January 30, 2023

Xavier Becerra
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024 (CMS-9899-P) (RIN 0938-AU97)

Dear Secretary Becerra:

Covered California is pleased to submit the following comments in response to the U.S. Department of Health and Human Services (HHS) proposed rule, the Notice of Benefit and Payment Parameters for 2024.

As the nation continues to see record enrollment in coverage through Affordable Care Act (ACA) Marketplaces, the proposed rule demonstrates the current Administration's commitment to deliver on the promise to expand access to low-cost health insurance through this rule. While Covered California supports many of the proposals in this rule as positive steps forward, our comments focus specifically on the consumer-centric proposals regarding limiting non-standard plan designs, improvements to the standard plan designs offered on HealthCare.gov, and allowing Exchanges to automatically move consumers to higher-value qualified health plans (QHPs). Covered California is also offering technical assistance on the proposed payment integrity program.

Mitigating the Risk of Choice Overload

Since 2019, the number of QHPs offered through HealthCare.gov has dramatically increased. As identified in this proposed rule, too many plan options[1] can lead to consumers experiencing choice overload, often resulting in enrollment decisions that do not maximize the benefits available to them.[2] HHS previously sought to address this issue through soliciting public input on limiting the number of non-standardized QHP options offered through HealthCare.gov to reduce the risk of choice overload.[3] In response to these requests, a majority of public commenters agreed that the number of

[1] Iyengar S.S. and Lepper M.R., *When Choice Is Demotivating: Can One Desire Too Much of a Good Thing?* (Dec. 2000). <https://faculty.washington.edu/jdb/345/345%20Articles/Iyengar%20%26%20Lepper%20(2000).pdf> [as of January 13, 2023].
[2] Covered California has compiled the major published literature related to benefit standardization. Implications of Different Approaches to Offering Standard or Non-Standard Benefit Designs, <https://hbex.coveredca.com/pdfs/CoveredCA-LitReviewStandardBenefitDesign-2022-01-27.pdf> (as of January 13, 2023).
[3] 87 Fed.Reg. 584 (January 5, 2022).

QHPs available to consumers through HealthCare.gov has increased beyond a point that is productive for consumers and that consumers do not have the time, resources, or health literacy to be able to meaningfully compare all available plan options.

Citing QHP submission data, HHS estimates that for plan year 2023, an average of 113 QHPs are available per consumer through HealthCare.gov, which is an increase of 107 QHPs per enrollee from plan year 2022. A 2021 report issued by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that in certain rating areas, QHP issuers were intentionally offering Silver-level plans with only slight differences, making it difficult for consumers to compare and choose the plan that worked best for them. ASPE found that from 2019 to 2022, the average number of Silver-level QHPs available to consumers increased from 12 to 45.

To address the excessive number of QHPs available to consumers, HHS proposes exercising its authority[4] to limit the number of non-standardized QHPs that a QHP issuer may offer through HealthCare.gov (Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs)) to two non-standardized plan options per product network type and metal level in any service area as a condition of QHP certification. HHS estimates that under the proposed limit, the average number of non-standardized QHPs available to each consumer would be reduced from 107 in plan year 2022 to 37 in plan year 2024.

Committing to Standard Plan Designs

While HHS re-adopted standard plan designs (also known as Simple Choice plans) beginning with the 2023 plan year, Covered California reiterates[5] its support for HHS' continued commitment to improving standard plan designs offered through HealthCare.gov. While HHS only makes minor updates to the standard plan design options available for the 2024 plan year, it is important to highlight the importance of standard plan designs for consumers.[6]

Since 2014, Covered California has only allowed QHP issuers to offer patient-centered standard plan designs to consumers. Development and ongoing adjustments to Covered California's patient-centered standard plan designs are done with input from a standard benefit design workgroup that includes consumer advocates, health and dental plans, hospital and provider associations, agents, navigators, and other interested stakeholders.[7] As a result, QHP issuers compete with one another based on premium, network, quality, consumer tools, and service.

