March 2, 2020

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 2021; CMS-9916-P (RIN 0938-AT98):

Dear Secretary Azar,

Covered California is submitting comments in response to the proposed regulations CMS-9916-P. The comments in this letter focus on the proposed policies promoting value-based insurance design (VBID), the automatic re-enrollment process, quality rating information display standards, and user fee rates for the federally facilitated (FFE) and state-based exchanges (SBEs) using the federal platform (SBE-FPs).

Promoting Value-Based Insurance Design (VBID)

The Department of Health and Human Services (HHS) is proposing to develop "value-based" model qualified health plans (QHPs) that contain consumer cost-sharing levels aimed at driving utilization of high-value services and lowering utilization of low-value services when medically appropriate. HHS is soliciting comments on establishing minimum standards for these value-based model QHPs and how they could be displayed to consumers. Covered California strongly supports having ALL benefit designs be done centered in how they foster value for consumers. We are actively working to incorporate added elements reflected in the proposal into the patient-centered benefit designs that are standard for all coverage offered by Covered California's eleven contracted QHPs. As proposed, HHS does not do enough to empower consumers and leaves largely to the discretion of the many health plans contracted under the FFE their structure of benefit designs. Covered California urges HHS to return the path that the prior administration was on to offer benefit designs -- or "simple choice" plans -- that incorporates elements of VBID in all coverage offered. Offering patient-centered benefit designs that are the same across QHPs ensures that

consumers can compare health plans on an “apples to apples” basis and select the right health plan for them.

Covered California offers the same patient-centered designs across all health plans that were developed with input from clinicians, consumer and health care advocates, health plans and policy experts. Californians seeking coverage through the marketplace can easily compare health plans knowing that every health plan has the same cost-sharing levels and benefits, enabling consumers to shop for value. Our patient-centered benefit designs are constructed to minimize financial barriers to access for consumers, reduce confusion and promote higher-value care delivery, such as better use of primary care. Elements that reflect these goals include not applying the deductible to most out-patient care; limiting the out-of-pocket costs for high-cost prescription drugs; minimizing coinsurance; and having lower copayments for higher-value care and services.

Covered California supports HHS’ efforts to promote consumer-driven health care via value-based benefit design, and as a workgroup participant in the University of Michigan’s VBID-X project, we are currently working on incorporating several VBID-X services with zero cost-sharing to build on our patient-centered benefit plan designs for the 2022 plan year. Lower cost-sharing for the services listed in Table 11 has the potential to improve access and adherence to high-value care for individuals with high-cost chronic conditions, as well as the prospect of improved disease management outcomes down the road.

The principles of VBID extend beyond the provision of specific services at zero or reduced cost for particular conditions; they apply to other broader categories of services, such as primary care visits, generic drugs, and lab tests are high-value for individuals at any health status. Many benefit designs in the individual market subject these services to high deductibles and coinsurance, creating a financial barrier to care and potentially higher costs down the road for unmanaged chronic diseases and conditions. In addition, outside of California QHPs have many incentives to “game” benefit designs to be able to price their product at a lower Actuarial Value – NOT because that is a better value for consumers, but to reach a lower price point compared to competed QHPs as the same metal level. Playing with benefit designs to have a superficially lower price based on factors consumers do not understand is the farthest thing from “value-based” design.

Covered California recommends that HHS extend the promotion of VBID beyond specific services to include broader categories of care via patient-centered standard cost-sharing rules and benefit plan designs. In pursuit of the objective to incentivize more cost-effective consumer behavior, benefit designs should ensure that important outpatient care, such as primary care visits and generic drugs, are given first-dollar coverage, and the application of deductibles is only allowed for secondary levels of care (e.g. inpatient admissions, skilled nursing). At a minimum, health plan issuers that propose a VBID plan design using the services listed in Table 11 should be required to

demonstrate that the plan design overall is informed by principles of VBID through reduced cost-sharing for outpatient care and generic drugs.

In response to HHS' request for comments on VBID, Covered California can provide the following insight:

- Depending on the mix of VBID services and cost-sharing levels, a VBID program will likely increase the actuarial value of plan designs, particularly at the Bronze and Silver levels. To encourage adoption of VBID while ensuring that the plan design overall is value-based, Covered California recommends an expanded AV de minimis range for VBID plan designs. This would help a VBID program "fit" into existing plan designs while meeting the AV requirement. In addition, in the absence of truly patient-centered designs that are standard across carriers, HHS should consider at least standardizing the Actuarial Value offered by carriers so VBID designs cannot be artificially under-priced.

