



AMERICAN BENEFITS

COUNCIL

July 12, 2017

Submitted electronically via <http://www.regulations.gov>

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

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

Dear Sir or Madam:

We write on behalf of the American Benefits Council (“Council”) to provide comment in connection with the Request for Information (“RFI”) “Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients,” published in the Federal Register on June 12, 2017, by the Centers for Medicare and Medicaid Services (“CMS”), U.S. Department of Health and Human Services (“HHS”) (82 Fed. Reg. 26885).

The Council’s approximately 425 members are primarily large, multistate U.S. employers that provide employee benefits to active and retired workers and their families. Collectively, the Council’s members sponsor directly or provide services to health and retirement plans covering more than 100 million Americans.

HHS seeks comment from interested parties to inform ongoing efforts to reduce regulatory burdens and improve health insurance options under the Patient Protection and Affordable Care Act (“ACA”) and to create a more patient-centered health care system that adheres to the principles of affordability, quality, innovation and empowerment.

The Council appreciates the opportunity to provide comment to HHS with respect to reducing regulatory burdens imposed by the ACA and stabilization of the health insurance markets.

REDUCING REGULATORY BURDENS IMPOSED BY THE ACA

The Council supports reducing regulatory burdens imposed by the ACA, especially with respect to employer-sponsored coverage – which has been, and continues to be, a source of comprehensive and affordable coverage for the majority of working Americans.

As stated in the Council’s public policy strategic plan, [*A 2020 Vision: Flexibility and the Future of Employee Benefits*](#), employer-sponsored benefit plans are designed with the express purpose of giving employees the opportunity to achieve personal health and financial well-being. This serves as the foundation for employees to achieve higher productivity and, in turn, drives successful organizations. Employers currently provide health coverage to more than 177 million Americans, *nearly ten times more people* than are covered by the individual market.

One of the reasons why the employer-sponsored benefit system works so well is that employers typically pay, on average, 82 percent of the cost of health care benefits.¹ This helps ensure working Americans and their families have continued access to affordable health care. This popular, affordable, high-quality coverage, in turn, leads to better health outcomes, lower costs and more satisfied and productive employees.

It is imperative that Congress and the federal agencies take steps to minimize unnecessary, duplicative, and/or inappropriate regulatory burdens on all forms of health coverage – including group and individual coverage. This is especially the case for employer-sponsored coverage that remains the cornerstone of our country’s health coverage delivery system.

Under the ACA, employers have been subject to increased regulatory burden, which has resulted in increased business costs for small and large employers alike. This is, in part, due to required compliance with a myriad of statutes, regulations and sub-regulatory guidance. Included in this intricate regulatory framework is, for example, often unnecessary and duplicative employer reporting and disclosure requirements.

Specific solutions for reducing regulatory burden for employers include:

- **Facilitating electronic disclosure:** A seemingly small but important step on the road to reducing the cost of health benefits is to simplify the rules for electronic disclosure of any benefits documents employers are required to provide employees. Specifically, employers should be allowed to use electronic distribution as the default method of distribution, from which employees could affirmatively opt-out in order to receive paper copies. As HHS may be aware,

¹ Employer Health Benefits 2016 Annual Survey, Kaiser Family Foundation/ Health Research & Educational Trust, 2016

many – if not most – of the Council’s members use electronic means to communicate important workplace information with their employees, including with respect to annual enrollment. Such electronic means may include the use of emails and company intranets. Allowing employers to leverage these cost-effective communication strategies will help reduce the burdens and costs associated with existing and any future notice and disclosure requirements.

- **Minimizing unnecessary and duplicative notices and disclosures:** Related to the above, the ACA also imposed a series of disclosure obligations on employers with respect to their plans, including, for example, Summary of Benefits and Coverage (“SBC”) requirements. The Council urges HHS to work with the departments of Labor and the Treasury to identify disclosures, or aspects thereof, that could be eliminated or streamlined to reduce unnecessary burdens and costs on employers and related health coverage. For example, The Council recommends HHS work with the departments of Labor and the Treasury to amend regulations and sub-regulatory guidance to provide more flexibility to plans related to the federal SBC templates, instructions, coverage examples and specific distribution requirements for employers. The Council also recommends an enforcement safe harbor for the SBC page limit requirement.
- **Reducing regulatory burden for HIPAA administrative simplification:** The Council urges HHS to not finalize the proposed rule on HIPAA administrative transactions and operating rules, “Certification of Compliance for Health Plans,” which, if implemented as proposed, would establish a complex and costly process for covered entities. The Council also recommends that HHS amend the health plan identifier (“HPID”) final rule, which requires issuers to obtain and use the HPID, to be consistent with the recommendations approved by the National Committee on Vital Health Statistics (“NCVHS”) on June 21, 2017.
- **Allowing for centralized employer exchange notice administration and requiring use of uniform forms:** The ACA and implementing regulations require each Health Insurance Marketplace to notify any employer whose employee was determined eligible for advance premium tax credits (“APTC”) and cost sharing reductions (“CSRs”) because the employee attested that he or she was neither enrolled in employer-sponsored coverage nor eligible for employer coverage that is affordable and meets the minimum value standard.

