February 19, 2019

Secretary Alex Azar
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW.
Washington, D.C. 20201

Re: Covered California comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020; CMS-9926-P (RIN 0938-AT37) – User Fee Recommendations

Dear Secretary Azar,

Covered California is submitting comments in response to the proposed regulations CMS-9926-P. The comments in this letter refer to the proposed decrease in the User Fee for 2020 for Federally-facilitated Marketplace (FFM) and State-based Marketplaces on the Federal Platform (SBM–FPs). Covered California has also submitted comments on premium adjustment, risk adjustment data validation, and prescription drug formulary changes and joined with the Executive Directors of all 13 state-based marketplaces to submit comments regarding automatic re-enrollment and stability in cost-sharing reduction funding.

The Department of Health and Human Services (HHS) is proposing to reduce the FFM user fee for 2020 by 0.5 percentage points, which would change the user fee to 3.0 percent of premium for the FFM and 2.5 percent of premium for SBM-FPs. Due to the fact that HHS and the Centers for Medicare and Medicaid Services (CMS) have not publicly released budget figures and expense allocations for operating the federal marketplace, it is difficult to fully assess the appropriateness of this proposal. However, as detailed below, we are deeply concerned that the assessment reduction of 0.5 percent of premium is likely only able to be "justified" based on the administration's decisions to drastically reduce spending on marketing, outreach and appropriate fostering of consumer-centric policies in the 39 states for which it has taken on the responsibility of promoting lower costs and better competition. Such actions are the definition of "penny-wise and pound foolish" — investments in marketing to promote a better risk mix and policies that help consumers understand the value of coverage and would reduce premiums many times over the 0.5 percent cost in assessment. Largely due to making these investments, premiums in California are approximately 20 percent

lower than those in states served by the FFM due to the healthier risk mix of those enrolled. The "efficiency" of a half-percent reduction in the FFM assessment must be considered against the lost opportunity of lowering premiums by enrolling more and healthier consumers.

The regulations note that the assessment on issuers is specifically intended to cover the costs of the "special benefits [issuers receive] from the following federal activities:

- Provision of consumer assistance tools;
- Consumer outreach and education;
- Management of a Navigator program;
- Regulation of agents and brokers;
- Eligibility determinations;
- Enrollment processes; and
- Certification processes for QHPs."

While the regulations do not provide any details on how the FFM meets these required activities, other public reports have detailed substantial reductions in investments in marketing, outreach and the federally required Navigator program with CMS decreasing navigator funding by roughly $26 million[1] (down to $10 million for 2018) as well as spending only $10 million on marketing and outreach[2] in both the 2018 and 2019 plan year. It appears that a major factor in lowering the assessment is the administration's decision to pull back on needed marketing and outreach activities.

What follows is a discussion of why and how pro-consumer and pro-competition policies, such as have been adopted in California, can lead to premium reductions of as much as 20 percent and foster real and robust competition among health plans.

Covered California's Assessment and Spending as Frame of Reference

Outside of the FFM, Covered California runs the largest Affordable Care Act marketplace in the nation. Serving the largest state, Covered California promotes coverage in the individual market — on and off-exchange — that totaled about 2.4 million people in 2018. Covered California is wholly transparent about our annual budget and how our health plan user fee is put to use to operate an effective exchange that works for consumers (see Appendix, Figure 1: Covered California Budget 2018-2019 Fiscal Year). For 2019, Covered California's user fee was 3.75 percent of "on-exchange" premium and current plans are to reduce the assessment to 3.5 percent in 2020. Of note, when those costs are spread across the entire individual market that assessment translates to approximately 2.3 percent of premium.

