

January 30, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Attention: CMS-9899-P
PO Box 8016
Baltimore, MD 21244-8016

Submitted Electronically via www.federalregister.gov

RE: [CMS-9899-P] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

Dear Secretary Becerra:

In the proposed rule “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024” [RIN 0938-AU97], the Department of Health and Human Services (the Department) proposes changes to the current regulations in place that implement the Patient Protection and Affordable Care Act (ACA). Overall, the changes in the proposed rule would weaken the ACA’s current regulatory framework. The following comments focus on the most concerning changes that threaten to restrict consumer access to innovative new health plans and undermine program integrity.

Restrictions on consumer access to innovative new health plans

As in any industry, health insurance consumers depend on robust competition between health issuers to access better, more innovative health plan options from year to year. Product and service designs are constantly evolving to give consumers options with higher quality, more features, and lower costs. Every day consumers see how competition delivers better ways to shop for groceries, higher resolution phone cameras, more feature-rich cars and cheaper televisions. Competition depends on the ability to introduce and test innovative new products. The market for health insurance is no different. Yet, the proposed rule includes several policies that will limit the number and type of health plans which health issuers can offer.

Limits on non-standardized plan options

The most harmful proposal would limit the number of non-standardized plan options. In the 2023 Payment Notice, the Department finalized a requirement that all health plans which offer a

qualified health plan (QHP) on the federal Exchange platform must also offer a standardized health plan.¹ At the time we opposed this requirement. We noted how the federal government is not well suited to designing products and services in any industry, and health insurance is no exception. Now the Department is proposing to limit the number of non-standardized options that QHP issuers can offer. Specifically, the proposal would prohibit QHP issuers from offering more than two non-standardized options per product network type (e.g., health maintenance organization or preferred provider organization) and metal level in any service area.

If finalized, this prohibition would impose a substantial disruption in coverage for millions of consumers who obtain health insurance through the federal Exchange platform. To comply, QHP issuers would be required to discontinue many of the QHPs they currently offer. The Department admits that this new requirement would end the current coverage chosen by 2.72 million of the 10.21 million people (26.6 percent) covered through the federal Exchange platform in plan year 2022.²

The Department asserts that individuals who lose coverage would be seamlessly transitioned to new coverage using existing processes for addressing instances of plan discontinuation. Aside from the fact that such processes can never be guaranteed to be seamless for everyone, the effect would be the result of deliberate government action, rather than market decisions made by suppliers.

Congress intended the Exchanges to function as a consumer choice market. While Congress established basic standards for QHPs and delegated to the Department the authority to administer and enforce those standards, it did not grant the Department blanket license to substitute its own judgment for the judgements of sellers and buyers on the Exchange.

It is also inconsistent for the Department to justify other provisions of this proposed rule that would allow individuals to retain subsidized coverage when they fail to verify eligibility for subsidies or follow clear eligibility requirements based on concerns over possible coverage disruptions, yet at the same time shrug off the guaranteed disruption in coverage to over 25 percent of the consumers that it expects this provision to produce.

When selling the ACA, President Obama famously promised, “If you like your health care plan, you can keep it.”³ When selling his own health plan during the 2019 presidential campaign, President Biden repeated that promise with this guarantee: “If you have private insurance, you can keep it.”⁴ That promise will be violated if the Biden administration cancels current QHPs to limit the number of QHPs in the future.

An even more damaging aspect of this provision is that it would lock out innovation for the entire market. In effect, the limitation would mean health insurance issuers could only position

¹ 87 FR 27208.

² 87 FR 78280

³ Angie Drobnic Holan, “Lie of the Year: ‘If you like your health care plan, you can keep it,’” *Politifact*, December 12, 2013, at <https://www.politifact.com/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/>.

⁴ Jon Greenberg, “‘If You Like Your Plan, You Can Keep It.’ Biden’s Invokes Obama’s Troubled Claim,” *Kaiser Health News*, July 30, 2019, at <https://khn.org/news/if-you-like-your-plan-you-can-keep-it-bidens-invokes-obamas-troubled-claim/>

two non-standardized health plans to contrast with the standardized plan. With flexibility to adjust only two plans, QHP issuers will be constrained in their ability to test new plan designs. That will significantly restrict innovation. At best, a QHP issuer might reserve one of the two non-standardized plans for some modest innovations.

