DC Health Benefit Exchange Authority

March 2, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9926-P
P.O. 8010
Baltimore, MD 21244-1810

Re: HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans – CMS-9916-P

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (DCHBX) appreciates your consideration of our comments.

By way of background, DCHBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people --District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we've opened for business, we have cut the uninsured rate by 50% and now nearly 97% of District residents have health coverage. We offer 156 options to small businesses from Aetna, United Health Care, CareFirst Blue Cross Blue Shield, and Kaiser Permanente. We also offer 25 options to residents from CareFirst Blue Cross Blue Shield and Kaiser Permanente. Two years in a row (2017 and 2018), our consumer decision support tools rank number one among state-based marketplaces and the FFM.

DCHBX supports CMS's proposals that would strengthen markets and the Affordable Care Act (ACA) and strongly opposes proposals that would create barriers to coverage and impose unnecessary administrative burdens. In summary, we oppose the proposal to change auto renewal, oppose the proposed new and burdensome reporting requirements, oppose the proposed new cost sharing requirements, support the proposed changes to incurred claims for MLR specific to prescription drugs, and support certain proposed changes for SEPs. We also greatly appreciate CMS's recognition of state flexibility and encourage continued flexibility for state-based marketplaces.

Auto "Re-Enrollment" (also called Auto-Renewal)

CMS is soliciting comments on the existing practice of automatically renewing health insurance coverage when a consumer does not make changes to that coverage. Specifically, CMS appears to be considering either taking away or reducing advance premium tax credits (APTC) for insured people who do not

"shop" at renewal when the APTC "cover[s] the entire plan premium."[1] DCHBX strongly opposes this because it will harm insured people, it is prohibited by federal law and contradicts Congressional intent, is contrary to insurance industry practice, and is unsubstantiated by data. This would make premiums unaffordable.

It is not clear whether this is proposed rule-making or a request for information that will be followed by proposed rulemaking. Legally sufficient proposed rulemaking requires "either the terms or substance of the proposed rule or a description of the subjects and issues involved."[2] The ideas put forward in this proposed rule fall short of the legal requirements in part due to lack of clarity of how and to whom this would apply to. For example, it is not clear what the term "entire plan premium" means. It could mean the entire amount owed for a particular policy. Or it could mean "only" the premium attributable to essential health benefits (EHBs). In many states, including the District, plans include coverage beyond the EHB. APTC can only cover the portion of the premium associated with EHB.[3] Therefore, even customers with a high level of APTC will always have some portion of their premium that they must pay each month.

It is also not clear whether consumers who actively "shop", but pick the same plan during annual renewal, without submitting updated eligibility information, would be considered to have "auto-renewed" and be subject to APTC removal or reduction.

Despite the ambiguity, it is clear that CMS's proposal is targeting working Americans who are insured because of the substantial premium reductions provided by APTC. This is not the first time CMS has considered such a policy. CMS first sought input on auto-renewal in its 2020 Notice of Benefit and Payment Parameters NPRM. When that rule was finalized, CMS acknowledged that "commenters who addressed this topic unanimously supported retaining automatic reenrollment processes."(*Emphasis added).*[4] DCHBX was among those commenters who were strongly opposed to CMS restricting or prohibiting auto-renewal.

Congress also opposed CMS's efforts to restrict or prohibit auto-renewal. In section 608 of the Further Consolidated Appropriations Act of 2020, an amendment was made to ACA section 1311(c) which required auto-renewal of customers in the FFM who did not actively select a plan and did not actively terminate during the plan year 2021 renewal season.[5] Contrary to the suggestion by CMS in the proposed rule, auto-renewal without APTC does not comply with the Congressional intent of the amendment. Customers receiving APTC, particular those for whom the APTC covers all or nearly all of the premium, will not be meaningfully renewed if their APTC is eliminated or reduced because they won't be able to pay the full-price premium – the FFM will not be complying with the law.

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[1] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Notice of Proposed Rulemaking. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans," 85 Federal Register 7088, 7119 (Feb. 6, 2020).
[2] 5 U.S.C. §553(b)(3)
[3] 26 C.F.R. §1.36B-3(j).
[4] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Final Rule. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020" 84 Federal Register 17454, 17460 (April 25, 2019).
[5] Further Consolidated Appropriations Act, Pub. L No. 116-94, section 608. (Dec. 20, 2019). (Codified at 42 U.S.C §18031(c)(7)).

