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June 12, 2017

Public Comment on HHS/CMS Reducing Regulatory Burdens of PPACA - **ID: CMS_FRDOC_0001-2193**

Thank you for the opportunity to submit Public Comment on Reducing the Regulatory Burdens of PPACA; the opportunity to propose ideas for making it easier for people to purchase and maintain enrollment in health insurance plans that are affordable; and that increase the access-to and the affordability-of healthcare. I apologize for the length of this document; however, it serves as a reinforcement of how numerous, burdensome, complicated, and occasionally contradictory, the Regulations that have been issued to administer and enforce PPACA have become, since 2010. The provided suggestions, and potential solutions, focus on using a common-sense approach and reducing the administrative burdens, which have increased significantly over the last few years. The provided suggestions are based on my 16 years of experience working with 1,000's of Individuals and Business owners as a Health Insurance Agent and Health Insurance Consultant.

Summary

In this section, a few items are highlighted; however, more detailed and broader information is provided on the following pages, separated by topic, including walking through the health plan purchasing, enrollment, verification and maintenance process. An alternate item for consideration is to allow both PPACA and AHCA, if approved, to operate "concurrently" during the transition period, through 2019.

Veterans Benefits should be reviewed and VA Benefits, earned for "Service", should be treated as are Medicare Benefits, earned for having earned-income for the requisite minimum number of quarters. VA Benefits "should not" be categorized as an "Employer Group Plan", as Veterans are not "Employees".

The Actuarial Value Calculator (AVC) was originally intended to be a "tool" to compare and assign health plans on a weighted basis using the cost-sharing and out-of-pocket expenses of a health plan. The AVC was created by Actuary's that assigned values to a limited number of medical services and assumes all people use the average number of medical services every year. The AVC is now used to design all health plans in the Country; and it should not be used in this manner. The AVC should only be used to weight the minimum legally required benefits, the 10 'core' EHBs; as designed, without incorporating any State mandates or Specialty Care; and those services can be priced separately as additional benefits.

The intent of PPACA was to ensure that Consumers would always have available community-based individuals to assist them in navigating the health insurance system, at no cost to them. Unfortunately, this is not the case today, for a variety of reasons. The simplest way to address this issue, create jobs and provide year-round assistance to people is to mimic the compensation structure of Medicare Advantage plans, regulated federally, with two exceptions. One, make semi-annual payments to assistance providers, Feb and Aug, based on active enrollment. Second, allow both licensed Brokers and "Certified" Assistors, or Agency's, to receive compensation, based on actively servicing the client.

With regards to Stabilizing the Individual and Group health plan marketplaces, they do not operate independently of each other; and changes in one will destabilize the other, negatively impacting cost-of-care and access-to-care for individuals. If employers are 'not subject to a penalty' if employees access Subsidies to purchase Individual plans for themselves or their families, redefine the 'affordability rules'. Example; set a minimum employer contribution toward health plan purchase, not based on an employee's income, also easing the Administration of Subsidies. Today, it is common for employers to offer low-cost high-deductible health plans with costs closely tied to Medicaid eligibility, limiting potential penalties.

The "no wrong door" policy for Medicaid and Exchange enrollment, primarily used in State-based marketplaces, needs to be eliminated. Medicaid should be uncoupled from the Exchanges due to the confusion it creates for Individuals, the varying Medicaid eligibility rules, the duplicative administrative costs of Medicaid having a separate IT system, and the stricter federal oversight of Medicaid funds.

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Veterans Benefits Categorization v. Employer Plans, Medicare and Medicaid

The method under which Veterans Benefits are categorized and administered today should be reviewed and the "designation" of VA Benefits as Employer-Group Benefits should be changed to reflect that VA Benefits are "earned for Service", and be treated the same as how Medicare Benefits are treated under PPACA. Medicare eligibility is earned by having earned-income for the requisite minimum number of payroll quarters; and Individuals are not required to surrender their Medicare Benefits if they or their spouse enrolls in an Individual health plan on an Exchange. After all, Veterans are not "Employees" of the VA system as employees have different government health benefits, by contract.

