



February 28, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021 (CMS-9916-P)

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the proposed **Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021**.

ACHP is a national leadership organization bringing together innovative health plans and provider groups that deliver affordable, high quality coverage and care. ACHP members are non-profit, community-based, provider-aligned health plans that provide coverage in all lines of business for more than 22 million Americans across 35 states and the District of Columbia. Our member organizations improve the health of the communities they serve and are leaders in care coordination, patient-centered medical homes, accountable health care delivery, information technology use and other innovations to improve affordability and quality of care. ACHP member organizations remain steadfast in offering competitive products in the individual market and even reducing premiums.

Highly functioning and stable individual and small group markets are paramount in ensuring consumers have access to high quality health care and coverage. These markets operate in a delicate balance and disruption could result in loss of affordable coverage options for working families. Consumers deserve a robust market with fierce competition and robust choice. Focused on consumers, ACHP and our members are devoted to well-functioning Federal and State-Based Exchanges.

ACHP's policy comments concentrate on the following priority areas:

- **Auto Re-enrollment:** ACHP does not support the proposed changes to auto re-enrollment which would increase burden on low-income and vulnerable consumers,

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result in fewer consumers being able to afford coverage and create instability in the individual market.

- Risk adjustment: ACHP supports the proposed changes to enrollee-level data collection sources and risk-adjustment data validation methodology updates.
- Value-Based Insurance Design: ACHP strongly supports CMS encouragement of value-based insurance design and requests modifications to healthcare.gov to ensure consumers can easily take benefit design into consideration when selecting a plan.

We respectfully offer the following comments.

Automatic Re-enrollment

ACHP is alarmed by the proposal to modify the automatic re-enrollment process. Specifically, ACHP is concerned with the proposal that any enrollee who would, under existing rules, be automatically re-enrolled in their plan with an advance premium tax credit (APTC) covering the entire premium would instead be re-enrolled without any APTC or with a reduced APTC. We strongly urge CMS to not finalize the proposal and retain the existing policy of automatic re-enrollment in an existing plan with the individual's existing premium subsidy. Auto-reenrollment is common in the commercial market. It allows consumers who are happy with their coverage to maintain their current plan without the hassle of re-enrolling.

Critically, this proposal will be most burdensome for the lowest-income and vulnerable consumers. Re-enrolling individuals in plans with premiums that are unaffordable under existing affordability rules would raise considerable confusion for a group of consumers who already confront challenges in affording basic necessities. Further, it will likely require these individuals to take on financial obligations for their health coverage that they cannot afford – even when they remain eligible for continued subsidies. There is also a significant risk that this proposed policy would discourage consumers from selecting any plan, lead to an increase in the number of uninsured, revive cost shifting to cover increased Emergency Department visits and raise medical debt for consumers.

Given that consumer education and outreach has had limited success in the past and that outreach budgets continue to face cutbacks, ACHP has severe reservations this would mitigate the problem.

The proposed payment notice justifies the re-enrollment proposal by stating that CMS is seeking to reduce errors and general consumer confusion. We believe the proposed approach would do the opposite. CMS should explore the reasons why some enrollees do not respond when required to undergo redeterminations and look to Exchange communications and operations to identify these issues rather than place significant financial burden on these enrollees. Additionally, CMS should seek to incorporate the

principles of behavioral science which emphasizes the power of inertia for people faced with complicated choices and the burdens of enrollment and plan selection that have an outsize impact on program participation.

ACHP also notes that this proposal may not be in line with section 608 of the Further Consolidated Appropriations Act, 2020 (P.L. 116-94) which requires that individuals be reenrolled for plan year 2021 in their existing plan if it is available.

Risk Adjustment

Enrollee-level data. ACHP appreciates the proposal to continue the transition to recalibrating the risk data used in the models that produce risk adjustment coefficients. Specifically, we support CMS proposing to use three years of enrollee-level EDGE data rather than a combination of EDGE and MarketScan data. ACHP has long requested CMS use the most recent data possible to recalibrate the risk adjustment model to most accurately reflect costs. As such, we have supported and continue to support the transition from the use of MarketScan data to enrollee-level EDGE data. The use of enrollee-level EDGE data will ensure, in as timely a manner as possible, that the actual experience of enrollees in individual and small group health insurance plans is used for recalibration.

Risk Adjustment Data Validation (RADV) Adjustments where HCC Count is Low. ACHP supports the proposed process change to identify outliers for calculating failure rates beginning with the 2019 RADV year. The proposed change to the outlier identification process for issuers with too few hierarchical condition categories (HCCs) within an HCC group to be statistically significant improves the validity of the audit. Issuers with too few HCCs in an HCC group should not be counted as outliers – a policy that has subjected small plans to too often be considered to have high failure rates in error. Additionally, the proposal to identify issuers with fewer than 30 HCCs in an HCC group and not adjust risk scores based on the experience of that group will reduce skewing of the results. Eliminating those small counts from failure rates would mitigate the burden on smaller issuers where low HCC counts can appear to be anomalous.

We are encouraged by CMS' continuing efforts to monitor and improve the RADV methodology so that transfer adjustments continue to become fairer and more reliable. We encourage CMS to finalize the proposed policy and continue to look for opportunities for improvement. The success of the risk adjustment program and its data validation process is essential for stability and availability of coverage in the individual and small group markets.