Despite the universal opposition to restricting auto-renewal, CMS is once again suggesting alterations to the auto-renewal process and is using unsupported reasoning. CMS cites the following concerns: 1) consumers receiving APTC are less sensitive to premiums and premium changes; and 2) when a consumer's entire premium is paid for with APTC, consumers are less likely to update their information, which leads to eligibility and APTC errors. CMS offers no evidence to support the assertions that auto-renewal leads to any of the alleged problems. The stated concerns are not supported by evidence.

First, CMS fails to provide evidence that consumers with substantial APTC amount are less price sensitive than other consumers. We looked at our experience to test this assumption.[6] We focused on our SHOP experience because APTC is akin to subsidized job-based coverage. Like APTC recipients who do not pay 100% of their premium, workers with subsidized job-based coverage pay only a portion or in some cases nothing when their employer pays part or the entire premium. DC Health Link SHOP data reflects experience of 80,000 covered lives and more than 5,100 small businesses.

Looking at our data for plan year 2018, our experience with the small group market does not support CMS's assumptions related to price sensitivity. If CMS's assumptions were accurate, we would expect to see workers who pay the highest proportion of premium (where employers are contributing the least), shopping at higher rates than workers who pay the least or don't pay at all because their employer pays 100% of premium. For plan year 2018, among workers who were offered more than one plan to choose from, only 5% of workers with an employer contribution of 0% shopped at renewal, while 21% of workers who paid nothing for their premium, because their employer paid 100% of the premium, shopped. Employees with 70-79% and 90-99% employer contributions had the highest rate of plan changes.

EMPLOYER % CONTRIBUTION TO PREMIUM	EMPLOYEES SHOPPING % FOR 2018 PLAN YEAR
0%	5%
36-49%	6%
50-59%	20%
60-69%	21%
70-79%	28%
80-89%	26%
90-99%	28%
100%	21%

*Employers who offer choice of plans or choice of carriers to workers. This excludes employers who offer only 1 plan.

Also looking at employers that offer only 1 plan, if CMS's assumptions were accurate, we would expect to see employers who pay 100% of the premium to shop at higher rates than employers who contribute less than that. Our data shows that for the 2018 plan year, only 26% of employers paying 100% of the

[6] Since our population of APTC recipients is about 10% of our enrollment and is small compared to our full pay customer population, looking at the behavior of our small group market provides a better understanding of how reduction in premium (because the employer pays a portion) impacts customer shopping at renewal.

premium shopped compared to 28% of employers paying 50-99% of premium. In other words, employers who contributed less actually shopped more.

EMPLOYER* CONTRIBUTION TO PREMIUM	2018 % of employers actively shopping
50-99%	28%
100%	26%

Based on our experience there is no basis for CMS's suggestion that customers receiving APTC are less price sensitive. Also, Federal Employees Health Benefit Plan (FEHBP) reports that approximately 6% of covered federal employees make a plan change during open season.[7] On average around 13% of Medicare Part D enrollees make active plans selections.[8]

CMS's justification also includes concern over wasteful use of limited federal dollars subsidizing coverage that people may not want. This justification also falls apart under scrutiny. The tax advantages provided to employer sponsored coverage (ESC) dwarf those associated with premium tax credits. Tax subsidies for ESC cost the federal government approximately $260 billion in 2017[9] whereas premium tax credits for the same year were less than $28.8 billion.[10] If the subsidy for ESC were treated as a budget item, it would be the government's third largest expenditure on health coverage, after Medicare and Medicaid, which were $591 billion and $375 billion respectively in 2017.[11] CMS's decision to target the APTC population for savings when federal expenditures to support their coverage is comparatively small, and their market behavior is so similar to other populations, is unjustified.

If the real goal is to encourage active shopping, then CMS needs to have the right decision support tools that work for different age groups, different populations, different health insurance literacy levels, and are culturally and linguistically appropriate for different populations. And, for people who don't use the on-line system but instead use navigators, CMS should increase funding through grants to navigators to ensure that all of those people have the in-person support they need. For consumers who use brokers, CMS should consider commission support for re-enrollment every year. In the context of privatizing many functions of Healthcare.gov, it is unclear whether CMS plans to share consumers' private confidential information with web-based enrollers and others to ensure consumers with APTC can re-enroll each year. It is clear that there is no funding for a robust paid media campaign to educate people that CMS will take away or reduce their APTC even through in prior years, the APTC was renewed.