The most concerning issue with the current designation is that it requires Veteran's to surrender the VA Benefits they have earned for serving the Country, if they wish to purchase an Individual health plan AND qualify for either Medicaid or a Subsidy on an Exchange. It is not simply the Veteran that is impacted, the seriousness of the current enforcement is that the Veteran's family is also excluded from these other programs, if the Veteran does not surrender their VA Benefits. This is due to the VA Benefits being considered an "affordable employer-plan" with no cost-sharing; therefore, excluding the Veterans family from accessing financial assistance, Subsidies, on the Exchanges.

It is important to note that it does not appear that PPACA forced this designation of VA Benefits as Employer-Group Health Benefits; but that it was a bureaucratic decision to issue this anti-Veteran and Veteran family designation, probably due to lacking the understanding that VA Benefits are comparable to Medicare Benefits, as they are both "earned" benefits that are for-life, once earned.

With regards to the Veterans themselves, instead of relinquishing their VA Benefits to access a health plan on the Exchanges; there should be consideration to allow Veterans to enroll in the Catastrophic Plans available either On-or-Off the Exchanges, regardless of their age, considering the VA Benefits are primary and the Individual health plan is secondary. It would be an expense to the Veteran; however, it is a low-cost plan that increases the access-to-care, noting that the VA is still the primary care provider.

Medicare

The main administrative issues related to Medicare and PPACA, from a basic health plan administrative perspective, are around the household definition for qualifying for financials assistance, and the elimination of the Medicare Part D donut hole, the coverage gap. With the regards to the 'donut hole', in Medicare Part D plans, it should be eliminated, as planned within PPACA, or faster, if possible. From a cost and care perspective, it is more important to help people afford and maintain their health through the use of medications than having their health destabilize, potentially requiring them to access care in high cost environments or develop more health issues and driving up long-term costs of medical services.

When a person applies for a health plan on an Exchange, a major issue is that there a significant number of households in which one person is on Medicare and one person is not on Medicare, primarily due to being too young to be on Medicare. There are also situations in which the Medicare enrolled Individual has children or grandchildren as legal dependents, creating other administrative issues. Under the current Subsidy system, the Exchanges carve-out the Medicare eligible Individual and pro-rate the Subsidy for the non-Medicare enrolled Individual, or family members; however, due to how household income is calculated, the payback of assistance has become a real issue and forced many people to opt-out of accessing Subsidies, due to full payback of the Subsidy at tax filing time. While AHCA proposes a much simpler system of Tax Credits, which should make accessing assistance much easier and decrease the growing number of older uninsured adults, due to this issue and health plan cost, consideration should be given to modify the rule or regulation determining how income pro-rating is calculate and what income is included in the calculation, note that Social Security income, even non-taxable Social Security income, impacts this calculation, as it is included as adjusted gross income.

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Medicaid

The issued PPACA regulations and rules have created many issues and unintended consequences for many families throughout the Country. With some States having opted to expand Medicaid, while others did not expand Medicaid, the Medicaid administrators in each State were placed in situations in which regulations and rules became confusing, contradictory and maybe even inapplicable, leading to many work-arounds and a patchwork of exclusions. These exclusions have become problematic and created issues for people, when they filed their tax returns, as they end up having to pay back their Subsidies.

The “no wrong door” policy for Medicaid and Exchange enrollment, primarily only used in State-based marketplaces, which was well intentioned, created significant confusion for people and needs to be eliminated. Medicaid should be uncoupled from the Exchanges to eliminate this confusion; and to make it easier on State Medicaid agencies. Medicaid agencies already have their own eligibility and administrative systems, IT systems and processes, and have stricter federal oversight on how the Medicaid funds are spent. By having Medicaid agencies financially support the State-based Exchanges, the Medicaid agencies lose control of how Medicaid funds are spent; or if they are spent efficiently.

