

Statement for the
United States Senate
Committee on Health, Education, Labor and Pensions

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**Hearing on Increasing Market Stability and Options for
Repeal and Replace of the Affordable Care Act**

Submitted by



Janet Stokes Trautwein, CEO
National Association of Health Underwriters
1212 New York Ave
Suite 1100
Washington, DC 20005
(202)595-0639
jtrautwein@nahu.org
www.nahu.org

Executive Summary

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. NAHU members experience the realities of the current state of the health insurance market every day. While many people have gained coverage as a result of the ACA, our members are finding it increasingly difficult to help their clients find affordable high-quality health insurance coverage, particularly in the individual health insurance market.

The problems the individual market is experiencing are largely due to adverse selection, which occurs when people either wait until they are sick to obtain coverage or drop coverage as soon as they have been treated for their illness. This causes an imbalance in the insurance pool, with not enough healthy people in the pool to offset those in poorer health.

As lawmakers move forward with changes to the ACA, it will be important to take immediate steps to stabilize the health insurance market since some actions they might take could create problems in an already troubled market. If repeal of the ACA via budget reconciliation is pursued, the effective date of repeal should be delayed for premium tax credits to allow alternative measures to be put into effect first. Immediate regulatory action should be taken to address problematic open- and special-enrollment issues.

The most significant changes will need to be addressed by Congress on a bipartisan basis. It is possible to retain provisions of the ACA like guaranteed issue of coverage, no pre-existing conditions, coverage to age 26 and other important protections while making other significant changes that will bring down the cost of coverage and enhance coverage options. Consideration will need to be given to how we enroll people for coverage and how we encourage them to remain covered. We will need to look at creative solutions to address high-risk individuals in a way that does not discriminate against them but instead acknowledges the increased risk and mitigates it so that it does not increase costs for others who are insured. A most significant concern should remain making sure most people are covered somewhere, either through their own policy or through their employer, and that younger people understand and embrace the importance of continuous health insurance coverage. Continuous coverage can be encouraged and achieved with the right incentives.

The following pages detail our recommendations in these areas. We welcome the opportunity to work with members of this committee and others interested in enhancing market stability, health insurance choices and affordability.

Good morning. My name is Janet Trautwein and I am the CEO of the National Association of Health Underwriters. NAHU is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. Thank you for inviting me here today to talk about immediate steps to improve the stability of health insurance markets and increasing the affordability and availability of coverage.

NAHU members work on a daily basis to help individuals, families and employers of all sizes purchase health insurance coverage. They help their clients use their coverage effectively and make sure they get the most out of the policies they have purchased. Since the passage of the Affordable Care Act, our members have spent enormous amounts of time educating their clients about the law's provisions and helping their clients comply with its regulations.

Some provisions of the Affordable Care Act have been noteworthy and helpful to people seeking health insurance coverage. They no longer have to answer health questions to qualify for coverage, they are no longer penalized if they have a pre-existing condition, and dependent children up to age 26 may now remain covered under a parent's health insurance plan. Premium tax credits are available for the purchase of private coverage for those without a valid offer of employer-sponsored coverage to help with the cost of coverage for people from 100% to 400% of the federal poverty level.

On the negative side, these benefits have come with a cost. Although everyone can obtain coverage regardless of health status, coverage and provider choices are fewer and premiums and cost-sharing are higher, particularly in the individual market. Even though tax credits have helped people afford coverage, the overall cost has increased so much that, for many, their share of the cost is still more than they can afford. This is the current state of the market and does not take into consideration the effect of any new changes that may be made relative to the ACA – the individual health insurance market is already unstable and immediate steps need to be taken to stabilize it.

The problems the individual market is experiencing are the result of coverage being offered on a no-questions-asked basis without adequate mechanisms to ensure that the pool of insured individuals is made up of both healthy and unhealthy individuals on a continual basis. The structure and the process related to the current system encourage individuals to wait until they are sick to obtain coverage. In fact, much of the problem in the market today stems from the fact that people are signing up for coverage during open- or special-enrollment periods, obtaining the care they believe they need and then dropping coverage. This means that the overall pool of covered individuals is sicker than average. We call this phenomenon "adverse selection."

To prevent adverse selection, the Affordable Care Act included an individual responsibility provision requiring people to continually be covered by health insurance. In addition to

preventing adverse selection, the individual responsibility requirement was intended to ensure that people were continuously covered and able to obtain preventive and other care they needed on a timely basis. Unfortunately, while well-intended, the requirement did not provide an adequate incentive to maintain coverage continuously and has not been effective in preventing the adverse selection we see today.