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[7] Jory Heckman, "Open Season Ends Today: Here's What You Need to Know," Federal News Network, December 8, 2017, available at: https://federalnewsnetwork.com/open-season/2017/12/open-season-ends-dec-11-heres-what-you-need-to-know/.

[8] J. Hoadley, E. Hardgrave, L. Summer, et. al., "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans to Save Money?," Kaiser Family Foundation, October 10, 2013, available at https://www.kff.org/report-section/to-switch-or-not-to-switch-issue-brief/.

[9] Aaron E. Carroll, The Real Reason the U.S. Has Employer-Sponsored Health Insurance, N.Y. Times, Sept. 5, 2017. Available at: https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html

[10] Internal Revenue Service. SOI Tax Stats - Individual Income Tax Returns Publication 1304. 2017- Table 2.7: All Returns: Affordable Care Act Items. Available at: https://www.irs.gov/pub/irs-soi/17in27aca.xls

[11] Congressional Budget Office. "The Federal Budget in 2017: An Infographic" March 5, 2018. available at: https://www.cbo.gov/publication/53624

The second concern CMS articulates is about APTC eligibility errors. Eligibility errors should be addressed based on data of what the errors are and not by arbitrarily discontinuing the tax credits for those that are most in need. CMS provides no data that there is enhanced risk associated with this population of APTC recipients. The existing processes already address any risk. For example, there are existing processes that require marketplaces to recheck the federal hub at renewal and to create outstanding verifications if there are discrepancies.[12] Each year, DCHBX sends all customers receiving APTC a notice informing them of the information that will be used to determine their enrollment and Insurance Affordability Program eligibility for the upcoming year; this includes any updated information received based on checks with the federal hub. These notices are sent in September so that the customer has 30 days to respond with any updates. In preparation for the federal hub check, DCHBX reviews our records for potential APTC-eligible customers where the consent to check IRS records has expired. If the IRS consent is not active, the customer cannot receive an APTC renewal.[13] Therefore, we call these customers to have them renew their consent to ensure we can have the most accurate information. A second notice is then sent in October to all APTC customers, prior to the beginning of Open Enrollment with the eligibility determination. Included in these eligibility notices will be customers who will not receive APTC because the exchange received notification from IRS that the customer failed to file or failed to reconcile APTC received on a prior tax return.[14] DCHBX conducts enhanced outreach to these customers to request updated copies of their tax returns or to connect them with tax professionals who can help them file amended returns. All of these are direct ways that we inform customers about their APTC. This oversight also ensures that residents get appropriate APTC. Additionally, to mitigate the risk of customers having to pay back APTC, our shopping experience makes it very easy for customers to select less than the entire amount they are eligible for. Our shopping experience includes a default of 85% of the APTC amount a customer is found eligible for. Customers can either take less or more and 32% select less than the amount of APTC for which they qualify.

To enhance existing approaches, the FFM should consider additional education and outreach to help consumers better understand the requirement to report changes within 30 days that may impact eligibility. Navigators can also help consumers to better understand these requirements. CMS should increase funding for navigators to help educate consumers. Instead of taking positive steps to help consumers with APTC become smarter shoppers, CMS has created a thinly veiled scheme targeting workers most in need of financial assistance, the lowest income people and families, creating new eligibility requirements designed to kick people out of quality private health insurance by taking away their reduced premiums.

Harmful to Consumers and Insurance Markets – Any alteration, restriction, or prohibition related to auto-renewal will create consumer confusion, add barriers to coverage, and could result in millions of Americans losing their current health insurance coverage leaving them uninsured. It would also increase premiums for insured consumers.

Consumers have been auto-renewed in marketplace coverage since the inception of marketplaces, and insurance consumers of all types have always been auto-renewed into coverage when eligible as discussed below under industry practices. Even if the federal government increased its outreach and

[12] *See* 45 C.F.R. §155.335
[13] Id. at (k) & (l).
[14] *See* 45 C.F.R. §155.305(f)(4).

education efforts, there will be many consumers who either won't know about the change, won't understand the change, and/or won't act. Furthermore, people who are sick and need coverage are more likely to act than people who are healthy. This will result in premium increases as healthy people fail to act and are dropped from coverage. CMS should expect millions of Americans to lose their health insurance if it moves forward with any changes to auto-renewal. CMS repeatedly decries the harms of rising premiums, yet here proposes an administrative change that would directly cause such increases.

