July 12, 2017

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

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

Dear Administrator Verma,

The American College of Physicians (ACP) appreciates the opportunity to comment on this Request for Information. The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

While we oppose repealing and replacing the Affordable Care Act (ACA), we believe that improvements can and should be made. We welcome bipartisan ideas specifically those to stabilize insurance markets; expand consumer choice of insurance products and of physicians and hospitals; ensure network adequacy; support state innovation; reduce administrative burden; and support the critical role played by primary care physicians in providing accessible, high quality, and cost-effective care to all types of patients. ACP strongly supports the ACA's patient protections, including requirements related to essential health benefits, community rating, prohibitions on lifetime and annual dollar limits, and restrictions on coverage that is not comprehensive, such as short-term limited duration health plans. However, to ensure that patients would actually benefit from any proposed changes to current law, the College has developed 10 key questions that should be asked of any effort that would alter the coverage and consumer protections available under the ACA, emphasizing the importance of "first, do no harm" to patients. We hope that you will use these criteria to guide your efforts to strengthen current law.

To help inform your work to enhance patient-centered care and health insurance affordability, we respectfully offer the following recommendations:

1. *Empowering patients and promoting consumer choice. What activities would best inform consumers and help them choose a plan that best meets their needs? Which regulations currently reduce consumer choices of how to finance their health care and health insurance*

needs? Choice includes the freedom to choose how to finance one's healthcare, which insurer to use, and which provider to use.

ACP agrees that patients should have a broad choice of clinicians, including high-quality physicians. ACP remains very concerned about the network adequacy of qualified health plans. Although narrow network plans may offer lower premiums, they often limit choice of high-quality physicians and other health care professionals, forcing enrollees to use out-of-network physicians with higher cost sharing. Evidence shows that networks are narrowing, potentially restricting patients from accessing their preferred physician (i,ii). To ensure that patients have access to their preferred physician, the College supports more stringent quantitative network adequacy criteria (such as time and distance standards and patient-to-provider ratios); ongoing monitoring and oversight of provider networks; transparent provider network development criteria; accurate, easily accessible, and up-to-date provider directories; an accessible and swift appeals process for patients and physicians; and requirements that qualified health plans should be prohibited from excluding health care clinicians whose practices contain substantial numbers of patients with expensive medical conditions.

2. *Stabilizing the individual, small group, and non-traditional 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?*

ACP believes that the Administration should work with Congress to take immediate action to stabilize the nongroup insurance market by committing to funding the cost-sharing reduction payments through 2018 and beyond, enforcing the individual mandate, providing funding and attention to outreach and marketing efforts, encouraging states to initiate state market stabilization efforts, and working with state governors to attract insurers.

Specifically, ACP recommends that the Administration and Congress must make a clear, immediate and unambiguous commitment to preserve the ACA's cost-sharing reduction (CSR) payments to insurers at least through 2018, and better yet, for the long-term. In February 2017, nearly 6 million enrollees relied on CSR payments to help reduce the burden of co-payments, deductibles, and coinsurance (iii).

The call for continued CSR funding has been echoed by a diverse variety of stakeholders, including the National Association of Insurance Commissioners and the National Governors Association (iv,v). Without a guarantee that the CSR payments will be continued, many insurers will have no choice but to leave the exchanges or to raise premiums by 20 percent or more to make up the shortfall. Many insurers are deciding now whether they will be able to offer insurance through the exchanges for the 2018 enrollment cycle and the proposed premiums should they opt to stay in the exchange markets. Those that have submitted proposed rate filings have indicated that they may have to reevaluate and adjust premium rates if CSR funds are not funded and paid to insurers. Several have already announced substantial premium increases because of the uncertainty over whether the CSR payments will continue. It is imperative that CSR be preserved.

The individual mandate is the federal government's "stick" to encourage enrollment, stabilize the market, and achieve affordable premiums. By not enforcing the insurance mandate penalty, enrollment rates will drop among healthy enrollees who may be less inclined to purchase health insurance, leading insurers to increase premiums to compensate for the sicker risk pool. According to the 2018 Maryland individual market rate filing for CareFirst, "we have assumed that the coverage mandate introduced by ACA will not be enforced in 2018 and that this will have the same impact as repeal. Based on industry and government estimates as well as actuarial judgement, we have projected that this will cause morbidity to increase by an additional 20%" (vi). The Congressional Budget Office predicts that while premiums are rising, tax credits that insulate enrollees from rising costs as well as the individual mandate "are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas" (vii). The agency also states that insurers withdraw from the market due to a variety of factors including "substantial uncertainty about enforcement of the individual mandate and about future payments of the cost-sharing subsidies to reduce out-of-pocket payments for people who enroll in nongroup coverage through the marketplaces established by the ACA." By enforcing the individual mandate, the administration can help to balance the market's risk pool, attract healthier enrollees, and avoid dramatic premium rate increases.