Market Correction

There are steps that can be taken to stabilize markets. Some should be taken immediately, while others could come into effect over the next few years. It is very important to address things in the proper order to ensure that one modification or improvement builds on the one before it. So the things that need to be done are important, but it is important not to randomly pick and choose what is done, but to methodically address stability in the correct order.

Before we outline these steps, it is important to address the item of immediate pending changes that could occur in connection with repealing some parts of the ACA via budget reconciliation. It is a given that we do not want to make changes that will cause the health insurance market to deteriorate even further. While we can begin to work on strategies to correct market problems now, some corrections will take time to come into effect for both practical and political reasons. Some key items to consider relative to reconciliation are:

1. Allow those already receiving premium tax credits and those who might become eligible for them during the next three years to continue to receive them until January 2020. This keeps people in coverage and works against adverse selection.
2. Retain the small business tax credit for a similar period of time to allow those who have selected coverage based on presumed receipt of a tax credit to receive it.
3. Repeal the medical loss ratio requirement – it creates the wrong incentives relative to cost-effective care and can increase overall premium levels.
4. Repeal the Excise/Cadillac Tax to provide premium relief to businesses and incentives to continue offering coverage to employees.
5. Repeal the Health Insurance Tax to provide premium relief for all fully insured health plans.
6. We strongly advise that the repeal of the reinsurance program scheduled to run through 2017 **not** be repealed even though it was a part of the prior reconciliation effort to repeal. Coverage pricing for 2017 has already factored in reinsurance. Removal would increase market instability and hurt consumers, who would likely be faced with fewer or no plan choices in 2018. Some carriers might even be forced to leave the market during 2017.
7. For the same reason, we recommend no action to remove cost-sharing subsidies prior to the effective date of repeal of the current premium tax credits. Many who are receiving these credits are young families who serve to stabilize the overall market. They are likely to drop coverage if the cost of using their coverage is no longer affordable.

Whether or not parts of the ACA are repealed via reconciliation, action must be taken to enhance health insurance market stability. Since not all desired elements of a reformed marketplace can be achieved via reconciliation, if reconciliation successfully repeals some provisions, taking immediate action in a number of areas becomes even more imperative. Those items that can be corrected on a regulatory basis offer virtually immediate benefit for market stabilization.

Immediate Regulatory Actions to Increase Stability of the Individual and Small-Employer Markets

The ACA has had an enormous impact on the private health insurance marketplace, including the availability and affordability of health insurance options for individual consumers and on the ability of employers to offer affordable and comprehensive health insurance coverage to their employees. In addition to the breadth of the ACA statute itself, the resulting regulations and guidance, totaling more than 40,000 pages to date, have had a profound effect on our economy and all aspects of our national health coverage system.

NAHU has identified a number of these regulations that could immediately improve the stability of the health insurance market. We address these immediate action items here and have attached an appendix of others and that may be pending or eligible for congressional review that could provide important relief for individuals and businesses purchasing health insurance. We present these recommendations for administrative and congressional action in the very near future, which we believe will significantly reduce costs and increase access for business and individual consumers of private health insurance coverage.

Some of the areas where NAHU believes that the new Administration could positively impact via thoughtful and targeted regulatory change include but are not limited to:

1. Special enrollment periods should be limited only to those clearly defined in the ACA and should require submission of documented proof by the 15th of the month **before** coverage will be effective.
2. The extended 90-day grace period for individuals who are receiving premium tax credits should be reduced to the same 30-day grace period for other covered individuals.
3. HIPAA Certificates of Credible coverage, which for many years documented periods of coverage and showed when coverage began and ended, were discontinued in conjunction with the ACA. Immediate restoration of those certificates would facilitate proof of dates of coverage for multiple purposes, including documentation of continuity of coverage and loss of coverage for special enrollment purposes.
4. Allow continuation of “grandmothered” policies beyond the scheduled expiration date of 2017.
5. If the medical loss ratio is not repealed via reconciliation and until it can be repealed legislatively, there should be regulatory action to redefine the formula for MLR to specifically exclude broker commissions in the same way taxes are excluded from the formula.
6. Allow a more robust form of composite rating in fully insured plans to allow ease of administration for small employers that provide coverage for employees.
7. Remove the requirement for standardized benefit plans to be offered in Marketplaces.

8. Simplify the structure and burden of IRC §§6055 and 6056 employer reporting requirements.
9. Remove limitations on keeping grandfathered plans to allow greater changes in employee contributions toward coverage, deductibles and other benefit changes based on an annual allowable change vs. lifetime change.

Legislative Action in Regular Order

NAHU recognizes that many actions that are needed to stabilize the individual market cannot be done on a regulatory basis, nor are they likely to be eligible for inclusion in a reconciliation repeal effort. For this reason, we have developed a set of recommended actions to increase market stability.