Furthermore, this is an especially bad time to lock out innovation in the design of health plans. Federal rules recently went into effect which take historic steps to require both hospitals and health plans to finally make the care prices they negotiate transparent. To date, health plans have not been designed to reward patients for making value-conscious decisions. Now that accurate and actionable pricing information is becoming available to patients, there is a significant opportunity for health plans to innovate in designing plans that incentivize enrollees to choose more cost-effective care. This movement holds promise to both lower the overall cost of care and improve quality by better engaging the patient in all aspects of their care decisions. Unfortunately, the proposed limits on the number of non-standardized plans will hamper these innovations and any other innovations health plans may want to introduce.

In proposing this substantial limitation on the ability of QHP issuers to innovate, the proposed rule also fails to provide a sound legal basis for this action. The Department cites sections 1311(c)(1) and 1321(a)(1)(B) of the ACA for its authority to limit the number of plans. However, section 1311(c)(1) relates only to the specific criteria that each individual plan must meet to be certified as a QHP. It does not empower the Secretary to issue a broader set of regulations on QHP issuers as a condition of selling QHPs. This reading is consistent with the list of minimum criteria section 1311(c)(1) provides. Everything in that list relates to specific characteristics of a plan applying for certification as a QHP.

Importantly, section 1321(a)(1)(B) does not broaden the scope of the Secretary's power. It simply instructs the Secretary to "issue regulations setting standards for meeting the requirements under" title I of the ACA. It does not empower the Secretary to add to the statutory requirements. If sections 1311(c)(1) and 1321(a)(1)(B) can be used to justify this new requirement on QHP issuers, then there is no limit to what the Secretary can require above and beyond what the statute specifically requires.

Meaningful difference standard better, but is still unnecessary

As an alternative to limiting the number of non-standardized plans a QHP issuer can offer, the Department expresses a willingness to instead impose a new meaningful difference standard on QHP issuers. That new standard would generally require a QHP to have deductibles that differed by more than \$1,000 from a QHP with the same product network type and metal level tier. The Department estimates this alternative approach would produce a similar disruption in coverage, resulting in the cancelation of coverage for 2.64 million consumers.

This approach would be better than the inartful proposal to just limit issuer offerings to two non-standard plans. A meaningful difference standard would give QHP issuers more flexibility to innovate and introduce a new plan design, so long as it's meaningfully different. Though it is a better alternative, a meaningful difference standard will still do more harm than good because it will still impose a similar, albeit lesser, drag on innovation.

Solutions in search of a problem

Both ideas are ultimately solutions in search of a problem. The Department asserts that it is concerned about “choice overload,” which it argues can lead to poor enrollment decisions—including the decision to not enroll—due to difficulty in choosing among many options. However, the Department offers no evidence to support its starting premise that so-called choice overload is a substantial problem on the federal Exchange platform. The proposed rule simply cites the increase in choices without demonstrating any problem.

Yet, if the proliferation of choices from PY 2019 to PY 2022 deterred people from enrolling, then federal data should show a decline in the number of plan selections as a percent of HealthCare.gov users. Yet that metric remained relatively flat and even grew a bit from the PY 2019 open enrollment period (OEP) to PY 2022.⁵ Similarly, if consumer confusion was growing, it could be expected to result in a concomitant growth in the number of people reaching out to the call center for assistance. But call center volume from November 1 to December 15 dropped from 5.6 million during the PY 2019 OEP to 3.3 million during the PY 2022 OEP.

Rather than providing evidence of “choice overload” these data indicate that any hypothesized consumer confusion decreased while plan choices increased. Part of the reason why is likely due to the expanding use of choice architecture tools through HealthCare.gov and private web brokers. Consumers are indeed often faced with a wide array of choices in this and other markets. Fortunately, markets provide consumers helpful tools to narrow their choices and aid their decision making. Indeed, in recent years such tools have been developed and implemented to support the shopping experience across nearly every online storefront. Thanks to policies put in place during the Trump administration, consumers who use the HealthCare.gov platform have much broader access to these choice architecture tools.

Considering that federal plan selection data do not suggest any significant “choice overload” problem, rather than artificially constraining plan offerings, the Department should instead work to expand the availability and effectiveness of choice architecture tools through the federal Exchange platform. That approach would address any potential issue of “choice overload” without imposing the proposed harsh limits on plan choices that stifle plan innovation.