Industry Practice - In the entire insurance industry, not just in the health insurance industry, the norm is for carriers to automatically renew insurance policies. This is true for life and health insurance, property and casualty insurance, liability and other lines. In fact, CMS acknowledges that "automatic re-enrollment significantly reduces issuer administrative expenses, makes enrolling in health insurance more convenient for the consumer, and is consistent with general health insurance industry practice"[15] but nonetheless is still seeking to restrict auto-renewal.

Furthermore, the practice in job-based coverage is that workers keep their health plan without any action on their part. It is not common and actually unheard of for an employer to force employees to actively reenroll in their health plan even where the employer pays 100% of the employees' premium. Also, even governmental plans auto-renew workers. The health plan for federal government workers, FEHBP, automatically renews and does not require government employees to take action in order to keep their health benefits. Even looking at Medicare, the federal government does not require Medicare beneficiaries to make an active selection every year. Instead, beneficiaries have an opportunity to switch, and those who do nothing, get to keep their Medicare coverage. The norms in the insurance industry, the employee benefit industry, and Medicare is that health insurance is automatically renewed unless a person actively makes a change.

Contrary to Federal Law and Congressional Intent – Congress made clear, both when it passed the Affordable Care Act (ACA) and recently with the passage of an amendment to section 1311(c) of the ACA, that consumers are to receive prompt and continuous eligibility and enrollment. The proposed approach put forward by CMS is contrary to law.

The ACA sets forth eligibility standards for APTC. There is no discretion given to CMS to add additional requirements, such as requiring some APTC qualified people to shop at renewal. And if they don't shop, then they would not qualify for APTC. This criteria is not in the statute. Adding such criteria is akin to rewriting the statute, which is beyond the authority of federal agencies. Furthermore, exchanges are required to make APTC eligibility determinations. CMS does not cite statutory authority that would allow an exchange to deny or modify the APTC amount based on the fact that the eligible consumer failed to shop at renewal. Importantly, the 2019 amendment to ACA section 1311(c) explicitly requires auto-renewal. CMS's approach is contrary to the clear intent expressed by Congress through statutory amendment to section 1311(c). Customers receiving APTC, particularly those for whom the APTC covers all or nearly all of the premium will not be meaningfully renewed if they don't receive APTC because they won't be able to pay the full-price premium. Therefore, CMS's approach does not comply with 1311(c) and is contrary to federal law.

CMS Actions Have Harmed the Individual Market - Any proposal to eliminate or restrict auto-renewal must be viewed in context with other actions that have caused premiums to rise, have led to people

[15] HHS Notice of Benefit and Payment Parameters for 2021, at 7119.

losing their coverage, and have had a destabilizing impact on private health insurance markets and undermined the ACA. In addition to public statements by Administration officials, here are some examples from the Administration's record:

- Stopped reimbursing Cost-sharing reductions (CSRs) (causing premiums to increase and affecting decisions by some carriers to leave markets);
- Slashed paid media and education budget (negative impact reflected in lower enrollment);
- Slashed Navigator grant budget (negative impact reflected in lower enrollment);
- Enabled proliferation of junk plans like short-term, limited-duration plans and association health plans (will destabilize markets and open door to fraud and abuse)
- Created new barriers for people experiencing qualifying life events (will make people uninsured);
- Created new barriers for women seeking access to basic health care services (millions of women may lose coverage as a result);
- Expanded "public charge" rule to include health coverage like Medicaid (causing a chilling effect on immigrants who plan to apply for a green card, with many foregoing health insurance coverage due to fear of being denied citizenship in the future).

CMS' current approach will mean that APTC recipients, who are sick, will do what they need to keep their APTC, while the healthy population will drop out of coverage. This will increase premiums for full pay and APTC customers who remain covered.

Key to market stability is flexibility for states to adopt appropriate interventions and consumer protections to ensure stable markets that work for consumers. States have different markets and federal regulations need to recognize that. DCHBX supports market-stabilizing solutions, flexibility for states to build on federal standards, and policies that help people obtain affordable, quality health insurance. We oppose policies that may disrupt stable markets, and create barriers to consumer enrollment and renewal of health insurance. We strongly oppose requiring State-based marketplaces (SBMs) to restrict auto-renewal even if CMS requires it of the FFM.

