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Centers on Medicare and Medicaid Services
Attention: CMS-9972-P
P.O. Box 8012,
Baltimore, MD 21244-1850.

To Whom it May Concern:

The American Cancer Society Cancer Action Network (ACS CAN) is the advocacy affiliate of the American Cancer Society (the Society). The Society is a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society is the largest public health organization in the United States.

ACS CAN appreciates the opportunity to provide comments to the Department of Health and Human Services on the Proposed Rule published in the Federal Register on November 26, 2012. This rule implements provisions of the Affordable Care Act (ACA) relating to fair health insurance premiums, guaranteed availability, guaranteed renewability, risk pools, and catastrophic plans.

Overall, ACS CAN is very pleased that the proposed rule reflects a thoughtful and thorough implementation of key aspects of the ACA. In general, we believe the proposed rule is consistent with the broader policy objectives of the ACA. However, we are concerned that the implementation of the tobacco rating surcharge, if not fairly implemented for consumers in all markets could result in considerable confusion in accurately identifying tobacco users. Further, while HHS has done a commendable job drafting the insurance market reform rule, there is an overall lack of data collection, transparency and enforcement missing from the proposed rule. Our comments reflect the concern that transparency and enforcement requirements could be strengthened and suggest some areas for consideration.

## Comments

***Tobacco Rating (Sec 147.102 (a)(1)(iv))***

Definition of Tobacco Use

ACS CAN is one of the nation's leaders in combating the devastating toll of tobacco in the U.S. In 2012, 216,000 new cases of lung cancer are expected and the disease will have claimed the

lives of more than 160,000 people, mostly smoking-related. In our work to end the deadly effects of tobacco use for the past three decades, ACS CAN has supported a comprehensive approach to tobacco control using proven, evidence-based policies. These interventions include raising the price of all tobacco products through significant excise tax increases, implementing comprehensive smoke-free policies, and fully funding and sustaining tobacco prevention and cessation programs at all levels of government. In the broader context of our tobacco control efforts, we want good health coverage for those adversely affected by nicotine products. Tobacco users can experience serious health problems, including addiction to nicotine, but by having adequate, affordable health care they are most likely to receive the health care services they need to quit. Thus, our comments are made in the context of our organizational goals of continuing to seek tobacco control as widely as possible while enhancing access to care for those who have become tobacco users.

As noted in the proposed rule, no uniform, widely-used definition of tobacco use exists among states for either rating purposes or even in the context of some tobacco control laws. While there are clear clinical definitions of tobacco dependence used by HHS, many federal, state and local public health agencies, as well as the medical community, these medical-based definitions are not appropriate for rating purposes. Consumers enrolling in insurance plans are unlikely to understand the nuances of clinical tobacco dependence definitions and terminology that are required for an accurate assessment of their tobacco use status.

The extensive number and breadth of tobacco products being introduced by the tobacco industry each year (e.g., dissolvable tobacco products, tobacco strips and various types of electronic cigarettes ("e-cigarettes")) create significant complications in creating a consistent and workable definition of tobacco use. Some definitions of tobacco and tobacco use include a catch all phrase such as "other tobacco products" intended to cover emerging and future products derived from the tobacco plant that may not yet be on the market for consumers. Including this type of open-ended definition has the benefit of automatically including new and not-yet-known tobacco products as they are introduced without needing to go through any updating of plans, regulations or guidance. In the context of insurance rating, however, attempting to include all existing and emerging tobacco products while leaving room for any another product that may be also used by the consumer is cumbersome and confusing to the insurer and the consumer.

FDA has stated that it considers a wide variety of products to be tobacco products, including cigarettes, cigars, cigarillos, smokeless tobacco, snus, dissolvable tobacco, and e-cigarettes with nicotine derived from tobacco. At this time, however, FDA's tobacco regulations apply only to cigarettes, cigarette tobacco, roll-your-own tobacco and smokeless tobacco, with the opportunity to extend authority to any other tobacco products deemed to fit the definition. The FDA has stated its intent to extend its authorities under the Food, Drug and Cosmetic Act, to other categories of tobacco products that meet the statutory definition of "tobacco product," but has not done so yet. Therefore, the FDA does not use one, simple, perpetual term for identifying what is and what is not a tobacco product or tobacco user.[1] The general public may have difficulty determining what the agency with regulatory authority over tobacco even considers a tobacco product.