ACP believes HHS' March 13, 2017 letter encouraging states to seek Section 1332 waivers for reinsurance programs was a step in the right direction. Reinsurance can help to ensure patients get to keep the coverage they have while protecting insurers from high costs. According to HHS' June 30, 2017 report on transitional reinsurance payments and risk adjustment transfers for plan year 2016, the ACA's transitional reinsurance program has proven to be effective in stabilizing insurers with a substantial amount of high-cost enrollees, and, in concert with the risk adjustment program, has reduced the risk of adverse selection (viii). Alaska's reinsurance program has successfully reduced premium costs (ix) and Minnesota has established a premium rebate program to assist consumers ineligible for advanced premium tax credits. The administration should cooperate with state officials to stabilize their insurance markets and actively work to attract insurers to enter or maintain activity in underserved states. Such efforts have been fruitful to encourage insurer participation in underserved regions (x).

Many consumers are unaware of the availability of financial assistance that can lower the cost of their insurance. More intensive outreach and enrollment efforts will be vital as the open enrollment period for plan year 2018 has been shortened. In 2017, marketplace enrollment declined after HHS prematurely ended its open enrollment publicity and outreach campaign. Evidence suggests that enhanced television advertising can increase enrollment (xi).

ACP appreciates the opportunity to share our recommendations on ensuring that affordable, comprehensive health coverage is widely available. If you have questions please contact Ryan Crowley, Senior Associate, Health Policy at rcrowley@acponline.org.

Sincerely,

Jack Ende, MD, MACP
President
American College of Physicians

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[i] Polsky D and Weiner J. The Skinny on Narrow Networks in Health Insurance Marketplace Plans. The Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation. June 2015. Accessed at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027

[ii] Fisher ES, Lee PV. Toward Lower Costs and Better Care – Averting a Collision Between Consumer- and Provider-Focused Reforms. *N Engl J Med.* 2016;374:903-906. Accessed at http://www.nejm.org/doi/full/10.1056/NEJMp1514921

[iii] Centers for Medicare and Medicaid Services. 2017 Effectuated Enrollment Snapshot. June 12, 2017. Accessed at https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

[iv] National Association of Insurance Commissioners. Letter to Office of Management and Budget Director Mick Mulvaney. May 17, 2017. Accessed at http://www.naic.org/documents/government_relations_170517_letter_omb_costsharing_reduction.pdf

[v] National Governors Association. Letter to Congressional Leadership regarding Cost Sharing Reductions. April 24, 2017. Accessed at https://www.nga.org/cms/nga-letters/cost-sharing-reductions

[vi] CareFirst Blue Cross Blue Shield. Part III Actuarial Memorandum. Accessed at http://www.healthrates.mdinsurance.state.md.us/AllNewRateReq.aspx

[vii] Congressional Budget Office. Cost Estimate of H.R. 1628 Better Care Reconciliation Act of 2017. June 26, 2017. Accessed at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf

[viii] Centers for Medicare and Medicaid Services. Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year. June 30, 2017. Accessed at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf on July 6, 2017.

[ix] Alaska Department of Commerce, Community, and Economic Development Division of Insurance. Alaska 1332 Waiver Application. December 7, 2016. Accessed at https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=106061

[x] Haberkorn J. ACA bus rolls, enrolls in Mississippi. *Politico.* March 22, 2014. Accessed at http://www.politico.com/story/2014/03/obamacare-enrollment-mississippi-delta-104906

[xi] Karaca-Mandic P, Wilcock A, Baum L, Barry CL, Fowler EF, Niederdeppe J, Gollust SE. The Volume of TV Advertisements During The ACA's First Enrollment Period Was Associated With Increased Insurance Coverage. *Health Affairs.* 2017; 36(4):747-754. Accessed at http://content.healthaffairs.org/content/36/4/747 on June 13, 2017.