End the “all-or-nothing” policy for Medicaid eligibility! Under current rules and regulations, if any one person in a household is eligible for Medicaid, they “have” to enroll in Medicaid or pay full price for a health plan, due to being Subsidy-ineligible; and this directly results in breaking up families into separate health plans, without any recourse. In fact, under PPACA, there is “no asset test” for eligibility for Medicaid, simply an earned-income test, Adjusted Gross Income; therefore, millionaires are eligible for Medicaid, and regularly enrolled in Medicaid due to only being subject to an income-only test.

The “all-or-nothing” policy is especially harmful to families, an unintended consequence, as families are forced to be split up between Individual plans and Medicaid. The splitting of the family up into different programs, without giving them any options to all stay on the same plan, regularly leads to families having much higher out-of-pocket costs for their health plans and their cost-of-care, as pro-rated Subsidies for parents-only are greatly reduced; and parents may even lose their CSR eligibility. It is well documented that, if parents and children are on different health plans, access-to-care and ongoing care, including preventative care, are negatively impacted, primarily driven by the frustration and complication of having to navigate multiple health plan networks. Basically, people either don’t get care, or go to the ER for care.

There should be serious consideration given to creating an “opt-out” policy for Medicaid, that still allows people to be eligible for the pre-set Subsidy and/or health plan, maybe based on 100% of FPL for non-expansion States, or 138% for expansion States, based on the PPACA Subsidy levels, in lieu of splitting the families up into separate health plans. For example, if a person, family or a family member is eligible for Medicaid; and the family opts to stay insured together on a single health plan, then charge them either; 1) The minimum cost for a household income of 100% or 138% of FPL, and enrolled into a CSR94 Plan; or based on 150% of FPL and enrolled into a CSR87 Plan; or 2) The Subsidy is set to a fixed dollar amount, and allows the family to purchase any health plan with the pre-defined contribution amount.

Another unintended consequence of the “all-or-nothing’ policy is that if someone should have been on Medicaid all year; but instead was receiving a Subsidy on the Exchange for part of the year, they will have to pay back the Subsidy at tax time, as they were not eligible for the Subsidy. It’s impossible for people to predict future income or retro-actively adjust their income. In fact, if someone buys a plan on an Exchange, with or without a Subsidy, and it turns out the person was eligible for Medicaid all year, the person will not get their money back at tax time; since they should have been in Medicaid all year.

In the future, when considering Medicaid cost-sharing policies, serious consideration should be given to not charging people for their Medicaid plan, which deters enrollment and increases administrative costs; but does not reduce needed medical care. Instead, only consider cost-sharing on services; focusing on accessing care at the lowest cost points, and keeping health maintenance medications affordable.

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Plan Design and the Actuarial Value Calculator – Tool "not" System {One Size Fits All}

The Actuarial Value Calculator (AVC) was originally intended to be a "tool" to compare and assign health plans on a weighted basis using the cost-sharing and out-of-pocket expenses of a health plan. The AVC was created by Actuary's, that assigned values to a limited number of medical services, and assumes all people use the average number of medical services, every year. If one reads all the caveats included in the original Excel file, one will understand the purpose of the tool was simply to be able to differentiate how costs were shared between the health plan and the insured individual for basic health care services.

The AVC is now used to as the de-facto health plan design tool to design "ALL" health plans in the Country; and it should not be used in this manner. It was never intended to be the de-facto plan design tool, which is why PPACA allowed for a certified Actuary to approve any alternate plan designs that the tool could not accommodate; however, it was just easier to use the tool than to figure out how to get alternate plan designs approved by an Actuary and HHS/CMS. The 'reality' is that the AVC does not account for human behavior; and therefore, under-values the Platinum and Gold Tier plans, while over-valuing the Bronze and Silver Tier plans, based on how people actually make purchasing decisions. People that need services purchase better plans; and people that don't need services purchase the cheapest plan available to them, further distorting the AVC tool and making all health plans the same!