[1] FDA Center for Tobacco Products letter to stakeholders, April 25, 2011. http://www.fda.gov/newsevents/publichealthfocus/ucm252360.htm

In addition to the types of tobacco products covered, frequency of tobacco use and the time span during which products were used are important components to defining tobacco use. Is a tobacco user someone who smokes every day, most days or some days? How many cigars a week or a month are considered tobacco use? How many dips of smokeless tobacco per day or week would qualify? Does the tobacco use have to occur in the last thirty days, last year or in a lifetime? Would the definition cover occasional/light smokers, current smokers or ever smokers, as defined by the Institute of Medicine and used in many national and state tobacco use surveys?[2]

Any definition of tobacco use must take into account the evidence that tobacco users may have different perceptions of their status than insurers or public health authorities. The questions regarding tobacco use must minimize the potential for a consumer to be exposed to accusations of fraud or false reporting. Studies show that some smokers do not report to be smokers, raising the risk of not understanding enrollment questions about tobacco use status.[3],[4] For example, in studies of college students, more than half of students who reported smoking a cigarette in the last 30 days responded "no" to a the question of whether they are a smoker.[5],[6] Smoking trends are also pointing to fewer daily smokers, which may affect how smokers are identified or identify themselves.[7] Even among "occasional" smokers, large differences exist in smoking history, smoking patterns and perceived addiction.[8]

Users of newer or less common tobacco products may not even consider themselves tobacco users because they aren't using cigarettes or traditional smokeless tobacco. An occasional, or even regular, user of an e-cigarette, tobacco orbs or a flavored cigarillo does not necessarily identify as a smoker or tobacco user because they are not a smoking cigarettes and they do not consider themselves addicted to tobacco.

*Recommendation:*

We recommend that the general definition of tobacco use be based on the tobacco products FDA has the authority to regulate with a standard look-back period, but be refined for the purposes of insurance applications. FDA's tobacco regulations currently apply only to cigarettes, cigarette tobacco, roll-your-own tobacco, and smokeless tobacco, with the opportunity to extend authority to any other tobacco products deemed to fit the definition. These products could include cigars, cigarillos, snus, dissolvable tobacco, e-cigarettes, or any other product with nicotine that is derived from tobacco. While there is variation in the frequency of using tobacco that makes someone a "tobacco user," CDC and the Institute of Medicine use a 30-day timeframe to define a current user, which is a reasonable period that could be used in an insurance application, and

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[2] *Ending the Tobacco Problem: A Blueprint for our Nation's Future*. Institute of Medicine. National Academies Press, 2007.

[3] Cowling, DW et al. Improving the self reporting of tobacco use: results of a factorial experiment. *Tobacco Control* 2003;**12**:178-183 doi:10.1136/tc.12.2.178

[4] Stuber, J and S. Galea. Who conceals their smoking status from their health care provider? *Nicotine Tob Res (2009). 11:3: 303-307.*

[5] Berg, CJ, et al. Am J Prev Med. 2009 Apr;36(4):333-6. doi: 10.1016/j.amepre.2008.11.010. Epub 2009 Feb 6.

[6] Levinson, AH. et al Nicotine Tob Res. 2007 Aug;9(8):845-52.

[7] Sacks, R et all. Exploring the Next Fronteir for tobacco control: Nondaily smoking among New York City Adults. Journal of Environmental Public Health 2012. Epub May 20, 2012.

[8] Edwards, S.A. Are Occasional smokers a heterogenous group? An exploratory study. Nicotine Tob. Res. 2010 Dec.: 12(12). Epub 2010 Oct 26.

reasonably understood by the consumer. The definition should also include a measure of how often someone uses tobacco within that 30-day period. The World Health Organization (WHO) considers someone a "regular" tobacco user if they use at least one tobacco product a day, while other survey instruments ask respondents if they smoke or use tobacco every day, some days or not at all.

