

November 27, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Submitted via: www.regulations.gov

**Attn: CMS-9930-P
NPRM Notice of Benefit and Payment Parameters for 2019**

Thank you for the opportunity to comment on HHS' proposed HHS Notice of Benefit and Payment Parameters for 2019 proposed rule. The Center for Public Policy Priorities (CPPP) is a nonpartisan, nonprofit 501(c)(3) public policy organization that uses data and analysis to advocate for solutions that enable Texans of all backgrounds to reach their full potential. Improving access to health care for Texans has been at the core of our mission and activities since our founding 30 years ago.

We have provided our specific comments below.

Part 154 - Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

The changes proposed to the Rate Review sections would allow carriers to raise rates unchecked up to 15 percent each year. Comprehensive review of rate filing justifications plays a key role in ensuring that consumers pay a fair price for their health insurance coverage. This process is a key consumer protection. We urge the states and HHS to use the rate review process *more* to protect insurance enrollees, not *less*.

We oppose the proposal to raise the rate review threshold from 10 percent to 15 percent, which would normalize excessive rate increases.¹ Allowing carriers to finalize exorbitant rate increases without oversight, combined with the specter of lowered medical loss ratio safeguards, is especially troubling.

Prior significant rate increases are not a justification for future large and unchecked rate increases. This regulatory change would create a segment of rate increases that would have

¹ As stated by HHS, the threshold change is proposed "in recognition of significant rate increases in the past number of years." Federal Register Vol. 82, No. 211, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019*, at 51079.

been reviewed and possibly reduced were it not for this change, likely increases costs for consumers.

Rather than opening the gates for unchecked rate increases in 2019, we encourage HHS to lower the bar to a threshold more aligned with sustainable rates of health spending growth and support thresholds proposed in comments submitted by Consumers Union.

§ 155.20 – Standardized Options

We do not support the proposed changes to eliminate standardized options. Having standardized options assists consumers in making informed choices. When plans share a common benefits structure, including tiering and cost sharing, consumers can make apples-to-apples comparisons of plans and benefits. We also believe there is great value for consumers in simplified options, particularly when those options match high-value designs.

§ 155.210 – Navigator Program Standards

We strongly believe that continued investment in the Navigator and Certified Application Counselor programs is critical to promoting a healthy risk pool and ensuring that consumers, especially those who are low-income, enroll in a plan that best suits their needs. We work closely with Navigator and CAC programs across Texas. We believe that community and consumer-focused nonprofit groups and groups that are physically located in the state to provide *in-person* support are necessary to the enrollment process.

We are strongly opposed to and urge HHS to forgo the proposed changes that weaken the following current standards:

- Each exchange must have at least two Navigator organizations;
- At least one of the Navigator Programs must be a community and consumer-focused nonprofit group; and
- Each Navigator Program must maintain a physical presence in the exchange service areas.

We are dismayed at the proposed changes to reduce the number of required navigator entities in a state from two to one. The requirement to have two entities ensures that a state can have a general entity and one more tailored to specific needs within a state, whether that includes a focus on young adults, limited English proficient individuals, or other targeted populations. Further, removing the requirement that one entity be a community and consumer-focused non-profit is also troubling. Many of the individuals assisted by navigator entities have complex situations and community and consumer-based entities are best suited to address their needs. They already have the experience working with these populations on a regular basis.

We also oppose the proposal to remove the requirement that a navigator entity maintain a physical presence in the Exchange service area. In-person enrollment assistance is essential. In the third open enrollment period, almost half of all marketplace enrollees received assistance

from an in-person assister, with 8 in 10 reporting² they went to an assister because they did not feel confident enrolling on their own. Additionally, the longstanding community ties that many of these organizations already have has allowed them to offer and develop services unique to their communities, such as services in languages other than English, translation or transportation services.

Face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of application, plan selection, resolving data matching inconsistencies, and perhaps assisting with appeals.

Physically present entities remain available after open enrollment to provide assistance if questions arise, can assist in finding providers, and can help consumers prepare for re-enrollment. Navigators do much, much more than merely enroll eligible individuals and having the community presence and building the ongoing relationships with consumers is critical to ensure all eligible consumers obtain and maintain health insurance. In particular, individuals with low health literacy (in addition to low literacy in general), low internet proficiency and who live in rural areas may face additional challenges in enrolling and rely on assisters to help complete enrollment.

