March 2, 2020

Randy Pate, Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted electronically via: www.regulations.gov

RE: CMS-9916-P

Dear Deputy Administrator and Director Pate:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments in response to the proposed rule on the Notice of Benefit and Payment Parameters for 2021.

ACAP is an association of 74 not-for-profit and community-based Safety Net Health Plans (SNHPs). Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals, including over 765,000 Marketplace enrollees. Nationally, Safety Net Health Plans serve almost half of all Medicaid managed care enrollees. Fourteen of ACAP’s Safety Net Health Plan members and Partner Plans offer qualified health plans (QHPs) or basic health plans (BHPs) in the Marketplaces.

ACAP has chosen to respond to a subset of proposals in the guidance that are particularly relevant to Safety Net Health Plans (SNHPs), and we further wish to draw attention to a particular subset of our comments. ACAP appreciates the Administration’s desire to strengthen the integrity of the Marketplaces; our comments are focused on ensuring market stability for SNHPs and the consumers they serve in particular. ACAP’s member plan enrollees are generally low-income populations and we would like to emphasize that the comments herein support SNHPs in their efforts to serve their communities, which they are generally well-acquainted to by way of their experience with serving Medicaid enrollees.

Our comments are summarized in brief below, however, we wish to emphasize one area of comment in particular. Namely, **ACAP vehemently opposes any proposal to change the provision of advanced premium tax credits provided to individuals who are automatically re-enrolled into their plan of choice.** Automatic reenrollment is common practice in all lines
of business, and consumers are used to not making changes once they have found a plan they like. Generally consumers are not forced to take action on an annual basis to keep their employer-sponsored coverage, even if the coverage is fully paid for by the employer. The policy discussed by CMS would create significant consumer confusion, lead to loss of coverage, and have a disproportionate impact on low-income consumers.

**Summary of ACAP’s Comments**

- **Automatic Re-enrollment**: As stated above, ACAP opposes any proposal to change the provision of advanced premium tax credits provided to individuals who are automatically re-enrolled into their plan of choice.

- **Cost-Sharing Requirements**: ACAP supports CMS’ proposal to permit issuer discretion on the application of drug manufacturer “coupon accumulators.”

- **Medical Loss Ratio**: ACAP supports CMS’ proposal to allow issuers to include the cost of wellness incentives as quality improvement activities in the MLR calculation so long as they are not outcome-based wellness programs. However, more importantly, we urge CMS to go further and include activities that address social determinants of health as quality improvement activities in the MLR calculation.

- **Risk Adjustment Data Validation**: ACAP supports CMS’ proposed changes to the RADV program on outlier identification and an additional pilot year for pharmacy data.

- **Notice Requirements**: ACAP supports CMS’ proposed notice requirements excepted benefit HRAs and urge CMS to require the excepted benefit HRA notice at the time of offer rather than within 90 days after the beginning of the plan year.

- **Special Enrollment Periods**: ACAP is supportive of CMS’s proposals to expand SEP availability, which will permit consumers to sign up for the most appropriate coverage for them at an appropriate time.

- **Federally Facilitated Exchange User Fees**: ACAP supports reductions in user fees where possible in order to reduce premiums for consumers, however, we support retaining the 3 percent user fee for FFM issuers if such reduction a would mean a corresponding reduction in funding for outreach and education or the navigator program.

- **Premium Adjustment Percentage**: ACAP objects to the continued use of the current methodology for calculating the premium adjustment percentage and urges CMS to reinstate the previous methodology.
**Expanded Comments**

ACAP’s comments are expanded below, with additional background.

**Automatic Re-enrollment**

CMS is considering whether to modify the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with APTC that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC. **ACAP strongly objects to this proposal.** Re-enrolling Exchange beneficiaries in their plans without the associated premium subsidies would result in significant consumer confusion and even loss of coverage, especially for those consumers with $0 premiums. It is safe to expect that many consumers with low or no premiums are low-enough income that they simply will not be able to afford coverage otherwise, and when they receive their first month’s bill they will not be able to pay it. At this point, it will be too late to make changes, as open enrollment will have ended, and those consumers will likely enter the grace period for non-payment and ultimately be terminated from coverage. The end result is far from CMS’ stated goal of preventing against incorrect APTC expenditures and an inability to recover excess APTC. In fact, the end result of such a proposal would be to effectively end automatic re-enrollment, as even if the consumer were technically re-enrolled, s/he would not be able to keep that coverage in force without their APTC. Consumers receiving significant subsidies, particularly those whose income is low enough that their premiums would be full covered by APTC, simply cannot wait for tax-season to receive their reconciled PTCs.

In addition to loss of coverage, there will be significant consumer confusion. Although CMS suggests consumer outreach and education would alleviate the inevitable confusion, it is unlikely this would adequately prepare all re-enrolled consumers—in 2019, 1.8 million people were automatically re-enrolled in Exchange coverage, 270,000 with a $0 premium\(^1\). In addition to the burden on consumers, ACAP is concerned that outreach responsibility would fall primarily to the Exchange plans and would be most burdensome to small, non-profit plans like those ACAP represents.