Because self-attestation protocols for tobacco use appear to differ widely among states and plans today, the precise questions and format for tobacco use status that would produce the best results are not clear. HHS should use its planned consumer testing program to test various language, questions and definitions of tobacco. After evaluating the results, HHS should apply whichever protocol produces the most accurate, reliable and consistent measure of actual tobacco use.

We suggest HHS work with experts in communicating with consumers to create these questions, but offer some suggestions to provide examples of what could be asked. HHS should test various levels of detail in the definition from a fairly narrow definition of tobacco use to a definition that encompasses a broader range of tobacco products and frequency of use. If a list of products is included, insurers should be required to update the products yearly to include all products under FDA's authority. The testing should seek to measure the accuracy and consistency of responses. Examples of possible questions for testing include:

- Have you smoked cigarettes or cigars or used smokeless tobacco every day in the last 30 days?
- Have you smoked cigarettes or cigars or used smokeless tobacco at any time in the last 30 days?
- Have you used at least one of these tobacco products every day in the last 30 days: cigarettes, cigars, cigarillos, pipe, smokeless tobacco, snus, or dissolvable tobacco tablets?
- Have you used any of these tobacco products at any time in the last 30 days: cigarettes, cigars, cigarillos, pipe, smokeless tobacco, snus, dissolvable tobacco tablets, or any other product containing tobacco?

Identification of Tobacco Users

In the proposed rule, HHS recognizes that most issuers that rate for tobacco employ self-attestation to determine tobacco use status. Several different methods can be used to self-identify, from a general "yes/no" question for tobacco use, to listing types of tobacco products, to specifying a threshold for frequency and duration of use. However, self-reporting questions using tobacco or smoking addiction as the threshold could produce significant inaccuracies. Tobacco dependence is best measured in a clinical setting using proven, established protocols for assessing tobacco dependence. These measures are meant to be used by health professionals when evaluating patient health and needs, not by the general public unaccompanied by any professional guidance.

Some insurers use testing to assess tobacco use, such as blood or saliva tests that measure cotinine levels as a marker of tobacco use. We believe that these tests should not be used to

identify tobacco users because of problems with accuracy and impact on those trying to quit tobacco use. Relying on cotinine markers may produce false positive results for people heavily exposed to secondhand smoke at work or home, and for those currently using nicotine replacement therapy. These tests would likely prove overly burdensome and costly for both the employer and insurer, and for the consumer, especially if regular testing or verification would be required.

*Recommendations:*

- Tobacco users should be identified by self-reporting whether or not they currently use tobacco products. The goal of defining tobacco use is to provide a simple and precise assessment of the consumers' tobacco use status that minimizes misunderstandings or potential false reporting and accounts for changing trends in tobacco products and uses.
- Because self-attestation protocols for tobacco use differ widely among states and plans, the precise questions and format for tobacco use status that would produce the best results are not clear. HHS should use its planned consumer testing program off of the uniform enrollment application to test various language, questions and definitions of tobacco. After evaluating the results, HHS should apply whichever protocol equates to the most reliable and consistent measure of actual tobacco use. Methods for identifying tobacco users should be applied consistently across consumers to avoid any possibility of discrimination on the basis of age, geographic location, race or ethnicity, income, or other demographic characteristic.
- If a person becomes a new user during the year (i.e., they accurately said they were not at the time of enrollment), they should be allowed to enter a cessation program without charge for the service and without a surtax penalty.
- If a person self-attests as a tobacco user but initially refuses to enter a cessation program, they are subject to the surtax. If, however, during the year the user changes his mind and enters a cessation program, the surtax should stop at that point.
- HHS should clarify that a misstatement regarding tobacco use is not grounds for rescission. The department should further clarify that if there has been a misrepresentation, intentionally or unintentionally, the insurer can only collect the surtax that should have been paid for one year.
- Consistent with other ratings factors measurements, tobacco use should only be measured once a year at the time of enrollment or re-enrollment.

