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October 13, 2017

Michelle K. Koltov, MPH
Centers for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare and Medicaid Services (CMS)
Michelle.koltov@cms.hhs.gov

Dear Ms. Koltov,

This letter is being written to respond to your October 6, 2017 email. We have addressed each of your questions.

CMS Question: Has Iowa set a date yet for your tribal consultation? As I know you're aware, members of federally recognized tribes qualify for special cost-sharing reductions that result in no out-of-pocket costs for those between 100-300% FPL and more limited out-of-pocket costs for other income levels. We continue to be interested in hearing what the Sac & Fox Tribe of the Mississippi has to say as well as how you all plan to address costs for this vulnerable population.

Iowa Response: As detailed in Appendix J of the Iowa Insurance Division's final waiver submission dated August, 21, 2017, the Division sought to engage Iowa's Tribal entities on several occasions to provide tribal notice and to attempt to arrange a time for tribal consultation. The Division did not receive a response from Iowa's Tribal members regarding its request to arrange a time for tribal consultation. Recently, I again contacted a representative of the Meskwaki tribe (aka the Sac and Fox Tribe of the Mississippi) to inquire whether they would like to schedule a tribal consultation about the Iowa Stopgap Measure. While the representative did not require a formal tribal consultation, the Meskwaki Tribe requested a meeting to explain to counselors how tribal members will enroll in the Stopgap Measure. The Division will work to arrange a meeting time and will follow-up with CMS when the meeting is scheduled.

Regarding your question about out-of-pocket costs for the American Indian/Alaskan Native (AI/AN) population, the Iowa Stopgap Measure does not contain a provision to provide enhanced cost sharing reductions to the 93 members of the AI/AN population enrolled through the Marketplace in 2017¹. With all of the legal uncertainty generally surrounding cost-sharing reductions in 2018, we did not intend to include special cost sharing credits for this population in 2018. The cost sharing credits as proposed in our waiver supplement will, however, be provided to this population based on income and specifically, for those with income at or below 200 percent of the federal poverty level. Further detail about these credits is available at: <https://stopgap.iowa.gov/files/stopgap-measure-supplement-updated.pdf>.

¹ See CMS file entitled, *Enrollment Marketplace by State*, dated January 31, 2017.

CMS Question: We confirmed that the special enrollment period for those denied Medicaid or CHIP is a tri-department rule and so, like the loss of coverage special enrollment period, cannot be subject to the continuous coverage requirement as originally planned.

Iowa Response: We once again disagree with this position. The reference to the SEP for those denied Medicaid or CHIP coverage as a "tri-department rule" is vague and certainly conclusory. While CMS provided its limited legal opinion, albeit verbally, as to the inability to utilize continuous coverage requirements on SEP that have some arbitrary relationship to ERISA, no sound legal support has been provided for this proposed SEP. Further, no prior explanation as to "tri-department rule" has been provided to Iowa. The analysis below presumes that this is a similar argument to that made to several other proposed continuous coverage requirements and the alleged violation of ERISA rules cited by CMS.

Iowa engaged in dialogue with CMS on the issue continuous coverage, including several exchanges of questions regarding the proposed continuous coverage periods. On June 28th, CMS asked IID if there would be any exceptions for continuous coverage (i.e. if coverage was unaffordable in the previous year (9.5%), tribal members, Medicaid/CHIP denial). No further explanation was provided at that time as to why an exception for Medicaid/CHIP may be required.

The only substantive question Iowa received in response to its proposed continuous coverage period related to Medicaid/CHIP denials was whether there were any backlogs in the denial process for these programs. This question was addressed and answered in correspondence dated July 17, 2017 (in response to questions received July 11, 2017.) This same question was raised in comments received by the IID from CMS on July 25, 2017 in response to the SEP continuous coverage requirements proposed in the public draft of the waiver. Significantly, the July 25, 2017 correspondence provided clear directives from CMS that several continuous coverage proposals would not be accepted; however this correspondence provided no further information on the SEP for Medicaid/CHIP other than again asking if there were backlogs.

It must be presumed that this position, claiming this as a "tri-department" rule, is based on CMS' interpretation that requiring continuous coverage may violate ERISA, specifically 29 U.S.C. §1163. As noted in my prior correspondence to Randy Pate on July 31, 2017, the underlying source of such an objection is opaque as the cited section of ERISA is part of the COBRA laws requiring a group health plan to offer continuation of group health insurance under certain circumstances. The Iowa Stopgap Measure is intended only to provide coverage in the individual and non-group market, a market that requires more stabilization to prevent the gaming that has been widespread since the implementation of the ACA. Employer based coverage has employment as a stabilizing factor, a significance difference from the individual and non-group market at issue in the Iowa Stopgap Measure. Further, the COBRA statutory scheme requires continuing coverage, which means that a continuous coverage requirement is already built in to that statute.