Mandate on plans to use a provider network

The Department also proposes a strict mandate that all QHPs must use a provider network. This is another solution in search of a problem which will also work mainly to block consumer access to better health plans.

The proposed rule offers no substantive evidence that QHPs without a provider network will harm consumers or pose any other problem. The proposed rule only cites the experience of negotiating with one issuer and comments made in response to the 2022 Payment Notice.

⁵ The percent of HealthCare.gov and CuidadodeSalud.gov users as a percent of plan selections made from November 1 to December 15 increased from 53.8 percent during the PY 2019 OEP to 54.5 percent during the PY 2022 OEP. Centers for Medicare & Medicaid Services, Open Enrollment Period Public Use Files.

Commenters raised concerns that plans without networks would burden consumers. However, those comments were entirely speculative and cannot speak to future plan design innovations that do not currently exist.

The Department simply does not have enough experience working to certify non-network plans to justify a blanket prohibition on such plans. The Department admits that only a single issuer has sought to certify a plan without a network on the federal Exchange platform. This first initial experience—this single sample—cannot provide The Department with sufficient information to judge the potential consumer benefits and harms from new non-network plan designs that might be offered in the future.

As noted previously, the historic implementation of federal price transparency rules creates opportunities for new health plan designs. Price transparency may hold particular promise for developing new plan designs that don't use a network. Fully transparent prices will potentially increase the competitive pressure among providers to lower prices in a way that lessens or even obviates the need for health plans to negotiate pricing. Some large, self-insured employer health plans already administer arrangements that allow enrollees to see any doctor and base reimbursement on a reference price. To ensure a reference-based pricing individual market plan would create a sufficient choice of providers, a bill proposed in Minnesota in 2021 required the reference price to be above a certain percentage of the Medicare rate.⁶

Also, given that plans without provider networks might better take advantage of price transparency and boost provider competition, the provision in this proposed rule that would prohibit such plans is contrary to President Biden's executive order 14036 on promoting competition in the American economy. That executive order directed the Secretary of Health and Human Services to "support existing price transparency initiatives for hospitals, other providers, and insurers."⁷ Yet, as just discussed, non-network QHPs may offer the best opportunity to expand the use and benefits of these initiatives.

Furthermore, there is no need for this mandate because the current QHP certification process already works to address any potential consumer harm that might occur under a plan without a provider network. In the single instance when a health plan sought to certify a QHP without a provider network, the Department explained that the certification process involved "lengthy negotiations."⁸ That shows that the Department already has the authority it needs to assess whether a proposed QHP offered a sufficient choice of providers. Therefore, any possible harm can already be addressed through the existing process.

If more health plans propose QHPs without networks in the future, the Department will gain more experience with how such plans can ensure sufficient choice of providers. Once such experience has been gained, it may warrant future regulatory revisions, but today there is not enough experience or information to justify a blanket prohibition on this type of health plan.

⁶ Minn. H.F. 2195, 92nd Legislative Session, 2021-2022, available at <https://www.revisor.mn.gov/bills/bill.php?b=House&f=HF2195&ssn=0&y=2021>.

⁷ 86 FR 36987 (July 14, 2021), available at <https://www.federalregister.gov/documents/2021/07/14/2021-15069/promoting-competition-in-the-american-economy>.

⁸ 87 FR 78206 at 78286.

While the Department might contend that it can revisit this provision in the future should QHP issuers show stronger interest in offering non-network plans, that would be to ignore the fact that imposing a strict blanket prohibition will stifle future investments in such products.

Ultimately, this proposed mandate would be a dramatic departure from prior interpretations and applications of the ACA. As the Department itself stated in the proposed 2022 Payment Notice, “Nothing in the PPACA requires a QHP issuer to use a provider network.”⁹ The 2022 Payment Notice added that federal regulation “does not impose any network adequacy certification requirement for QHPs that do not use a provider network, and has not since the inception of the Exchanges.”¹⁰

In this proposed rule, the Department now states that they doubt a plan without a network can comply with the statutory requirement at section 1311(c)(1)(C) that a plan must “at a minimum ... include within health insurance plan networks those essential community providers” that serve low-income and medically underserved people. Yet that is simply a restatement of an existing requirement for a plan with a network. It does not support the contention that all plans must have networks. If Congress had intended to require every QHP to use a provider network, it could have included such a requirement in the statute, but it did not.