Council members’ experience to date is that these notices are often sent to various departments within the employer, controlled group entities, and company representatives. Additionally, these notices vary from one state to another and the federally facilitated marketplace in the disclosure and/or requests of information. The result is that employers spend innumerable time and resources locating, analyzing, and responding to these notices.

Accordingly, employers should be allowed to designate a third-party administrator (“TPA”) or a single employer in the employer’s controlled group to receive the exchange notice. Additionally, all exchanges – both state-based exchanges and the federal Marketplace – should be required to use the same notice template for the Exchange notice to minimize complexity for employers or their designee.

Lastly, we note it is very important that any efforts aimed at reducing regulatory burden not come at the cost of the employer-sponsored system. Accordingly, we urge HHS to keep the employer-sponsored system in mind as it considers possible reforms and ensure that future actions do not adversely affect a system that has been, and will surely continue to be, the primary coverage solution for the vast majority of working Americans and their families.

EMPOWERING PATIENTS AND PROMOTING CONSUMER CHOICE

Under the ACA, HHS has a significant amount of flexibility to regulate health insurance coverage per the Secretary’s general rulemaking authority, as well as specific authority with respect to certain ACA provisions. For example, HHS has the authority to:

- provide certification for minimum essential coverage (“MEC”).
- regulate excepted benefits by providing more flexibility for existing excepted benefits and designating additional types of benefits as excepted.
- approve ACA Section 1332 waivers for states.

While HHS has been granted significant flexibility under the ACA by Congress to regulate coverage, it is critical that this flexibility be exercised in a manner that does not adversely affect employer-sponsored coverage.

Of specific note, ACA Section 1332 allows states to apply to HHS for waivers from certain ACA requirements. To ensure the employer-sponsored system is adequately protected, these waivers should only be extended to state action related to the individual market and not to state action regarding employer-sponsored plans. Otherwise, these waivers could be a means to circumvent Employee Retirement Income Security Act (“ERISA”) preemption, which, in turn, could erode long-standing interests in, and recognition of, the need for national uniformity for ERISA-governed plans. Accordingly, we strongly urge HHS to take steps, as part of its review and approval of state waiver applications, to ensure that employer-sponsored coverage – including ERISA preemption – is not weakened by the Section 1332 waiver provisions.

AFFIRMING THE TRADITIONAL REGULATORY AUTHORITY OF THE STATES IN REGULATING THE BUSINESS OF HEALTH INSURANCE

The Council supports state regulation of health insurance. However, any state authority must *not* impair the long-standing judicial and congressional recognition of ERISA and its preemption provision.

Forty years ago, Congress had the wisdom when it enacted ERISA to include a provision that ensures ERISA plans are free from most state and local regulation. While wholly supportive of state regulation of insurance (under the McCarran-Ferguson Act), Congress understood that it is critical that employers be able to offer uniform plans to their employees working in multiple states, or on a nationwide basis, as the case may be. Without ERISA uniformity, employers would have to comply with a patchwork of varying state laws and would need to monitor and adapt to constant state-level changes (e.g., evolution of current paid leave laws at the state and local level). This would result in increased costs and complexities for employer-sponsored plans, which could cause many employers to stop offering coverage. As noted above, *over 177 million Americans rely on employer-sponsored coverage*. Accordingly, it is imperative that any congressional or agency action reinforce the ability of employers to continue to offer coverage to their employees and their employees' families on a uniform basis.

STABILIZING THE INDIVIDUAL, SMALL GROUP, AND NON-TRADITIONAL HEALTH INSURANCE MARKETS

The Council supports efforts to stabilize the individual health insurance market. The individual market is an important source of coverage for individuals who may not have access to employer-sponsored coverage, including early retirees and part-time employees. Moreover, an ill-functioning or non-existent individual health insurance market not only presents obvious concerns for those individuals who rely directly upon it, but it also imposes significant costs and challenges for the employer-sponsored *group* health insurance system. This is because an ill-functioning market should be expected to result in cost-shifting to other payers in the system – including employers and employer-sponsored plans – for example, in the form of increased reimbursement rates as providers seek to recover costs for uncompensated care.

While the Council and its members certainly support congressional and agency actions intended to foster a well-functioning individual insurance market, it is imperative that any efforts to stabilize the individual market not adversely affect employer-sponsored coverage.