[1] https://www.cms.gov/newsroom/press-releases/grants-awarded-federally-facilitated-exchange-navigator-program

[2] https://www.cms.gov/newsroom/fact-sheets/federal-health-insurance-exchange-2019-open-enrollment

For the current fiscal year (FY 2018/19) Covered California's total budget of $340.2 million is divided into five major categories — all related to promoting enrollment and retention:

- **Outreach, Sales and Marketing —** $107 million, 31 percent of budget: reflects paid advertising, support for agents, public relations, a navigator program, and other outreach-related efforts;
- **Service Center/Positive Consumer Experience** — $105 million, 31 percent of budget: Covered California operates and directly employs workers for a phone, mail and chat-based consumers support center;
- **Technology/Enrollment Systems** — $70 million, 21 percent of budget: the on-line search, shop & compare and enrollment system is operated in conjunction with the state's Medicaid program (Medi-Cal in California) (see CoveredCA.com);
- **Plan Management/Evaluation** — $17 million, 5 percent of budget: reflects negotiating with health plans, structuring and evaluating patient-centered benefit designs, and efforts to promote lowering of costs in the health care delivery system; and
- **Administration** — $41 million, 12 percent of budget: the general financial, oversight, personnel and other core administrative functions.

Given the lack of transparency of the administration's expenditures, it is not possible to do a clear direct comparison of the respective investments in each area between Covered California and the FFM. It is possible, however, to make comments informed by more than five years of experience in and commitment to running a well-functioning marketplace that works not only for consumers receiving premium tax credits but also ensures that high-value and affordable options are available for the one million Californians that purchase individual market coverage without a tax credit. Some of the key indicators that can and should be used to assess the efficacy and how effectively an individual market is meeting the needs of its consumers include:

- **Risk mix:** California has a healthier risk mix than that in FFM or other SBM states — with a risk mix that is about 20 percent healthier than the FFM average (see Appendix, Figure 2: Comparison of FFM, SBM and California Risk Scores, 2014-2017). The Wakely Consulting Group, conducting an independent analysis found that Covered California's better than average risk mix is not driven by demographics (i.e., not driven by having a younger average age), but by the better health profile of the individuals who enrolled across demographic groups.[3]
- **Premiums:** California's healthier enrollment translates to 20 percent lower costs than Covered California would have otherwise had if its risk score were the same as the national average – specifically, on-exchange premiums were $2.6 billion lower for 2015 and 2016. Covered California's marketing and outreach investments in 2015 and 2016 likely lowered premiums by 6 to 8 percent.
- **Level of competition:** Covered California has 11 participating qualified health plans; 82 percent of consumers with three or more carriers from which to choose in 2019 (compared to 58 percent of consumers nationally with three or more

[3] Health Affairs. "National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success." https://www.healthaffairs.org/do/10.1377/hblog20180710.459445/full/.

options); and only 4% of consumers with only one plan (compared to17 percent nationally.[4]

- **Take-up rate:** Covered California's extensive marketing and outreach helped the state's individual market have one of the best take-up rates for 2018 which the Kaiser Family Foundation estimates at 64% for California and 44% for the 39 states served by the FFM.[5]
- **New enrollment:** The primary driving factor in the loss among FFM enrollment has been a consistent and dramatic reduction in the number of people newly signing up for coverage. In the past four years, the FFM has seen a 49 percent reduction in open-enrollment plan selections (see Appendix, Figure 4: Comparing New Sign-ups, Covered California and FFM, 2016- 19). While Covered California's drop in new enrollees who signed up during the 2019 open-enrollment period surpassed what states served by the FFM experienced, the decline in the FFM is compounded by the fact that those markets have already experienced several sharp decreases in new enrollment.
- **Off-exchange enrollment:** A Kaiser Family Foundation analysis comparing the first quarters of 2017 and 2018 – periods which enroll the highest number of consumers – shows that nationwide total individual market enrollment fell by 2 million or 12 percent, a drop that was driven by a 38 percent decrease in the off-exchange market which contracted by 2.3 million consumers.[6] Although Covered California does not yet have data for 2018 off-exchange consumers, the share of unsubsidized enrollment in California's individual market has held relatively steady between 2015-17 (see Appendix, Figure 5: Total Individual Market Enrollment by Subsidized vs. Unsubsidized).[7]