The AVC should only be used to weight the minimum legally required benefits, the 10 'core' Essential Health Benefit's, as designated in PPCA. The tool does not and should not be viewed as incorporating any State mandates or Specialty Care, as those services can be offered and priced separately. For example, if a State-specific Mental Health Benefit is mandated, those benefits should not be forced to be assigned to the cost-sharing variables in the AVC, as they can be adjusted for when actuaries price the health plans, based on how the health plan covers the benefits. Plan design and pricing have a significant number of variables, and the service being covered tends to have more bearing on price.

PPACA has had the unintended consequence of destabilizing the health care cost growth rate due to combining the Medical and Prescription Drug Benefits within one (1) single Maximum-Out-Of-Pocket (MOOP) cost limit for Individuals, accelerated by the strict use of the AVC tool in plan design. While Medical benefits costs had been the primary focus, Prescription Drug costs exploded in the last five years; and since they must be 'combined' within the Medical MOOP, the result has been skyrocketing health plan premiums, driven by prescription drugs costs. In fact, today, there are many drugs that can satisfy a person's entire annual MOOP in one (1) single fill, resulting in a full coverage health plan. People are then incentivized to access as much care as possible during the plan year, while being covered at 100% for all medical care and prescription drug costs.

Once the use of the AVC as the de-facto design tool is addressed, health plans should be authorized to more closely mimic the Medicare Program. Medicare and Medicare Advantage Plans have "separate" Medical and Prescription Drug benefits today, which allows for better management of the health care system and long-term cost containment of the medical care inflation rate. Therefore, consideration should be given to allow health plans to "separate" Medical and Prescription Drug MOOPs, meaning one (1) MOOP for Medical services and one (1) MOOP for Prescription Drugs, even if the plans are still required to maintain one (1) total MOOP for the combined benefits, allowing for better cost control methods.

The time has come for a "NEXT" Generation CDHP (Consumer Driven Health Plan). CDHPs/HSAs have been undermined by monthly drug prices that are in the $1,000s, primarily as a result of prescription drugs having to be covered as embedded benefits, within all health plans. HSAs have been around since 1997, over 20 years, as the Archer MSA program; and people still can't "shop" for healthcare services and lack options, mainly in rural areas. The 'next" generation CDHP/HSA should focus on directing people to access low-cost services and prescription drugs ($0 preventive care/maintenance), exclusive of satisfying the deductible. Therefore, consideration should be given to exempt some Doctor office visits, Clinics and generic prescription drugs (Tier 1 & 2) from the HSA/CDHP Deductible.

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Individual and Group Health Insurance Marketplaces – Interactions and Stabilization

With regards to Stabilizing the Individual and Group health plan marketplaces, one must understand that they do not operate independently of each other; and changes in one will destabilize the other, impacting cost-of and access-to care for individuals. If employers are 'not subject to a penalty' when employees access Subsidies on the Exchanges to purchase Individual plans for themselves or their families, then redefine the 'affordability rules'. Today, it is common for employers to offer low-cost high-deductible health plans with employee contributions closely tied to Medicaid eligibility, limiting potential penalties as employees and their families are effectively made ineligible for Subsidies. Small Businesses have also reduced people's hours, making employees ineligible for health insurance; or stopped offering health insurance altogether; since employers know people can buy lower-cost health plans on their own.

One of the issues, related to affordability and Subsidies is how employer-offered coverage can make employees, and their families, unable to receive a Subsidy in the Individual health insurance marketplace. Employers do this by offering an inexpensive base plan, on which the employer contribution is based; and employees that want better health insurance must then pay more, by paying 100% of the price difference for themselves, and their families. This strategy of offering of a base-plan with a buy-up must to be reviewed, as it hurts families; and has been expanded by employers trying to avoid PPACA penalties.