Similarly, **ACAP objects to CMS’s alternative proposal** in which APTC for automatic re-enrollees would be reduced to a level that would result in an enrollee premium that is greater than zero dollars, but not eliminated entirely. Consumer confusion, and ultimately loss of

\(^1\) [https://www.healthaffairs.org/do/10.1377/hblog20200201.566219/full/]
coverage for low-income consumers, would still present a significant challenge to market stability and health plan operations in this landscape.

**ACAP objects to any proposals to change the automatic provision of full APTC amounts for consumers who are auto-reenrolling in coverage. This proposal is directly targeted at low-income consumers and will result in significant coverages losses for some of the country’s most vulnerable. We urge CMS to not finalize any changes to APTC applicability for automatic reenrollment in the final rule.**

**Cost-Sharing Requirements**

CMS proposes to revise the cost-sharing definition so that amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support (coupons) offered by drug manufacturers are permitted, but not required, to be counted toward the annual limitation on cost sharing. While we wish to express our concern that this may result in increased costs to consumers—particularly those with high-cost, chronic conditions—**ACAP supports CMS’s proposal to leave the use of prescription drug coupons with regards to cost-sharing limitations to the issuer’s discretion.** Given that ACAP plans have varied policies on drug manufacturer coupon accumulators, issuer flexibility in this case is appreciated. We do urge CMS to monitor to what extent consumer access to affordable medication is impacted by this rule.

**ACAP supports CMS’ proposal to permit issuer discretion on the application of drug manufacturer “coupon accumulators.”**

**Medical Loss Ratio**

CMS seeks comment on a number of provisions related to the calculation of medical loss ratios (MLRs). While ACAP declines to comment on all of the proposals within, we do want to note that **ACAP supports CMS’s proposal to allow issuers in the individual market to include the cost of certain wellness incentives as QIA in the MLR calculation.** We note, however, that this should not be outcome-contingent wellness programs and our support is contingent upon clarification that any such wellness programs ought not have any discriminatory impact on the consumer’s premiums.

We appreciate that CMS recognizes the value of quality improvement activities to enrollees’ health outcomes and in fact urge CMS to go further by including a wider range of plan actions in the MLR calculation. Plans across the country, especially mission-driven, community-focused plans like those ACAP represents, are increasingly recognizing the paramount
importance of addressing social determinants of health disparities such as housing, nutrition, education, employment, and transportation. Although ACAP plans are doing as much as they can to improve outcomes, these crucially important activities are still considered “administrative costs” under current MLR calculation and funding guidelines. As CMS is now poised to financially incentivize wellness activities like smoking cessation and weight management, ACAP urges it to further support and incentivize the excellent work community-focused plans are doing to address social determinants insecurities among their members.

ACAP supports CMS’ proposal to allow issuers to include the cost of wellness incentives as QIA in the MLR calculation, however, we urge CMS to go further and include a wider range of activities, such as those addressing social determinants of health, as quality improvement activities in the MLR calculation.

Risk Adjustment Data Validation

CMS requests comment on two proposed changes to the risk adjustment data validation (RADV) program: to consider issuers to be outliers only if they have 30 or more HCCs recorded on EDGE for any HCC group in which their failure rate appears anomalous, and to treat the 2019 benefit year RADV as a second pilot year for the purposes of prescription drug data validation. ACAP supports both of these proposals.

For smaller issuers with fewer sampled enrollees for RADV purposes, the first change will reduce unnecessary outlier designations and better account for random variation in sampled enrollees’ HCC condition counts. The second proposal is also welcome, as it allows for more preparation time before implementation of a complex process with potentially large effects on plans.

As ACAP wrote in its formal comments on the November 2019 RADV White Paper², ACAP plans’ primary concern with regards to the RADV program is the disproportionate impact of a negative outlier on risk adjustment transfer amounts for issuers within the confidence interval but with failure rates significantly below the national average. The program’s current format requires state risk adjustment transfers to be budget neutral, which in this case can force plans with negative failure rates to reopen their books to pay out funds to other plans whose negative failure rates place them just outside the confidence interval. We again urge CMS to find a solution to this issue, which too often results in plans paying out RADV transfers despite accurate coding on their part.

ACAP supports CMS’ proposed changes to the RADV program on outlier identification and an additional pilot year for pharmacy data.

Notice Requirements

CMS proposes to require sponsors of non-Federal governmental plans that offer excepted benefit HRAs (EBHRAs) to provide a notice to eligible participants that contains specific information about the benefits available under the excepted benefit HRA, including eligibility, annual and lifetime caps, and other benefit limits. ACAP fully supports this proposal and, in fact, urges CMS to go further and provide notice requirements at the time of offer, rather than 90 days after the beginning of each plan year.