Using the Tools of The Affordable Care Act for Consumers and Competition

The Affordable Care Act (ACA) established an economic framework and financial assistance structure designed to ensure that individual market coverage works for all enrollees. Healthy individuals were provided both positive and negative incentives to maintain coverage through premium tax credits and the individual mandate penalty, respectively. Individuals with health conditions have benefitted from the prohibition of preexisting condition exclusions and elimination of lifetime and annual benefit limits. And all consumers have benefitted from a core set of essential health benefits that ensure they can receive the care they need when unexpected health issues arise. This framework was designed to balance healthy and sick enrollees in a common risk pool of

[4] Kaiser Family Foundation. Insurer Participation on ACA Marketplaces, 2014-2019. https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/
[5] Kaiser Family Foundation. Marketplace Enrollees Receiving Financial Assistance as a Share of the Subsidy Eligible Population. 2018. https://www.kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/.
[6] Kaiser Family Foundation. Data Note: Changes in Enrollment in the Individual Health Insurance Market. July 2018. https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/.
[7] Centers for Medicare and Medicaid Services. Trends in Subsidized and Unsubsidized Individual Health Insurance Enrollment. July 2, 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf

ACA-compliant health plans with the benefits inuring to consumers in the form of lower premiums.

California has remained committed to this framework since 2014. That commitment has been reflected in state-policies such as the expansion of Medicaid, the recent passage of legislation to ban short-term plans and the Governor and the legislature's active consideration of implementing a state-level individual shared responsibility penalty and new subsidies. The commitment has also been evidenced by Covered California's actions to promote enrollment, foster competition among carriers and support patient-centered benefit designs.

This commitment, however, does not appear to have been maintained by the FFM and through national policies undertaken at the federal level. Over the last two years, the Administration has deprioritized marketplace operations while consistently promoting policies that fracture the common risk pool and lead to instability and higher costs in the individual market. These actions have hurt subsidized and unsubsidized consumers alike through lower health plan participation, higher premiums, and federal endorsement of insurance products that deny access to millions and — for those who do pass underwriting processes could leave consumers bankrupt in the event of an unforeseen accident or illness that are not subject to coverage or payment standards.

To better understand what a marketplace can and should do with its assessment to promote lower premiums and better consumer-centric competition, Covered California provides the following observations on how it has sought to foster strong marketplace management in defense of low- and middle-class Americans who should have the benefit of affordable, high-quality coverage that is available to hundreds of millions of Americans with employer-sponsored coverage, Medicare and Medicaid. These comments are intended to inform the Administration's consideration of its adjusting its assessment in the context of how it could make investments to best foster lower prices and better access to care.

Markets Do Not Manage Themselves: Exchange Functions are Critical to Promote Enrollment and a Good Risk Mix Necessary for Marketplace Stability

In addition to funding marketing and outreach, federal law and regulation requires all exchanges to perform certain function and permits the user fee revenue to recoup the costs for various exchange functions. These functions include making marketing and promotion, eligibility determinations and enrollment, appeals, oversight and financial integrity, qualified health plan certification, quality activities (e.g., quality improvement activities, consumer satisfaction surveys, etc.), and program integrity.[8]

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

[8] 45 CFR Part 155.

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. Equally important is ensuring that health insurance products meet the needs of consumers and do not present barriers to accessing needed care. Covered California's activities include:

- **Marketing and Outreach:** In 2017, 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.

- **Patient-Centered Benefit Designs and Assisting Plans to "Price Right:"** As a fully functioning exchange, Covered California works directly with health plans to assist with benefit designs and "pricing right" by sharing risk data with them. Through convening a Benefits Design Workgroup comprised of health plans, actuarial staff, and consumer advocates, Covered California develops plans that have the intent of simplifying consumer choice to aid better decision making, limit out-of-pocket costs, and promote access to high-value care. This is why 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 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 physician without the cost being subject to a deductible.

  Covered California believes that 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 (see Appendix, Table 2: Comparison of 2018 Silver Plans for a 27-Year Old in Sacramento vs. Atlanta). In addition, all

too often consumers face unnecessary deductibles not because of their making uninformed choices but because of confusion. When selecting a plan, consumers must weigh dozens of factors that will determine their out-of-pocket costs. In California, our patient-centered benefit designs narrow the choices a consumer must make to premium, provider networks, and quality because cost-sharing and the applicability of the deductible is standardized for all benefits within a metal tier.