As HHS recognizes in the preamble, “we believe entities with a physical presence and strong relationships in their FFE service areas tend to deliver the most effective outreach and enrollment results.” (81 Fed. Reg. 51084). Given this recognition, it is appropriate to maintain the requirements that a navigator have a physical presence in the area(s) in which it receives funding to assist consumers.

We believe that the proposed changes, coupled with the 40 percent cut in funding to navigators this year, will likely result in few navigator options and potentially no in-person enrollment assistance from a navigator or certified application counselor, which will hurt consumers and their ability to successfully enroll in a plan that meets their needs. **Therefore, we urge HHS to reconsider the proposed changes and maintain the current requirements.**

§ 155.305 – Eligibility Standards

We oppose the removal of the direct notification requirement as proposed. Without proper notice, consumers who receive adverse information do not know why the action is being taken and do not have the information they need to access a hearing that will afford them the opportunity to explain why the agency’s decision is incorrect. The Marketplace should issue direct individual notice following failure to reconcile and the notice should include the specific reason the action is being taken and information on how the consumer can challenge the decision. Individuals who will lose their advance premium tax credits (APTCs) due to a failure to

² Kaiser Family Foundation, 2016 Survey of Health Insurance Marketplace Assister Programs and Brokers, June 8, 2016: <https://www.kff.org/report-section/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers-section-1-assister-programs-characteristics-and-people-helped/>

reconcile necessarily have limited incomes and many cannot afford the luxury of paying for a benefit until they can determine what next steps they need to take to maintain their subsidy. They need a notice that contains the legally required information that will allow them to decide whether to rectify the issue or perhaps challenge the determination and, if so, to present their claim in a timely and effective way.

§ 155.320 – Income Inconsistencies

We oppose HHS’ proposal to generate income inconsistencies for consumers whose attested projected annual income is greater than the income amount represented by federal data sources if the attested income is over 100% FPL while the returned data source indicates an income under 100% FPL.

As we have seen over the course of five open enrollment periods, low-income consumers often face difficulty estimating their annual incomes, They may have fluctuating income due to shift work, seasonal work, time off needed for child/elder care, or a host of other reasons. We should not further penalize them by creating a data inconsistency which will require the individual to provide additional information to resolve. Additionally, the “trusted” data sources are often 1-2 years old and many consumers may have received a rise in their incomes for legitimate reasons merely due to the passage of time or changing jobs.

HHS suggests in the preamble that this change would be “helpful” to consumers based on incorrect information: “This proposal also would help limit tax filers’ potential liability at tax reconciliation to repay excess APTC.” (81 Fed. Reg. 51086). Any consumer who attests to income above 100% FPL but ends the year with an actual income below 100% FPL is *exempt* from repaying excess APTCs. In most states, consumers in this situation who overestimate their income will be far worse off because they could have otherwise been eligible for Medicaid, which has lower cost-sharing, no deductibles, and often no premiums.

We strongly recommend that HHS keep the current regulations regarding income inconsistencies.

§ 155.335 – Annual Eligibility Determinations

HHS seeks comments on whether allowing HHS to access tax data for 5 years should be shortened. We do not support shortening this time period. Under current requirements, many individuals can find themselves ineligible for APTCs if they do not authorize HHS to check their tax data. For consumers who choose to allow HHS to access tax data with the expectation that it will ease the requirements for reenrollment, shortening this period will only add a new responsibility on consumers to have to authorize access in shorter intervals.

§ 155.420 – Special Enrollment Periods

We support the proposed changes related to dependents as well as excluding the special enrollment period (SEP) in paragraph (d)(12) from paragraph (a)(4)(iii). Certainly if information about a plan or benefit has a material error, an individual should be allowed to select a new plan from any metal level and should not be limited to the metal level in which the individual originally enrolled.

We also support the proposal to amend paragraph (a)(5) to exempt qualified individuals from the prior coverage requirement if, for at least 1 of the 60 days prior to the date of their qualifying event, they lived in a service area where there were no QHPs offered through an Exchange.

