS proposes to impose new Federal network adequacy standards for the FFE, including time and distance standards as well as appointment wait time standards. While we

[8] 83 FR 16930, at 16975.
[9] *See* Benjamin Scheibehenne, Peter Todd, and Rainer Greifeneder, "Can there ever be too many options? A meta-analytic review of choice overload," *Journal of Consumer Research,* 2010, vol. 37, no. 3, at 411.
[10] *See* Tibor Besedeš, Cary Deck, Sudipta Sarangi, and Mikhael Shor, "Reducing Choice Overload without Reducing Choices," *The Review of Economics and Statistics* (October 2015).
[11] PPACA § 1311(c)(1)(A); and 45 CFR 147.104(e).

support the goal of ensuring adequate networks for consumers, the proposed modification of the network adequacy requirements are unlikely to achieve this goal and will in fact increase administrative burdens and costs for consumers.

First, as HHS recognizes in the preamble discussion, there is wide variation between states in network adequacy standards. But rather than reflecting some kind of inequity or vacuum that needs to be filled by Federal regulation, these differences reflect very real and legitimate differences in geography, population density, rural versus urban mix, provider concentration, and other factors. In addition, HHS has recognized the ongoing national shortage of healthcare providers, a problem that has been even further exacerbated by the pandemic. Doctors, nurses, and other health care providers are leaving the profession at an alarming rate, creating acute local staffing shortages that impact patient care. These problems are even worse in rural areas, where it is often difficult for patients to get an appointment with any provider at all, much less a specialist. Imposing a one-size-fits all national standard as HHS proposes will do nothing to alter these realities.

Time and distance reviews for QHPs were administered for the 2015 to 2017 plan years. However, the experience with these early reviews indicate that the process served only to add an unneeded layer of administrative burden and cost. The Federal time and distance reviews conducted from plan years 2015 to 2017 had little or no impact on increasing network breadth. The reviews merely caused issuers to generate myriads of written justifications for why a particular provider or specialty was unavailable. In the end, HHS still mainly deferred to states, and, as multiple studies have shown, the reviews still resulted in narrow networks in QHPs.

Not only is imposing a Federal network adequacy standard unhelpful, but it could actually harm consumers by imposing significant new administrative burdens on issuers that increase costs and drive up premiums. Now, rather than only having to receive approval of their networks from the state regulator, issuers will have to gain the approval of two separate regulators, each with different and potentially conflicting standards. This will inevitably add time, burden, and cost to the process of building and receiving approval for provider networks, which will ultimately negatively impact consumers.

Due to the wide variation in access to providers that exists state-to-state, state regulators remain in the best position to address network adequacy determinations. State regulators better understand the unique needs of the consumers in their markets and are in the best position to oversee issuer provider networks in order to protect their citizens. Instead of pursuing a one-size-fits all Federal standard, HHS should continue to defer to states for network adequacy determinations.

HHS also seeks comment on network adequacy in state exchanges. For the same reasons as discussed above, HHS should not seek to impose additional requirements on SBEs regarding network adequacy. Again, the wide variation between state network adequacy standards is due to the underlying variation in state markets themselves, and should not be subjected to a one-size-fits all Federal standard.

Essential Community Providers (ECPs)

HHS proposes two changes to the ECP standards that QHP issuers must meet. The first new standard would require QHP issuers to enroll at least 35% of ECPs in their service areas. Second, ECPs would be required to be included in the lowest-cost tier in order to count.

The proposed 35% standard will increase administrative burdens and costs for consumers. As HHS stated in its solicitation of comments on the potential negative impacts of increasing network adequacy standards, increasing red tape and regulation in this area will serve to strengthen the hands of providers in network negotiations, leading to increased costs for consumers. Rather than doubling down on the same onerous policies that nearly caused the market to fail in the early years of the Exchanges, HHS should explore flexibilities for states that would allow them to increase affordability and competition, which benefit consumers far more than rigid, ineffective mandates.

Sincerely,

/s/

Peter J. Nelson
Senior Policy Fellow