



July 10, 2017

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

RE: Comments regarding the Request for Information on Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients; Notice ID: CMS–9928–NC ([82 Fed. Reg. 26885](#))

The National Federation of Independent Business (NFIB) submits these comments for the record to the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) regarding the Request for Information (RFI) on Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act (ACA) & Improving Healthcare Choices to Empower Patients published in the June 12, 2017, edition of the *Federal Register*.

NFIB is the nation’s leading small business advocacy association, representing small and independent businesses in Washington, DC, and all 50 state capitals. A nonprofit, nonpartisan organization founded in 1943, NFIB’s mission is to promote and protect the right of its members to own, operate, and grow their businesses. The membership of NFIB includes small and independent businesses directly and indirectly impacted by regulations implementing the ACA.

HHS limited the RFI to seeking recommendations for changes to regulations that would decrease the burdens of the ACA but remain consistent with the requirements of the statute. These NFIB comments submit such recommendations for decreasing the regulatory burdens, but NFIB emphasizes that it remains committed to securing the repeal of the ACA statute and its replacement by patient-centered, market-based healthcare policies that meet the needs of America’s small and independent businesses. No amount of regulatory changes under the ACA statute can solve the fundamental problems with the statute itself that continue to increase costs and reduce flexibility for small business owners. Small businesses need health insurance that is affordable, flexible, and predictable.

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I. Background

The rising cost of health insurance has been NFIB members' number one concern since 1986.¹ The ACA accelerated cost increases for small business owners by mandating new benefits, restricting plan design flexibility, and imposing new taxes and fees on individual and small group market health insurance policies. As a result, fewer small businesses offer group health insurance to employees. In 2010, 39.2 percent of businesses with fewer than 50 employees offered health insurance.² Five years later, the offer rate dropped by 25 percent to 29.4 percent of small businesses.³ Cost is the primary reason small business owners do not offer health insurance.⁴

HHS emphasized four areas for comments:

- 1) Empowering patients and promoting consumer choice;
- 2) Stabilizing the individual, small group, and non-traditional health insurance markets;
- 3) Enhancing affordability; and
- 4) Affirming the traditional regulatory authority of the States in regulating the business of health insurance.

The following recommendations focus on these four goals for small business owners and their employees.

¹ Wade, Holly, [Small Business Problems and Priorities](#), NFIB Research Foundation, August 2016.

² [Table II.A.2\(2010\)](#), Medical Expenditure Panel Survey, Agency for Healthcare and Research Quality, Department of Health and Human Services, 2010.

³ [Table II.A.2\(2015\)](#), Medical Expenditure Panel Survey, Agency for Healthcare and Research Quality, Department of Health and Human Services, 2015.

⁴ [Small Business's Introduction to the Affordable Care Act, Part III](#), NFIB Research Foundation, November 2015.

II. Enhance Small Business Flexibility through Employer Payment Plans

The ACA prohibits annual limits on Essential Health Benefits for in-network services.⁵ This statutory requirement has led to unintended regulatory consequences that limit innovative small business offering arrangements.

Because the increasing cost of group health insurance made offering the benefit more difficult, many small businesses instead directly paid or reimbursed their employees' individual market health insurance premiums and medical expenses. NFIB Research Foundation estimated that 16 percent of small businesses reimbursed their employees who purchased health insurance on their own in 2015.⁶ This arrangement allowed employers to offer a form of a tax-preferred health benefit and helped employees afford health insurance.

Regulatory and Legislative History: HHS issued regulations and guidance documents prohibiting the longstanding practice of small businesses helping employees with individual market health insurance. Congress partially restored the ability to assist employees who purchase coverage on their own, but further regulatory relief is necessary.

On August 28, 2010, HHS issued an Interim Final Rule (IFR) regarding annual limits on benefits and requested comments for stand-alone Health Reimbursement Arrangements (HRAs).⁷ The IFR divided HRAs into three categories – integrated HRAs, retiree-only HRAs, and stand-alone HRAs.

On August 19, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS issued supplemental guidance exempting certain stand-alone HRAs from the annual limit prohibition.⁸ CMS recognized that prohibiting stand-alone HRAs would cause disruption and limit access to the benefit.

On November 18, 2015, HHS reversed course and issued a Final Rule regarding annual limits on benefits that ended exemptions for stand-alone HRAs.⁹ This prohibition disrupted the arrangements for many small businesses.

⁵ Section 1001, Part A, Subpart II, Section 2711, Public Law 111-148.

⁶ [Small Business's Introduction to the Affordable Care Act, Part III](#), NFIB Research Foundation, November 2015.

⁷ [75 Fed. Reg. 37188](#), "When HRAs are integrated with other coverage as part of a group health plan and other coverage alone would comply with the requirements of PHS Act section 2711, the fact that benefits under the HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies requirements. Also, in the case of a stand-alone HRA that is limited to retirees, the exemption from the requirements of ERISA and the Code relating to the Affordable Care Act for plans with fewer than two current employees means that retiree-only HRA is generally not subject to the rules in PHS Act section 2711 relating to annual limits. The Departments request comments regarding the application of PHS Act section 2711 to stand-alone HRAs that are not retiree-only plans."

⁸ Cohen, Gary, [CCIIO Supplemental Guidance \(CCIIO 2011-IE\): Exemption for Health Reimbursement Arrangements that are Subject to PHS Act Section 2711](#), August 19, 2011. "Accordingly, applying the restrictions on annual limits set forth in section 2711 and the IFR to HRAs would result in a significant decrease in access to HRA benefits. Therefore, this guidance exempts as a class all HRAs that are subject to the requirements of section 2711 and that were in effect prior to September 23, 2010 from having to apply individually for an annual limit waiver for plan years beginning on or after September 23, 2010 but before January 1, 2014. If an employer that maintains an HRA also maintains other coverage, whether or not that coverage is integrated with the HRA, that other coverage must meet the requirements of section 2711 or obtain a waiver."

⁹ [80 Fed. Reg. 72192](#), "Although in certain circumstances HRAs and other account-based plans may be integrated with another group health plan to satisfy the annual dollar limit prohibition, these final regulations incorporate the general rule set forth in prior

The Internal Revenue Service (IRS) interpreted these HHS regulations and imposed severe penalties on small businesses for utilizing stand-alone HRAs through subregulatory guidance.¹⁰ If small businesses continued the practice, they risked significant consequences of \$100 per employee, per day penalties.

On December 13, 2016, President Obama signed the 21st Century Cures Act into law.¹¹ Section 18001 of the law extended transition relief from the penalties for small businesses that reimbursed employees' individual market health insurance plans through calendar year 2016. The law also codified a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) that allows businesses with fewer than 50 full-time equivalent employees to offer up to \$4,950 for individuals and \$10,000 for families in tax-preferred contributions to employees for individual market health insurance. This protection and partial restoration of the arrangements improved but did not fix the inflexible situation.

Recommendation: NFIB recommends HHS issue guidance or formal regulation under appropriate statutory authority clarifying that employer payment plans (such as stand-alone HRAs or direct payment of individual market premiums) are not group health insurance. The below legislative text from Section 103 of H.R. 1275, *World's Greatest Healthcare Plan of 2017*, may serve as drafting guidance:¹²

CLARIFYING EMPLOYER'S ABILITY TO REIMBURSE EMPLOYEE PREMIUMS FOR PURCHASE OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

An employer healthcare arrangement, such as a health or medical reimbursement arrangement (HRA) or other employment plans, under which an employer reimburses an employee for the premiums for the purchase of individual health insurance coverage does not constitute a group health plan for any purposes, including for purposes of applying any of the following:

- (1) The Public Health Service Act (including sections 2711 and 2714 of such Act, 42 U.S.C. 300gg-11, 300gg-14).*
- (2) The Patient Protection and Affordable Care Act.*
- (3) The Internal Revenue Code of 1986.*
- (4) The Employee Retirement Income Security Act of 1974.*
- (5) The HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act, 42 U.S.C. 1320d-9(b)(3)).*

subregulatory guidance clarifying that an HRA and other account-based plans may not be integrated with individual market coverage, and therefore an HRA or other account-based plan used to reimburse premiums for the individual market coverage fails to comply with PHS Act section 2711."

¹⁰ [Employer Healthcare Arrangements](#), IRS. "As explained in Notice 2013-54, these employer payment plans are considered to be group health plans subject to the market reforms, including the prohibition on annual limits for essential health benefits and the requirement to provide certain preventive care without cost sharing. Notice 2013-54 clarifies that such arrangements cannot be integrated with individual policies to satisfy the market reforms. Consequently, such an arrangement fails to satisfy the market reforms and may be subject to a \$100/day excise tax per applicable employee (which is \$36,500 per year, per employee) under section 4980D of the Internal Revenue Code."

¹¹ Public Law 114-255.

¹² H.R. 1275, [World's Greatest Healthcare Plan of 2017](#), 115th Congress.

- (6) *The Health Insurance Portability and Accountability Act of 1996.*
 (7) *COBRA continuation coverage under title XXII of the Public Health Service Act (42 U.S.C. 300bb–1 et seq.), section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).*

Additionally, NFIB recommends that HHS create a special enrollment period (SEP) for small employers to enroll employees into QSEHRAs. The 21st Century Cures Act was enacted in mid-December 2016, more than halfway through the calendar year 2017 open enrollment period. Therefore, it is unlikely that many small businesses enrolled in the restored arrangements.

These recommendations would empower patients and promote consumer choice by allowing employees to choose a health insurance plan that best fits their needs. They would also enhance affordability for the 52.4 percent of small business employees without an offer of employer-sponsored health insurance by allowing non-offering employers to assist with their individual market premiums and qualified healthcare expenses.¹³ By accomplishing these two goals, the recommendations would help stabilize the individual market by encouraging more healthy Americans, especially unsubsidized individuals, to enter the individual health insurance market.

III. Prioritize Affordability by Revising the Essential Health Benefits Package

The Essential Health Benefit (EHB) package is a list of ten mandated benefits and services that all individual and small group market health insurance plans must cover.¹⁴ The EHB package layered new federal benefit mandates on top of existing state benefit mandates, adding a redundant – and sometimes conflicting – layer of regulation on individual and small group market health insurance products.

Regulatory History: On December 16, 2011, CCIIO within CMS released a bulletin requiring states to select an EHB benchmark plan from a limited list of options.¹⁵ Many states based the EHB benchmark plan on an existing small group market health product. However, nearly every benchmark plan required benefit supplementation because few existing policies covered every benefit mandate required by the ACA.^{16,17} There is an opportunity to revisit EHBs because the ACA requires periodic review and update of the package.¹⁸

Recommendation: NFIB recommends HHS define a premium target when reviewing and updating the EHB to promote affordability. The ACA required HHS to consult with the Institute of Medicine (IOM) before issuing a regulation on EHB. In October 2011, the

¹³ [Table I.B.2\(2015\)](#), Medical Expenditure Panel Survey, Agency for Healthcare and Research Quality, Department of Health and Human Services, 2015.

¹⁴ Section 1302, Public Law 111-148

¹⁵ [Essential Health Benefits Bulletin](#), Center for Consumer Information and Insurance Oversight, December 16, 2011.

¹⁶ [45 CFR 156.110\(b\)-\(c\)](#)

¹⁷ [Final List of Essential Health Benefits](#), Centers for Medicare and Medicaid Services, 2017.

¹⁸ Section 1302(b)(4)(G)-(H), Public Law 111-148.

IOM recommended that HHS define a premium target to take cost into account.¹⁹ The previous Administration prioritized comprehensiveness over affordability when designing the package. Defining a premium target would promote affordability in the redesigned EHB package and help stabilize the individual and small group markets.

Considering the EHB regulations have had a substantial impact on a significant number of small businesses by increasing premiums and cost-sharing, NFIB also recommends HHS conduct a Regulatory Flexibility Analysis (RFA). The previous Administration claimed the regulations only impacted insurance carriers, but the consequences of the cost increases fell directly on premium payers – individuals and small businesses. HHS failed to issue any premium analysis concerning the creation or update of EHBs. An RFA that includes a premium impact analysis from the CMS Office of the Actuary would assist with prioritizing EHB affordability.

IV. Embrace Innovation by Reforming the SHOP Exchange Marketplace

The Small Business Health Options Program (SHOP) exchange marketplace was intended to assist small businesses with enrolling employees in qualified small group market health plans.²⁰

Regulatory History: NFIB envisioned the SHOP exchange marketplace as a platform that could provide small business owners and employees with more health insurance options. It would also handle administrative functions like premium aggregation, similar to private exchanges. Employers would contribute a defined contribution or percentage of a premium, and employees could choose a health insurance policy that best fits their needs.²¹ Instead, the SHOP exchange marketplace became a more heavily-regulated small group market with minimum participation requirements and without a defined contribution option.

Little information regarding the SHOP exchange marketplace exists. Before CMS' recent announcement canceling online enrollment beginning in 2018, CMS only published SHOP exchange marketplace enrollment figures once, despite Congressional

¹⁹ Institute of Medicine, [Essential Health Benefits: Balancing Coverage and Costs](#) (p. xii), October 6, 2011. "Defining a premium target, which is a way to address the affordability issue, became a central tenet of the committee. Why the Secretary should take cost into account, both in defining the initial EHB package and in updating it, is straightforward: if cost is not taken into account, the EHB package becomes increasingly expensive, and individuals and small businesses will find it increasingly unaffordable. If this occurs, the principal reason for the ACA—enabling people to purchase health insurance and thus covering more of the population—will not be met. At an even more fundamental level, health benefits are a resource, and no resource is unlimited. Defining a premium target in conjunction with developing the EHB package simply acknowledges this fundamental reality. How to take cost into account became a major task. The committee's solution in the determination of the initial EHB package is to tie the package to what small employers would have paid, on average, for their current packages of benefits in 2014, the first year the ACA will apply to insurance purchases in and out of the exchanges. This 'premium target' should be updated annually, taking into account trends in medical prices, utilization, new technologies, and population characteristics."

²⁰ Section 1311(b)(1)(B), Public Law 111-148.

²¹ [Regulatory comments by Small Business Coalition for Affordable Healthcare](#), CMS-9989-P Patient Protection and Affordable Care Act; Establishment of Qualified Health Plans; Proposed Rule, October 21, 2011. "In particular, the Coalition supports HHS' statutory interpretation to codify section 1312(a)(2)—to require that SHOPs allow qualified employers to select a level of coverage under which a qualified employee may choose an available plan. This option will allow employers to essentially offer a defined-contribution option and permit employees to choose the plan that best fits their individual needs."

inquiries.²² CMS never published figures related to the temporary and limited small business health insurance tax credit obtained through the SHOP exchange marketplace.

One positive feature of the SHOP exchange marketplace is a limited, one-month open enrollment period without minimum employee participation requirements from November 15 – December 15. Minimum participation requirements serve as a barrier to entry for small businesses to begin offering group health insurance. The SHOP exchange marketplace currently requires 70 percent minimum employee participation, a regulatory standard not required by the statute.

Recommendation: NFIB recommends HHS study the feasibility of converting the current SHOP exchange marketplace structure into a fully-insured, defined-contribution exchange. Small business owners could contribute a defined amount or a percentage of the premium. This arrangement is similar to the way that larger businesses offer health insurance to employees through private exchanges and the way that Members of Congress obtain health insurance through the DC Health Link SHOP exchange marketplace. This recommendation would empower patients and promote consumer choice.

NFIB recommends HHS be more forthcoming with enrollment information including how many small businesses utilized online enrollment versus direct enrollment and how many businesses obtained the small business health insurance tax credit through the SHOP exchange marketplace.

When the SHOP exchange marketplace becomes available through direct enrollment exclusively in 2018, small business owners will not know whether they are purchasing a group health insurance plan inside or outside the SHOP exchange marketplace. Therefore, NFIB recommends that HHS coordinate with IRS, using Section 1332(a)(3) “pass through funding” waiver authority, to provide access to the temporary and targeted small business health insurance tax credit on small group market plans purchased outside the SHOP exchange marketplace. NFIB recommends any savings achieved by canceling online enrollment for 2018 be passed along in the form of lower premiums for small business owners and their employees. These recommendations would increase transparency and promote affordability.

NFIB recommends HHS eliminate the minimum 70 percent employee participation requirement. If HHS determines elimination of the minimum participation requirement is impossible, the limited SHOP exchange marketplace enrollment period without minimum participation requirements should be aligned with the individual exchange marketplace’s open enrollment dates – November 1 – December 15. This recommendation would stabilize the small group market by allowing for more small business employees to participate.

²² Counihan, Kevin, [Update on SHOP Marketplaces](#), CMS Blog Post, July 2015.

V. Create Small Business Parity by Restoring Association Health Plans

Association Health Plans (AHPs) allow small businesses the option to band together to offer affordable health insurance to employees through greater negotiating power, more balanced risk pools, and large group market classification. The small group market is subject to state and federal benefit mandates and additional regulatory requirements, which increase premiums. The large group market does not have as many requirements, offering lower premiums. AHPs served as a valuable option for small business owners and employees in states where they existed. For example, in Washington State, there were over sixty association health plans offering coverage to over 500,000 individuals.²³ Through subregulatory guidance, CMS regulated certain advantages of AHPs out of existence.

Regulatory History: On September 1, 2011, CMS issued guidance requiring AHPs to be subject to all small group insurance requirements including community rating, state benefit mandates, and federal EHBs. These requirements defeat the advantages and cost savings that AHPs provide.²⁴ This subregulatory guidance impeded and unnecessarily interfered with states' primary role in regulating the health insurance markets they know best.

Recommendation: NFIB recommends HHS rescind the previous CMS guidance, which did not undergo the formal notice-and-comment regulatory process. Rescinding the guidance would affirm the traditional regulatory authority of the States in regulating the business of health insurance.

VI. Promote Health Insurance Competition by Issuing Guidance on Interstate Healthcare Choice Compacts

During his inaugural Joint Address to Congress, President Trump said, "And finally, the time has come to give Americans the freedom to purchase health insurance across state lines, which will create a truly competitive national marketplace that will bring costs way down and provide far better care. So important."²⁵ HHS can examine a

²³ Stark, Roger, [Association Health Plans and Small Business Health Insurance Exchanges in the Affordable Care Act](#), Washington Policy Center, August 2015.

²⁴ Cohen, Gary, Centers for Medicare and Medicaid Services Office of Oversight, [Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations](#), September 1, 2011. "Conversely, the term 'group market' refers to health insurance coverage offered in connection with a group health plan. 45 C.F.R. § 144.103. The group market is divided into the small group market and the large group market, depending on the number of employees employed by the employer. PHS Act § 2791(e)(2)(6). The PHS Act derives its definitions of group health plan and employer from the ERISA definitions of employee welfare benefit plan and employer. PHS Act § 2791(a)(1), (d)(6). Under ERISA section 3(5), an employer is 'any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.' Thus, reference to ERISA is needed when establishing the existence of a group health plan and determining the identity of the "employer" sponsoring the plan. CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules."

²⁵ [Remarks from President Donald Trump in Joint Address to Congress](#), February 28, 2017.

competitive national marketplace by fulfilling a neglected statutory requirement. The ACA required the Secretary of HHS to consult with the National Association of Insurance Commissioners (NAIC) to “issue regulations for the creation of healthcare choice compacts” between two or more states by July 1, 2013.²⁶

Regulatory History: HHS never consulted with the NAIC and never issued regulations, ignoring the statutory deadline.²⁷ Certain states passed laws preparing for interstate healthcare choice compacts, but these state statutes provide little assistance because the Secretary of HHS must approve the compacts.

Recommendation: NFIB recommends HHS consult with NAIC and issue guidance for interstate healthcare choice compacts. While the statutory requirements may be too restrictive to increase health insurance choices and lower health insurance premiums, vetting the provision with state insurance commissioners will be a valuable exercise. This recommendation would affirm the traditional regulatory authority of the States while promoting interstate competition for health insurance.

VII. Provide Medicare Reimbursement Predictability for Small Suppliers and Providers

On December 13, 2016, President Obama signed the 21st Century Cures Act into law. The law restored significant cuts in Medicare reimbursements for durable medical equipment (DME) suppliers and providers that went into effect on July 1, 2016.²⁸ The restored reimbursements have yet to be paid. Most of these suppliers and providers are small businesses.

Regulatory History: On February 10, 2017, CMS notified contractors that they could begin restoring Medicare reimbursement on May 1, 2017.²⁹ Nonetheless, it could be November 2017 before suppliers receive full reimbursement. Returning this delayed cash flow is critical for suppliers and providers to keep their businesses open. Many businesses struggle with the payment delays for services provided nearly one-year prior. These delays are causing suppliers and providers to encounter problems with creditors and bankers because they lack certainty on when this additional revenue will be paid.

Recommendation: NFIB recommends HHS issue an IFR to disburse reimbursements as soon as possible. NFIB also recommends HHS conduct a report on the impact that the

²⁶ Section 1333(a), Public Law 111-148.

²⁷ Leonard, Kimberly, [An Obamacare Provision Even Republicans Can Love](#), US News and World Report, January 6, 2016.

²⁸ Section 16007, Public Law 114-255.

²⁹ [Change Request 9968](#), Extension of the Transition to the Fully Adjusted Durable Medical Equipment, Prosthetics, Orthotics and Supplies Payment Rates under Section 16007 of the 21st Century Cures Act, CMS, February 10, 2017.

reimbursement cuts have had on beneficiaries and businesses, as required by the 21st Century Cures Act.³⁰ This recommendation would empower patients and promote consumer choice by providing access to beneficiaries and preventing small suppliers and providers from closing their doors.

NFIB recommends HHS also conduct an RFA of the DME competitive bidding regulations as they have had a substantial impact on a significant number of small businesses.

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NFIB urges HHS and CMS to act on the recommendations above to provide affordable, flexible, and predictable health insurance to small and independent businesses while ensuring the agency meets its regulatory objectives. Thank you for the opportunity to comment on the Agencies' RFI on Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients.

Sincerely,



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³⁰ Section 16007(b), Public Law 114-255.