One item we often forget when discussing what people will pay for health insurance is that most people that are covered by an employer-based health plan are paying $100 to $300 per month for their share of an Individual-Only health plan. When discussing what people are paying to purchase health plans through the Exchanges, most people forget that income is not always taken into consideration when the employer offers employees and their families health insurance. Under PPACA, people purchasing with Subsidies, in some cases, are paying far less than they would have paid, making the same income, if they were working full time and offered employer-based coverage.

There should be serious consideration given to incentivizing the employer-based group health insurance marketplace, considering it is the foundation for our entire healthcare system. If employer-based coverage fails, the system fails. Along these lines, it may be time to set "new standards" for what should be deemed 'minimum employer-offered financial assistance'. Employers could offer employees Defined Contributions, or an Employer HRA program to their employees. Employer-offered HRAs need to have set limits on how much an employee can be reimbursed, such that the program does not destabilize the health insurance marketplaces, reimbursing employees only a portion of what they pay to buy their own Individual health insurance plans. Otherwise, small employers would not need to offer health insurance.

I believe that in setting a new standard for 'minimal employer-offered financial assistance' for an employee's purchase of a health plan offered by an employer, we should make sure that it correlates to the proposed Tax Credit program. In addition, the tax implications of the health plan premium payments need to be taken into consideration, when determining the employer contribution to any health plans that are offered by the employer to the employees and their families. For example; If an employer offers employer-based coverage, the employer must offer financial assistance that is a minimum flat dollar amount, or a percentage that exceeds that minimum, per month, with adjustments for US region and a person's age; basically, a Defined Contribution arrangement, with multiple health plan options. In the future, under a flat Tax Credit program, it could be the equivalent of 1.5 times of the available Tax Credit, inclusive of HRA funds, or higher, as financial assistance to the employee and/or family, for the employee to be able to purchase the employer-based Individual-only health plan, dependent on if spouse and children would still eligible for the Tax Credit in the Individual health insurance marketplaces.

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Marketplace Operations – Exchanges and Call Centers

It is shocking that suddenly, under PPACA, well-established laws, rules, policies and procedures that had been implemented, over decades, have basically been shelved and ignored, as though they were unnecessary and no longer served a purpose. It is unfortunate that this was the approach taken; basically, deciding that the entire health insurance education and distribution system, that existed for decades, would instead be immediately replaced by government agencies, with little or no real-world experience in the health insurance marketspace or with health insurance plans.

Fundamentally, I believe this to be the main reason, for the failure of PPACA. Why? Well, historically, and other than with health insurance, the health insurance marketplaces operate separately from the general business service community, with 10,000s of Insurance-only specific rules and regulations that were expressly written with the intent of protecting Consumers; and with strict State and Federal Government oversight. However, the newly created Exchanges and their Call Center operations replaced these established programs and destabilized the existing system, due to lack of knowledge of the intricacies of the system, and the lack of oversight of the entities and their government employees, who face no disciplinary action or job loss, no matter how competent they are or how they treat people.

Under PPACA, the primary role of the Exchanges and their Call Centers was to “enroll” individuals in health insurance plans offered through the Exchanges; and “administer” the program, meaning the determination of Subsidy eligibility, the processing of the Subsidies, providing year-round community-based assistance for Consumers, and maintaining the back-office infrastructure, including IT infrastructure. However, some Exchange’s decided that their primary role was not as defined under PPACA; but was really whatever they defined it as themselves, effectively creating monopolistically control of State health insurance marketplaces. It is time to make sure Exchanges are reminded of their role; and since, they only take direction from HHS/CMS, HHS/CMS must provide them with direction.

One of the best ways to impactfully address the implosion of the marketplaces; and make any program successful, is to revert to a hybrid of the prior system, that was discarded with the rollout of PPACA and replaced by an unaccountable and dysfunctional Government bureaucracy. Historically speaking, insurance carriers either provided significant Consumer enrollment and support services; and carriers worked directly with extensive networks of local health insurance agents and brokers that provided Consumers with in-person and hands-on enrollment and support services. PPACA unbalanced this entire system, destroying it; and effectively only replacing it with websites and toll-free phone numbers for Consumer assistance, which may employee staff in other States with no knowledge of State-based insurance laws, Provider Networks, or other community-specific knowledge. The most egregious issue was that the Call Centers employed staff that were not allowed to advise Consumers, only enroll them.

