December 30, 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 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations; CMS-9914-P (RIN 0938-AU18)

Dear Secretary Azar,

Covered California is submitting comments in response to the proposed regulations CMS-9914-P. Attached you will find our detailed comments and concerns regarding the proposed policies addressing the new Exchange Direct Enrollment marketplace option, new direct enrollment (DE) standards, codifying 1332 waiver guidance, user fee reductions, special enrollment period changes, qualified health plan (QHP) audits, and the quality rating standards (QRS) hierarchy request for comments.

Covered California makes these comments based on our technical and market experience as a State-based Exchange (SBE) that has successfully expanded coverage, offered consumers both stability and choice through multiple competing health plans, fostered enrollment that has resulted in a healthier risk mix – leading to premiums that are about 20 percent lower than what they would have been if they had the risk mix in the federal marketplace states. Our comments are also based on our experience and analysis of what efforts are necessary to uphold the integrity of the Affordable Care Act (ACA) and its goal to provide quality, affordable care to Americans across all states.

In some cases our comments and questions are technical, but in three areas – the establishment of the user fees for the Federally-facilitated Exchange (FFE), codifying the 1332 Waiver Guidance and the creation of the new Direct Enrollment Exchanges - we have fundamental concerns that the proposed regulations would undercut the intent of the ACA, raise costs to consumers, and foster a return to the pre-

ACA days where consumers were at the mercy of unrestrained actions by health plans and perpetuate the current federal paradigm where consumers are not given critical information about coverage options, including the availability of federal subsidies.

We look forward to your consideration and response to the comments and concerns we raise in the attached detailed comments.

Sincerely,

Peter V. Lee
Executive Director

cc: Covered California Board of Directors

Attachment: Covered California Comments on Notice of Benefit and Payment Parameters for 2022, December 30, 2020

Covered California Comments
Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations; CMS-9914-P (RIN 0938-AU18)

The Covered California's comments address the following six domains:

A. User Fee Reductions

The Patient Protection and Affordable Care Act (ACA) expressly prohibits the expenditure of federal funds for the continued operations of Exchanges after 2015. States are required to ensure Exchanges are self-sustaining, including allowing an Exchange to charge participating health insurance providers user fees to fund operations. Similarly, the federal government is required to collect the needed assessment to operate all elements of the Federally-facilitated Exchange (FFE). At 45 CFR 156.50(c) in this proposed regulation, HHS proposes to reduce the FFE user fee from 3.0 percent of total monthly premiums to 2.25 percent of total monthly premiums and to reduce the SBE-FP user fee from 2.5 percent of total monthly premiums to 1.75 percent of total monthly premiums.

HHS states it is proposing these changes "in order to reflect enrollment, premium and HHS contract estimates for the 2022 plan year."[1] HHS estimates that the proposed reductions will decrease user fee collections by approximately $270 million in 2022. However, HHS also states that despite the lower user fee rate, they expect to have "sufficient funding available to fully fund user-fee eligible Exchange activities."[2]

HHS cites OMB Circular A-25, which establishes federal policy regarding user fees. As noted in the proposed regulation, user fees "will be assessed against each identifiable recipient of special benefit derived from federal activities beyond those received by the general public".[3] HHS identifies the following special benefits provided to issuers for the 2022 benefit year, which align with the legal and operational requirements for Exchanges that include:

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

In the discussion that follows, these comments compare Covered California and the FFE's activities and resources applied to meet the requisite functions of a marketplace to meet the goals of ACA. Both the FFE and Covered California are large Exchanges serving millions of consumers, with multiple health plans providing services. (See, Figure 1: Comparison of the Federally-facilitated Exchange and Covered California – 2016 and 2020).

However, it is important to recognize that the FFE has changed dramatically over the past four years as the current administration has implemented policies that have reduced new enrollments and otherwise changed the scope and nature of who is and is not served by the FFE, with consumers being actively encouraged to enroll in non-ACA

[1] 85 Fed. Reg. 78573 (Dec. 4, 2020) < https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>
[2] 85 Fed. Reg. 78630 (Dec. 4, 2020) < https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>
[3] 85 Fed. Reg. 78630 (Dec. 4, 2020) < https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>

compliant plans outside of the FFE. The impact of these policies is evident in the decrease in new enrollment and total enrollment in the FFE in the period from 2017 to 2020, while in most cases enrollment in Covered California has either increased or remained constant.

Figure 1: Comparison of the Federally-facilitated Exchange and Covered California – 2017 and 2020

	Federally-facilitated Exchange			Covered California		
	2017	2020	% Change	2017	2020	% Change
New Enrollees OE Plan Selections	3,013,107	2,086,338	31% Decrease	368,368	418,052	13% Increase
Renewing OE Plan Selections	6,188,698	6,200,533	.2% Increase	1,188,308	1,120,767	6% Decrease
Total OE Plan Selections	9,201,805	8,286,871	10% Decrease	1,556,676	1,538,819	1% Increase
Average Effectuated Enrollment	7,198,034	7,596,174	6% Increase	1,321,234	1,490,854	13% Increase
Number of Issuers	149	159		11	11	
Gross Premiums	$41B	$54B		$7.2B	$10B	

Covered California is the largest State-based Exchange. Going into the 2021 Open Enrollment Covered California had 1.5 million consumers and eleven QHP issuers.[4] Also, going into 2021, there were an estimated 800,000 California consumers purchasing ACA compliant products in the off-Exchange individual market. The large number of unsubsidized consumers – consumers who are still able to afford coverage – is the product of Covered California's policies to promote a healthy risk mix, plan competition and products that provide meaningful value for consumers. The FFE has enrollment of 7.6 million going into the 2021 Open Enrollment, but in many states in the FFE, off-Exchange unsubsidized enrollment has almost disappeared as those not receiving subsidies have been priced out of coverage.