The following recommendations are made in the order they appear to importantly address “first things first.” Randomly selecting from these items when the correct stabilizing actions have not been taken will not provide the desired market outcome.

Our recommendations, in order, are:

1. While ACA tax credits are still in effect, allow premium tax credits to be used outside of the Marketplace if there are fewer than two choices offered in a state. Alternatively, this could apply in certain counties within a state. This would ensure that those who are eligible for a tax credit have a place to use the credit. It does not require the creation of new infrastructure: The Marketplace would still be used for eligibility determination and tax credits would be sent to insurance carriers as they are today. Since coverage outside of the Marketplace is currently still subject to ACA regulations, coverage outside of the Marketplace would be of equal quality to that being offered inside the Marketplace. **The purpose of this provision is to ensure continuous coverage and prevent adverse selection.**
2. Allow any person to purchase the catastrophic category of coverage regardless of age or income status. Since market stabilization has not yet been achieved and premium levels are high, many people are priced out of coverage. This provision would allow purchase of some level of affordable coverage for all. We further recommend that the current schedule of ACA tax credits be permitted to apply to this type of coverage. Right now, only those who are exempt from the individual mandate and those under 30 are allowed to purchase catastrophic coverage, and tax credits may not be used for this category of coverage. **The purpose of this provision is to create incentives and affordable access for at least a baseline of coverage. Currently, many people are unable to afford their share of the premium for Bronze-level coverage even with a tax credit. This**

provides an additional option for bringing people into the insurance pool rather than remaining uninsured.

3. The current structure of open enrollments and special enrollments must be addressed. We recommend changing the current annual open enrollment to a one-time or less-frequent-than-annual open-enrollment period. We further recommend that special-enrollment opportunities be tightened significantly to remove subjective eligibility and be allowed only for lifestyle changes such as loss of coverage (documented), marriage, divorce, death of a spouse or birth or adoption of a child, and that a person be permitted a maximum 60-day break in coverage. Once the initial enrollment period opportunity expired, we recommend that any person enrolling with more than a 60-day break in coverage be subject to late enrollment penalties for five years* with a mandatory six-month waiting period for those who do not meet a continuous-coverage requirement. **This type of provision will be a strong incentive to maintain coverage and has worked very well in Medicare Part B. It allows the preservation of guaranteed issue without application of pre-existing-conditions limitations, but discourages people from waiting until they are ill to obtain coverage. It also encourages a person not to drop coverage so that the penalties would begin anew. The five-year period is less than the lifetime penalty imposed by Part B but enough of an incentive that it encourages continued coverage.**

4. Begin action on allowing **and providing funding** for states on **hybrid high-risk pools** (hybrid version to insure risk and not be coverage-issuing pools) to be in effect by January 1, 2019. These special high-risk pools would be available as a state option where carriers could cede risk relative to individuals who had not maintained continuous coverage, for a reasonable fee. If a carrier cedes risk for an individual, any late-enrollment penalties are paid to the pool, minus the pool fee for ceding the risk.

A number of state high-risk pools are still in existence and could be converted to this model. The advantage of this model is that the insured individual still receives coverage through a traditional insurance plan and is not turned down for coverage due to a health condition. The insurer is able to either cede the risk to the pool and forego late-enrollment penalties or retain the risk and receive late-enrollment penalties. The other market stabilizer is the mandatory waiting period (similar to Part B).

This avoids the undesirable elements of the high-risk pools of the past; individuals in the pool would have the same coverage as anyone else could have. Premiums would not be based on health status. At the same time, it allows the risk of unhealthy individuals to be offset by the pool. This means that the cost of the high-risk individuals would not borne by everyone in the regular insured pool, and overall premiums would go down.

5. If ACA tax credits are repealed via reconciliation or some other mechanism, they will need to be replaced with another type of tax credit. NAHU feels that the greatest market stability would be obtained by making these credits income-adjusted, which would provide for a larger credit for those who most need it so that they can afford to remain continuously insured. This income adjustment does not need to replicate what is in place today, but assistance is particularly needed for those below 300% of FPL.

If the credit is not income-adjusted, it should, at a minimum, be refundable and advanceable and age-rated with at least five rating categories. Weighting should encourage younger individuals to enroll.

The purpose of this provision is to provide assistance to those without an offer of employer-sponsored coverage to enhance their ability to afford coverage and increase the number of people continuously covered – thereby increasing overall market stability.