Undermines program integrity

The Department also proposes to change basic income verification requirements used to determine eligibility for advance payments of the premium tax credit (APTC) that would undermine program integrity.

Key elements of the current income verification process

Federal regulations require applicants to provide basic information to confirm their income to ensure that they are eligible for APTCs. Under 45 CFR 155.305(f)(4), applicants must file a tax return and reconcile the receipt of any APTCs for a year for which tax data would be utilized for verification of household income and family size. In the event that they fail to file and reconcile, and the IRS does not have income tax return data to verify income, 45 CFR 155.320(c)(1)(i)(B) requires the Exchange to verify income using the process set out in 45 CFR 155.315(f)(1). When the Exchange cannot verify income using tax return data, this process requires the Exchange to provide the applicant 90 days to “present satisfactory documentary evidence” to verify their income.

All of these requirements are carefully coordinated to ensure the accuracy of the applicant’s claimed income on which calculation of the applicable APTC amount is based. The income verification requirements impose only a minimal burden on the part of applicants. Furthermore, it is reasonable to expect applicants to follow these basic rules as a condition of receiving a potentially very generous subsidy. In 2021, the average enrollee qualified for \$508.73 in APTCs

⁹ 85 FR 78635.

¹⁰ Id.

per month which amounts to \$6,104.74 on an annual basis.¹¹ If it turns out they were not qualified, the applicant may be responsible for a large repayment when they reconcile their taxes. Any amount paid in error and not repaid represents a substantial cost to the federal taxpayer. Accurate verification of income is therefore a critical protection for both the applicant and the federal taxpayer.

The proposed changes

The Department proposes three changes to substantially weaken all three elements of the income verification process just discussed.

- First, they propose to change the failure to file and reconcile (FTR) process. Currently, Exchanges must determine an enrollee ineligible for APTC after a year of FTR status. The Department proposes to require Exchanges to wait for two consecutive tax years to pass before determining an enrollee ineligible for APTC.
- Second, the Department proposes to require Exchanges to allow people attest to their income without providing any other verification when IRS does not have tax return data available for verification.
- Third, the Department proposes to give people an automatic 60-day extension in addition to the 90 days that regulations currently provide. This automatic extension would supplement the existing flexibility to provide an extension when the applicant demonstrates a good faith effort to comply.

Over the course of several years, the Department issued rules to implement and strengthen the current eligibility verification process. Those rules were adopted after the Department was presented with evidence and testimony showing that the process was open to abuse and prone to errors. Nonetheless, this proposed rule would backtrack on these rules without providing substantive evidence that anything has changed to lessen the potential for abuse and errors. Instead, the Department justifies the changes by asserting that the current processes are overly punitive to consumers and burdensome to Exchanges.

Current income verification process is fair and accommodating

The effort to characterize the current income verification process as "punitive" has no merit. The current process is fair and accommodating to applicants at every step. In fact, there's a good argument that the process is too accommodating.

To begin with, filing a tax return is already a basic requirement that applicants should already be doing. Requiring this information on a timely basis is an entirely reasonable request, especially considering how this tax information is used by the Exchanges to verify income. Without this tax return information on file with the IRS, substantially more people would need to take the extra step to provide documentation to verify their income. Therefore, this requirement reduces the burden on both the Exchanges and the applicant who will eventually need to file taxes at some point anyway.

¹¹ Centers for Medicare & Medicaid Services, Effectuated Enrollment: Early 2022 Snapshot and Full Year 2021 Average (September 16, 2022).

In the event an applicant has not filed a tax return, they are given ample notice and time to file. The first notice goes out before the OEP begins. The Exchanges then recheck IRS data in December of the OEP to see if they filed after this notice. The applicant may attest to filing their income on the application and qualify to receive APTCs even if their tax filing does not yet show up during this recheck. If someone with an FTR status does not attest to filing taxes, then they will lose eligibility for APTCs. For those who attest to filing their taxes, this recheck process is repeated early in the new year and in the spring.¹² After each recheck, if the FTR status still exists, they receive another notice that they must file and reconcile to continue receiving APTCs. They only lose their APTC after they fail to respond to the final notice in the spring. So, they receive APTC despite their FTR status for several months into the plan year. Some might, reasonably, argue that paying APTCs for an enrollee with an FTR status without more than an attestation is too accommodating. Indeed, even after their APTC is discontinued, an enrollee can regain APTCs by finally fulfilling the requirement to file and reconcile their taxes.