Covered California's patient-centered standard plan designs adhere to the principles of value-based insurance design by considering the value and cost of clinical services to improve population health and consumer care experience, while staying within the

[4] 42 USC §§ 18031 and 18044.
[5] Covered California Comments on 2023 Payment Notice on Standardized Options (January 27, 2022), <https://www.regulations.gov/comment/CMS-2021-0196-0129> [as of January 13, 2023].
[6] Handel, Benjamin, and Kate Ho. (August 2021) *Industrial Organization of Health Care Markets*. NBER Working Paper 29137 <https://www.nber.org/system/files/working_papers/w29137/w29137.pdf> [as of January 13, 2023].
[7] Covered California plan year 2023 Patient-Centered Benefit Designs and Medical Cost Shares <https://www.coveredca.com/pdfs/Health-Benefits-table.pdf> (as of January 13, 2023).

guardrails of the actuarial value (AV) limits. This allows for variation and innovation on the part of QHP issuers, including consumer incentive programs that are approved to the extent they can demonstrate they are focused on closing gaps in care, promoting and encouraging utilization of high-value services, and promoting healthy behaviors.

As HHS makes annual adjustments to its standard plan designs, Covered California recommends that HHS expand the services receiving first-dollar coverage. Specifically, Covered California recommends that HHS include additional service categories such as labs, x-rays, and outpatient facility and outpatient physician fees that are not subject to the deductible. These are critical services that support primary care services, as laboratory services and diagnostic imaging services are essential for physicians to properly assess health conditions for treatment.

Covered California recognizes that the right balance in plan design is complex and challenging when reviewing options, and that trade-offs must be carefully considered to ensure that cost does not become a barrier to accessing care. Through robust discussions with stakeholders, QHP issuers, and consumer advocates since 2014, Covered California has developed patient-centered standard plan designs that promote access to care, with goals to improve the health of our population, improve the consumer experience of care, and reduce the cost of health care. We continue learning through each year of benefit design development and welcome the opportunity to engage with HHS and other stakeholders to assess impacts on utilization trends resulting from benefit design structures. We are continually working to improve our designs so that they will have a positive impact to consumers and support improved health outcomes.

Getting Consumers in High-Value Plans

HHS established the Exchange re-enrollment hierarchy in 2014 to ensure continuous coverage for consumers who opted to not make an active plan selection (also known as passive renewal) during the annual open enrollment period. Historically, HHS' re-enrollment hierarchy has prioritized placing enrollees in metal levels most similar to their current enrollment and has not considered the availability of lower premium plans at the same or higher metal level. Like Covered California, HHS is seeing enrollees who are unknowingly electing to be automatically reenrolled in a Bronze-level QHP when they are eligible, or may become eligible after the annual redetermination process for cost-sharing reduction (CSR) payments only available in Silver-level QHPs. To address this, HHS collected public comments on incorporating the net premium, maximum out-of-pocket amount, deductible, and total out-of-pocket cost of a plan into the Exchange re-enrollment hierarchy.[8]

In response, HHS proposes, among other changes, to allow Exchanges to amend their re-enrollment hierarchies to automatically re-enroll enrollees who are eligible for CSRs and would otherwise be placed in a Bronze-level QHP without CSRs to a Silver-level QHP with CSRs in the same product with a lower or equivalent premium after advanced premium tax credits (APTC).

[8] 87 Fed.Reg. 584 (January 5, 2022).

After reviewing enrollment data, Covered California identified instances where consumers were eligible for Silver-level QHPs with CSRs (specifically Silver 94 QHPs) but remained enrolled in high-cost sharing Bronze-level QHPs, foregoing richer coverage at a comparable net subsidy monthly premium. More specifically, the differences between a Bronze-level QHP and a Silver 94 QHP in Covered California's 2023 patient-centered standardized plan designs are considerable: $65 for a doctor's visit compared to $5, $18 for a generic prescription compared to $3, a $6,300 medical deductible compared to $75, a $500 drug deductible compared to $0, and an $8,200 maximum out-of-pocket compared to $900.