State Selection of EHB-Benchmark Plan for Plan Years Beginning on or After January 1, 2020, and Annual Reporting of State-Required Benefits (45 C.F.R. §156.111)

CMS is proposing to amend 45 C.F.R. §156.111 to add a new section (f) that would require states to file an annual report to the U.S. Department of Health & Human Services (HHS) on state mandated benefits starting plan year 2021. As proposed, states would be required to annually: report all state benefit mandates; the date of enactment, including whether they were passed before or after December 31, 2011; identify which benefit mandates are in addition to essential health benefits and are subject to defrayal under 45 C.F.R. §155.170; identify which benefits are not in addition to essential health benefits and the basis for the state's determination; and other information about mandated benefits as required by HHS. A state official would be required to sign the report and provide an annual update. As proposed, if a state fails to submit this report, HHS would complete a similar report for the state and make its own determinations about whether or not a state mandate is subject to the defrayal process required under §155.170. CMS is also seeking comments on an alternative option: whether CMS should conduct the annual review of state laws instead of states reviewing their own laws.

DCHBX strongly opposes both and requests that CMS withdraw the proposal and reject the alternative. Similar to other ACA implementation and compliance issues, CMS should address compliance concerns directly with the state(s) at issue.

CMS explains that the new state reporting requirement would ensure compliance with the federal requirement for states to defray costs of new benefit requirements. However, CMS fails to provide any evidence that there is an issue with compliance with this requirement. CMS only states that unnamed stakeholders have concerns that there "may be states" not defraying costs. CMS should address any concerns with compliance with an individual state or states, not create new administrative burdens and an unnecessary process applicable to all states. The proposal is a new administrative burden, the type the Administration instructed agencies to reduce to the maximum extent permitted by law. Specifically, President Trump issued an Executive Order that stated "to the maximum extent permitted by law, to afford the States more flexibility and control to create a more free and open health care market; provide relief from any provision or requirement of the PPACA that would impose a fiscal burden on any State…."[16] Further, in 2017, CMS solicited comments on " . . .changes that could be made, consistent with current law, to existing regulations under HHS's jurisdiction that would result in a more streamlined, flexible, and less burdensome regulatory structure, including identifying regulations that eliminate jobs or inhibit job creation; are outdated, unnecessary, or ineffective; impose costs that exceed benefits; or create a serious inconsistency or otherwise interfere with regulatory reform initiatives and policies."[17]

This proposal not only contradicts President Trump's Executive Order and CMS' purported goals of reducing regulatory burden, but it would also create and impose new regulatory burdens on states. The new reporting structure would require state officials to either procure consultants or divert existing staff from other work to comply with an entirely new reporting process.

CMS's two options -- doing an analysis for all states or just for states not able to do the analysis themselves -- do not take into account the numerous state insurance regulation activities related to whether something is a benefit mandate. If CMS incorrectly interprets a state requirement, that interpretation would interfere with state form review, rate review, plan certification, market conduct exams, enforcement, and even consumer assistance. State insurance regulation and oversight dates back to the 1800s, has been recognized by Congress in McCarran Ferguson – states being the primary

[16] Centers for Medicare and Medicaid Services, "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choice To Empower Patients," 82 Fed. Reg. 26885, 26886 (June 12, 2017).
"On January 20, 2017, President Trump issued Executive Order 13765, 'Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal,' to minimize the unwarranted economic and regulatory burdens of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148). To meet these objectives, the President directed the Secretary of Health and Human Services (the Secretary) and the heads of all other executive departments and agencies with authorities and responsibilities under the PPACA, to the maximum extent permitted by law, to afford the States more flexibility and control to create a more free and open health care market; provide relief from any provision or requirement of the PPACA that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications; provide greater flexibility to States and cooperate with them in implementing health care programs….." Id.
[17] Id. at 26886.

regulators of insurance, and by the Supreme Court. If a state retains its state insurance oversight responsibilities and there is a conflict with CMS' interpretation, it is not clear what options exist except for CMS to overrule state Legislatures' and Executives' will, state insurance Commissioners' authority, and marketplace exchanges' state-based authority. Consequently, although we appreciate the two alternative to alleviate the new burden on states, neither one is a practical alternative that recognizes the role of states in regulating insurance, keeping markets stable, and protecting insurance consumers.