- **Promoting Higher Value Care:** Exchanges have an affirmative obligation to ensuring enrollees receive high-quality care, not simply just operating a website for enrollment. In this regard, Covered California has expanded upon the federal Quality Improvement Strategy requirements through a stakeholder process with its health plans, providers, and consumer advocates. Through contract requirements referred to as "Attachment 7," Covered California sets forth specific requirements related to improving quality, lowering costs, promoting better health and reducing health care disparities, both for our enrolled population and more broadly in the health care system. These contract requirements are monitored by Covered California staff and resources, in addition to the annual plan certification process.

Federal Policies are Eroding Individual Market Enrollment, Increasing Federal Costs and Pricing Out Middle-Class Americans Who Do Not Qualify for Subsidies

There are multiple factors that go into making a marketplace successful — so it is very difficult to assess the impact for 2020 of the proposed reduction of the FFM assessment from 3.5 percent to 3.0 percent. What is abundantly clear, however, is that taken together the policies adopted by the current administration are failing to meet the needs of consumers in the 39 states served by the FFM. By not investing in marketing or promoting policies that foster a better risk mix,

The impact on enrollment nationally for the 2019 plan year has already been documented in reports on enrollment through the FFM, with overall plan selections dropping 4 percent, driven largely by a 16 percent decrease in the number of new consumers signing up during open enrollment (see Appendix, Table 1: Comparing Net Plan Selections, Covered California and FFM, 2019 Open Enrollment). The drop in enrollment for 2019 builds on large decreases experienced by states served by the FFM in the 2016, 2017 and 2018 open-enrollment periods. Taken together, during the three years leading up to the 2019 open-enrollment period, states served by the FFM experienced a 39 percent decline in new enrollments, decreasing from 4 million to 2.5 million. In contrast, during the same three years, California saw a modest decrease in new enrollment, going from 425,000 to 388,000 (a 9 percent drop) (see Appendix, Figure 3: Comparing Net Plan Selections, Covered California and FFM, 2016-19).

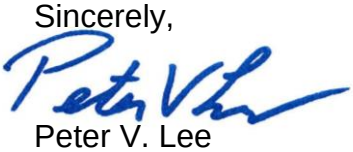
The primary driving factor in the loss among FFM enrollment has been a consistent and dramatic reduction in the number of people newly signing up for coverage. In the past

four years, the FFM has seen a 49 percent reduction in open-enrollment plan selections (see Appendix, Figure 4: Comparing New Sign-ups, Covered California and FFM, 2016-19). While Covered California's drop in new enrollees who signed up during the 2019 open-enrollment period surpassed what states served by the FFM experienced, the decline in the FFM is compounded by the fact that those markets have already experienced several sharp decreases in new enrollment.

While Covered California has remained committed to reaching all eligible consumers in the state, federal policies that have affected states served by the FFM have not reflected such a commitment. These policies include the removal of the penalty in 2019, cutbacks in marketing and outreach, promotion of short-term and other non-ACA-compliant health plans that pull consumers out of the common risk pool, as well as other policies in prior years. Taken together, these policies and affirmative steps put FFM states on a path to having an individual market that is made up of subsidized individuals who find their way to coverage and a virtual high-risk pool for unsubsidized consumers with poor health conditions.