6. Allow states to regulate their markets by allowing them to modify age-rating rules for their individual and small-employer markets. Create a fallback level for rating rules of 5:1 if a state does not actively elect another formula or does not elect to retain 3:1 rating. Retain prohibition of rating based on health status by issuers in the individual and small-employer markets. **The purpose of this provision is to bring more younger individuals into the insurance pool and enhance market stability.**
7. Allow states flexibility in plan design relative to coverage for an essential benefits package but retain coverage for dependents to age 26, prohibition on lifetime limits, mental health parity and prohibition on pre-existing conditions. States would elect one plan offered in the state in the small-employer market annually to indicate which covered items and services would be included in the essential benefits package for that state. This would not dictate plan design but would indicate what must be covered by a plan. This provision is a consumer protection to ensure that adequate coverage is available for all. Using benefits in the small-employer market ensures an adequate level of coverage regardless of the content or even the existence of a federally prescribed package of benefits.

The following items could also enhance market stability but only after initial stabilization occurred in the areas above:

1. Allow states that wish to increase competition to permit coverage to be offered in the individual market from carriers domiciled in other states. Coverage offered must reflect the essential benefits package in the domiciled state or the state where coverage is being offered.

2. Allow states that wish to increase competition to permit coverage to be offered through bona fide association health plans. Coverage offered must reflect the essential benefits package in the domiciled state or the state where coverage is being offered.
3. Increase flexibility for HSAs, for example, by allowing contributions equal to the out-of-pocket maximum and a limited number of office visits to be covered before the deductible each year. This would encourage more people to be covered by giving them the advantage of a HSA combined with an underlying health plan that would have more practical features important to the average individual and family.

Conclusion

The items discussed here are suggestions for immediate action to stabilize the private health insurance market. There are other actions that need to be addressed, particularly relating to employer-sponsored coverage and maintaining the integrity of those programs. However, NAHU sees these items as important immediate steps to ensuring the affordability and availability of private health insurance coverage for all Americans.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee.

Follow-up questions can be addressed to Janet Trautwein, CEO of the National Association of Health Underwriters, at jtrautwein@nahu.org or (202) 595-0639.

Regulations Impacting Employers and Health Insurance Consumers That Have Been Proposed by the Obama Administration but Have Not Been Finalized

Proposed Revision of 5500 Annual Information Returns and Reports

The Obama Administration proposed an enormous overhaul and expansion of the 5500 annual information returns and reports most employer-sponsored group benefit and retirement plans must submit annually to the Departments of Labor and Treasury. Not only would the rule require entities that currently have to comply with reporting requirements to drastically expand the amount of information they provide annually to the federal government, it would also expand reporting obligations to over 2 million new small businesses. The proposed reporting expansion will be extremely expensive and complicated for employers of all sizes to implement. Furthermore, it is unclear what the Departments of Labor and Treasury will even do with the new data they plan to collect. Comments were due on this proposed rule on December 5, 2016, and it has yet to be finalized. **NAHU recommends that the Trump Administration rescind this proposed rule.**

Premium Tax Credit NPRM VI

On July 8, 2016, the Department of Treasury issued proposed regulations that address the treatment of cash incentives provided to employees who waive coverage under an employer's health plan. The proposed rule sets out very complex requirements for employers to follow, and places liability and requirements on employers to police the veracity of employee attestation. If finalized as proposed, employers will likely cease providing any type of compensation to employees who do not need coverage through the employer group plan. **NAHU recommends that the Trump Administration rescind this proposed rule.**

Information Reporting of Catastrophic Health Coverage and Other Issues under Section 6055

On July 29, 2016, the IRS issued a proposed rule to clarify a number of technical issues related to information reporting under IRC §6055. This proposed rule does provide employers with some guidance to avoid liability for reporting errors, but the compliance date is for the 2016 plan year, which is much too soon. **NAHU urges the Trump Administration to make the effective date of any TIN-solicitation requirements, processes and timelines the 2017 plan year, reported on in 2018.**

Expatriate Health Plans, Expatriate Health Plan Issuers and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; Short-Term, Limited-Duration Insurance

On June 10, 2016, the Departments of Health and Human Services, Treasury and Labor issued a proposed rule to provide implementation guidance on the Expatriate Health Coverage Clarification Act (EHCCA), which was signed into law on December 16, 2014. The rule also imposed significant limitations on short-term, limited-duration insurance policies

Relative to expatriate health plans, NAHU members who work with expatriates to find coverage both on the group and individual level believe that some provisions of the proposed rule, as drafted, would have a burdensome and negative effect on many expatriates, particularly those doing missionary work overseas. Furthermore, we have concerns that the language in the proposed rule will impair the ability of United States insurance companies to compete with foreign competitors. **NAHU urges the Trump Administration to review the comments of all stakeholders with regard to the EHCCA provisions of the proposed rule and make the various suggested amendments that will ensure that American insurers will be on a level playing field with foreign competitors – and that American expatriates doing missionary work will not be penalized.**

