



November 27, 2017

Acting Secretary Eric Hargan
Attention: CMS-9930-P
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW.
Washington, DC 20201

Re: Covered California comments on Patient Protection and Affordable Care Act; HHS
Notice of Benefit and Payment Parameters for 2019; CMS-9930-P (RIN 0938-AT12)

Dear Acting Secretary Hargan,

Covered California is submitting comments in response to the proposed regulations CMS-9930-P. In making these comments we want to underscore appreciation that the Department of Health and Human Services (HHS) continues to support innovation by States operating state-based marketplaces (SBMs) by allowing for flexibility in implementing many of the proposed regulations. We provide the following comments based on our experience and analysis of what efforts are necessary in order to ensure a viable risk mix and ongoing sustainability for states that may operate in the federally-facilitated marketplace.

USER FEE

The Department of Health and Human Services (HHS) is proposing to update the Federally Facilitated Exchange (FFE) user fee for 2019 (with a fee of 3.5 percent of premium) and for state-based exchanges on a Federal Platform (SBE-FP) (with a fee of 3 percent of premium). Although the FFE user fee does not apply to SBMs such as Covered California, we want all marketplaces across the nation to be successful and make these comments to contribute to building on the success we have already seen across the nation.

Covered California believes that when the FFE or state-based exchanges spend less proportionally on marketing and outreach, this jeopardizes their respective risk pools and negatively impacts the premium trend in future years. If HHS were spending a comparable percentage of premium for the FFE as is California (1.4 percent), we

estimate that its total expenditures for marketing, outreach and sales for 2018 would be over \$480 million. This would be money well spent to ensure a good risk mix and keep premiums low for all those – both subsidized and unsubsidized – who enroll in states supported by the FFE.

The fundamental element required for the success of any marketplace is generating enrollment that reflects, and continually refreshes, the risk mix to ensure the lowest possible premiums for all consumers. Exchanges face constant churn with a substantial portion of consumers moving out of exchanges each year to other forms of coverage and new enrollees joining as they become newly eligible. A good risk mix and a viable business proposition for exchanges does not “just happen” – insurance must be sold. Selling insurance – which is different than providing a free benefit to a beneficiary, as is the case in most Medicaid programs – requires ongoing and significant investments in marketing and outreach to both promote retention of current enrollees and attract new enrollees that reflect a balanced risk pool.

In September, Covered California released a report – [“Marketing Matters: Lessons from California to Promote Stability and Lower Costs in the National and State Individual Insurance Markets”](#) – which shows marketing and outreach are proven ways to increase enrollment, lower premiums, save consumers money and stabilize the individual insurance market. The report finds that not only are marketing and outreach critical investments to promote enrollment, but they appear to have a large return on investment since bringing more healthy people into the risk pool further lowers premiums, saving money for everyone. Covered California’s extensive marketing and outreach helped the state’s individual market have one of the best take-up rates and lowest risk scores in the nation. As a result, premiums were between \$850 million and \$1.3 billion lower than they would have been if the state had the national average risk mix in 2015 and 2016. Covered California estimates that every marketing dollar it has spent has yielded more than a three-to-one return on investment (ROI). Efforts to promote the value of coverage and the options available to consumers boosted the enrollment of healthy consumers and likely lowered premiums by five to eight percent in 2015 and 2016.

STANDARDIZED OPTIONS – SIMPLE CHOICE PLANS

The Department of Health and Human Services is proposing to discontinue standardized plan options for the 2019 benefit year. In 2017, HHS began allowing insurers in the FFM to begin offering standardized plans that would be displayed in a manner that would make them easy for consumers to find. These standardized plans cover more basic services before consumers meet their deductibles, ensuring that consumers can obtain basic care without a financial barrier.

Covered California offers [patient-centered benefit designs](#) that were developed with input from consumer advocates, health plans, and policy experts. The benefits of patient-centered benefit designs are significant and allow consumers seeking coverage through the marketplace to easily compare health plans knowing the every health plan

has the same cost-sharing levels and benefits. Patient-centered benefit designs were designed to minimize financial barriers to access for consumers, reduce confusion and to have designs that actively reinforce efforts to promote higher value care delivery, such as better use of primary care. Covered California's patient-centered benefit designs allow consumers at every metal tier to visit their primary care physical without the cost being subject to a deductible.

Covered California urges HHS to reconsider ending standardized plan options for the 2019 benefit year and consider expanding the integration of simple choice plans in the federal marketplace. In fact, we urge HHS to only promote the use of simple choice plans on healthcare.gov as these plans have common deductibles and annual limits on out-of-pocket spending. More choice is not always better as consumers with expensive health care conditions could, for example, inadvertently select a plan that limits coverage for specialty drugs. In addition, all too often consumers face unnecessary deductibles not because of their making uninformed choices but because of confusion.

ESSENTIAL HEALTH BENEFITS

HHS proposes to provide greater flexibility to states when selecting their essential health benefits (EHB) benchmark plans for benefit years 2019 and beyond. Covered California appreciates the flexibility afforded to states to retain their current EHB benchmark plan without taking any action, as any changes to the current EHB structure would be a significant undertaking.

SHOP

HHS proposes to allow SHOPS to operate in a leaner fashion, which the FF-SHOP will take advantage of. This includes ceasing FF-SHOP online enrollment and premium aggregation. While we appreciate the apparent flexibility given to state-based exchanges, Covered California does seek additional clarity regarding the ability of state-based SHOPS to operate with added flexibility, including under the rules governing the status quo. While preamble language suggests such flexibility is possible, mandatory regulatory language in the proposed rules do not specifically carve out state-based SHOPS nor provide the option for state-based SHOPS to apply alternative protocols or to maintain the status quo.

Thank you for your consideration of our comments. If you have any questions or would like more information, please feel free to contact me.

Sincerely,



Peter V. Lee
Executive Director

cc: Covered California Board of Directors