In general, we are concerned about consumer confusion tied to excepted benefit HRAs, as they simply are not adequate when it comes to providing comprehensive coverage. Excepted benefit HRAs are well-suited to be used for supplementary dental or vision coverage, for example, but simply do not provide enough funding to cover comprehensive health care coverage. We are concerned that consumers will use such coverage for short-term, limited-duration insurance (STLDIs), for example, which does not include the full ACA consumer protections. ACAP has made known its belief that while STLDIs have a role as transitional coverage, it is not adequate insofar as providing comprehensive coverage. Consumers have a right to know what is likely to be covered—or not covered—prior to making any decisions that will impact a full year’s coverage. **ACAP supports this proposal**, which would make consumers in EBHRAs fully aware of their coverage limitations. However, ACAP urges CMS to require that notice be provided the time of offer, given that EBHRAs are not comprehensive coverage, and such notice should aim to spell out exactly what benefits a consumer can expect the plan to cover.

CMS also proposes to require QHP issuers to send to enrollees a termination notice for all termination events, regardless of who initiated the termination. In general, ACAP supports efforts that will help ensure that consumers are aware if and why their coverage is being terminated. Furthermore, these notice requirements would help reduce customer service call volume if consumers have another avenue to understand the reasons for their coverage termination. However, we also wish to note that termination notices can be confusing to consumers and there may be scenarios in which a termination notice is not helpful. For example, we would support a termination notice when a member is no longer with a given issuer, however, it would not be appropriate when an enrollee moves from one plan to another offered by the same issuer.
ACAP supports CMS’ proposed notice requirements in general, however, we urge CMS to require the excepted benefit HRA notice at the time of offer rather than within 90 days after the beginning of the plan year.

Special Enrollment Periods

CMS requests comment on several proposals relating to the administration of special enrollment periods. These proposals, if enacted, would:

a. Allow enrollees and their dependents who become newly ineligible for CSRs and are enrolled in a silver-level QHP to change to a QHP one metal level higher or lower;
b. Allow a qualified individual who is not an enrollee, who qualifies for a special enrollment period, and has one or more dependents who are enrollees, to add him or herself to a dependent’s current QHP;
c. Provide that special enrollment periods currently following regular effective date rules instead be effective on the first of the month following plan selection;
d. Eliminate the option to move forward by no more than 1 month the effective date of enrollments that have been pended due to special enrollment period verification; and
e. Clarify that individuals and dependents who are provided a QSEHRA with a non-calendar year plan year may qualify for a non-calendar year special enrollment period.

ACAP supports all of the above proposals, as they would allow consumers with changes in status to better access the most appropriate coverage for their situation. However, we also ask for clarification on proposal a above as to whether consumers switching metal levels mid-year would be forced to restart their deductibles, coupon accumulators, and the like. We urge CMS to leave such decisions to the discretion of the issuer or, in the case of switching to a different metal level plan offered by the same issuer, to ensure that cost-sharing requirements already met be transferred to the new plan.

ACAP member plans generally have not seen SEP abuse and are, in fact, supportive of all CMS’s proposals to expand SEP availability. The above proposals will all permit consumers to sign up for the most appropriate coverage for them at an appropriate time.

Federally-Facilitated Exchange User Fees

CMS seeks comment on whether to keep the FFE user fees at 3 percent, or alternately, whether to reduce the user fee to 2.5 percent. If user fees are retained at 3 percent, CMS has spelled out a number of activities from which plans will benefit, including consumer outreach and
education, the navigator program, regulation of agents and brokers, eligibility determinations, enrollment processes, and certification processes. With the increased functionality and use of enhanced direct enrollment, and improvement in the enrollment process, there has been a decrease in the involvement from a federal perspective in the enrollment process. Therefore, in general, we believe the offset could be appropriate. However, while decreasing the user fee would enable issuers to lower prices for consumers, our Member issuers have expressed concern about whether a decrease in user fees would lead to a resulting decrease in funding for the above activities, particularly outreach and education and the navigator program. If that is to be the case, ACAP would object to any decrease in user fees, as we are strong believers in the efficacy of these programs. Loss of adequate funding for these vital activities would place an increased financial and administrative burden on plans, particularly small issuers that would be disproportionately impacted by any need to bring such efforts in-house.

ACAP supports lowering user fees when possible. However, ACAP supports retaining the 3 percent user fee for FFE issuers if a reduction in user fees would otherwise decrease funding for outreach and education or the navigator program.

**Premium Adjustment Percentage**

CMS proposes to update the premium adjustment percentage using the methodology finalized in the 2020 NBPP. ACAP wishes to reiterate its comments from the 2020 NBPP, in which we objected to last year’s methodology changes to the premium adjustment percentage, as it was not required by statute and only served to increase costs for consumers, particularly low-income consumers. Given the instability of the individual market and the impact on low-income and vulnerable populations, we urge CMS to withdraw the new methodology and return to the previous methodology used in 2019.

ACAP objects to the continued use of this faulty premium adjustment percentage methodology and urges CMS to reinstate the previous methodology.

**Conclusion**

ACAP thanks CMS for its willingness to consider the aforementioned issues. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7508 or hfoster@communityplans.net).

Sincerely,
/s/

Margaret A. Murray
Chief Executive Officer