With regard to the proposed additional standards for short-term, limited-duration health insurance policies, requiring that the coverage must be less than three months in duration and may not be renewed, will result in hundreds of thousands of people being shut out of needed coverage options for part of each year. Furthermore, the new proposed cap on the duration of such policies and the restriction on policy renewals raise enormous enforceability, claims-processing and fraud concerns. Also, we believe the rule, as proposed, would limit coverage choices for consumers who currently buy short-term coverage to meet a gap in their group coverage options and never intend to seek individual-market coverage. NAHU agents report that this kind of consumer represents over half of the short-term coverage marketplace today. NAHU feels that the Obama Administration exceeded the bounds of its regulatory authority in this area. The primary responsibility to regulate excepted benefits rests with the states, and therefore the requirements in the proposed rules are wholly inappropriate and unnecessary. As for the proposed design restrictions for these policies, particularly with regard to fixed indemnity policies, the proposed rule will significantly alter common benefit-design options already available to employers and employees in the marketplace and negatively impact employee choice. **NAHU urges the Trump Administration to rescind the excepted-benefit provisions of the proposed rule.**

Health Reform Rules That Have Not Yet Been Issued/Are Not Being Enforced by the Obama Administration

Affordable Care Act §2716 Non-Discrimination Provisions Applicable to Insured Group Health Plans

The ACA required that existing IRS benefit plan non-discrimination requirements and related annual testing requirements that self-funded employer plans must abide by be extended to all employer-sponsored health benefit plans of all sizes. However, these existing requirements, which were originally designed for large-employer pension plans, cannot easily be expanded in a way that would make any sense for smaller-employer and fully insured group health benefit plans. NAHU analysis done in 2010 in anticipation of this requirement being imposed on small-group benefit plans showed that up to 80% of small-group benefit plans of less than 50 employees would fail the current non-discrimination testing imposed on large self-funded plans simply because too many of their employees are covered under other minimum essential coverage, such as a spouse's plan. As such, the IRS issued Notice 2011-1 in January 2011 noting that the Treasury Department and the IRS, as well as the Departments of Labor and Health and Human Services (collectively, the Departments) determined that compliance with §2716 should not be required until after regulations or other administrative guidance of general applicability has been issued under §2716. To date, no regulations have been issued to enforce compliance with this ACA requirement. **NAHU strongly urges the Trump Administration to continue the Obama Administration's policy of not issuing regulations to require expanded compliance with §2716 and to publicly announce its intention to not enforce compliance beyond the requirements currently in force on self-funded employer group plans.**

W-2 Reporting for Smaller Plans

While the ACA statute requires virtually all employers that offer health insurance coverage to employees to report information about their benefits to employees via the Form W-2, in 2011 the IRS issued Notice 2011-28, which made the reporting optional for smaller employers that file fewer than 250 Forms W-2 for the prior calendar year until further notice. The IRS has not issued any further guidance mandating reporting for smaller employers so, for the 2016 tax year W-2 reporting cycle, which is due by January 31, 2017, only employers that issue 250 or more forms W-2 have to comply. **NAHU strongly urges the Trump Administration to continue the Obama Administration's policy of not issuing regulations to require expanded compliance with W-2 reporting for smaller employers.**

Recently Finalized Regulations That Could Be Subject to Congressional Review

Non-discrimination in Health Programs and Activities

On May 18, 2016, the Obama Administration finalized a regulation implementing the prohibition of discrimination under §1557 of the ACA. This rule imposes significant costs and mandates on health plan design that must be implemented for the 2017 plan year, which in many cases starts for employer plans on January 1, 2017. Even though not all employers should be affected by the rule, since most employer groups will get their coverage through a health insurance carrier or work with a TPA that is covered by the new rule, the construction of the health insurance policies most employer groups will be able to buy will be affected, which can be confusing to employers. **NAHU recommends that this final rule be revised so that only entities directly under the control of HHS must comply with these new requirements.**

ERISA Fines

On June 30, 2016, the Department of Labor issued an interim final rule that significantly increases various penalties under the Employee Retirement Income Security Act of 1974 (ERISA). NAHU recognizes that the amount of the civil penalties that were adjusted in many cases had never been adjusted previously, and we believe that the formula used to increase the penalties was fairly applied in the interim final rule. However, we question the need for an interim final regulation that raised fines almost immediately rather than the use of the traditional regulatory process. Further, we question why health benefit plan fines needed to be raised at this time. Given that the fines established originally to help ensure compliance with ERISA and subsequent health plan requirements have always been significant and are still intimidating to employers in some cases over four decades later, we do not believe that the increase is needed at this time. **NAHU recommends that the Trump Administration issue a final regulation setting the fine rates at their pre-August 2016 levels.**

