THE COUNCIL
The Council of Insurance Agents & Brokers

July 12, 2017

Via Electronic Submission - www.regulations.gov

Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attn: CMS-9928-NC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-9928-NC – Request for Information on ACA Regulatory Cost Burdens

To Whom It May Concern:

The Council of Insurance Agents and Brokers ("The Council") appreciates this opportunity to comment on the Department of Health & Human Services' ("Department" or "HHS") request for information ("RFI") regarding minimizing the economic burden of the Affordable Care Act ("ACA") and improving affordability, accessibility, quality, innovation, and empowerment in the health care system.[1]

First, the Council urges you, consistent with President Trump's Executive Order 13765[2] and the goals set forth in the Department's RFI, to establish a national benchmark health plan in lieu of current costly state-enhanced "benchmark" plans. As discussed in further detail below, adoption of a basic national plan is a cost reduction and administrative streamlining tool that the ACA directed the Department to develop. The Obama Administration chose not to do so, and in the way it directed the States to establish their own individual benchmark plans, it essentially ensured that allowing for less benefit-rich (and thus less costly) plans currently is prohibited. We encourage you to change this policy as soon as possible.

Second, in addition to developing a national benchmark plan, we urge you to deploy additional cost reduction tools such as revisiting the Department's current regulations and guidance with respect to essential health benefits ("EHB"), and exploring additional changes to the QHP framework (discussed in further detail below).

[1] Centers for Medicare & Medicaid Services (CMS), HHS, Request for Information, *Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients*, 82 Fed. Reg. 26885 (June 12, 2017).

[2] Executive Order 13765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal*, 82 Fed. Reg. 8351 (Jan. 24, 2017).

By way of background, The Council represents the largest and most successful property/casualty and employee benefits agencies and brokerage firms. Council member firms annually place more than $300 billion in commercial insurance business in the United States and abroad. Council members conduct business in some 30,000 locations and employ upwards of 350,000 people worldwide. In addition, Council members specialize in a wide range of insurance products and risk management services for business, industry, government, and the public.

Develop a National Benchmark Plan

The President's Executive Order instructs you and other agency heads to "exercise all authority and discretion available" to alleviate ACA-related fiscal burdens on States, individuals, families, healthcare providers, and other industry participants. Like the Administration, The Council and its members are committed to combatting rising health care costs in the near and long term. One way to address immediate cost concerns for many Americans, we believe, is for HHS to act upon an often-overlooked mechanism in the ACA—namely, development by the federal government of a standard, streamlined benchmark health plan. A basic, standardized plan design established by the Department would increase efficiencies in plan delivery, reduce complexity and confusion in the marketplace, and make more affordable coverage available to more Americans.

The ACA requires HHS to establish such a national benchmark by defining and standardizing the minimum benefits package for qualified health plans ("QHPs").[3] Further, the ACA dictates that if States impose benefit mandates for QHPs that go beyond the benchmark plan requirements (i.e., beyond HHS-defined essential coverage), the States must defray the cost of those additional benefits.[4] Notably, the ACA scheme does not preclude States from mandating more benefit-rich plans for their residents; it simply puts the additional financial burden of exercising that option on those particular States, instead of the federal government. The expectation was that the national benchmark plan would be basic and affordable (yet still contain the menu of essential health benefits ("EHBs") identified in the ACA, which were modeled after typical pre-

[3] *See* 42 U.S.C. § 18022(b) ("The Secretary *shall define* the essential health benefits" within certain general categories and items such as: ambulatory patient services, emergency services, hospitalization, prescription drugs, lab work, etc.) (emphasis supplied); 42 U.S.C. § 18021 (defining "qualified health plans" as those that provide essential health benefits, as defined by HHS, among other requirements); 42 U.S.C. § 18031(d)(3)(B) (States may require benefits beyond HHS-defined essential health benefits if they defray the cost of those additional benefits).

[4] 42 U.S.C. § 18031(d)(3)(B) (states may require QHPs to offer benefits in addition to HHS-defined benefits, but the state must make payments to the individual or the plan to defray the subsidy cost associated with those additional benefits).

ACA employer-provided coverage), and the State subsidization requirement would lead to massive reform of benefits mandates across the country.

The opportunity for broad mandate reform—with its attendant cost and administrative benefits—was not realized, however, when the previous Administration decided not to define and adopt a basic national plan design, and instead, allowed each State to establish its own "benchmark" plan design that includes each and every benefit mandate required by that State before 2012 (e.g., in some states, provision of electric breast pumps, chiropractic visits, etc.).[5] These enhanced State-mandated plans, which are now locked in place under current regulations, drive up costs for insurers and consumers, and take away the *option* for consumers to select a more basic plan that costs them less. Today, even if States want to narrow their benefit requirements, they are not permitted to do so.

Fundamentally, health plans in the U.S. have become too "rich" for a lot of Americans. While benefits packages may be more robust, deductibles are so high that many families cannot actually access care. Council members report that individuals and families want the *choice* to purchase more basic coverage if it means that upfront costs will decline and they can get the services they need. Today, however, insurers are prohibited from offering what some people want to buy, at least in part because State-mandated benefits go beyond the ACA's EHBs and force people into higher-cost, richer plans.

Refine Scope of EHBs

Relatedly, we believe there are opportunities for HHS to pare down current EHB definitions and guidance to better reflect standard benefit offerings (i.e., those historically offered under pre-ACA insurance contracts) in the ten EHB categories. For instance, preventive, wellness, and chronic disease management services now include, *inter alia*: counselling interventions for weight management, healthy diet, physical activity (for cardiovascular disease risks); BRCA-related genetic counselling; breast- feeding support and interventions; exercise or physical therapy to prevent falls in community-dwelling adults over age 65; intensive, multicomponent behavioral interventions for obesity; intensive behavioral counselling for sexually transmitted infections; and habilitative services such as speech and occupational therapy services for young children that are delayed in developing these functions but are not necessarily the direct result of an underlying medical condition.

[5] *See* 45 C.F.R. 155.170(a)(2) ("A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the [EHBs]" (and thus must be subsidized by the State).).

While these relatively specialized and generous benefits/programs certainly are valuable to some consumers, they have increased the base cost of policies for everyone and may be perpetuating "too rich" benefit mandates for many American families. Accordingly, we encourage HHS to revisit its current guidance and evaluate the scope of services appropriate for a streamlined, basic, less costly benchmark plan.

Expanding plan options and competition is a hallmark of Republican proposals to reform our health care system, give consumers the freedom to purchase what they want, and control rising costs. To that end, one increasingly popular idea is to allow sales of health plans across state lines. The Council contends that establishing a basic national benchmark with standard EHBs—which could even be modeled after existing State benchmarks—would serve the same purpose as interstate sales (i.e., proliferation of basic, affordable plans) without triggering complexity and concerns related to our state-based insurance system, oversight responsibility, and consumer protection functions of the States.[6] And, as noted above, these tools are available to HHS now, and would not require a multi-year "off ramp" like some other reform proposals.

Other Potential Cost Saving Solutions

Additionally, the Council urges HHS to explore opportunities for additional cost-saving mechanisms under its authority to define and regulate QHPs. Possible options may include:

- Utilizing some phased in indexed pricing for EHBs offered through QHPs (e.g., by 2020, reimbursements under a national benchmark plan for EHBs will not exceed 150% of CMS/Medicare rates, will not exceed 125% by 2025, etc.);
- Potentially allowing pharmacy benefits to be offered and purchased separately from other EHBs through CO-OP-type plans; and/or
- Creating a stop loss insurance pool for QHP sponsors.

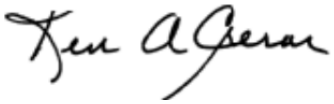
* * *

We applaud your efforts to address the current health care system's financial burden on American families. Focusing on cost-drivers in the system is essential to preserving a functioning private health care market. We welcome the opportunity to speak with you further about the potential cost containment strategies discussed herein, as well as other possible solutions to address rising prices and overall population health.

[6] Additionally, an interstate sales approach would favor larger national insurance carriers over smaller regional carriers, and could negatively impact competition in the industry.

Thank you for your consideration.

Respectfully submitted,



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