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,

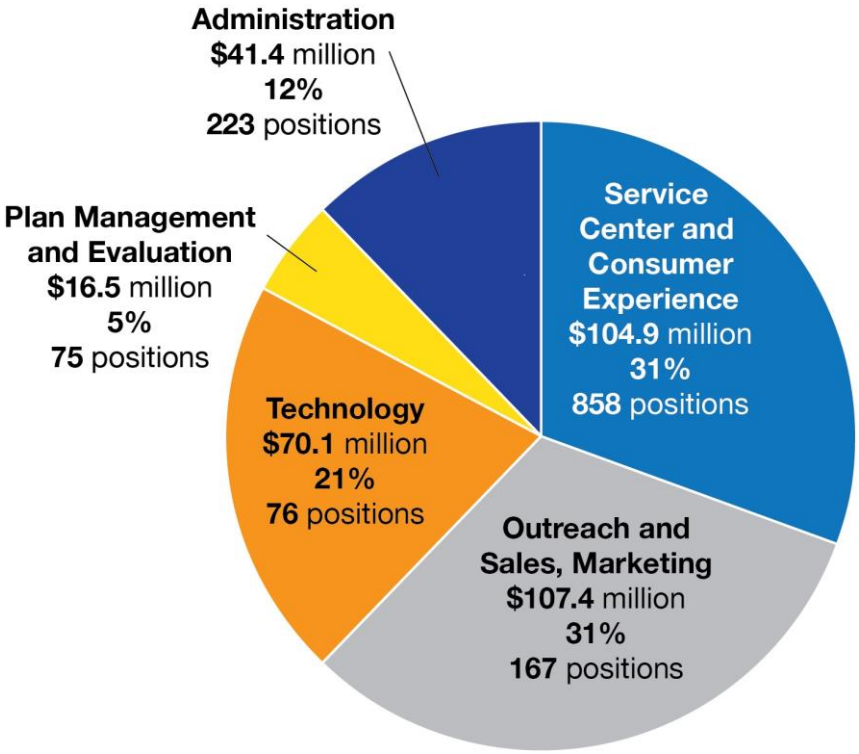


Peter V. Lee
Executive Director

cc: Covered California Board of Directors

Appendix

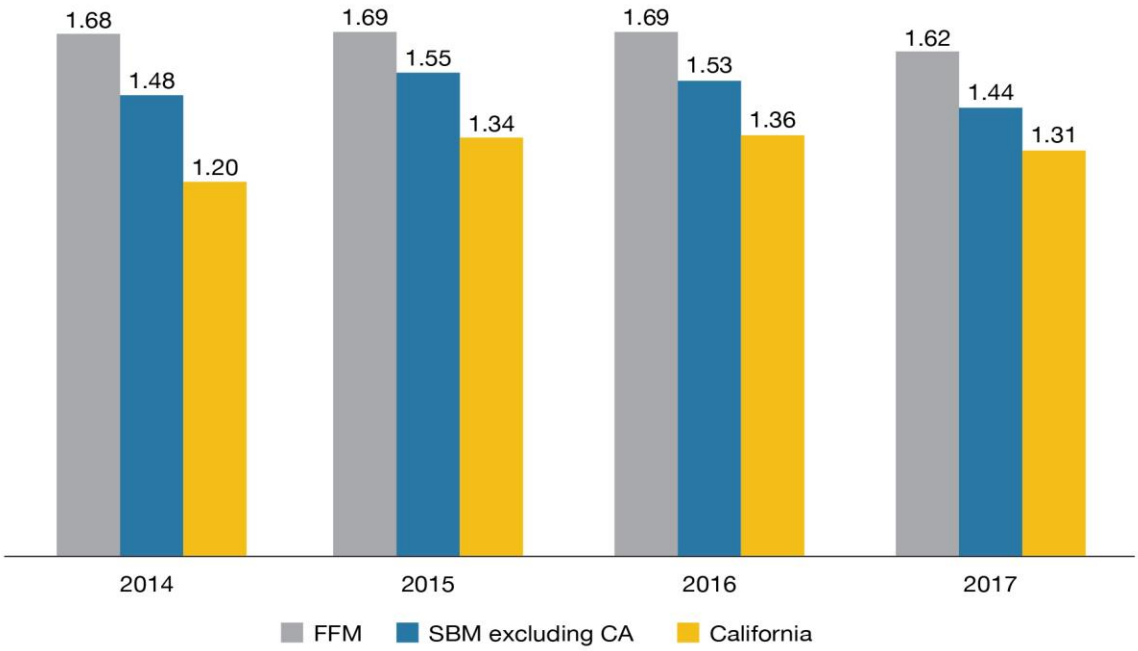
Figure 1: Covered California Fiscal Year 2018-2019 Operating Budget: $340.2 million