- VBID adoption could be further facilitated by additional detail on the applicable CPT/DRG codes and qualifying drugs for the list of services in Table 11. Establishing uniformity and specificity in the list of VBID services would further support the establishment of minimum standards for VBID in the marketplaces.

- Establishing a VBID with zero cost-sharing for some services may have impacts on mental health parity. Additional guidance on avoiding adverse impacts on mental health parity may help facilitate a broader VBID adoption.

- California is pursuing VBID as a pilot program in specific rating regions to study the efficacy of VBID in the individual market and suggests HHS provide guidance to other states on pursuing a similar approach outside of California.

This VBID policy is a step in the right direction, and we recommend HHS also return to its consumer-driven health care system in which consumers are able to compare QHPs on an "apples to apples" level and truly select the plan that is right for them.

Automatic Re-Enrollment Process

HHS is again considering making changes to the automatic re-enrollment process for the Exchange population. Barred by Congress from taking action to end the automatic re-enrollment process, HHS now appears to be looking for ways to unnecessarily complicate the "broad industry practice" of automatic renewal for the most vulnerable population. Consumers' ability to obtain health insurance coverage should not be contingent on economic status. Among the proposals that HHS is considering is automatically renewing enrollees who receive APTC that covers the entire premium, without APTC. HHS is also considering, for the same population, renewing the enrollee but not entirely eliminating APTC. As HHS acknowledges, automatic re-enrollment is standard practice in the insurance industry, including employer-sponsored health insurance and Medicare. It has remained standard practice because it plays a critical

role in ensuring continuity of coverage and care, as well as easing burdens on consumers and insurance carriers. The fact that HHS is again considering deviating from industry practice with no evidence or data that the problem exists is concerning.

It is not clear what problem this proposal aims to solve. CMS' concerns about automatic re-enrollment appear to be founded on questions regarding program integrity and the appropriate administration of premium tax credits. In fact, in the preamble to the proposed regulation, HHS states that automatic re-enrollment "may lead to incorrect expenditures of APTC, some of which cannot be recovered through the reconciliation process due to statutory caps." However, an analysis from the Treasury Inspector General for Tax Administration that compares PTC statistics for processing years 2017–2019 shows the total number of tax returns with excess APTC was the lowest in 2019.[1] The report further illustrates that the amount of excess APTC, as a percentage of total PTCs (which were either received in advance or claimed at the time of filing) was also the lowest in 2019. Similarly, the total APTC that was not repaid as a percentage of total PTCs was also the lowest in 2019. We ask HHS to produce data that clearly shows that this belief is grounded in reality.

Complicating automatic re-enrollment of coverage would create significant disruption for consumers, carriers, and Exchanges while treating Exchange enrollees differently based on their income. For many consumers, it would generate considerable confusion and unnecessarily introduce access and continuity of care issues to the extent they experience an unexpected gap in coverage that may result in missed medical treatments or unfilled prescriptions. Consumers would need substantial education and support to navigate changes to established re-enrollment practices, which would require a sizeable investment in consumer outreach, enrollment assistance, and marketing. This places an undue hardship on consumers that is out of sync with the administration's policy of reducing consumer burden and limiting new regulations.

Federal rules already provide a robust framework for ensuring the program integrity of Exchanges, including reducing eligibility errors and misspending of APTC. Exchanges have comprehensive processes in place for verifying income, checking consumer data against federal sources, requiring changes to be reported, and discontinuing advanced premium tax credits for consumers who fail to file and reconcile their federal income taxes. This framework ensures eligibility is determined correctly throughout the year and further makes any change unwarranted.

Quality Rating Information Display Standards for Exchanges

HHS is proposing to codify and further clarify SBE flexibility to customize the display of quality rating information for their respective QHPs.[2] HHS notes that they will allow SBEs that operate their own eligibility and enrollment platform to make some state-

[1] Treasury Inspector General for Tax Administration. *Results of the 2019 Filing Season.* January 22, 2020. https://www.treasury.gov/tigta/auditreports/2020reports/202044007fr.pdf.
[2] The term ''quality rating information'' includes the QRS scores and ratings and the results of the enrollee satisfaction survey (which is also known as the ''Qualified Health Plan (QHP) Enrollee Experience Survey'')

specific customizations but will not allow these states to develop their own programs to replace the quality ratings calculated by HHS.