Promoting Value-Based Insurance Design

ACHP strongly supports the proposal to offer Qualified Health Plans (QHPs) the option to design a value-based insurance plan that would include the coverage of high-value services at lower cost-sharing amounts and lower-value services at higher cost-sharing amounts. As previously noted, the use of value-based insurance design has shown promising results in improving quality and reducing costs. While issuers have a great deal of flexibility to

incorporate value-based insurance design features in their plans under existing rules, we appreciate CMS outlining a value-based QHP model identifying the items and services for which plans might consider to be low-value and high-value. By incorporating value-based insurance design principles that include differential cost-sharing for high- and low-value services, and high performing providers, plans can tailor benefits to maximize value for consumers, particularly those with chronic conditions.

While ACHP supports the drive to value over volume, we are concerned that this proposal fails to incentivize consumers to purchase value-based insurance plan options. We encourage CMS to go further and establish two companion policies. The first should include a consumer education policy that would ensure enrollees understand the plan and its services and benefits. Without proper education and understanding of their value, these value-based insurance plan options are at risk for low enrollment and consumer confusion and dissatisfaction.

Second, CMS should establish a policy that requires the Exchanges to provide preferential display for plans meeting a minimum set of value-based insurance design principles. Exchange displays should be clear and simple for consumers to understand when plans meet a minimum set of value-based insurance design principles so that consumers can make informed choices. This preferential display could be either the ability to filter and search for value-based plans or an individual page on healthcare.gov separating the value-based plans from the metallic plan options. Without such attention to the value-based insurance plan designs, consumers will likely be unable to properly evaluate these plans over traditional metallic plans and determine their individual value.

Exchange User Fees

We support the proposal to retain the same percentage level for Exchange user fees for 2021 and explore lowering those amounts if CMS can cover administrative costs with lower fees. As premiums rise, charging the same percentage of fees for federal administrative activities should mean that collections for such activities are rising. We urge CMS to ensure that collections do not exceed the minimum necessary to competently conduct the necessary activities.

User fees in excess of the minimum necessary amounts could have the effect of raising premiums in the individual and small group markets. Higher than necessary premiums could reduce enrollment. For those reasons we urge CMS to ensure fee collections are the lowest amounts necessary. Additionally, in response to the request for feedback on the possibility of lowering those fees below the proposed percentages, ACHP supports lowering those fees below the proposed levels if doing so provides the necessary resources to conducting those federal Exchange activities competently at the lowest possible cost.

Medical Loss Ratio

ACHP strongly supports CMS' clarification that issuers in the individual market can include the cost of wellness incentives as quality improvement activity expenses in numerator of

the medical loss ratio (MLR) calculation in the same manner as permitted for the group market. The MLR is a measure of the value provided to consumers as a percentage of the premium. Plans that engage in quality related activities and that provide wellness incentives offer greater value to consumers. Research shows that consumers with wellness incentives are more likely to participate in wellness programs which have the potential to increase the health of enrollees and prevent future health care costs.¹

ACHP also supports the proposed clarification that prescription drug rebates and price concessions be reported as non-claims costs for the purpose of MLR calculations. The proposed changes increase the likelihood that enrollees receive the benefit of prescription drug rebates and price concessions. It also addresses an inequity in which some issuers benefit from compensating pharmacy benefit managers by allowing them to keep prescription drug rebates or price concessions, which inflates incurred claims and MLRs. We appreciate that this proposal better aligns MLR provisions with Medicare Advantage plans and Medicaid managed care plans, both of which require that the full amount of prescription drug rebates and price concessions be deducted from incurred claims. Such alignment is an important goal that could help to keep operations as simple as possible.

ACHP urges HHS to continue to work to address the high cost of pharmaceuticals starting with the prices charged by manufacturers. Ensuring that enrollees see some benefit from rebates and price concessions only addresses one piece of the puzzle.

Quality Rating Information Display

ACHP supports the proposal to provide flexibility to state-based exchanges in displaying quality information consistent with the August 2019 Quality Rating Information Bulletin. That guidance permitted flexibility by allowing for limited state customizations. We also urge CMS to clarify that states are not permitted to develop their own programs and replace the quality ratings developed by CMS in their entirety.

Other

While ACHP has no concern with supplying enrollees with termination of coverage notices for all circumstances, we raise the operational burden of this requirement. ACHP urges CMS to consider evaluating alternatives to traditional termination notices in the instances where it is not explicitly clear that it is the issuer's responsibility.

Conclusion

ACHP appreciates the opportunity to comment on the proposed Notice of Benefit and Payment Parameters for 2021. ACHP welcomes additional opportunities to engage with the Administration to ensure a robust and competitive individual market that provides

¹ Mattke,S., et al, Incentives for Workplace Wellness Programs: They Increase Employee Participation, but Building a Better Program Is Just as Effective. Santa Monica, CA: RAND Corporation, 2015.
https://www.rand.org/pubs/research_briefs/RB9842.html

coverage options for all. If there are questions or a need for additional information, please contact Michael Bagel, ACHP Director of Public Policy, at mbagel@achp.org.

Sincerely,

A handwritten signature in black ink that reads "Ceci Connolly". The signature is fluid and cursive, with "Ceci" on top and "Connolly" below it.

Ceci Connolly
President and CEO
Alliance of Community Health Plans