Based on experience, the most effective method for making sure that Consumers are provided with the help they need navigating the health insurance marketplaces is to provide community-based assistance. Consumers and Small Business owners need assistance that operates on a year-round basis with an Account Management philosophy, not a Sales philosophy. One of the best ways to accomplish this, from a HHS/CMS Regulatory perspective, is to establish a national Compensation system and structure that mimics Medicare Advantage plans; and not reinvent the wheel. However, since there are not enough, and a decreasing number of, agents or brokers, specifically servicing the Individual and Small (Micro) Business health insurance marketplaces today, the new Compensation program should focus on addressing the long-term need of bringing more people into the industry. An approach is to create a “Certification” program, leveraging Community Health Worker programs around the Country, by authorizing these individuals to enroll and advise people with health insurance plans, while they also provide them with year-round assistance navigating the health care system. Authorizing these Individuals and Agencies, in addition to Agents and Brokers, to receive the Compensation, should lead to the creation of 10,000s of jobs nationally; and provide people with year-round community-based help.

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Marketplace Operations – Customer Assistance, Enrollment and Verification Processes

In this section, I will walk through part of the process that Consumers experience when attempting to enroll through an Exchange and be approved for a Subsidy. It is important to note that some of these items many not be true across the Country, as my experience was with a single State-based Exchange. The focus is on identifying problematic steps in the process that could be improved by HHS/CMS.

Marketing – Awareness

During OE1, significant efforts were made to reach out to all communities, including recruiting, educating and deploying Navigator agencies and leveraging community advocates to identify local people to serve as In-Person Assistors in as many community's as possible for the initial rollout of PPACA. However, these programs were the first ones to get funding stripped from them; and they are effectively non-existent today. These programs need to exist; and people need local community-based support to navigate the health insurance marketplaces. The issue is more compounded now that marketing and advertising is done on a narrow and limited basis, meaning few people are aware of the programs; and most importantly, when changes are made to the programs, such as a 6-week enrollment window.

Marketing – Agents and Brokers

Insurance Agents were not originally incorporated into Exchange operations. By not planning for Agents, an opting to hire Agents to work in the Call Center, accounting for over 80% of all Agent-assisted enrollments in OE1 and OE4, the IT system did not allow for clear and transparent management of client accounts or for easily assisting consumers through the enrollment process. In essence, since the IT system never incorporated Agents, the Exchange staff took over control of all client accounts from both Agents and Insurance Carriers. If there were any issues, at all, related to a client account, it required a lengthy phone call to the Call Center or the Exchange staff themselves. The process is so frustrating that many clients walk-away uninsured; therefore, creating a pool of high-risk individuals with health issues.

Call Center – Enrollment Process

When one calls into the Exchange Call Center, representative start by asking application questions, instead of asking the person the reason for their call. From time-to-time, mainly outside open enrollment, the representatives will ask about the nature of the call before beginning the enrollment process. The whole system is backwards, the opposite of how most customer service centers operate; and when they are busy, the representatives are usually very rude with people trying to get assistance. It is not unusual for people to be mistreated; and it is impossible to file a complaint as the State-based Exchange oversees itself, meaning no agency in the State has authority over them. If there were an independent non-government 3rd party that people could turn to for assistance which could track the issues, complaints and final resolution, I am sure customer service would increase immediately, instead of being an after-thought in the process. Today, tracking numbers are issued only by the Call Center; and every time the person calls, a new tracking number is created and the old one closed, which is nonsensical when it is an open issue. The only practical reason for this process is to make issues appear minimal.