Tobacco Rating Application

A health insurance surcharge for tobacco use and what is for many, a chronic disease of tobacco addiction, is likely to produce adverse consequences. There is little evidence that financial incentives or disincentives through insurance premiums change individual behavior. Tobacco rating is an unproven way to improve public health when we have several thoroughly tested, evidence-based interventions that are proven to reduce smoking consumption and prevalence, including higher tobacco taxes on all tobacco products, smoke-free laws and cessation and prevention programs. From the experience of states like California and Massachusetts and cities

like New York, we know that comprehensive tobacco control polices can reduce smoking rates by 23 percent or more over just a few years.[9]

More importantly, higher health insurance premiums due to the tobacco surcharge will create a barrier for individuals who need coverage the most. A recent analysis by Rick Curtis and Ed Neuschler of the tobacco rating impact on California consumers confirms this unintended result.

> "Smokers with lower incomes who are eligible for premium tax credits would generally face **prohibitively high health insurance premiums** under the maximum 50 percent tobacco-rating factor allowed by the ACA."[10] [emphasis added]

In their example, an average adult who identifies as a tobacco user could have a premium of $5,200 for an exchange benchmark plan with the surcharge, representing 18.7 percent of her income, well above the 8 percent of income considered affordable under the ACA. Not only do the premium ratings increase the price of health insurance, this policy will result in greater numbers of uninsured than would exist without a tobacco rating. In California, between 200,000 and 400,000 people would remain uninsured if the 1.5 rating is implemented.[11] ACS CAN believes that this consequence goes directly against the purpose of the ACA, to provide access to quality, affordable health insurance to a greater population.

We are also strongly concerned about the specific populations that would likely be priced out of affordable health insurance. Tobacco users, particularly smokers, are disproportionately in a racial minority, low-income and less educated. Native Americans have a smoking prevalence of about 33 percent and African American smoking prevalence is above 20 percent.[12] Thirty-four percent of the nearly poor and 31.4 percent of the middle income population smoke in the U.S. while only 20 percent of those with higher incomes are current smokers.[13] Across all racial groups, those who are classified as nearly poor or middle income have higher smoking rates than those of higher income.[14] Tobacco-related diseases like cancer, lung and heart disease disproportionately impact these populations, who are less likely to get adequate medical services and are more likely to die of these tobacco-related conditions than higher income or non-racial minority individuals. For example, lung cancer rates for African American and white men with lower education levels are 4-5 times higher than for college graduates.[15]

If HHS proceeds with implementing the tobacco rating factor, we have several important recommendations for reducing the adverse impact of the rating. We strongly urge HHS to include these provisions in its final regulation. Consumers must have full and clear information about the premium surcharge, what they must do if they wish to avoid paying the surcharge, and the cessation services available through the insurance plan. The information must be simple, in consumer-understandable language, and not require excessive time or burden on part of the

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[9] IOM Blueprint
[10] Curtis, Rick and Ed Neuschler, Institute for Health Policy Solutions, June 2012.
[11] Curtis.
[12] IOM, 2010.
[13] IOM, 2010.
[14] IOM, 2010.
[15] Cancer Facts & Figures, 2012. American Cancer Society.

consumer. Without this information, it is very likely that purchasers might misunderstand how and why the rating is applied, how it impacts their premiums or the cessation options.

The tobacco rating factor should not be applied to people under 18 covered under the insurance policy. Adolescent tobacco use initiation, patterns of use and cessation treatments are substantially different than those of adults. Children are not going to be responsible for paying the premium surcharge, thus are not directly impacted by the implied financial incentive to quit. Furthermore, accurate and complete assessments of tobacco use by dependents under 18 are likely difficult. Adolescents cannot be relied on to provide parents or other adult family members with honest assessments of the products they use or the frequency of use, due to family dynamics and other personal situations. The high premium surcharge may even discourage youth from revealing tobacco use, thus raising the likelihood that they will not get needed help to quit. Discussion of tobacco use is best left up to the family and the family's health care professionals, not an insurance application with potentially very large legal and financial implications. If this cannot be done under federal law, we encourage you to clarify that states have the option to limit tobacco rating to adults.