Covered California believes strongly in the need to have common national measures and benchmarks, SBEs should retain the flexibility to modify the QHP performance ranking methodology (e.g., star rating assignments) given this element of the CMS methodology is still in development with periodic revisions. There were major changes to the ranking methodology for plan year 2020 and future refinements are expected. Covered California has partnered with CMS in evaluating and advancing improvements to the QRS and seeks to continue in this role as the program is refined and reaches a point in which the methodology is proven and stable.

FFE and SBE-FP User Fee Rates for the 2021 Benefit Year

HHS is proposing to keep the federal user fee steady for the 2021 benefit year with FFM states paying a 3.5 percent fee and SMB-FP states paying a 3.0 percent fee. 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. We, along with other organizations have repeatedly asked HHS to publicly disclose detailed expenditures of the user fee that it collects. CMS estimated the federal government would collect $1.2 billion in user fees for calendar year 2018 while maintaining the significant cutbacks in marketing and outreach seen in recent years. Based on CMS reports, total marketing and navigator funding to support enrollment in 38 states was $20 million in 2019, compared to $163 million in 2017. During that time there have been dramatic losses at the federal level among new and unsubsidized enrollment due to higher than necessary premiums.

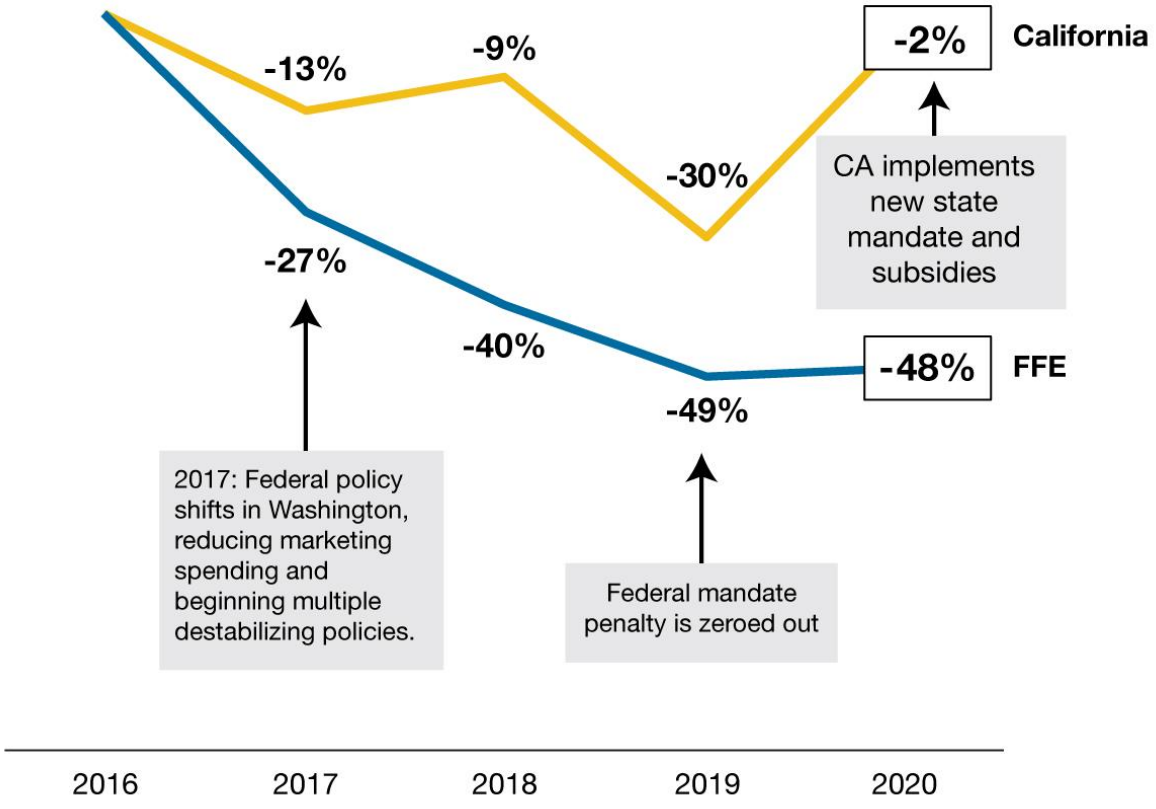
Covered California assesses a 3.5 percent user fee on its 11 health insurance carriers and approximately one-third of that total, which amounts to $121 million in plan year 2020 or 1.2 percent of premium, funds Covered California's marketing and outreach operations. This spending is appropriate because for both SBEs and the federal marketplace one of our obligations to conduct marketing and outreach. Beyond it being part of our and the federal government's obligation, Covered California's investment in marketing and outreach has helped it maintain a consumer pool in a continuation of a policy that has contributed to California consistently having a "risk score" approximately 20 percent below the national average for the individual market, which is likely to have saved enrollees and the U.S. Treasury an estimated $12.5 billion over the past five years.[3]