Source: Covered California Fiscal Year 2018-2019 Final Budget. June 15, 2018.
https://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2018-19_Budget-6-15-18.pdf

Figure 2: Comparison of FFM, SBM, and California Risk Scores, 2014-2017

Covered California had a 20 Percent Lower Risk Score than FFM States in 2017



Source: Covered California. Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets. September 2017. https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

Table 1: Comparing Net Plan Selections, Covered California and FFM, 2019 Open Enrollment

Category	Marketplace	2018	2019	Change
New sign-ups[5]	FFM	2,460,431	2,072,115	– 15.8%
	Covered California	388,344	295,980	– 23.8%
Renewals	FFM	6,283,211	6,339,499	+ 0.9%
	Covered California	1,133,180	1,217,903	+ 7.5%
Total	FFM	8,743,642	8,411,614	– 3.8%
	Covered California	1,521,524	1,513,883	– 0.5%

Source: Covered California. 2019 Open Enrollment Early Observations and Analysis. January 30, 2019. https://hbex.coveredca.com/data-research/library/CoveredCA_2019_Open_Enrollment_Early_Analysis.pdf.

Figure 3. Comparing Net Plan Selections, Covered California and FFM, 2016-19, in millions

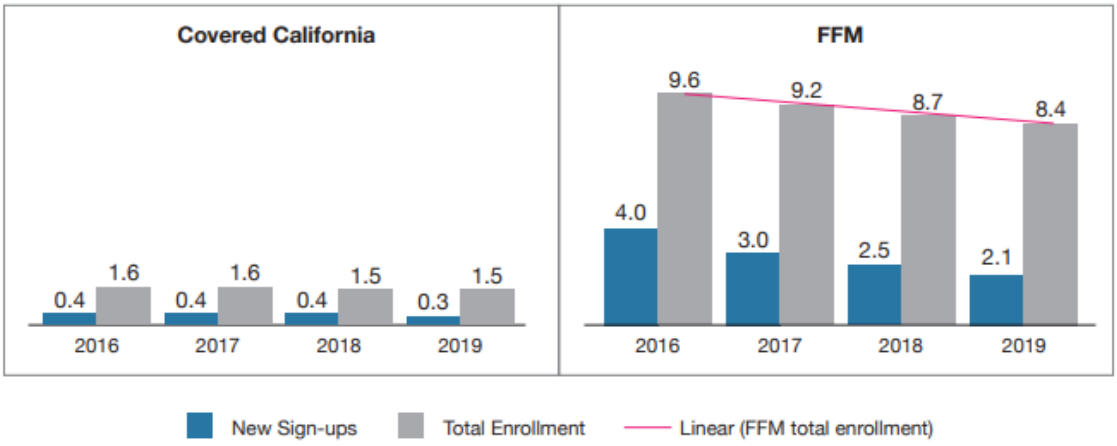
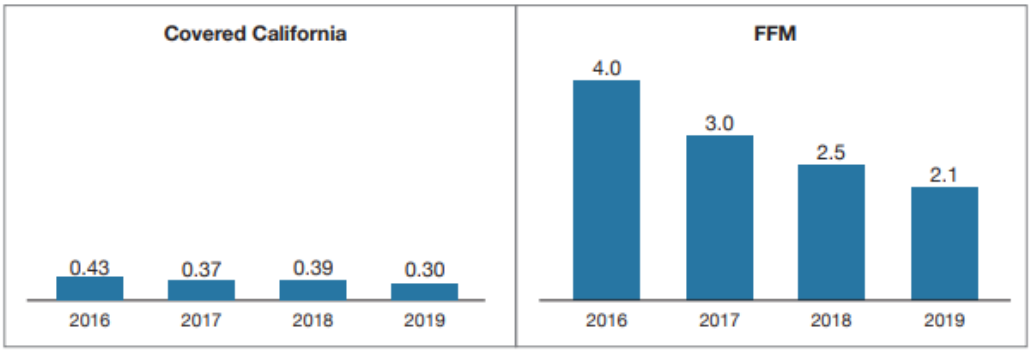


Figure 4. Comparing New Sign-ups, Covered California and FFM, 2016-19, in millions



Source: Covered California. 2019 Open Enrollment Early Observations and Analysis. January 30, 2019. https://hbex.coveredca.com/data-research/library/CoveredCA_2019_Open_Enrollment_Early_Analysis.pdf.