*Recommendations:*

- Require that consumers be provided the opportunity to state that they wish to enroll or intend to enroll in a cessation program during the insurance purchasing process, whether online, over the phone or by other means.
- An indication by the tobacco user purchasing insurance that he or she intends to enroll in a cessation program is sufficient to avoid paying the tobacco surcharge. Limiting the types of cessation programs, requiring completion of certain treatments or tracking use of cessation services can discourage successful quit attempts. Tobacco users may not be able to quit successfully while in treatment and should be able to schedule their quit attempts and what treatments they will use according to what will give them the greatest chance of success, not the insurance companies' requirements. Tobacco addiction is a chronic disease that takes most smokers 4-6 quit attempts over multiple years to successfully quit.[16]
- Require that insurers post a clear disclaimer with the premium information, in consumer-friendly language, that failure to indicate intention to enroll in a cessation program will result in higher premiums.
- Any requirements for consumers to show cessation enrollment or intent to enroll in cessation should not be more frequent than once a year.
- The regulation and any subsequent guidance should emphasize that states have the freedom to use a lower than 1.5:1 tobacco use rating. HHS should specifically enumerate the implications of the high, lower and no rating, so that state plans are provided clear information about the implications of the tobacco rating, including its impact on access to insurance for lower-income populations.
- Specify that the tobacco use rating applies to only those beneficiaries age 18 and older.

[16] Centers for Disease Control and Prevention. *MMWR.* 60:44, November 11, 2011.

Cessation Services

It is imperative that evidence-based cessation services must be offered and be free of charge to the consumer in both the small group and individual markets if the consumer is subject to the tobacco surcharge. Including cessation treatments as a covered health benefit increases quit rates by 30%.[17] While the ACA provides that cessation services must be offered in new plans in the small group and individual markets, a recent review of implementation of this provision in several states shows that plans are not following the law. In an analysis of individual market, small group market, state employee, and federal employee plan contracts, researchers found extensive discrepancies in implementation and wide variation among the plans claiming to offer cessation benefits.[18] The analysis found that 26 of the 39 contracts excluded some or all tobacco cessation services, despite other provisions indicating that coverage is provided. Seven of the contracts required cost-sharing for tobacco services, including counseling and prescription cessation drugs, in direct conflict with ACA requirements that USPSTF graded 'A' preventive services be offered without cost-sharing. Many of the plans contained barriers to access to cessation treatment, such as medical necessity requirements, pre-existing condition exclusions, specific program requirements, and even health risk assessments. Cost sharing, even when minimal, and these types of administrative barriers are shown to decrease access to cessation services and impede reduction of tobacco use rates.

*Recommendation:*

- Clear guidance from HHS that plans must offer cessation services without restrictions in other plan provisions, cost-sharing or administrative barriers.

Coordination with Wellness Programs

HHS proposes to coordinate implementation of the tobacco surcharge with employer wellness programs, citing administrative efficiency and encouragement of the use of tobacco cessation services offered in the program. We commend the Department's efforts to extend cessation services to a broader population through insurance plans, but we do not fully support the proposal to directly link the two provisions. Successfully quitting tobacco use is a unique and complex process for millions of people, and tobacco addiction is a chronic condition not easily remedied. Cessation requires comprehensive and tailored treatment options and services that are easily and readily accessible to any tobacco user who wants to quit, including phone counseling, individual and group counseling by addiction experts, medications, and over the counter therapies. A general employer wellness program may contain some cessation services, but as the detailed features are not set out in regulation or guidance, it is very likely that some or even many tobacco users will not have access to adequate quit resources. In order to avoid the tobacco surcharge, tobacco users should not be required to enroll in a general wellness program that deals with a variety of lifestyle behavior and health issues. Tobacco users may benefit from weight management, nutrition and other services within the wellness program. What they

[17] Fiore MC, Bailey Jaen CR, Baker TB, et al. *Treating Tobacco Use and Dependence. 2008 Update.* Rockville, MD: U.S. Department of Health and Human Services., Public Health Service. May 2008.

[18] Kofman, J.D. et al. *Implementation of tobacco cessation coverage under the Affordable Care Act: Understanding how private health insurance policies cover tobacco cessation treatments.* Health Policy Institute, 2012.

require, however, is focused, high-quality, evidenced based cessation treatment as recommended by the U.S. Public Health Service and the CDC.