The proposed rule would appear to extend this already generous re-check and notice process another full year. That is not a reasonable accommodation. This extension will only serve to open the process to abuse when people know they can ignore an FTR status notice for the entire plan year and more.

Requiring applicants to provide documentation to verify their income is also a small ask from someone requesting potentially thousands of dollars in APTC subsidies. Moreover, giving someone 90 days to collect information about their current and expected income is ample time. Even with the back and forth that can happen in these situations, the Department provides no evidence that the time allowed is insufficient. Rather, the Department's prior experience with special enrollment period (SEP) verifications suggests that 30 days would be enough time for most people to provide documentation.

In 2017, the Department issued the Market Stabilization Rule which required pre-enrollment verification to qualify for certain SEPs.¹³ When electronic verification was not possible, the rule required the applicant to provide documentation within 30 days. An early review of that process found that the Department averaged a one-to-three-day response time to review the documents consumers submitted and, more importantly, over 90 percent of SEP applicants who were required to submit documents were able to successfully verify their eligibility.¹⁴ Considering the success of meeting the 30-day deadline for SEP document verification, the current 90-day deadline should provide ample time for most people. There's certainly no reason to think the deadline is overly punitive.

Nonetheless, the Department now proposes an automatic 60-day extension to this 90-day deadline. This extension is entirely unnecessary considering how the federal rule already allows

¹² See Centers for Medicare and Medicaid Services, Failure To File and Reconcile (FTR) Recheck (April 16, 2018), available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ENR_FailureToFileAndReconcileRecheck_5CR_062518_71.pdf.

¹³ 82 FR 18346.

¹⁴ Centers for Medicare & Medicaid Services, The Exchanges Trends Report (July 2, 2018).

the Department to give an applicant an extension “if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.”¹⁵

The benefits of the current income verification process outweigh the burdens

To further justify the changes income verification processes, the Department asserts the costs and burdens of these processes outweigh their benefits. However, the proposed rule’s regulatory impact analysis (RIA) reveals the exact opposite. The RIA estimates that these changes to loosen the current income verification rules will increase federal APTC spending by \$548 million per year.¹⁶ By contrast the rule will save \$66 million in federal spending on labor to administer the current verification process. So, on net, the changes for just these three income verification requirements will cost the federal taxpayer \$482 million per year.

Beyond the cost and benefit to the federal taxpayer, the Department expresses substantial concern over how these requirements can burden applicants and stresses the importance of maintaining continuity of coverage. We share the Department’s interest in helping people maintain continuous coverage. However, there is always a balance between ease of administration and program integrity. The current income verification rules strike an appropriate balance and, in fact, could be strengthened to protect program integrity even more. As just outlined, the rules provide ample accommodations to applicants which allows them to easily follow the income steps. These accommodations mitigate any risk these verifications might otherwise pose to continuous coverage.

The Department agrees that removing document verification creates a program integrity risk, but then suggests the fact that people must attest under penalty of perjury mitigates this risk. Yet anyone intentionally violating eligibility requirements to gain subsidies will not be stopped by the additional threat of perjury. For those who may make a more honest error, removing the document verification step may expose them to a perjury prosecution

Altogether, the proposed changes would loosen the federal income verification process to a point where there is virtually no verification and open the process to substantial abuse. Moreover, the rules own RIA demonstrates the substantial value and savings the current verification process provides to the federal taxpayer. Therefore, we urge the Department to not finalize the proposed changes the APTCs income verification rules and processes.

Conclusion

The provisions of this proposed rule that would restrict the ability of issuers to offer non-standardized QHPs and require all QHPs to have networks would impose significant impediments to beneficial innovation in plan design. Those provisions are also contrary to Congressional intent and conflict with President Biden’s EO 14036 on promoting competition.

¹⁵ 45 CFR 155.315(f)(3).

¹⁶ \$373 million per year due to FTR proposals plus \$175 million per year due to DMI proposals. Table 16 at 87 FR 78300-78301.

The provisions of this proposed rule that would further delay action when an applicant fails to file and reconcile (FTR) and that would require reliance on unverified self-attestations of income to resolve data matching issues (DMI) would undermine program integrity and, by the Department's own estimates, increase taxpayer expenditures on APTCs by nearly half-a-billion dollars per year.

Consequently, the Department should delete all those proposed changes before finalizing this rule.

Sincerely,

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