EEOC Wellness Program Rule

On May 17, 2016, the Equal Employment Opportunity Commission published final rules on wellness programs under the Americans with Disabilities Act and Genetic Information Nondiscrimination Act. These rules are intended to provide clarity about how employers can operate wellness programs and not run afoul of either the ADA or GINA. These rules were proposed and finalized after the EEOC initiated three lawsuits against high-profile employers for allegedly committing ADA violations in the administration of their wellness programs, which have so far all been decided in favor of the employers.

The finalized rules raise a number of concerns for employer-sponsored wellness plans. First, the wellness-program standards imposed by these new rules are different, and in some cases more

extensive, than the preexisting HIPAA and ACA wellness-program rules. With regard to the value of the wellness incentives, the EEOC standard actually conflicts with, and reduces, the discount standard specifically allowed by the ACA and discourages the use of wellness programs by employers. **NAHU recommends that Congress and Trump Administration suspend implementation of the new EEOC wellness program rules.**

Recently Finalized Regulations with Questionable Status

DOL Fiduciary Rule

The Obama Administration finalized a version of the fiduciary rule on April 6, 2016, so it is likely to be outside of the scope of congressional review. However, we know there is significant interest in making changes to the rule as soon as possible and want to highlight a rarely noted but extremely problematic provision of the rule that negatively impacts health plans. In the final rule, the definition of “plan fiduciary” was expanded to cover not only service providers who assist employers and employees with individual retirement account (IRA) options, but also those who assist with Health Saving Accounts (HSAs) and Archer Medical Savings Accounts (MSAs), including providing advice on a one-time basis. NAHU is concerned that, as this provision of the rule is implemented, both employers and licensed agents and brokers will be inclined to eschew the HSA option for employees in favor of other benefit designs due to the new complexity and liability that will be associated with HSAs. **NAHU recommends that in any revision of plan fiduciary requirements, to preserve the group HSA marketplace and protect employee access to the HSA option and its many benefits, the Trump Administration exclude HSAs and MSAs from the scope.**

Notice of Benefit and Payment Parameters 2018

The Obama Administration released the proposed 2018 Notice of Benefit and Payment Parameters on August 31, 2016. This proposed rule contains a wide range of provisions impacting the individual and group health insurance markets and the health insurance marketplaces. The White House Office of Management and Budget is currently reviewing the rule and every indication is that the Obama Administration plans to finalize it before the end of the term. As such, this regulation would certainly fall under the bounds of congressional review. **If so, NAHU urges Congress and the Trump Administration to review the provisions of the new rule thoroughly and seek input from stakeholders right away about what changes could be made using the rule as a vehicle to improve health insurance market competition, lessen the cost and access burdens on employers and individual health insurance market consumers, and improve the functionality of health-reform programs that may continue on at least a short-term basis.**

Immediate Regulatory Action to Improve Marketplace Operation

NAHU has worked extensively to try to improve conditions in the federal Marketplace, including participating as a vendor for broker training. While some improvements have occurred, it has been extremely frustrating for our members to try to assist their clients. Although we understand there may be little impetus for improving the Marketplace at this juncture, we list below some outstanding items that are very problematic to our members and their clients. Some of these serve to destabilize the individual health insurance market so we include them here for your review.

NAHU Requests to CMS That Have Not Been Resolved

- A dedicated portal for brokers to submit individual exchange applications and manage their clients' individual exchange coverage choices throughout the plan year and from year to year. **This has already been achieved through state-run marketplaces.**
- A customer-service channel dedicated to brokers for client-specific individual exchange issues outside of the traditional call center.
 - A broker call center number was made available this year, but only assists with password resets and questions regarding SEPs. **This has already been achieved through state-run marketplaces.**
- Amendments to the marketplace coverage application and transaction records to track and record the identifying numbers for all navigator/non-navigator assisters, call-center support personnel and certified agents who assist an enrollee. This will provide better consumer protection and inspire greater cooperation among the various types of individuals providing consumers with application and coverage assistance.
- Enhanced priority to technology efforts that will allow both agents and individual consumers access to direct-enrollment portals through health insurance issuers and web-based brokers.
- Access to participating carrier plan designs at least two weeks in advance of open enrollment so agents and brokers may adequately prepare to assist their clients on the first day of open enrollment.

