ERIC The ERISA Industry Committee

The Only National Association Advocating Solely for the Employee Benefit and Compensation Interests of America's Largest Employers

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October 6, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9934–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: RIN 0938-AS95 (Notice of Benefit and Payment Parameters for 2018)

To Whom It May Concern:

The ERISA Industry Committee is pleased to respond to the request of the Centers for Medicare and Medicaid Services ("CMS") for comments on the proposed rule regarding the Notice of Benefit and Payment Parameters (NBPP) for 2018. The proposed rule was promulgated under various provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Act (collectively, "ACA"), and was published by CMS in the *Federal Register* on September 6, 2016.

ERIC'S INTEREST IN THE PROPOSED RULEMAKING

ERIC is a nonprofit organization representing the nation's largest employers that maintain health care, retirement, and other employee benefit plans covered by the Employee Retirement Income Security Act of 1974. ERIC is the only national association that advocates for large employers on health, retirement and compensation public policies at the federal, state and local levels. ERIC enhances the ability of its member companies to provide high-quality health care benefits to millions of active and retired employees, and their families. These benefits help ERIC members to attract and retain talent and maintain a healthy and productive workforce. Each ERIC member employs at least 10,000 Americans, while some are in the 100,000 and even 1,000,000 employee range – and the number of individuals covered by each of their group health plans far exceeds the number of employees.

ERIC's members, which sponsor some of the largest private group health plans in the country, are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers, retirees and their families with high standards of quality, cost containment, and effectiveness.

The proposed rule modifies existing CMS regulations to further "fine-tune" various ACA requirements. ERIC is commenting specifically on two matters.

SUMMARY OF ERIC'S CONCERNS WITH THE PROPOSED RULE

The subject of our first concern is the employer appeals process. Among other things, the proposed rule modifies 45 C.F.R. §155.555 to permit the continued use of a paper-based appeals process for employer appeals. While we recognize that implementing an electronic-based appeals process is challenging, we do not believe that CMS should continue to delay the implementation of that process, particularly for employer appeals.

More importantly and as explained in detail below, ERIC members believe that the Exchange notices and the employer appeals process should be suspended immediately. There is no reason to perpetuate a process that is riddled with errors, that wastes employer and government resources and that produces no definitive outcome. It is an appeals process in name only, and CMS would be well served to suspend the process until such time, if any, that the process can be coordinated effectively with the IRS.

Second, we are extremely concerned about the ongoing controversy surrounding the ACA reinsurance program. In our view, CMS does not have legal authority to extend the program beyond the end of 2016. Similarly, we do not believe that CMS' refusal to transfer an allocable portion of the 2014, 2015, and 2016 reinsurance contributions to the Treasury Department justifies a continuation of the program or an additional collection of mandatory "contributions" to fund such a transfer, were it to take place. The fact that the amount of reinsurance contributions collected is less than anticipated does not give CMS authority to extend the reinsurance program or to collect additional reinsurance contributions.

Our recommendations and suggestions on both topics are spelled out in greater detail below.

COMMENTS ON PROPOSED RULE

I. SUSPEND THE EMPLOYER APPEALS PROCESS

Section 1411(f)(2) of the ACA directs the Secretary of the Department of Health and Human Services to establish an employer appeals process. Specifically, the statute provides as follows:

> The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee.

CMS first promulgated regulations implementing the employer appeals process in 2013.[1] Those regulations provide a lengthy set of rules applicable to Exchanges handling employer appeals, including timelines for submitting appeals, notice requirements, adjudication principles, confidentiality provisions and various other requirements. Additional regulations outlined the manner in which Exchanges must accept employer appeal requests, including by telephone, mail, in person and via the internet.[2]

In the 2013 regulations, CMS delayed the requirement for Exchanges to implement an electronic-based appeals process through the end of 2014.[3] This requirement was delayed again pursuant to CMS sub-regulatory guidance issued in 2015 and 2016.[4] The proposed rule would further delay the requirement through the end of 2018.