Additionally, different from the authority CMS has to implement federal law in states that refuse or unable to, in this case CMS is giving itself authority to interpret state insurance law. Neither the ACA nor other laws related to health insurance give CMS authority to interpret state insurance law.

DCHBX requests that the proposal and the alternative option be withdrawn.

Cost-Sharing Requirements (45 C.F.R. §156.130(h))

CMS is proposing a change to coverage of prescription drugs under essential health benefits (EHB) that would permit qualified health plans to exclude prescription drug coupons from the annual out-of-pocket limit due to a regulatory conflict between the CMS regulations and Internal Revenue Service (IRS) guidance governing high deductible health plans. This proposal would exacerbate the negative effects of the modification that CMS finalized in the 2020 Notice of Benefits and Payment Parameters.

In the 2020 Notice of Benefits and Payment Parameters, CMS amended 45 C.F.R. §156.130 to allow carriers to exclude any form of direct support from drug companies, including coupons, from a consumer's annual out-of-pocket limit on cost-sharing only if a generic equivalent prescription is available. DCHBX opposed this change when it was proposed and we oppose the new proposal that would expand this provision to allow carriers to exclude any form of direct support, such as coupons, from a consumer's out-of-pocket limit regardless of the availability of a generic equivalent.

When originally proposed, CMS stated the intent was to encourage the use of generic equivalent medications and to address the rising costs of prescription medications by promoting the use of more affordable generic alternatives when they were available. The new proposal eviscerates this argument and allows carriers to shift prescription drug costs onto consumers in all cases. Coupons from drug manufacturers are made available to off-set the cost of new or expensive prescription medications which may be the only medically appropriate treatment. This proposal would unduly harm consumers who need financial assistance to afford needed care, and this proposal could result in discriminatory practices that directly target people with rare or expensive conditions.

As DCHBX previously commented, this provision places the burden of fixing a systemic problem related to cost and coverage of prescription medications on the backs of consumers. Under this proposal, consumers may incur unexpected costs due to no fault of their own. Some people will choose not to fill necessary prescriptions due to cost. Instead of shifting costs to consumers, CMS should work with other federal agencies and stakeholders to address the costs of prescription drugs and better educate consumers on the availability and safety of generic equivalent medications where they exist.

DCHBX encourages CMS to continue to consider options to address increasing health care costs that do not penalize consumers and discourage people from getting medically appropriate care. Any new policies should protect people from discriminatory practices that target people based on their medical needs.

DCHBX strongly opposes this proposed expansion of an already problematic policy of shifting costs to patients. While DCHBX acknowledges the conflict in law CMS regulations created related to high deductible health plans, the CMS created conflict should not be used now as a subterfuge to shift more costs to patients who need prescription medication.

Medical Loss Ratio

Other Non-Claims Costs (45 C.F.R. §158.160)

CMS is proposing to require that carriers deduct price concessions received by the carrier or an entity providing pharmacy benefit management services to a carrier, including prescription drug rebates, from incurred claims. CMS estimates that this will result in $18.4 million in savings to consumers. DCHBX supports this proposal because it would result in cost savings for consumers and ensure that claims costs only include revenues extended on enrollee pharmacy costs

Special Enrollment Periods (45 C.F.R. §155.420)

CMS is proposing several changes to the special enrollment period (SEP) provisions under 45 C.F.R. §155.420. First, CMS is proposing to create a new a SEP under §155.420(d)(1)(ii). The new SEP would allow consumers to enroll into individual market coverage when they become newly eligible for a qualified small employer health reimbursement arrangement (QSEHRA) or change individual market plan elections to take advantage of the benefits offered by electing a QSEHRA. DCHBX supports this proposal because it would provide workers the opportunity to take advantage of newly available funding from their employers toward health insurance coverage and encourages CMS to finalize this SEP as proposed.

Second, CMS is proposing to amend §155.420(b)(3) to provide more flexibility to allow earlier effective dates for special enrollment periods. This proposal would allow exchanges to make coverage effective sooner for consumers, reducing possible gaps in coverage that may result from the current effective date rules. This proposal would also allow exchanges to determine appropriate effective dates for their customers and make consumer-friendly effective date policies more consistent. DCHBX supports this proposal and encourages CMS to finalize as proposed.