On the issue of potential conflict between sections 2705(b) and 2705(j) noted in the proposed regulation, we recommend that small employer plans that do not offer a wellness program and who chose to apply a tobacco use rating be required to also offer tobacco cessation benefits at no cost. The enrollee would be free to find an appropriate cessation program in their community. Without such a requirement, tobacco users would face significant financial burdens without sufficient resources to quit that are necessary to avoid the surcharge. Very few tobacco users can quit without quality cessation resources. So, the absence of these services directly conflicts with the public health goal of the ACA and the surcharge of decreasing tobacco use. Offering adequate cessation services, as documented by the U.S. Public Health Service and in dozens of studies, increases successful quit rates by up to 30 percent.[19] Successful quitting should be the ultimate goal of implementation of these provisions.

*Recommendation:*

- The ability of a tobacco user to forego the surtax should not be directly linked to participation in a cessation program offered through a wellness program. The enrollee should be allowed to use a cessation program offered through an employer or insurer's wellness program, but the enrollee should also have the option of participating in any evidence-based cessation program that they choose, both in the individual or small group market.

**Limitations of Ratings Factors**

The proposed rule firmly establishes that insurers may not use any factors beyond age, family status, geographic area, and tobacco use to establish premium rates. The preamble further clarifies that use of other factors such as occupation, prior coverage, credit scores, and claims experience are prohibited. Data mining has become so advanced today that the content of consumer purchases can indicate a health condition before the consumer is even aware of that health condition. As insurers move towards more advanced data analysis of non-health factors to identify high risk individuals, the prohibition of any factor used in underwriting other than age, family status, geographic area, and tobacco use is critically important.

*Recommendations:*

- We recommend that the proposed regulatory language be maintained to ensure a clear prohibition on the use of any other data for insurance ratings, other than age, family status, geographic area, and tobacco use, as specifically defined in the ACA.

**Rating for Geography (§147.102 (5))**

[19] Fiore, 2008.

We applaud the Department for requiring the same geographic ratings areas to be used by insurers both inside and outside the exchange. Allowing variations in the geographic areas used inside versus outside the exchange may have opened up the possibility of adverse selection in the exchange. Ensuring a consistent use of ratings areas protects the health of the exchange and reduces consumer confusion concerning the cost of health insurance.

States may use one of three proposed methods for establishing their ratings areas. These approved ratings areas may either be a single rating area for the state, ratings areas based on 3-digit zip codes or ratings areas based on MSA and non-MSA classifications. If a state does not use one of the three proposed methods, the proposed rule indicates that CMS will review the proposals and that these ratings areas must be actuarially justified. The approved methods for determining ratings areas should be sufficient for practically all states. If a state chooses to develop a different method for determining geographic ratings areas, then this request and the data used to support it should be subject to a public comment period at both the state and federal levels.

While the rule limits geographic ratings areas to seven per state, it is silent on the size of ratings factors insurers may use in implementing these areas. Thus, there may continue to be wide swings in premiums as consumers move from one part of the state to another. We would ask that the ratings factor used for each geographic area also be actuarially justified.

We are concerned that there is no data collection or reporting requirement associated with the implementation of these geographic ratings areas. While an initial limitation to seven ratings areas appears reasonable, it is critical that data be collected to determine how these methods impact consumers' experience with health insurance, particularly in smaller population and more rural states. Further, many of these changes to the insurance market are subject to much public skepticism. Making transparent the success of these reforms is incumbent on the administration.

We are concerned that limiting the number of geographic ratings areas to no more than seven may still be problematic in small population states. Allowing states to carve up lightly populated geographic areas could allow insurers to underwrite for health status in more vulnerable communities. Further, lightly populated areas may have significant variation from year to year. Consumers already experience confusion over rate increases and ratings factors. Allowing a geographic factor to be based on an estimate that may significantly shift annually may cause additional consumer confusion at a time when the Department is trying to increase health insurance literacy.

*Recommendations:*

- Maintain the limit on the number of geographic ratings areas to no more than seven with a requirement for a minimum population size in each area.
- States using something other than the three approved methods should have the proposed geographic areas subject to an open comment period at both the state and federal levels.
- All geographic ratings area should be subject to a minimum population test to avoid unnecessary fluctuations in the geographic ratings factor.