- **Market stabilization and Cost-Sharing Reduction (CSR) funding:** The Council supports HHS activity related to market stabilization in the Market Stabilization Final Rule. Additionally, the Council firmly supports the funding of CSR

payments. It is vital for both the individual and group markets that CSR payments be continued. If CSR payments were to cease, Americans could face higher premiums and more limited insurance choices, as insurers could choose or be forced to raise rates, terminate coverage or exit the exchanges. The loss of health coverage for potentially millions of people has obvious serious consequences for them and for the future viability of the individual insurance market as a whole. The most critical action needed to help stabilize the individual market for 2017 and 2018 is to remove uncertainty about continued funding of CSRs.

- **Effective self-sustaining reinsurance programs:** The Council supports carefully designed and effective reinsurance programs. However, such programs should not require or rely on employer contributions. Funding mechanisms to stabilize the individual market should not increase the cost for employer-sponsored coverage. For example, employment-based plans should not be required to fund reinsurance programs (as was the case under the ACA).

ENHANCING AFFORDABILITY

The Council supports HHS' efforts – as well as those of other federal agencies – to utilize existing authority to help provide for increased access to affordable, comprehensive coverage.

Specifically, the Council supports agency actions related to the following:

- **Value-based arrangements:** Value-based purchasing and value-based insurance design, in which consumers and purchasers ultimately pay for care based on quality outcomes, are more direct ways to address the key elements of high costs: unit price and chronic conditions. As such, the Council supports efforts to improve the transparency of price and performance data to enable individuals to become better consumers and to encourage continuous quality improvement. Employer plans have led the way in implementing innovative payment reforms, and HHS should also continue to pursue innovative demonstration projects and new payment approaches to increase quality and reduce the costs of coverage.
- **HIPAA-excepted benefits:** As mentioned previously, HHS, along with the departments of Labor and the Treasury, has the authority to expand or clarify excepted benefits to allow for greater choice and more affordable coverage and allow employers to sponsor programs that have meaningful benefits. The Council is generally supportive of agency actions focused on expanding certain HIPAA-excepted benefits, specifically with respect to on-site clinics and wellness programs, including additional relief for employee assistance programs (“EAPs”) utilizing expanded disease management and mental health counseling services.

- **Maximum Out-of-Pocket (“MOOP”):** The Council recommends that HHS work with the Departments of Labor and the Treasury to remove the requirement that an individual MOOP apply to persons enrolled under a family plan, (i.e., embedded MOOP). This requirement has restricted employer flexibility in structuring cost-sharing in employer health plans, which can be to the detriment of employees. For example, mandated embedded MOOPs can result in a plan increasing deductibles in order to offset the embedded MOOP mandate. Higher deductibles directly impact all covered individuals, while MOOPs generally impact only those with high out-of-pocket costs.
- **Mental Health Parity and Addiction Equity Act (“MHPAEA”):** The Council urges HHS to work with the departments of Labor and the Treasury to address complex and burdensome implementation requirements of the MHPAEA, particularly with respect to MHPAEA testing requirements for financial requirements and nonquantitative treatment limits (NQTLs). Permitting the use of “any reasonable method” in conducting parity testing, consistent with prior final regulations would provide flexibility in the design and management of mental health and substance use disorder benefits and facilitate quality and affordable care for employees.
- **Modified ACA Section 1557 applicability and notices:** On May 18, 2016, HHS’ Office for Civil Rights (“OCR”) published a Final Rule implementing ACA Section 1557, “Nondiscrimination in Health Programs and Activities” (“Section 1557 Final Rule”).

In determining the scope of Section 1557, OCR should more closely hew to the statutory language of Section 1557, which expressly limits the application of Section 1557 to those “health programs or activities” with respect to which the covered entity receives federal financial assistance (FFA). We urge that employer group waiver plans (“EGWPs”) be excluded from the scope of Section 1557. These arrangements provide comprehensive and cost-effective prescription drug coverage to retirees and their spouses. In support, we note that Congress could not have intended that employers become subject to Section 1557 merely for sponsoring retiree drug benefits for retiree and spouses. Rather, we believe Congress was concerned with applying Section 1557 to those entities that receive material FFA as a result of the enactment of the ACA, specifically with respect to on-exchange individual insurance. To apply Section 1557 to employer-sponsored retiree prescription drug plans creates disincentives for establishing and maintaining EGWPs, with the downstream result that American retirees and their families could be left without coverage upon which they have otherwise come to depend.

The Section 1557 Final Rule also implemented onerous requirements to provide notice and tagline with every “significant” document, as broadly defined by OCR. These requirements impose a substantial regulatory burden and cost on covered entities, including issuers and employers that receive FFA. This cost is likely being passed on to the consumer, thus decreasing the affordability of coverage. We recommend that HHS modify guidance to reduce the volume of required notices and taglines.

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Thank you for considering these comments submitted in response to the RFI. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700. We look forward to working with you to reduce regulatory burdens and stabilize the health insurance markets.

Sincerely,



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