Application Improvements

- Once the application has been completed, an "application review" screen should appear showing the application as it will be submitted so that the applicant can review the application in its entirety for accuracy one last time before submission.
- In its current state, in order to edit the application, the applicant must go through the entire application in order to make any changes. The ability to open the application for specific changes (address, income, birth of child) without revisiting each question would be very beneficial.

- Uploading requested documents through the application process often results in errors in uploaded documents that are not retained in the healthcare.gov system. A confirmation page or email receipt to the applicant signifying that a document was successfully uploaded would largely alleviate this.
- An application identifying number (ID) is generated once an application has been successfully submitted and provided on-screen to the beneficiary. We would like to request that this application ID, or another identifier provided to the beneficiary, be used to mark all FFM communications regarding a specific beneficiary or applicant. Often, calls are made to the call center, no reference number is given and consumers are told there is no way for the call center to trace past communication with healthcare.gov. Using the application ID assigned by healthcare.gov or another unique identifier to effectively link the consumer to all of their interactions with the FFM would provide a level of accountability and a smooth and easy conduit to connect conversations over the course of multiple touches.
- Throughout a coverage year, one spouse may obtain employer-sponsored coverage. Often, this coverage is deemed “affordable,” causing a married couple enrolled in a subsidized plan on the exchange to lose their subsidy. However, NAHU members have come across instances in which the couple calls to cancel the plan for the spouse who has obtained employer-sponsored coverage, but they are never asked why the spouse is canceling their plan, whether the employer-sponsored coverage is affordable or whether a change in income should be reported. This results in the remaining spouse, and possibly other family members, continuing to receive subsidized coverage, only to be faced with a large tax bill once their income and employer-sponsored coverage of one spouse is reconciled at the end of the tax year. When a couple calls to cancel the plan of a spouse, this should trigger questions in the script of the call center to inquire about employment-sponsored coverage of the spouse, and a change in income in order to prevent couples such as these to receive inaccurate subsidies that they will then have to pay back through their taxes the following year.

Agent Access

- Agents and brokers are only able to access their accounts by going in to each separate client’s account. A single certified agent account would be extremely beneficial to allow agents to access a list of all of their clients’ accounts, and the ability for agents to review the applications and receive communication on any status or actions required on the account would ensure that their clients’ applications are complete and accurate. In addition, the system should also allow agents to log in to the CMS Enterprise Portal to enroll a new consumer, renew an existing consumer’s application and re-enrollment, and make updates to a consumer’s application throughout the plan year.

- There have been several instances in which agents have called healthcare.gov to act on their client's behalf only to be told that they are no longer authorized to do so even though the client has authorized the agent to act on their behalf for the allotted 365 days. There should be no change to the "Agent" or "Authorized Representatives" field unless the consumer requests such a change, and the agent of record should be on display if accessed by a call-center representative.
- Currently, all correspondence regarding an applicant is sent to the applicant via the HIM Message Center. We would like to request that agents and brokers be included on all correspondence to the applicants. Often, the agents are not alerted to a problem until after an insurance claim has been denied or coverage has been discontinued. If agents were included in the client communication from the initial message, these issues could be resolved before a denial of coverage is issued.

Consumer Access to Agents

- Earlier this year, NAHU wrote to HHS Secretary Burwell to address the troubling and increasing prevalence of insurers reducing or eliminating broker commissions during the plan year. While CMS has been very clear that it does not require or regulate broker compensation for marketplace products, CMS does stipulate that if an issuer provides broker compensation, then the issuer must provide the same level of compensation for all substantially similar QHP products whether they are sold via the exchange Marketplace or in the off-exchange Marketplace.
- NAHU also believes that CMS has the responsibility and authority under its rate-review and QHP-certification processes to ensure that issuers maintain the services that they promise via filed and approved rates throughout the plan year. Much like CMS stipulates that issuers may not change and reduce their initially specified service areas mid-plan-year, we believe it is appropriate for CMS to stipulate that the services promised as part of approved rates, including access to the purchasing services and plan year, and renewal of consumer support offered by a licensed health insurance agent or broker, not be eliminated partway through a given plan year. Otherwise, consumer services that are promised as part of the approved rates of the policy may be reduced, and the consumer would see no corresponding premium reduction.
- Ultimately, consumers, especially those most at risk, are left with fewer choices and without experienced and educated insurance professionals. At a time when the market is changing and becoming more complex, this is unacceptable.

Note: We believe this adverse selection that has resulted in commission cuts, narrow provider networks, increasing out-of-pocket expense and premium increases can be corrected with many of the recommendations we are making in this document.