We also support allowing women who are losing access to pregnancy-related CHIP coverage to qualify for a 60-day SEP. This will create a much needed pathway to coverage for eligible women in Texas who have exhausted their CHIP-Perinatal coverage.

Finally, we also support the technical correction to update the cross-reference to 26 C.F.R. 1.36B-2T that finalized the special enrollment period for survivors of domestic abuse or spousal abandonment.

§ 155.430 – Effective Dates for Termination

We support the proposed changes to make it easier for consumers to request a specific termination date. As HHS notes, “allowing enrollees to terminate their coverage immediately or on a future date of their choosing also would provide consumers with greater control over ending their QHP coverage and would help minimize or eliminate overlaps in coverage”. (81 Fed. Reg. 51091). Individuals should be able to prospectively cancel their coverage without having to call back multiple times or worry about having dual coverage.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

§ 156.111 and § 156.115 - State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019 and Provision of EHB

We are opposed to HHS’ proposed changes to the Essential Health Benefits (EHBs) standard which would lower the threshold of covered services and leave many consumers without access to the health care they need. The EHB requirement has helped ensure people have access to **basic** health care services and has closed health care coverage gaps that for decades had left individuals underinsured. Before the ACA, consumers often did not have health coverage for services that are now covered as EHBs. For example, prior to the ACA, one-in-five people enrolled in the individual market lacked coverage of prescription drugs and mental health

coverage was often excluded from health plans.³ Also, here in Texas, no plans for sale in the individual market included maternity benefits. These services can be a small percentage of the relative benefit costs in commercial market plans, yet scaling back on their coverage would significantly raise out-of-pocket costs for individuals who need them.⁴

HHS' proposed changes to the EHB benchmark options, including the proposed definition of a "typical employer plan," would jeopardize adequate coverage of the ten EHB categories and subject consumers to medical debt. We are concerned that HHS' proposed EHB benchmark options may lead to the selection of rare, outlier benchmarks, with extremely limited coverage of critical services.

We are strongly opposed to and urge HHS to forgo the proposed changes to EHBs and the selection of benchmark plans. In particular, we oppose the following changes that would likely result in states electing to scale back EHBs and consumers losing access to critical services and financial protection:

- Offering new options for selecting an EHB benchmark plan for plan years beginning on or after January, 1 2019;
- Modifying the definition of a typical employer plan;
- Allowing benefit substitution within and between different statutorily required EHB categories; and
- Continuing the policy requiring states to defray the cost of state-mandated benefits after 2011.

Plan Design: We fear that an annual option to alter EHB plan design will lead to a race to the bottom across states, pursuing less generous, narrow benefit designs that will increasingly harm, and discriminate against, consumers facing health challenges. The proposed approach for selecting a new EHB package, which includes an annual selection from three different state options, relies on the premise that plans should be less generous than what is currently offered. This will narrow states' opportunity and flexibility to respond to consumers' needs by allowing states to select or develop plan designs that are less generous than what are currently available, risking key benefits for people with chronic illness, people with disabilities, children and other beneficiary groups.

For example, a state could simply select a less generous benefit category from another state replacing their own. As such, a state could select a benefit from another state that eliminated autism services, infertility treatment or hearing aids--as a result, these consumers would incur the cost of these medically necessary services. In addition, this approach could severely harm efforts to address addiction and overdose deaths if a state chose to replace its mental health

³ Dania Palanker et al., *Eliminating Health Benefits Will Shift Financial Risk Back to Consumers*, The Commonwealth Fund, Mar. 24, 2017, <http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers>.

⁴ Rebekah Bayram & Barbara Dewey, *Are Essential Health Benefits Here to Stay?*, Milliman, March 2017, <http://us.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf>.

and substance use disorders benefit category with one that limits or excludes medication-assisted treatment, residential treatment, and recovery supports to prevent relapse. Moreover, if states select the third option of creating a new EHB altogether, although the benchmark plan would have to include coverage of the 10 statutorily prescribed EHB categories, states could select a benchmark plan that would significantly scale back coverage relative to current ACA plans. Therefore, **we urge HHS to reject any approach that diminishes the scope and benefits of EHB benchmark.**

Definition of a Typical Employer Plan: We are deeply concerned that HHS’s proposed definition of a typical employer plan would create a loophole for states to select a benchmark plan that, for instance, sharply limits the number of hospital days or doctor visits available each year, covers only generic medications, or offers only preventive services.