**Rating for Age (§147.102(6))**

We applaud HHS for proposing to implement the age ratings in such way that minimizes annual premium rate increases and ensures a consistent and fair application of these age factors to all consumers. Beginning in 2014, states may not vary age premiums by more than a 3:1 ratio. The proposed rule implements the 3:1 ratio through single-year age bands beginning at age 21 and ending at age 65. Large increases in health insurance premiums make it very difficult for consumers to adequately plan their household finances from year to year. The use of single-year age bands helps consumers avoid a premium cliff that would occur if the age bands were larger, such as five years.

HHS also stipulates that the age-related rating factor can only be applied once a year, either at the time of issuance or at re-enrollment. This assures consumers that they will not face multiple premium increases during the year. This is consistent with the way rate increases are handled for many other consumer services and will ease consumer comprehension.

States may also choose to enact narrower age bands (e.g. 2:1), and indeed in a handful of states, this is already the case. HHS has asked that these states submit their rating methodology within 30 days from the close of the comment period. We understand that HHS must move forward with creating their risk adjustment methods at an enhanced pace. However, states are faced with an enormity of tasks in implementing all of the ACA provisions and we would ask that any state that already institutes this narrower age band be given reasonable leeway in submitting their age curves to HHS.

The proposed rule also indicates that states may establish their own age curve if they do not wish to use the model age curve. We would ask that for the first year, all states be required to use the same age curve. There are many significant changes to the market place that will occur in 2014. The more variations that exists in the implementation of these provisions, the more difficult it will be to understand and highlight the success of the ACA in reforming the insurance marketplace. The model curve that HHS has developed is a reasonable implementation of these ratings factors and there is very little reason why a state would need to develop an alternative 3:1 age curve. Any alternative proposals for age curves should be subject to public comment at both the state and federal levels.

We strongly support the use of a uniform age rating curve. In the proposed rule, HHS prohibits insurers from varying the age curves across products, geographies, etc. Not only does this provision bring a clarity and uniformity to the marketplace, but it prevents insurers from subtly designing products to dissuade high risk individuals from enrolling and may segment the market.

Finally, the 3:1 age rating factor is one of the most important provisions of the ACA. It guarantees consumers a fair health insurance premium throughout their life. Yet, the rule calls for very little data collection, reporting or enforcement. It is critical that consumers understand the benefits they are receiving under this provision. HHS must collect data and report on the implementation of the 3:1 (or tighter) age rating, including changes to premiums, consumer comprehension and consumer experience in states using narrower age bands or alternative age curves.

*Recommendations:*

- We strongly support the use of a uniform age rating curve that prevents insurers from varying curves across products/plans or geographic regions.
- Age-related premium increases should only occur at the time of enrollment or re-enrollment.
- Single-age bands are appropriate for the implementation of the age rating requirements as this prevents consumers from experiencing significant increases in their premiums from year to year.
- States using a narrower age rating band should be allowed to go forward in a timely manner.
- HHS must collect data and report on the implementation of the 3:1 age rating, including changes to premiums, consumer comprehension and consumer experience in states using narrower age bands or alternative age curves.

**Guaranteed Availability (§147.104(B))**

The proposed rule ensures that all consumers can enroll in the plan of their choice. Insurers must accept all applicants regardless of their claims history, health status, etc. We support the provision in the proposed rule that aligns open enrollment periods in the individual and small group markets inside and outside of the exchange. This alignment allows consumers to better compare their health care options and to make the most appropriate choice for their families. Further this alignment helps prevent adverse selection against those enrolled in the exchanges by ensuring that all insurers are competing on a level playing field.