As a preliminary matter, ERIC members do not believe that CMS should continue to delay the implementation of an

[1] See 45 C.F.R. §155.555, 78 Fed. Reg. 54070 at 54136 (August 30, 2013).
[2] See 45 C.F.R. §155.520.
[3] See 78 Fed. Reg. 54070 at 54098 (August 30, 2013) ("We are finalizing this provision as proposed but reiterate that a paper-based process, as discussed above, is acceptable for the first year of operations.")
[4] See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Paper-based-Appeals-Process-Guidance.pdf (delaying the implementation of an electronic-based appeals process through the end of 2015) and https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-for-paper-based-appeals-3-22-2016.pdf (delaying the implementation of an electronic-based appeals process through the end of 2016).

electronic-based appeals process. Doing so thwarts the administrative efficiencies that can and would result from using an internet-based system. CMS should work with the Exchanges to develop protocols under which Exchanges can communicate quickly and efficiently with employers, and a paper-based appeals system does not accomplish those goals.

But ERIC members identified a more fundamental problem. As ERIC members have begun to receive appeal notices from both federal and state Exchanges, it has become evident that the employer appeals process is fatally flawed. The ACA assumes that an employer appeals process is necessary because an Exchange has "determined" that an employer either doesn't provide minimum essential coverage or that an employer doesn't provide affordable coverage. The reality is that Exchanges aren't making these "determinations" at all – the Exchanges make no effort to contact employers to verify employment, to verify the type of employment (full-time or part-time), to verify whether employer coverage was offered or to verify whether employer coverage is adequate or affordable. Without verification of these facts, the Exchange "determinations" and related employer appeal "notices" are meaningless and confusing.

In addition, the employer appeal notices currently in use are severely deficient – they do not provide specific information that would enable an employer to make an informed appeal. For example, the notices do not specify when an individual submitted an application for premium tax credits, do not specify the specific month or months for which advance premium tax credits were approved, and do not specify the reason or reasons why advance premium tax credits were approved. Some ERIC members with very large beneficiary pools have reported that the data included on notices was not sufficient to quickly identify exactly who the notice referred to, and required a burdensome search. CMS should consider requiring that more information be included on notices to make it easier to identify who exactly has received said credits.

A simple illustration will make the point. One ERIC member received a "notice" in July 2016, asserting that the federal Exchange had determined that an employee was eligible for premium tax credits for one or more months in 2016 and, as a result, the employer "may have to pay" an employer shared responsibility tax to the Internal Revenue Service ("IRS"). The notice says that the applicant "indicated" she was an employee and that she didn't have an offer of health coverage from the employer, or did have an offer of health coverage but it wasn't affordable, or was in a waiting period and unable to enroll in health coverage (this is form language; the individual's specific attestation wasn't specified). The notice provides the employee's name, birthday, last 4 digits of the Social Security number and the marketplace application ID (which has no significance to an employer), but does not specify when the individual applied for Exchange coverage.

Upon investigation, the ERIC member determined that the applicant was a former employee. Her employment terminated in January 2015, she had employer coverage at the time, and she elected COBRA continuation coverage for February through December 2015. But the individual was not an employee at the time the federal Exchange determined that the individual was entitled to advance premium tax credits, meaning that all of the statements in the notice are false. Why didn't the federal Exchange know this? The answer is simple – the Exchange did not verify any of the employment or employer coverage information submitted with the individual's application.

The problems associated with Exchange verification processes are not new. The U.S. Government Accountability Office ("GAO") has issued a series of reports sharply criticizing CMS and the Exchanges for failing to verify even the most basic information submitted on Exchange applications.[5] For the 2014, 2015, and 2016 coverage years, GAO

[5] See the following GAO Reports: GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act*, GAO-15-702T (July 16, 2015); GAO, *Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage*

submitted fictitious Exchange applications falsifying various items of information. Unfortunately, the Exchanges routinely approved advance premium tax credits for many of the fictitious applicants even when the Exchanges took modest steps to verify information. To date, the GAO's undercover work has focused on verification problems associated with straightforward matters such as citizenship or immigration status, Social Security numbers and household income, and has not even begun to address the more challenging verification problems associated with the employment/employer coverage issues discussed above.