The ACA requires that coverage of EHBs in the individual and small group market be equal in scope to the benefits provided under a typical employer plan.⁵ The law gives the Secretary of HHS the authority to determine the scope of a typical employer plan but requires that the Secretary’s determination be informed by a survey of employer-sponsored coverage conducted by the Department of Labor (DOL).⁶ The typical employer requirement guarantees minimum coverage of EHBs.

The proposed rule would define a typical employer plan as “an employer plan within a product [...] with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more states, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more states.”⁷ We object to this definition of typical employer plan for two reasons. First, the proposed definition ignores the concept of typicality of benefits as adopted in the ACA. In fact, it would allow an *atypical* plan to become the benchmark, based on its use by a single employer as opposed to a reflection of what is generally covered across employers more broadly. Second, adopting the proposed definition of a “typical employer plan” would lower the threshold for minimum coverage of EHBs, opening the door for insurers to offer plans with skimpier benefits and weakening the protections that the ACA affords to individuals with disabilities and complex medical needs.

The proposed approach will lead to more limited and imbalanced EHBs that will fail to meet the health needs of many, leaving consumers under-insured and at risk. Therefore, **we urge HHS to maintain the current definition of typical employer plan.**

Benefit Substitution: Aside from the proposed EHB-benchmark plan process, we are concerned about HHS’s proposal to allow benefit substitution *between* different statutorily required EHB categories. If insurers are allowed to swap within and between benefit categories even while retaining the actuarial value, consumers will be left with gaps in coverage and higher out-of-

⁵ 42 U.S.C. § 18022(b)(2)(A).

⁶ *Id.*

⁷ 82 Fed. Reg. 51104.

pocket costs for consumers in need of services that are substituted and not covered by the issuer. For example, hospital care services and habilitative and rehabilitative care could be limited while outpatient visits are enhanced, leaving a consumer in need of both hospital care and rehabilitation with fewer available resources in their plan to support a hospital stay and post-hospital care. For children, this could translate into restricted access to habilitative services often required for children with developmental delay or autism. Mental health and substance use disorders services could also be limited, preventing people from getting the care needed to live healthier lives and hold down jobs.

This will also make it difficult for consumers to compare health coverage options, making plan selection challenging. HHS recognizes that this proposal would increase the burden on consumers as they would “need to spend more time and effort comparing benefits offered by different plans in order to determine what, if any, benefits have been substituted and what plan would best suit their health care and financial needs.”⁸

In addition, without a standard set of EHBs that issuers must cover, it is unclear how state regulators would ensure adequate coverage of EHBs. HHS notes that by allowing substitution between categories, states “may encounter difficulties in ensuring that all categories are filled in such a way that amounts to EHB”.⁹ This will open the door for inadequate coverage of the ten EHB categories.

We urge HHS to eliminate any provision allowing issuer flexibility to substitute benefits within EHB categories, and not allow substitution of benefits between categories.

§ 156.230 and §156.235 – Network Adequacy Standards and Essential Community Providers

Health insurance plans with limited networks of providers are not new and are not confined to the ACA marketplaces. Although narrow networks can reduce the cost of health insurance while providing some level of care, for many individuals, especially those with chronic conditions, they are often inadequate. Beyond the breadth of a network, inadequate or outdated provider directories can lead to consumers unwittingly receiving out-of-network care resulting in exorbitant bills. We believe it is necessary to maintain strong minimum federal network adequacy standards that are at least as protective as the current ACA standards.

We strongly urge HHS to:

- Continue its role in oversight and enforcement of network adequacy standards to “ensure a sufficient choice of providers;” and
- Reject the proposal to lower the standard for inclusion of Essential Community Providers (ECPs) from 30 percent to 20 percent in a plan’s service area.

⁸ 82 Fed. Reg. 51131.