We recognize that this statutory provision is referenced in the ACA provisions regarding guaranteed issue and enrollment periods for the individual and group market. Specifically, Public Health Service Act § 2707, provides that "[a] health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 1163 of Title 29)." 42 U.S.C.A. 300gg-1(b)(2). This vague reference to Section 603 of ERISA can be read to require that the definitions of qualifying events provided in that section be used to define a qualifying event under this section that would trigger a SEP. While this provision contains a

vague reference to Section 603 of ERISA, it does not contain any statutory language expressly prohibiting a continuous coverage requirement for a special enrollment period.

Significantly, this provision grants HHS broad statutory authority to implement the ACA and delegates substantial discretion to HHS to “promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).” 42 U.S.C.A. §300gg-1(b)(3). Given the breadth of the statutory delegation of power, HHS has the authority under current law to permit a state to allow issuers to implement the proposed continuous coverage requirement. HHS recognized this inherent authority when it contemplated a continuous coverage requirement in conjunction with the market stabilization regulations issued earlier this year. Specifically, HHS noted that “[w]e continue to explore policies that would promote continuous coverage and that are within HHS’s legal authority.” 82 Fed. Reg. 18346, 18368. HHS clearly recognizes the impact such a requirement may have to stabilization, and has not ruled out using such a provision in the future. See 82 Fed. Reg. 18346, 18366-68 (Apr. 18, 2017).

Moreover, HHS has repeatedly noted the desire for consistency between the on- and off-exchange SEP rules. In fact, in implementing the off-exchange SEP statutory provision, HHS cross-referenced the parallel SEP regulations for on-exchange coverage. See 45 C.F.R. §147.104(b)(2) (cross-referencing the “triggering events” in 45 C.F.R. §155.420(d)). Therefore, the substantive provisions of the off-exchange SEP rule are based on, and inextricably intertwined with, the on-exchange SEP rules.

Clearly the provisions for on-exchange SEPs are waivable under ACA section 1332. See 42 U.S.C. §18052(a)(2)(B). If the on-exchange SEP rules are modified by a 1332 waiver, for example by adding a continuous coverage requirement, then that modification automatically would be incorporated into the off-exchange SEP (due to the cross-reference to 45 C.F.R. §155.420(d) in 45 C.F.R. §147.104(b)(2)). Consequently, even if the off-exchange SEP rules are not directly within the scope of a §1332 waiver, HHS can modify those rules indirectly by amending the on-exchange SEP rules pursuant to a §1332 waiver.

As such, Iowa respectfully disagrees with CMS’ conclusion that denial of Medicaid or CHIP provides an exemption to the continuous coverage requirement within Iowa’s §1332 waiver.

CMS Question: In reviewing the application we had a question regarding the amount of money Iowa plans to use for the Iowa credit. The narrative of the application states that Iowa plans to \$305M for premium credits. However, the actuarial analysis models Iowa spending \$316M on premium credits. Can you please reconcile these differences? And let us know which is the correct number and if so, does this impact the analysis/coverage?

Iowa Response: The differences in the numbers are due to the numbers being based on a range of estimated enrollment that would be covered at each income level with premium credits. The NovaRest report that you requested was assembled using an earlier estimate within the range. The final estimate for the expected population was reported on page 40 of the waiver in the section describing the “Deficit Neutrality Requirement,” wherein it stated, “As noted above, enrollment in the Iowa Stopgap Measure will vary but if an estimate of 68,000 Iowans enroll, approximately \$305 million will be used for premium credits.” The \$305 million was the final estimate based upon our enrollment assumptions.

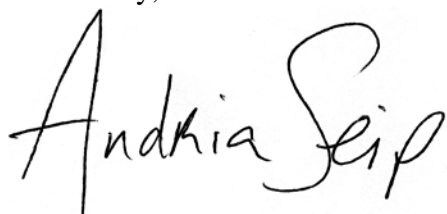
However, we have carefully considered trends in Iowa’s economy and believe due to falling incomes, an additional 1,000 individuals in our individual health insurance market are estimated to have fallen or will

be falling below 400% FPL in 2018 and will now migrate into the subsidized segment of the market and be eligible for APTC. Given that our estimates now reflect 69,000 participants, the premium credits under the Stopgap Measure will cost an additional \$6.6 to \$7 million for a total of \$312 million. This increase in enrollment will also result in an increase of \$10 million in the APTC 'pass-through' amount without the waiver. The total APTC pass-through amount is now \$432 million.

We must again note the extraordinary challenge of projecting enrollment in the midst of an insurance market collapse, which is occurring because of very sharp annual rate increases that began several years ago. We are seeking to project 2018 after 3 years of adverse selection, and historical rate requests, which are likely to drive another estimated 20,000 mostly healthy individuals – who pay the full premium – from the individual market.

Please let me know if you have additional questions.

Sincerely,

A handwritten signature in black ink that reads "Andria Seip". The signature is written in a cursive, flowing style.

Andria Seip, J.D., M.S.
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