However, we are concerned that the period for special enrollment is too short for consumers' needs. The proposed rule limits the special enrollment period to 30 days. Many consumers have never shopped for insurance before; rather, they have relied on their employers to provide them a limited selection. Consumers who lose coverage from an employer could find themselves shopping for coverage in the exchanges, and they will have little or no experience actually "shopping" for a health plan. Depending on the selection of plans in the exchanges, it is possible that consumers could find this activity overwhelming at first. Further, many of the qualifying events for special enrollment are associated with significant life disruptions. Consumers need time amidst that change to understand all of their options in this new marketplace and make the best choice for themselves and their families. For that reason, a special enrollment period should be extended to 60 days, which is consistent with the period consumers have for electing COBRA. Further, we strongly support notification of special enrollment rights to consumers with coverage in the individual market. The ACA extends many of the insurance protections in the large group market to the individual market. However, a massive education effort is needed to ensure that consumers fully understand the extent of their rights and responsibilities in this new marketplace. Part of that effort must include a consumer-friendly notification of their special enrollment rights.

The proposed rule also recognizes that not all insurers will have the capacity to accept every potential enrollee. It allows insurers to not accept new enrollees if they do not have network capacity or financial ability to expand enrollment. However, in these circumstances they must

apply this denial uniformly to everyone and may not accept new enrollees for at least 180 days after the denial. This is a reasonable provision but we recommend that the Department collect and publicly publish data on the frequency of these denials and the experience of consumers who have been denied due to a network or financial reason.

*Recommendations*:

- Require insurers in the individual and small group markets to have the same open enrollment periods, regardless of whether they are selling the plan/product in the exchange.
- Extend the special enrollment period to 60 calendar days to ensure that consumers have an adequate period of time to understand and compare their coverage options.
- Require issuers to provide a consumer-friendly notification to those in the individual market on their special enrollment rights.
- HHS must collect data on denials of coverage based on network or financial capacity to better understand how this affects consumers' experience in the marketplace.

**Single Risk Pool (§147.104(E))**

We strongly support the proposed requirement preventing insurers from segmenting the market through the use of more than one risk pool. The proposed rule requires that insurers must consider all of its enrollees (other than those in grandfathered plans) to be part of the same risk pool in the individual and small group markets. As noted in the preamble to the proposed rule, a single risk pool prevents de facto underwriting. Further, the proposed rule outlines the reasons that a premium may vary which further prevents insurers from carving up the market to avoid high-risk individuals. In addition, we support the policy that would give states the option to merge their individual and small group markets. Finally, it is unclear how or whether affiliates of large insurers will be treated for purposes of having a single risk pool

*Recommendations:*

- As proposed, require insurers to consider all of its enrollees (other than those in grandfathered plans) to be part of the same risk pool in the individual and small group markets, regardless of whether the plan/product is sold inside or outside of the exchanges.
- Technical clarification should be made on how subsidiaries or affiliates of large insurers will be treated if the parent company maintains its business outside of the exchange.

**Transparency and Enforcement (§147.104(F))**

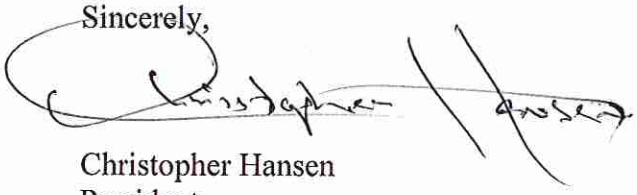
For consumers to make informed decisions, it is imperative that they have access to more comprehensible information about plans and their performance (e.g. claims denials and billing delays, appeals, etc.). It is also critical that the states and HHS have clear enforcement and reporting requirements to monitor the implementation of these changes in the insurance market. Throughout this document we have noted areas where enforcement or transparency could be increased. Our overall recommendations are summarized below.

*Recommendations:*

- Require public comment periods at both the state and federal levels for all alternative ratings submissions from the states.
- Require data collection and reporting on consumer experience and understanding of the allowed ratings factors, special enrollment rights and denials of coverage.
- Require all plans in the individual and small group markets to post their plan Summary Plan Descriptions (SPDs) or insurance contracts on their web sites.

Thank you again for the opportunity to share our comments on this critical proposal. The proposal represents an exceptional effort by the department to reform many problematic practices in the individual and small group markets. The proposed rule firmly guarantees all Americans access to fair health premiums regardless of their health status. If you have any further questions, you may contact Stephen Finan, Senior Director of Policy for ACS CAN, at Stephen.Finan@cancer.org or 202-661-5780.

Sincerely,



Christopher Hansen
President