⁹ *Id.*

The rule as proposed will gut federal protections to identify and improve the most egregious of inadequate insurer networks. Relying on accreditation standards when a state cannot perform an adequate review is not a sufficient substitute for regulatory review. The private accreditation process generally uses a self-certification method for determining network adequacy, so plans set and assess compliance with their own standards.¹⁰ Furthermore, accreditation bodies do not make network adequacy standards publicly available, have no mechanism for resolving consumer complaints, and cannot take action against an insurer for failing to meet standards beyond revoking or suspending an insurer's accreditation.

Plans sold on the marketplaces must be able to serve a diverse set of enrollees. It is critical that plans are able to meet their needs by maintaining a sufficient number of Essential Community Providers with experience providing quality care to consumers from diverse backgrounds and low-income families with the greatest health needs. Reducing the standards on Essential Community Providers inclusion will fail to ensure reasonable and timely access to care for low-income and medically underserved individuals and their families. HHS has required QHPs in the FFM to comply with a 30 percent threshold for the past three years, and compliance has not caused any hardship to QHPs. Non-profit and publicly funded clinics are critical to overall and reproductive health of low income individuals.

In addition, HHS states that it will continue to allow issuers to use the ECP write-in process to identify ECPs that are not on the HHS list of available ECPs. We urge HHS to eliminate this option that permits issuers to forgo the ECP standard completely by submitting a narrative justification that describes why they could not meet the standard but still have a network that is sufficient to meet the needs of low-income and medically underserved enrollees. This provision has the potential to become the exception that swallows the rule. Without an adequate number of actual ECPs in an issuer's network, people who rely on ECPs for their care will have less access to the care they need.

G Part 158 -- Issuer Use of Premium Revenue: Reporting and Rebate Requirements

§ 158.162, § 158.221 and § 158.301 - Reporting of Federal and State taxes; Formula for Calculating an Issuer's Medical Loss Ratio; Standard for adjustment to the medical loss ratio

The Affordable Care Act (ACA) established a federal minimum medical loss ratio (MLR) standard. The ACA's standard requires insurers in the individual and small group markets to meet an 80% MLR while insurers in the large group market must attain an 85% MLR. The ACA applies this standard to an insurer's aggregate performance in a market rather than each individual policy. If insurers fail to meet this standard, they are required to provide a rebate to consumers.

¹⁰ Mark Hall & Caitlin Brandt, *Network Adequacy Under the Trump Administration*, HEALTH AFFAIRS BLOG (Sept. 14, 2017), <http://www.healthaffairs.org/doi/10.1377/hblog20170914.061958/full>.

The ACA's MLR standard has successfully improved value for consumers by incentivizing insurers to increase the percentage of premiums spent on medical care and decrease overhead costs.¹¹ According to the Congressional Research Service, during the first year that the MLR was in effect insurers paid out over a billion dollars in rebates to nearly 13 million individuals.¹² In contrast, by 2016, insurers paid just under \$397 million to approximately 4.8 million people.¹³ Additionally, the average MLR for the individual market was 91.8% while for the small group market the average was 85.6%. Based on the data *most insurers are meeting or exceeding the MLR standard.*¹⁴

Despite the success of the MLR standard, HHS has proposed several harmful methods of undermining this provision of the ACA. These changes will shift the focus away from the impact on consumers and focus instead on the impact to insurers. **We urge HHS to continue to ensure that insurers are selling policies that provide value to consumers, and not to adopt the following changes:**

- Allowing insurers to exclude employment taxes from premiums in calculating their MLR;
- Permitting insurers to automatically claim 0.8 percent of earned premium as a quality improvement expense; and
- Simplifying the process for states to apply for a reduction in their MLR standard.

Reporting of Federal and State Taxes: In the proposed rule HHS expresses concerns about market stability and proposes to ameliorate that issue by permitting issuers to exclude federal and state employment taxes from premiums in their MLR and rebate calculations starting with the 2017 reporting year. This proposed rule's preamble explicitly states that most issuers were already doing so and there is no indication that this change will improve market stability. Data noted above indicates that most issuers are meeting or exceeding the MLR standard and consumers have benefited from insurer compliance. **We urge HHS to maintain the current rule requiring issuers to include employment taxes in earned premiums and prohibiting their deduction from MLR and rebate calculations.**

Allocation of Expenses/Quality Improvement Expense - The quality improvement expenses in the numerator of the MLR calculation plays an important role in motivating insurers to allocate a percentage of expenses to quality improvement activities that benefit consumers. The "quality improvement" definition recommended by the National Association of Insurance Commissioners (NAIC) for medical-loss ratios (MLRs) and adopted by HHS in 2010 was designed

¹¹ The Commonwealth Fund, Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3 (March 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/mar/medical-loss-ratio-year-three>.