In response, Covered California implemented an initiative to automatically renew certain Bronze-level QHP enrollees into Silver-level QHPs during the 2022 and 2023 renewal period.[9] As a result, Covered California automatically moved approximately 8,000 households from Bronze-level QHPs to Silver 94 QHPs. To ensure households had ample time to switch to their prior plan, Covered California performed this move at the beginning of the renewal period. Covered California also provided impacted consumers a tailored notice to inform them of the action taken on their behalf, including the benefits of the Silver 94 QHP compared to the Bronze-level QHP. At the end of the 2023 Open Enrollment Period, approximately 93 percent of households in the crosswalk remained in their new Silver 94 QHP. While Covered California looks forward to further data on the outcomes of the initiative, we are encouraged by the take-up of Silver-level QHPs with CSRs and support HHS' efforts to create more opportunities to connect enrollees to higher value plans.

Ensuring Proper APTC Payments

The Payment Integrity Information Act of 2019 requires federal agencies to review and identify programs that may be susceptible to improper payments, estimate and report on the amounts, and outline actions to reduce the number of improper payments. HHS determined that APTC payments are susceptible and subject to additional oversight. To measure improper payments of APTC, HHS developed the Exchange Improper Payment Measurement (EIPM) program for states utilizing HealthCare.gov as well as the SEIPM pilot program for State-based Exchange (SBEs), HHS proposed establishing the permanent SEIPM program in the 2023 NBPP and received comments from SBEs, including Covered California[10], that indicated concerns with the proposed requirements related to the timeline and data collection.

In 2019, HHS developed an initiative to provide the SBEs with an opportunity to voluntarily engage with HHS to prepare for the implementation of the SEIPM pilot program. This initiative contained three options for SBEs to participate in – program analysis, program design, and piloting. Covered California strives to ensure accurate eligibility and enrollment determinations which impacts the accurate payment of APTC, which is why Covered California elected to participate in the SEIPM pilot program, to ensure that Covered California is fully equipped to implement the permanent SEIPM

[9] Covered California Board Meeting, (September 16, 2021) <https://board.coveredca.com/meetings/2021/September/Policy.and.Action.September.2021.pdf> [as of January 13, 2023].
[10] Covered California Comments on 2023 Payment Notice on Standardized Options (January 27, 2022), <https://www.regulations.gov/comment/CMS-2021-0196-0129> [as of January 13, 2023].

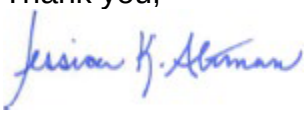
program. Covered California and the Centers for Medicare and Medicaid Services (CMS) are preparing to start the third and final “pilot” phase of the SEIPM pilot program in which Covered California will be submitting revised Sample Scenarios to CMS to test for improper payment of APTC.

HHS is now proposing a new required pilot program – the Improper Payment Pre-Testing and Assessment (IPPTA) program for SBEs, which would replace the current SEIPM pilot program. The proposed IPPTA and the SEIPM pilot programs have very similar elements while remaining separate pilot programs with different requirements and deliverables, creating the appearance of duplicative efforts. As mentioned earlier, Covered California has been working with CMS for two years on the SEIPM pilot program and has dedicated significant operational resources including the establishment of a dedicated SEIPM pilot program team that is solely focused on communication with CMS, and working with impacted divisions. While HHS indicates that activities completed within the SEIPM pilot program may fulfill new requirements under the IPPTA program, the lack of detail in the proposal is concerning. If finalized as proposed, Covered California is concerned that after dedicating nearly 3 years of resources to the SEIPM pilot program, the IPPTA program would be launched, collecting and testing many of the same elements of the SEIPM pilot program. Covered California is also concerned with the lack of information on the sunsetting of the SEIPM pilot program and how the information and data already submitted through the SEIPM pilot program will relate to the IPPTA program. Covered California further encourages HHS to fully integrate valuable lessons learned from the SEIPM pilot program into the IPPTA program, to ensure collected investments made by HHS and certain SBMs through the SEIPM pilot program are effectively utilized.

Covered California continues to support the necessary efforts to ensure accuracy within the APTC program to help ensure the ongoing sustainability of ACA Exchanges but is concerned with the duplicative efforts including the dedication of operational resources and a lack of clarity with the new IPPTA program.

We appreciate your consideration of Covered California’s comments and look forward to continuing our partnership with you to ensure that the ACA continues to work effectively and build on its foundation as we work to ensure that all Americans have access to affordable health coverage. If you have any questions or would like more information, please feel free to contact me.

Thank you,



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