Figure 5: Total Individual Market Enrollment by Subsidized vs. Unsubsidized (in millions)

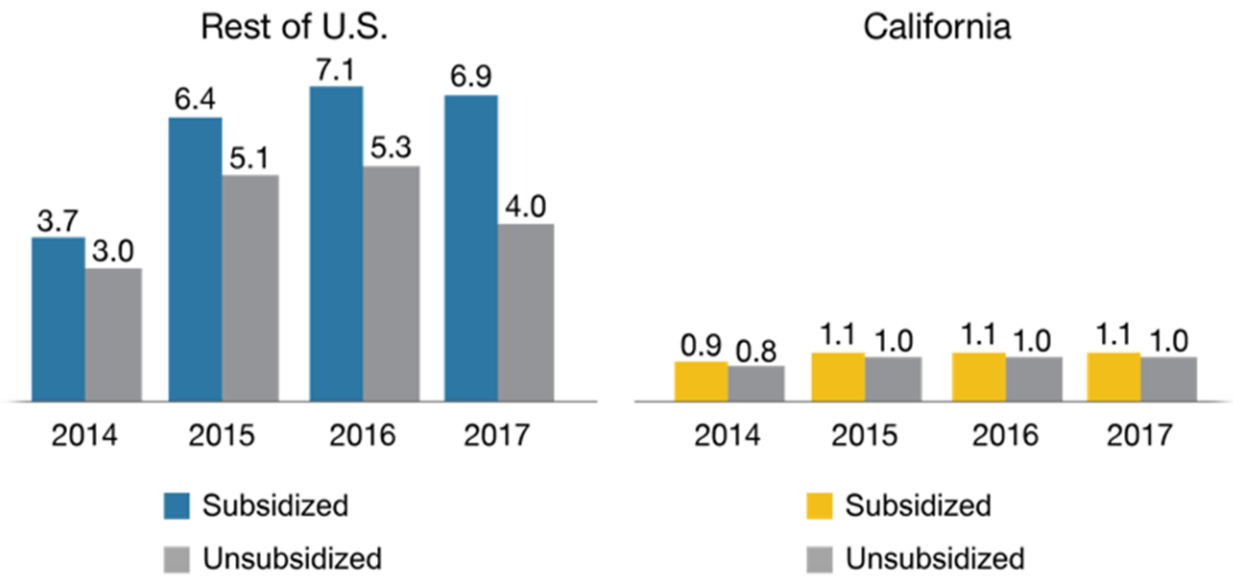


Table 2: Comparison of 2018 Silver Plans for a 27-Year Old in Sacramento vs. Atlanta

	Sacramento, CA	**Atlanta, GA**
Number of Silver Plans	5	11
Number of Carriers	5	2
Gross Premium	$366 - $504	$342 - $404
Advanced Premium Tax Credit	$122/month	$72/month
Monthly Net Premium* **(after Advanced Premium Tax Credit)**	$244 - $382	$270 - $332
Deductibles	$2,500 Medical $130 Drug	$2,750 - $7,050 Combined
Maximum Out-of-Pocket	$7,000	$6,000 - $7,350
Factors Consumers Must Consider When Selecting a Plan	Premiums ✓ ~~Deductibles~~ ~~Cost-sharing amounts~~ ~~Maximum Out-of-Pocket~~ Provider Networks ✓ Quality ✓	Premiums ✓ Deductibles ✓ Cost-sharing amounts ✓ Maximum Out-of-Pocket ✓ Provider Networks ✓ Quality ✓