The larger issue with the Call Center staff is that they were all non-licensed staff that could not answer any questions about the program or the health insurance plans being offered on the Exchange. It would have made more sense to spend a couple of dollars more per hour on staff; and not have to have people call many times to navigate the process. Licensed and experienced Agents could typically complete the online enrollment, assuming no web site issues, within an hour for the initial enrollment, into an actual health plan, versus multiple calls of at least an hour. This needs to be addressed, and US District Court Rulings (3/16 - Missouri), stated Certified individuals can provide advice; therefore HHS/CMS can make this a standard policy. The other item is that Agents working for an hourly rate in the Call Center should be operating under a licensed Agency; and they should not be able to take ownership of clients served.

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Call Center – Verification Process

Once one completes the application process, more issues arise, making it through the verification process; hoping that no errors were made in the enrollment process; and that one's income does not increase slightly during the year, resulting in having to partially or entirely pay back the Subsidy at tax return time. The major overall issue with the Call Center handling of the verification process is that dozens of people may work on every single applicant account throughout the verification process and the year. If there are any non-standard items in an applicant's file, it is common for the applicant to be cancelled during the audit or verification process due to multiple representatives mishandling the account. This all goes back to the point of not having a sound customer service system and client relationship management system; otherwise, all the notes would be easily accessible and there would be fewer issues for applicants trying to get insurance. For example, a client should not be issued a brand-new application number every single time a change is made to their account, or when a request for information is issued; therefore, making it practically impossible for a person to know the most recent application number.

When applicants complete the enrollment, they are mailed confirmation letters, or emailed the letters, depending on the selected preference. It is typical for applicants to receive 3-to-4 letters in the mail, at the same time, that contain from two double-sided pages to twelve double-sided pages, which creates confusion for applicants. When applicants receive the stacks of letters, they panic, resulting in many more phone calls to the Call Center. Applicants should just be mailed the information they need to complete for the application process, not dozens of pages of disclosures; and especially not the same 3-to-4 letters after each-and-every call to the Call Center that results in any change, no matter how minor.

Once all required documents are submitted to the Call Center back-office, other issues inevitably occur; and these are key ones that some policy changes may be able to simplify to help applicants.

Income Verification: The process today is that if an applicant submits income verification documents, pay stubs, that do not show an income that is within 10% of estimated annual income, then the result is a 'failure to verify' and the applicant either loses their Subsidy or has their health plan cancelled. Basically, if one shows monthly pay stubs with an income of $2,000 this month; but the annual estimated income is $30,000, the result is a 'failure-to-verify". It is important to know that the PPACA income verification system was designed based on the assumption that 80% of all US Taxpayers have less than a 10% variance in income year-over-year. Ironically, no one thought to think, is that because those people have full time jobs with benefits? The reality is that people needing to access Subsidies "are people with variable incomes"; and the current verification system was not designed for them.

I would strongly recommend HHS/CMS issue new guidance that better addresses the issue that most people applying for Subsidies have "variable" income. Therefore, the annul estimated income should override current monthly income, in all cases except for Medicaid, making it easier for applicants to pass the verification test and be approved for Subsidies, for purchasing a health insurance plan.

CSR Issue: The issue with the CSRs is due to the point above, Income Verification. If an applicant is enrolled in a CSR plan; and they fail to verify income, the applicant has their application and health insurance plan cancelled, on the pretense that there is no comparable plan to reassign them. If the applicant was receiving a Subsidy, for a non-CSR plan, then the Subsidy would be cancelled; but not the health plan without a Subsidy, assuming payment is not over 30-days, as On-Exchange non-Subsidy plans have 30 days to pay, not 90 days. *{This was reported as impacting 2/3rds of Cancellations in CT}*

Cancellations: With regards to all cancellations of On-Exchange health plans, if applicants are cancelled for failure-to-verify or for failure-to-pay within the 30-or-90 day period, no notice is mailed out to applicants; and most concerning is that applicants are occasionally cancelled retro-active to the first of the month, based on when the information becomes past due. Since the Exchange controls everything, even the Carriers are not made aware of why applicants or insureds are cancelled, and all assume the Exchange notifies people that their health insurance plan has been cancelled, including when and why.