¹² Congressional Research Service, Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress (August 26, 2014), <https://fas.org/sgp/crs/misc/R42735.pdf>.

¹³ Centers for Medicare and Medicaid Services, 2015 MLR Rebates by State (October 19, 2016), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2015_Rebates_by_State.pdf

¹⁴ Centers for Medicare and Medicaid Services, The 80/20 Rule Increases Value for Consumers for the Fifth Year in a Row (November 18, 2016), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Medical_Loss_Ratio_Annual_Report_2016-11-18-FINAL_005.pdf.

to ensure that insurers only classify as quality improving expenditures those that improve healthcare quality. The newly proposed paragraph §158.221(b)(8) would erode the backbone of the MLR and is contrary to the recent recommendation of NAIC that no changes be made to existing rules.

We urge HHS to maintain the current rule requiring issuers to track and report their quality improvement activities in order to claim them as expenditures when calculating their MLR. HHS's proposal to permit insurers to include a percentage of QIA activities *without any indication that the insurer implemented those activities* is counter to the spirit of the rule. HHS's proposal would automatically increase insurer's MLR without requiring insurers to take action to improve consumers' health. This option to include 0.8 percent increase could unfairly advantage an insurer who would otherwise fail to meet the required MLR. In effect, this proposal could result in a consumer losing their rebate while essentially providing insurers with an undeserved giveaway.

Standard for Adjustments to the Medical Loss Ratio (Sec. 158.301) – We oppose encouraging states to lower the MLR standard, and making it easier to do so, as well as the assertion that lowering the threshold is the appropriate solution to “help stabilize the individual market” in the states. Easing the process for states to lower the MLR is likely to raise already-high premiums for consumers; HHS itself states that MLR adjustments during the first year would cut MLR rebates of up to \$64 million. Those \$64 million would come straight out of the pockets of consumers and into the profits of carriers. Allowing the Secretary broader discretion to waive the MLR requirement will undermine the product's value to consumers, cost consumers millions of dollars in rebates and is unlikely to create a more stable market.

The MLR threshold is neither unreasonably high nor a tough bar to meet. Most insurers are meeting or exceeding the MLR standard. The average MLR in 2016 for the individual market was 91.8% while for the small group market the average was 85.6%.¹⁵

The current MLR thresholds and process for adjusting the threshold has worked. Within the first three years under the ACA MLR rule, the MLR requirement saved consumers over \$5 billion, either through consumer rebates or reduced health plan spending on overhead.¹⁶ During that same time, the size of the MLR rebate went down, indicating much greater compliance with the MLR rule.¹⁷ Following the inaugural years of the ACA, the option to adjust the MLR threshold existed but no state sought to do so.

This NPRM claims that lowering the bar for MLR will stabilize the market but provides no evidence that MLR is either linked to carriers leaving the market or carriers setting high premiums. Carriers are leaving the market for reasons unrelated to the MLR: (1) smaller and

¹⁵ Centers for Medicare and Medicaid Services, The 80/20 Rule Increases Value for Consumers for the Fifth Year in a Row (November 18, 2016), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Medical_Loss_Ratio_Annual_Report_2016-11-18-FINAL_005.pdf.

¹⁶ Commonwealth Fund, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3*, March 2015.

¹⁷ *Id.*

younger carriers were unable to compete with larger more established carriers, especially after key features of the “3R” programs—Risk Adjustment, Risk Corridors, and Reinsurance—were not implemented as designed, and (2) compounding political unknowns about the viability of ACA as a whole, along with continued implementation of key provisions of the ACA (such as the individual mandate and payment of cost sharing reductions). None of these has to do with the MLR and each could be addressed via other avenues that are not proposed in this NPRM.

Thank you for your attention to our comments.

Sincerely,

A handwritten signature in black ink that reads "Stacey Pogue". The signature is written in a cursive, flowing style with a large initial 'S'.

Stacey Pogue
Senior Policy Analyst