CONNECT for HEALTH COLORADO®
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February 15, 2019

BY ELECTRONIC DELIVERY

Centers for Medicare and Medicaid Services,
Department of Health and Human Services
Attention: CMS-9926-P
Mail Stop C4-26-05,
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020

Dear Administrator Verma:

The staff of Connect for Health Colorado, the state-based health insurance marketplace (SBM) for Colorado, greatly appreciates the opportunity provided by the Centers for Medicaid and Medicare Services (CMS) to comment on the proposed "HHS Notice of Benefit and Payment Parameters for 2020." The proposed regulations that would have a particular impact on the Colorado Marketplace are listed below.

A. Silver Loading

CMS does not propose changes to silver loading for the 2020 benefit year, but supports a legislative solution to fund Cost Sharing Reduction (CSR) payments in 2021 and beyond. In the absence of an appropriation, CMS seeks comment on alternatives to silver loading. Connect for Health Colorado agrees that a congressional appropriation is the best approach to fund CSRs.

In the absence of a congressional appropriation, we strongly encourage CMS not to constrain a state's ability to utilize silver loading. Requiring states to adopt the broad loading model would presumably lead to lower enrollments, as evidenced in the general experience of the states that previously took this approach. Broad loading could also lead to an unhealthier risk pool. With premiums rising across all metal tiers under the broad loading model, consumers with health conditions would be

more motivated than healthier consumers to stay in the individual market. Additionally, broad loading would likely shift subsidized consumers from bronze and gold plans to silver plans and force nonsubsidized consumers to pay higher premiums at all metal tiers, and could force them to leave the market altogether.

Overall, the shift from silver loading to broad loading would likely result in multiple levels of consumer harm as rising prices push initial disenrollment, and those high prices further degrade the risk pool as healthy consumers forego high cost enrollment in later years. These market disruptions then lead to increased volatility and uncertainty for issuers which may cause some issuers to leave or avoid the individual market and causes those who remain to increase premiums more than they otherwise would in order to cushion for the unknown. Issuers, consumers, and Exchanges would greatly benefit from a more measured approach.

B. Automatic Re-Enrollment

Connect for Health Colorado is deeply concerned about potential changes in Exchange ability to automatically re-enroll consumers in accordance with existing law[1] with the stated intention of improving customer reporting of individual changes in circumstances or more active engagement in plan selection. While these changes appear constructive, they will likely cause adverse impacts to customers who desire to stay with their current plan.

Connect for Health Colorado supports various methods of increasing enrollee reporting of individual changes in circumstances and active engagement from enrollees in plan selection. Connect for Health Colorado also works to improve health literacy among enrollees to empower enrollees to better understand and optimize care, and has developed tools to assist consumers in selecting and understanding the best plan for their needs.

Connect for Health Colorado has spearheaded several activities to encourage and increase individual reporting throughout the benefit year, and during the annual Open Enrollment Period. Among those activities are noticing, prompting customers to report changes upon login, and Service Center outreach for simultaneous enrollment situations. Connect for Health Colorado also features reminder language on its website throughout the year; and reminds consumers, our assistance network, and our broker partners regularly via e-mail and via social media campaigns. This

[1] This includes federal and state law on guaranteed renewability, as well as federal regulations on re-enrollment found at 45 C.F.R. §155.335(j).

work is augmented by additional marketing and outreach projects throughout the year.

Additionally, Exchanges already use periodic data matches which may reduce the frequency of inaccurate information being used for financially assisted consumers.

State based exchanges have also been at the forefront of developing and improving tools to empower customers and facilitate active plan selection. This includes Connect for Health Colorado's nationally recognized Quick Cost and Plan Finder tool, which customers can use to evaluate key health plan details, view information about providers and drug formularies, estimate costs, and compare plans. Since 2017, Connect for Health Colorado has continued to improve this tool and invest in myriad additional resources for consumers to make informed choices about their healthcare needs.

Consumers who have access to automatic re-enrollment, always have the option of reviewing available plans and making an active plan selection during the Open Enrollment Period. During the most recent Open Enrollment Period, 53% of consumers who had the option to automatically re-enroll made an active selection. Consumers who passively automatically re-enrolled during this period may have done so for various reasons. They may have ongoing medical treatment which relies on continuity of care or may simply be content with their current plan. In the absence of clear information indicating that those enrollees are dissatisfied or misunderstand their plans, and in the presence of data indicating that the majority of consumers who have the option of auto-enrollment are making active choices, the assertion that this process requires correction does not appear reasonable.

Connect for Health Colorado also respectfully requests additional clarity and detail on the anticipated changes to automatic re-enrollment. Any changes to this process, including requiring active re-enrollment for all consumers, would result in substantial strain on Exchange infrastructure, Exchange customer service resources, and Brokers and Assistance Network partner organizations. Even minor changes to this process would severely limit the ability to complete necessary enrollment activities for all consumers within the Open Enrollment Period. Moreover, the substantial risk of consumer harm, especially for consumers who were successfully automatically re-enrolled in their preferred plan for multiple years and may not understand this sudden change. Overall, operationalization of any change in this complex process will require costly and time intensive updates to both Exchange and Carrier systems, including annual Open Enrollment and renewal notices, and additional outreach and support for affected consumers. Changes to this architecture are especially burdensome and costly for all involved parties.

Moreover, State-Based Exchanges and Departments of Insurance require detailed information on the proposed changes in order to assess how a proposal would interact with existing federal and state law on guaranteed renewability.

C. Premium Adjustment Percentage (45 CFR § 156.130)

CMS proposes to use an alternative premium measure for purposes of calculating the premium adjustment percentage for the 2020 benefit year and beyond. The proposed change will use an adjusted private individual and group market health insurance premium taken from National Health Expenditure Account (NHEA) data and "would result in a faster premium growth rate measure than if we continued to use employer sponsored insurance premiums as was used for prior benefits years."[2] CMS previously noted, and reiterates in the proposed rule, that an indexing methodology change might occur "after the initial years of implementation of the market reforms, *once the premium trend is more stable*."[3]

The proposed changes will result in a:

- Higher maximum annual limitation on cost sharing;
- Higher employer shared responsibility payment amounts (meaning fewer employed individuals would qualify for the APTC); and
- Higher required contribution percentages used in determining APTC (to be officially determined by the Department of the Treasury).

We are concerned with making the change as proposed and urge CMS to delay finalizing this change for 2020.

Research on whether the individual market has stabilized is decidedly mixed.[4] Starting in 2017, Congressional attempts to repeal the Affordable Care Act caused a destabilizing policy environment which contributed to significant premium increases. Further subsequent actions, such as Congress's decision to "zero out" the individual

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[2] *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020*, 84 Fed. Reg. 227, 287 (Jan. 24, 2019).

[3] 84 Fed. Reg. at 286 (Emphasis added). See also, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13744, 13802. https://www.federalregister.gov/d/2014-05052/p-744

[4] Hall, M. July 2018. *Stabilizing and strengthening the individual health insurance market: A view from ten states*. USC-Brookings Schaeffer Initiative for Health Policy. www.brookings.edu/research/stabilizing-and-strengthening-the-individual-health-insurance-market.

mandate starting in 2019, the Administration's decision to halt cost-sharing reduction (CSR) payments to issuers in late 2017 in the absence of Congressional appropriations, expansion of Association Health Plans (AHPs) and Short-Term Plans (STPs), and significant cuts to reinsurance payments to issuers, have generally contributed to market uncertainty, which impacts cost. The actual effects of these policies, along with potential effects of pending regulatory changes that would expand the availability of HRAs, further complicate the picture.

We thus urge CMS to delay the proposed indexing methodology change to a future time when the premium trend in the individual market has proven to be more stable. In proposing any future index methodology change, the evidence for concluding the premium trend in the individual market has stabilized justifying a change should be clearly articulated. Additionally, given the delayed release of the proposed rule and compressed timeline for providing comments, we urge CMS to delay making such an important change without providing more time and notice to stakeholders in order to provide more thorough and meaningful input.

D. Additional Special Enrollment Period (45 CFR § 155.420(d))

Connect for Health Colorado supports the creation of a new special enrollment period, at the option of the Exchange, for off-Exchange enrollees who experience a decrease in household income and are determined to be eligible for advance payments of the premium tax credit (APTC) by the Exchange. We support regulatory changes that provide consumers with more opportunities to maintain continuous coverage. We also support state flexibility and appreciate the option for Exchanges to determine whether or not this special enrollment period best meets the needs of each state depending on state-specific special enrollment period verification practices and other factors.

E. Coverage of and Segregation of Funds for Abortion Services (45 CFR § 156.280)

The Hyde Amendment of 1976 withholds federal Medicaid funding from abortion services except in cases where the mother's life is threatened or in cases of incest and rape. Some health insurance issuers choose to cover an abortion that is elective, or a non-Hyde abortion. CMS is proposing that, beginning in plan year 2020, if a QHP issuer provides coverage of non-Hyde abortion services in one or more QHPs, the issuer must also offer at least one QHP that mirrors, or provides identical coverage to, the coverage of the non-Hyde plan, but omits the non-Hyde coverage. The

intention of this proposal is to provide consumers with limited plan choices the ability to choose between a plan that covers a non-Hyde abortion and a plan that does not cover such services. CMS is also proposing that the issuers be able to determine the metal level of the mirrored plan. This could potentially lead to having different metal levels for mirrored coverage.

Connect for Health Colorado is concerned that the proposed rule will result in an administrative burden on carriers, and will result in customer confusion that could lead to plan terminations. Connect for Health Colorado strongly supports the issuer maintaining control over the proposed changes in coverage and does not believe that there should be any changes or new requirements regarding how plans are displayed on either Exchange or direct enrollment websites.

F. Ability of States to Permit Agents and Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (45 CFR § 155.220).

Web-brokers and direct enrollment providers offer another pathway by which consumers can potentially access on-Exchange coverage. Connect for Health Colorado supports consumer choice. However, Connect for Health Colorado also supports consumer protection and encourages CMS to institute appropriate safeguards to protect consumers from potential inappropriate activity by web-brokers.

Connect for Health Colorado appreciates and strongly supports the flexibility that CMS has provided to states within their web-broker proposal. We believe that each state is familiar with what works best for its consumers and should be allowed to implement this proposal to the extent the state deems appropriate.

G. Cost-sharing Requirements for Generic Drugs (45 CFR § 156.130)

CMS proposes a series of changes to coverage of prescription drugs, to the extent permitted by state law. One of these changes would allow issuers to make mid-year formulary changes when a generic drug becomes available. Under this policy, an issuer could add a newly available generic to their formulary and remove the associated brand drug or move it to a higher tier. Another of these changes would allow an issuer that covers both a brand drug and its generic equivalent under a QHP to consider the brand drug to not be part of Essential Health Benefits (EHB), if the generic is available and medically appropriate for the enrollee (unless coverage of the

brand is approved as part of the exception process under §156.122). Therefore, the issuer could impose annual or lifetime dollar limits on coverage of the brand drug under those circumstances. Additionally, PTC (and APTC) could not be applied to any portion of the premium attributable to coverage of brand name drugs not covered as EHB, so issuers of QHPs would be required to calculate that portion of QHPs' premiums and report it to the applicable Exchange.

From an Exchange perspective, Connect for Health Colorado is concerned with the combined effect of these policies which would result in mid-year changes to the premium attributable to EHB. In Colorado, premiums are reviewed by the state Division of Insurance (DOI) as part of the annual rate review process. Any changes to the EHB portion of premium as a result of any mid-year formulary changes would have to be submitted to, reviewed, and approved by DOI. Such mid-year reviews would be administratively burdensome for both DOI and issuers.

We are also very concerned with the associated impact to APTC calculations and premium amounts. It would be overly burdensome for an Exchange to reload the EHB percentages mid-year. Dedicating resources to update plan EHB percentages, and also test and validate such changes to APTC calculations and application of APTC to plan premiums, is expensive, time-consuming, and an administrative burden on Exchanges.

Such mid-year changes to APTC would also be very confusing for consumers who might report a change to the Exchange but then have a minor change in APTC or premium due to a recalculation and not understand why such changes occurred. These issues would result in calls to our customer support channels and unnecessarily strain the system. It would also cause issues during tax year reconciliation when consumers use Exchange consumer tools to look up and validate the Second Lowest-Cost Silver Plan (SLCSP). Inserting mid-year changes into this process would be very confusing for consumers, tax professionals, brokers, and all of the Exchange's consumer support channels.

Sincerely,

Connect for Health Colorado Staff