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Patient Protection and Affordable Care Act

November 18, 2009 | Cost Estimate

Cost estimate for the amendment in the nature of a substitute to H.R. 3590, as proposed in the Senate on November 18, 2009

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70.16 KB

Summary

Cost estimate for the amendment in the nature of a substitute to H.R. 3590, as proposed in the Senate on November 18, 2009

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Budgetary Treatment of Proposals to Regulate Medical Loss Ratios

CBO has been asked to review a proposal that would require health insurers to provide rebates to enrollees to the extent that their medical loss ratios are less than 90 percent. (A medical loss ratio, or MLR, is the proportion of premium dollars that an insurer spends on health care; it is commonly calculated as the amount of claims incurred plus changes in reserves as a fraction of premiums earned.) In particular, CBO has been asked to assess whether adding such a requirement to the provisions of the Patient Protection and Affordable Care Act (PPACA) put forward by Senator Reid (as an amendment to H.R. 3590) would change its judgment as to how various types of health insurance transactions that would occur under that legislation should be reflected in the federal budget.

In May, CBO released an issue brief entitled *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System*. That publication identified the primary elements of proposals that CBO thought were relevant to whether purchases of private health insurance should be treated as part of the federal budget. CBO concluded (on page 4) that "at its root, the key consideration is whether the proposal would be making health insurance an essentially governmental program, tightly controlled by the federal government with little choice available to those who offer and buy health insurance—or whether the system would provide significant flexibility in terms of the types, prices, and number of private-sector sellers of insurance available to people." (Note: CBO estimates the budgetary impact of legislation as it is being considered by the Congress; if legislation is enacted into law, the Administration's Office of Management and Budget ultimately determines how its effects will be reflected in the federal budget.)

The PPACA would make numerous changes to the market for health insurance, including requiring all individuals to purchase health insurance, subsidizing coverage for some individuals, and establishing standards for benefit packages. Taken together, those changes would significantly increase the federal government's role in that market. Nevertheless, CBO concluded that there would remain sufficient flexibility for providers of insurance and sufficient choice for purchasers of insurance that the insurance market as a whole should be considered part of the private sector. Therefore, except for certain transactions that explicitly involve the government, CBO would treat the cash flows associated with the health insurance system (for example, premium and benefit payments) as nongovernmental.

Certain policies governing MLRs, particularly those requiring health plans whose MLR falls below a minimum level to rebate the difference to enrollees, can be a powerful regulatory tool. Insurers operating at MLRs below such a minimum would have a limited number of possible responses. They could change the way they provide health insurance, perhaps by reducing their profits or cutting back on efforts to restrain benefit costs through care management. They could choose to pay the rebates, but if they raised premiums to cover the added costs they would simply have to rebate that increment to premiums later. Alternatively, they could exit the market entirely. Such responses would reduce the types, range of prices, and number of private-sector sellers of health insurance—the very flexibilities described in CBO's issue brief.

In CBO's judgment, an important consideration in whether a specific MLR policy would cause such market effects is the fraction of health insurance issuers for whom the policy would be binding. A policy that affected a majority of issuers would be likely to substantially reduce flexibility in terms of the types, prices, and number of private sellers of health insurance. Taken together with the significant increase in the federal government's role in the insurance market under the PPACA, such a substantial loss in flexibility would lead CBO to conclude that the affected segments of the health insurance market should be considered part of the federal budget. (CBO made similar judgments in its issue brief in assessing the level of required coverage that would, in combination with a mandate to purchase coverage, make the purchase of insurance essentially governmental.)

Setting a precise minimum MLR that would trigger such a determination under the PPACA is difficult, because MLRs fall along a continuum. However, CBO has identified MLRs in the principal segments of the insurance market above which a significant minority of insurers would be affected; if a minimum MLR were set at or below those levels, CBO would not consider purchases of private health insurance to be part of the federal budget. Compared with MLRs anticipated under current law, MLRs under the PPACA would tend to be similar in the large-group market, slightly higher in the small-group market, and noticeably higher in the individual (nongroup) market—for reasons that are discussed in CBO's November 30 analysis of the effect of Senator Reid's proposal on insurance premiums. Taking those differences into account, CBO has determined that setting minimum MLRs under the PPACA at 80 percent or lower for the individual and small-group markets or at 85 percent or lower for the large-group market would not cause CBO to consider transactions in those markets as part of the federal budget.

A proposal to require health insurers to provide rebates to their enrollees to the extent that their medical loss ratios are less than 90 percent would effectively force insurers to achieve a high medical loss ratio. Combining this requirement with the other provisions of the PPACA would greatly restrict flexibility related to the sale and purchase of health insurance. In CBO's view, this further expansion of the federal government's role in the health insurance market would make such insurance an essentially governmental program, so that all payments related to health insurance policies should be recorded as cash flows in the federal budget.

Congressional Budget Office

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