Third, CMS is proposing to amend §155.420(a)(4)(ii)(B) to permit enrollees and their dependents who experience a qualifying event under §155.420(d)(6)(i) or (ii) resulting in a loss of cost sharing reductions (CSRs), to change their enrollment from a silver plan to a gold or bronze level plan. When a consumer experiences a loss of CSRs they should be permitted to change plans to ensure their plan is affordable and otherwise meets their needs based on their change in circumstances. DCHBX supports this proposal and encourages CMS to finalize as proposed.

Finally, CMS is proposing to amend §155.420(a)(4)(iii)(C) to further restrict the ability of consumers to change metal levels when they experience a qualifying event. DCHBX continues to oppose restrictions on changing metal levels, which we believe to be arbitrary and capricious and contrary to longstanding HIPAA SEP rights, which required that eligible individuals have the same election rights as regular enrollees, including the right to select from any plan available. DCHBX asks that CMS eliminate metal level restrictions for all eligible individuals. CMS has recognized that a “one-size fits all” approach is not workable in all states. If CMS retains these restrictions that limit consumer choice, DCHBX asks that these restrictions only apply to the FFM and not to SBMs.

Requirements for Timely Submission of Enrollment Reconciliation Data (45 C.F.R. §156.265)

CMS is proposing to amend 45 C.F.R. §156.265(f) and (g) to clarify the QHP reconciliation process with exchanges. The proposed clarifications will help improve the reconciliation process allowing both QHPs and exchanges to have timely and accurate data. DCHBX supports these proposals.

Eligibility Redetermination During a Benefit Year (45 C.F.R. §155.330)

DCHBX supports the proposed flexibility provided to exchanges to not terminate QHP coverage without an explicit request from the customer in certain cases where the customer has more than one type of minimum essential coverage. Additionally, DCHBX supports CMS' clarifications regarding expeditious retroactive termination of customers for whom there is evidence of death via a periodic data match. These positive changes will enhance consumer experience with private health insurance.

Annual Premium Adjustment Percentage

CMS adopted a new methodology to calculate the annual premium adjustment percentage in the 2020 Notice of Benefits and Payment Parameters. This methodology is maintained in this proposed rule for PY2021. We continue to oppose the new methodology because it has negative effects on marketplace consumers, including reducing the amount of premium tax credits (APTC/PTC) and increasing the maximum out-of-pocket cap (MOOP) for plan year 2021. The new approach means that MOOP would increase by 4.9% from 2020 to 2021. Under this methodology an individual MOOP would increase to $8,550. As noted in our comments submitted on the 2020 proposed Payment Notice, CMS has acknowledged that the new methodology could result in a decline in Exchange enrollment and net premium increases for those who remain in the individual market.[18] While CMS admits that "the methodology should have a record of accurately estimating average premiums…"[19] the agency failed to provide data to justify how this change would more accurately estimate average premiums.

We strongly oppose the continued use of this new methodology because of the negative effect on consumers who receive APTC and an increase in financial exposure for all people who now have individual health insurance.

State Flexibility

Key to market stability is flexibility for states to adopt appropriate interventions to ensure stable markets that work for their consumers. States have made numerous decisions working with diverse stakeholders, to ensure that their policies and operations reflect local market conditions and are based on community and stakeholder support. States built on-line marketplaces to reflect state and local priorities.

We appreciate that the role of states is recognized and promoted. Executive Order 13765, issued January 20, 2017, instructs agencies to "provide greater flexibility to States and cooperate with them in implementing healthcare programs." Consistent with this principle, we encourage CMS to continue to

[18]Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Notice of Proposed Rulemaking. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 84 Fed. Reg. 227 at 287 (January 24, 2019).
[19] Id. at 285.

support state flexibility in all areas covered by the NPRM including but not limited to auto-renewal, employer-sponsored plan verifications, eligibility appeals, and quality rating systems and enrollee satisfaction survey systems. States understand local health insurance markets and the needs of the communities we serve. We support a strong federal floor of basic consumer protections with state flexibility to go beyond the basic federal floor.

Conclusion

DCHBX supports market-stabilizing solutions, flexibly for states, and policies that help people obtain affordable, quality health insurance. We oppose policies that limit state flexibility, may disrupt stable markets, and create barriers to consumer enrollment in health insurance. Thank you for considering our comments on issues that will directly impact DC residents and the continued operations of our marketplace. We look forward to working with you on these issues to empower consumers and ensure that consumers have access to quality and affordable coverage.

Sincerely,

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority