



February 19, 2019

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 2020 – CMS-9926-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 opened for business, we have cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

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

CMS is soliciting comments on the practice of automatically renewing health insurance for covered people who choose not to change their coverage. All state-based marketplaces (SBMs) currently successfully auto-renew people and focus limited resources to finding uninsured Americans. DCHBX strongly opposes any proposal to alter, restrict, or prohibit the well-established practice of "auto-renewal" -- renewing coverage automatically when a consumer does not make any changes, e.g. selecting a different health plan, to that coverage.

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, the Centers for Medicare & Medicaid Services (CMS) acknowledges that auto renewal is standard practice across the insurance industry but nonetheless is still contemplating changes.

Furthermore, the standard practice in job-based coverage is 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. Also, even governmental plans auto-renew workers. The health



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plan for federal government workers, the Federal Employees Health Benefit Plan (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. And consistent with current federal regulations and long standing industry practice, DCHBX has been auto renewing customers since we've opened for business. Importantly, we encourage our customers to shop every year during open enrollment and empower our customers with necessary tools to make informed decisions. Two years in a row (2017 and 2018), our consumer decision support tools rank number one among state-based marketplaces and the FFM. During open enrollment, our active shopping rates in the individual marketplace vary from 12% to 19%. For SHOP, 4-8% of small businesses change their plan offerings in any given year. And nearly 20% of employees in small businesses covered through DC Health Link SHOP actively shop when offered options. FEHBP reports that approximately 6% of covered federal employees make a plan change during open season.¹ On average around 13% of Medicare Part D enrollees make active plans selections.²

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 losing their coverage, and have a destabilizing impact on private health insurance markets and undermine the Affordable Care Act (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);
- Proposed new barriers for women seeking access to basic health care services (millions of women may lose coverage as a result);
- Proposed expanding "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).

Contrary to all norms in proposing a dramatic change to auto-renewal, CMS is raising the following concerns to justify the change: 1. consumers are less aware of options because consumers are not required to make an active decision annually; 2. consumers are less likely to update their information,

¹ "Open Season Ends Today: Here's What You Need to Know," Jory Heckman, 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/>.

² "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans to Save Money?" J. Hoadley, E. Hardgrave, L. Summer, et al; Kaiser Family Foundation, October 10, 2013, available at <https://www.kff.org/report-section/to-switch-or-not-to-switch-issue-brief/>.

which leads to eligibility and APTC errors; and 3. auto-renewal leads to consumer confusion. CMS offers no evidence to support the assertions that auto-renewal leads to any of the alleged problems.

The stated concerns don't hold up when closely examined. First, CMS needs to provide evidence that active shopping results in better outcomes for consumers. In other words, are consumers who actively shop better off than consumers who don't actively shop? Also does CMS 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, will CMS spend hundreds of millions of dollars to ensure that all of those people have in-person support they need? For consumers who use brokers, will CMS pay broker commissions to support re-enrollment every year? In the context of privatizing many functions of Healthcare.gov, is CMS planning to share people's private confidential information with web-based enrollers and others to ensure consumers can re-enroll? Will CMS spend hundreds of millions of dollars in paid media to educate people that CMS will no longer automatically renew people's insurance?

The second stated concern about eligibility and Advanced Premium Tax Credit (APTC) errors also does not hold up. There are many other ways to address updates to eligibility and APTC – ways that don't result in consumers losing their health insurance. For example, there are already processes in place to ensure that consumers update their information and that require marketplaces to recheck the federal hub at renewal (under 45 C.F.R. §155.335). In addition, the Internal Revenue Service (IRS) has reconciliation processes in place to address inconsistencies in APTC should they occur. To enhance existing approaches, CMS should consider additional education and outreach to help consumers better understand the requirement to report within 30 days changes that may impact eligibility. Navigators can also help consumers to better understand these requirements. CMS should increase funding for navigators to help educate consumers.

Third, the assertion that auto-renewal leads to consumer confusion has no basis and is contrary to consumer experience with job-based coverage, Medicare, and all other insurance. But even if CMS comes up with evidence to support this or any other of its assertions, the negative outcome of altering auto-renewal far outweighs any theoretical gains.

Any alteration, restriction, or prohibition of auto-renewal will create consumer confusion, add barriers to coverage, increase premiums, and could result in millions of Americans losing their current health insurance coverage. Consumers have been auto-renewed in marketplace coverage since the inception of marketplaces. Even if the federal government increased its outreach and 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. This is especially likely because in no other private insurance circumstance, is a consumer forced to reselect their same coverage in order to keep it. 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.

DCHBX strongly opposes any change that would impact SBMs. First, we support auto-renewal as a key service that promotes continuous health insurance coverage. Second, any change to these processes would require substantial changes to IT systems and operational practices without additional resources. As we have stated in the past, we encourage state flexibility to allow states to determine what processes

and policies best meet the needs of their insurance markets and consumers. Should CMS decide to stop auto-renewal for the FFM, we ask that SBMs be afforded the option of continuing auto-renewal.

Annual Premium Adjustment Percentage

CMS is proposing to use a new methodology to calculate the annual premium adjustment percentage. We oppose the new methodology because it would have 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 2020. The new approach means that MOOP would increase by 3.8%, for an individual from \$7,900 in 2019 to \$8,200 in 2020. CMS notes that the proposed change could result in a decline in Exchange enrollment and net premium increases for those who remain in the individual market. 84 Fed. Reg. 227 at 287. While CMS admits that “the methodology should have a record of accurately estimating average premiums...” 84 Fed. Reg. 227 at 285, the agency fails to provide data to justify such a significant change from 2019 to 2020.

We strongly oppose the 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.

Direct Enrollment and Web Brokers (45 C.F.R. §§155.220 and 155.221)

CMS is proposing changes to standards for web-based enrollers and direct enrollment entities. DCHBX continues to oppose the use of web-based enrollers and direct enrollment entities for the reasons we have articulated in prior comments. Below we specifically address proposed new standards.

We appreciate CMS’s effort to protect consumers. We are concerned that as proposed the new standards are not adequate to protect against harm. The new standards would mean that CMS would not be able to hold accountable entities that engage in abusive or fraudulent behavior, e.g. entities directing management, staff, contractors, and/or agents and brokers to engage in misconduct. Unless there is accountability for the company, it is not sufficient to hold accountable brokers or individuals that should be licensed as brokers to address harms to consumers. We recommend developing standards similar to those used by CMS in other federal programs, such as standards for Medicare Advantage plans, to ensure that web-based enrollers and direct enrollment entities are responsible for actions that harm consumers or are in violation of the law.

Essential Health Benefits (45 C.F.R. §156.130)

CMS is proposing several changes to coverage of prescription drugs under essential health benefits (EHB) within 45 C.F.R. §156.130. CMS states that it is seeking to address the increasing costs associated with prescription drugs, in particular name brand prescriptions. CMS is proposing to allow carriers to design their plans in way that will shift costs to consumers to financially incentivize consumers to use generic equivalent prescriptions.

CMS has two proposals related to coverage of generic medications, both of which would permit carriers to exclude covering name brand medications. First, CMS is proposing to amend §156.130 to allow carriers that cover a generic equivalent prescription to count only the cost-sharing associated with the generic option toward the annual limit on cost-sharing when an enrollee instead purchases a non-generic medication. This proposal would not only allow the health plan to exclude cost-sharing related

to name brand medications from the annual out-of-pocket limit, but this would also allow a plan to impose annual and lifetime dollar limits on brand name medications not in the EHB.

In the alternative, CMS is proposing to permit carriers to exclude a name brand medication from EHB if a generic equivalent is covered under the plan and medically appropriate for use by the patient. CMS is also asking for comments on whether these proposals should be mandatory for health plans, or optional.

While DCHBX supports the goal of addressing rising health care costs, including those related to prescription drugs, and supports promoting increased use of generic equivalent prescriptions when appropriate, we oppose both of these proposals because both approaches will increase costs for consumers. Both approaches place the burden of fixing a systemic problem related to cost and coverage of prescription medications on patients. Under both proposals 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 patients, CMS should work with other federal agencies with expertise in this area, such as the FDA, to conduct an education campaign to better educate consumers on the availability and safety of generic equivalent medications.

CMS also solicited comments on the use of therapeutic substitution and reference-based pricing. Unlike proposals that encourage the use of a generic equivalent drug to a brand name drug where the active ingredients are the same, therapeutic substitution and reference-based pricing may change the actual medications or therapies a patient would receive or be able to afford. DCHBX opposes both proposals. We oppose any therapeutic substitution, which would allow insurance companies to set aside medical provider's treatment recommendations in the interest of cost savings. Reference-based pricing also creates dangerous incentives and may lead patients to request medications that are inappropriate for them or forego treatment altogether, based on costs, leading to adverse outcomes for patients. These proposals if adopted would expose consumers to unnecessary risk.

Finally, CMS is proposing 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. DCHBX opposes this proposal as this would directly harm patients. Coupons from drug manufactures are made available to off-set the cost of new or expensive medications which may be the only appropriate treatment for patients. This proposal would unduly harm patients 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.

DCHBX encourages CMS to continue to consider options to address increasing health care costs that do not penalize patients 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.

Rules related to coverage of abortion services (45 C.F.R. §156.280)

CMS is proposing to require qualified health plans (QHPs) that offer coverage of non-Hyde abortion services to also offer at least one plan that excludes coverage of these services in each service area, to the extent consistent with state law. This proposal is in conflict with section 1303(b)(1)(A)(ii) of the ACA. Furthermore, CMS has failed to meet its statutory obligations when exercising authority under section 1321 of the ACA. For these reasons, DCHBX requests that this proposal be withdrawn.

First, this proposal is in conflict with section 1303(b)(1)(A)(ii) which states that a QHP “shall determine whether or not the plan provides coverage . . .” of non-Hyde abortion services. CMS states that it believes this proposal is consistent with section 1303 of the ACA because it interprets this section of the ACA as only barring the federal government from prohibiting QHPs from offering non-Hyde abortions. CMS’ interpretation is inconsistent with the plain language of the statute and CMS’ proposal would supplant its judgment for that of QHP carriers when Congress specifically deferred to carriers.

CMS also asserts that it is acting under its authority under section 1321 of the ACA. Section 1321 of the ACA is a requirement for CMS to consult with the National Association of Insurance Commissioners (NAIC) and stakeholders. While CMS states in the preamble that it generally consulted with the NAIC and stakeholders in the development of the 2020 Benefit and Payment Parameters proposed regulations, it does not clarify whether it consulted with stakeholders on this specific provision. Section 1321(b) requires:

In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

If CMS consulted with the NAIC and other stakeholders, we request that the views of stakeholders be shared as part of the notice and comment process. CMS should not finalize this proposal until it has met all statutory requirements.

CMS is also soliciting comments on ways that exchanges, including the FFM, can differentiate between QHPs with comprehensive abortion coverage versus those with more limited benefits. DCHBX recommends that any display decisions that CMS may wish to make be limited to the FFM and asks that states retain existing state flexibility on how plan information is displayed on SBM websites. States should continue to be allowed to make decisions around plan display based on their experience with their consumers. In fact, SBMs, including DCHBX, spend significant resources developing and providing new consumer decision support tools and enhancing plan display based on focus group testing, direct user observational testing, and A-B testing. Additionally, some changes to plan display are very costly.

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

CMS is proposing to create a new special enrollment period (SEP) in the individual market. The SEP would apply when a person experiences a decrease in income and becomes newly eligible for APTC. As proposed, the SEP would be optional for exchanges. We support this proposal.

The new SEP would help people maintain continuous coverage throughout the year. This proposal if finalized would help to address a known problem that many consumers with fluctuating incomes experience in the individual market. Currently, self-employed people or hourly wage earners whose income fluctuates lose their coverage if they can’t make premium payments. This new SEP will enable working people who experience a drop in income and become newly eligible for APTC to get back into coverage and prevent significant coverage breaks. In the District, because all individual health insurance is sold through DC Health Link, we interpret this proposed SEP to be available to residents with individual coverage who experience a change in income and become newly eligible for APTC. DCHBX supports this proposal and encourages CMS to finalize this SEP as proposed.

Prohibition on Discrimination (45 C.F.R §156.125)

In the preamble, CMS encouraged QHP carriers to offer coverage for medication-assisted treatment (MAT) for opioid use disorder. As CMS clarified MAT is a treatment for substance use disorders that include a medication approved by the Food and Drug Administration (FDA) for the treatment of opioid use disorders. In fact, health plans in the DC Health Link Individual Marketplace and SHOP already include this coverage. DCHBX supports CMS's efforts to help fight the opioid epidemic.

Transparency – Section 2715A and 45 C.F.R. §156.220

CMS states it believes increased transparency is important in a consumer-driven health care system, and that they are interested in providing consumers with greater transparency about their own health care data, QHP offerings, and the cost of health care services.

DCHBX supports the goal of greater transparency in health care and strongly urges CMS to work with the U.S. Department of Labor (DOL), and the Internal Revenue Service/Department of Treasury (collectively Tri-Departments) to implement section 2715A of the ACA. Section 2715A of the ACA expands of the transparency in coverage requirements under section 1311(e)(3) to group health plans and individual and group insurance carriers offering non-QHPs. Under 1311(e)(3) health plans are required, as part of plan certification, to provide information on:

- 1) Claims payment policies and practices;
- 2) Periodic financial disclosures;
- 3) Data on enrollment;
- 4) Data on disenrollment;
- 5) Data on number of claims that are denied;
- 6) Data on rating practices;
- 7) Information on cost-sharing and payments with respect to any out-of-network coverage;
- 8) Information on enrollee and participant rights under this title I of the ACA; and
- 9) Other information as determined appropriate by the Secretary.

By statute, this information is required to be submitted to the exchange, the Secretary, the state insurance commissioner, and made available to the public. While there has been some required reporting and disclosures, CMS has never fully implemented this requirement or developed meaningful reporting standards for QHPs under 1311(e)(3). Further, 2715A has never been implemented.

DCHBX has strong concerns about CMS developing new requirements that apply only to QHPs. Consistent with section 2715A, transparency requirements need to be implemented for QHP and non-QHP plans and group health plans to ensure meaningful information is available across the private markets and to ensure a level playing field for QHPs. Additionally, if applied only to QHPs, the cost of compliance will be passed on to people with QHP coverage instead of more broadly. This will result in higher premiums for people with quality health insurance coverage through marketplaces.

DCHBX shares CMS' general interest in data related to the cost of health care services and ways to improve consumer access to information about health care costs. Supporting that goal, DCHBX encourages CMS to work with its agency partners, IRS and DOL, to develop a federal all-payer claims database (APCD) using its authority under section 2715A, similar to what numerous states have already implemented. Because of limitations that states face due to ERISA preemption, a federal APCD that provides data for each of the 50 states and the District of Columbia is essential to fully understanding

health care costs. After the *Gobeille v. Liberty Mutual Insurance Company* (March 1, 2016) decision in 2016, which preempted Vermont's APCD law as applied to ERISA plans, states are unable to collect essential data from ERISA plans. That means only the federal government can require data production from ERISA covered plans, which comprise a majority of the health insurance market. Such comprehensive health claims data is essential to understanding the cost drivers in the health care system.

The Tri-Departments should also ensure that, as part of a transparency initiative, consumers are provided with data and information that is understandable for the average consumer and provided in a standardized format to allow consumers to compare information across health plans, carriers, and even states. This will be an important next step to improved transparency, which will help regulators and policymakers better understand the current market, and will also better enable consumers to make more informed decisions about their health care.

Separately, CMS is proposing to expand collection of masked enrollee-level data from the External Data Gathering Environment (EDGE) server and to expand the permissible uses of data currently submitted for risk adjustment purposes. DCHBX opposes proposals that would put enrollee-level data at risk of unauthorized disclosure or misuse.

Finally, CMS is soliciting comments on regulatory barriers for private entities and price transparency. DCHBX opposes any proposal that would allow disclosure and use of non-public CMS data. CMS has yet to fully implement transparency under 2715A and has not exercised the full authority granted to it under section 2718(d) that would enable CMS to set uniform and meaningful reporting standards for hospital charges. Rather than looking for ways to outsource transparency initiatives, the agency should use the authority granted to it by Congress and work with its government partners to create real transparency in the health care market.

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 support state flexibility with regard to "silver loading" or actuarial loading, and other policies within this proposed rulemaking to allow states to make decisions that is best for their markets, consumers, and providers. We strongly believe that states are in a much better place than CMS to understand local health insurance markets. We support a strong federal floor of basic consumer protections with state flexibility to go beyond and have even stronger consumer protections.

User Fees

The proposed user fees raises questions about what the assessment actually funds. CMS has taken steps to privatize key government functions and outsource key federal exchange functions to web-based

enrollers. CMS has already dismantled the federal SHOP, dramatically reduced the federal advertising budget, and slashed the Navigator grant budget. There have not been meaningful improvements nor new consumer decision support tools for customers. It is unclear how CMS plans to use the funds collected through the user fees as proposed for 2020. We encourage CMS to provide information about its operating and development costs including maintenance costs, and if applicable planned website enhancements and customer service enhancements.

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 marketplaces. 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