To review, the Exchanges are issuing appeal notices to employers based on advance premium tax credit "determinations" that have no basis in evidence. The Exchanges rely on self-attested employment and employer coverage information submitted by applicants on Exchange applications, but do not actually verify any of that information. The amount of non-verified employment and employer coverage information is staggering – for example, the Exchanges do not verify:

- whether the applicant is currently employed, and the name of the current employer;
- whether the current employer is an applicable large employer;
- whether the applicant works full-time or part-time;
- whether the applicant is/was entitled to employer-sponsored coverage;
- whether the applicant is/was offered employer-sponsored coverage;
- whether the applicant actually enrolled in employer-sponsored coverage, or the beginning and end dates of that employer coverage; or
- whether the employer coverage (assuming it was offered) was adequate (more than 60% minimum actuarial value) or affordable (employee-only cost less than 9.5% of household income, as adjusted).

Leaving aside the verification issues, ERIC members note that the employer appeal process is not authoritative and does not resolve anything – an employer could spend days or weeks appealing an Exchange notice and, win or lose, the appeal has no precedential value. Regardless of whether an appeal is filed, or the outcome of that appeal, the IRS could independently determine that an employer is subject to an employer shared responsibility assessment and/or that an applicant is not entitled to a premium tax credit.

In fact, some ERIC members have been advised by outside counsel or consultants to ignore the appeals process entirely. The process' lack of actual resolution, combined with the negative employee-relations fallout inherent in challenging an employee's ability to obtain health insurance, make the appeals process unattractive to many plan sponsors. The process has been described to ERIC as unserious, inconsequential, time-consuming, and a waste of resources.

In light of these issues, ERIC members believe that the Exchange notices and the employer appeals process should be suspended immediately. There is no reason to perpetuate a process that is riddled with errors, that wastes employer and government resources, and that produces no definitive outcome. It is an appeals process in name only, and CMS would be well served to suspend the process until such time, if any, that the process can be coordinated effectively with the IRS.

Year 2015, GAO-16-792 (September 12, 2016); and GAO, *Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year*, GAO-16-784 (September 12, 2016).

II. SUNSET THE TRANSITIONAL REINSURANCE PROGRAM

ERIC members support the sunset of the Transitional Reinsurance Program (TRP) and are concerned with administrative efforts to extend it. Section 1341 of ACA, which establishes the TRP, clearly states that the program may collect funds corresponding to plan years beginning in 2014, 2015, and 2016. After these first three years, the Exchanges were meant to be self-sufficient, no longer requiring stabilization by a transfer of funds from non-Exchange issuers and group health plan third-party administrators. However, in light of recent press and public commentary, ERIC members are concerned that CMS may not fully comply with Section 1341, for several reasons.

ERIC is aware that the Exchanges are currently under a great deal of strain. There are a number of reasons for this – carriers declining to participate in the Exchanges, worse than anticipated risk pools, lack of participation by healthy young individuals, and the skyrocketing premiums that go hand-in-hand with bad risks and declining competition. Undoubtedly it will require a number of legislative and regulatory changes to improve competition, risk profile, and premium stability within the Exchanges. However, this does not justify thwarting the statutory prohibition on continuing TRP beyond 2016 – specifically, CMS may not require ERIC members' self-insured group health plans or their third-party administrators to make additional "contributions" beyond 2016 in order to reinsure risks in the Exchanges.

At the same time, ERIC is also aware that CMS is facing pressure from Congress related to the statutory requirement in Section 1341 that $5 billion in TRP funds "*shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section*." It is unclear why funds collected were not handed over to the Treasury, and why CMS did not collect as much money as the statute directs. This is not ERIC's concern. However, the plan sponsors who ERIC represents, who insure millions of Americans, cannot and must not be held responsible for CMS' decisions and actions regarding TRP. If CMS transfers the statutory $5 billion to the Treasury, that money cannot and should not be collected by requiring additional TRP contributions from self-insured group health plans or their third-party administrators.

ERIC appreciates that in the NBPP, CMS is making efforts to improve the risk adjustment program. As part of those efforts, CMS is changing the risk adjustment formula to take into account high cost conditions and enrollees. In effect, the risk adjustment program will now also have a reinsurance element. This may be entirely appropriate, and a proper evolution of the program. But CMS must take into account that TRP contributions may not be collected after 2016 – and as such, this new reinsurance element of the risk adjustment program must be fully paid for by funds collected within the Exchange. The costs of this Exchange stabilization effort must not and legally cannot be shifted to working families who enroll in employer-sponsored group health plans outside of the Exchanges.

ERIC appreciates the opportunity to provide comments on this CMS proposed rule. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

James P. Gelfand
Senior Vice President, Health Policy