The actions and policies of California and of Covered California are in stark contrast to those seen at the federal level, which has maintained significant cutbacks in marketing and outreach while encouraging consumers to enroll in substandard coverage in the 38

[3] Covered California's First Five Years: Improving Access, Affordability, and Accountability, Dec. 2019, page 8: https://hbex.coveredca.com/data-research/library/CoveredCA_First_Five_Years_Dec2019.pdf.

states served by the FFE[4]. These policies have been demonstrated to directly contribute to far higher premium increases and lower new enrollment in states relying on the federal marketplace and dramatic drops in enrollment of unsubsidized consumers "off-exchange" in those states. New enrollment in those states that rely on the FFE has dropped 48 percent since 2016, which represents a reduction of nearly 1.9 million people. Covered California's new enrollment remained relatively stable (see Figure 1: Comparing New Enrollment in Covered California and FFE, 2016-2020).

Figure 1: Comparing New Enrollment in Covered California and FFE, 2016-2020[5]



[4] Covered California's First Five Years: Improving Access, Affordability, and Accountability, Dec. 2019, pages 31-34, detail the federal actions that undercut the Affordable Care Act and California's reactions to protect consumers and ensure quality care: https://hbex.coveredca.com/data-research/library/CoveredCA_First_Five_Years_Dec2019.pdf.

[5] Analysis of FFE states includes the 32 states served by the FFE and the six states with state-based exchanges facilitated by the federal platform (SBE-FP). We exclude Kentucky and Nevada from all counts due to these states switching marketplace types in 2017 and 2020, respectively. All plan selection totals data for the FFE are from CMS public data releases; however, because the "new" and "renewing" splits for Kentucky are not yet available from CMS for 2020, Kentucky share of "new" versus "renewing" is estimated using the ratio for Kentucky from 2019.

Overall, the enrollment of consumers in states served by the FFE has declined by over 1.2 million compared to 2016. During the same time period, Covered California's total enrollment has remained relatively stable (see Table 1: Comparing Net Plan Selections in FFE States and California, 2016-2020).

Table 1: Comparing Net Plan Selections in FFE States and California, 2016-2020[6]

	Federally-Facilitated Exchange			Covered California		
	New Enrollment	Renewal	Total	New Enrollment	Renewal	Total
2016	3,984,426	5,553,411	9,537,837	425,484	1,149,856	1,575,340
2017	2,903,122	6,128,467	9,031,589	368,368	1,188,308	1,556,676
% change from previous year	-27.1%	10.4%	-5.3%	-13.4%	3.3%	-1.2%
2018	2,403,621	6,159,449	8,563,070	388,344	1,133,180	1,521,524
% change from previous year	-17.2%	0.5%	-5.2%	5.4%	-4.6%	-2.3%
2019	2,030,713	6,212,832	8,243,545	295,980	1,217,903	1,513,883
% change from previous year	-15.5%	0.9%	-3.7%	-23.8%	7.5%	-0.5%
2020	2,065,908	6,137,874	8,203,732	418,052	1,120,767	1,538,819
% change from previous year	1.7%	-1.2%	-0.5%	41.2%	-8.0%	1.6%
Cumulative Change	**-48%**	**11%**	**-14%**	**-2%**	**-3%**	**-2%**

The loss in FFE enrollment comes in addition to a steep reduction in the number of unsubsidized consumers in the individual market nationally. As Covered California noted in its report, "Covered California's First Five Years: Improving Access, Affordability and Accountability" on page 9, unsubsidized enrollment in the individual market fell 47 percent between 2016 and 2018.

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.

[6] Analysis of FFE states includes the 32 states served by the FFE and the six states with state-based exchanges facilitated by the federal platform (SBE-FP). We exclude Kentucky and Nevada from all counts due to these states switching marketplace types in 2017 and 2020, respectively. All plan selection totals data for the FFE are from CMS public data releases; however, because the "new" and "renewing" splits for Kentucky are not yet available from CMS for 2020, Kentucky share of "new" versus "renewing" is estimated using the ratio for Kentucky from 2019.

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