With regard to on-Exchange enrollment, going into 2021 the FFE had about five times as many consumers as Covered California – "simple math" would be to take Covered California's budget and multiply it by five. However, there may be some areas in which there are economies of scale in which the FFE can provide services more efficiently – such as for the operation of HealthCare.gov – and, there may be some areas in which the likely expenses of the FFE might actually be less efficient – such as what it's expenditures might be if marketing were done effectively, given different and diverse approaches that might be required to target different populations across the nation.

Nonetheless, the contrast provides an important frame of comparison that serve as one basis for considering whether the proposed changes in user fees are a reflection of "enrollment, premium and HHS contract estimates for the 2022 plan year"[5] or are due to the current administration choosing to not fund core functions of a marketplace leaving the next administration with few resources to actively fulfill its obligations under the ACA.

[4]Covered California Begins Renewal of More Consumers Than Ever Before and Announces Final 2021 Rate Change at All-Time Low of 0.5 Percent. (Oct. 13, 2020). <https://www.coveredca.com/newsroom/news-releases/2020/10/13/covered-california-begins-renewal-of-more-consumers-than-ever-before-and-announces-final-2021-rate-change-at-all-time-low-of-0-5-percent/>
[5] 85 Fed. Reg. 78573 (Dec. 4, 2020) < https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>

It is the policy of Covered California to maintain the lowest user fee possible, while fulfilling its mission and delivering on the legal and operational requirements of the ACA. Over the past 7 years, Covered California has lowered its assessment 3 times (See Figure 2: Covered California's Health Plan Assessment as Percentage of Premium). The initial assessment on QHPs, in 2014 was 3.8% percent of premium. That assessment was established based on a financial analysis of what was required to fulfill required functions and build an operating reserve.

Figure 2: Covered California's Health Plan Assessment as Percentage of Premium

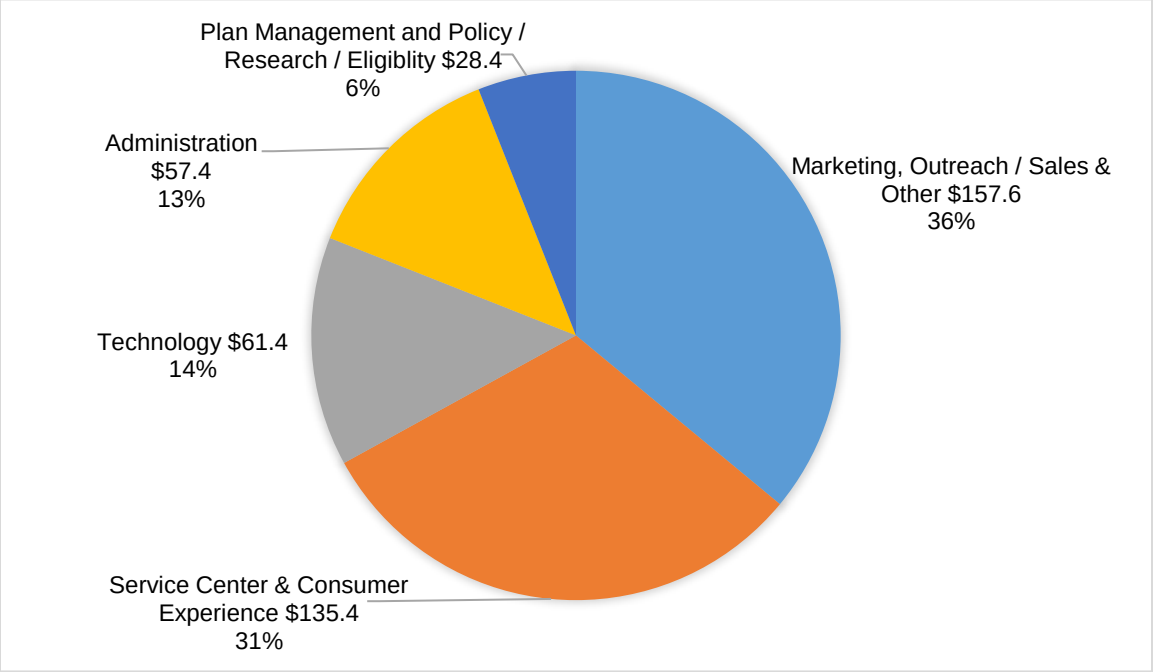
Plan Year	User Fee Assessment*
2014	$13.95
2015	$13.95
2016	$13.95
2017	4.00%
2018	4.00%
2019	3.75%
2020	3.50%
2021	3.25%

* Beginning in 2017, Covered California changed the assessment from a flat per-member, per-month (PMPM) rate to a percentage of gross premiums paid.

Covered California's budget for the current Fiscal Year of 2020-21 is about $440 million, which is based on the current assessment of 3.25 percent. Covered California plans to end the fiscal year with an operating reserve of nearly $362 million.[6] Covered California's budget is approved annually by its board of directors and subject to extensive public review. The detail provided in the approved budget describes staffing required to support each functional area, major contracts and direct expenses (see Figure 3. Covered California's FY 2020-21 Operating Budget – Distribution by Major Functional Area – $440.2 Million – 1,419 Authorized Staff). For the Fiscal Year 2020-21 budget, the Covered California board specifically included a one-year additional expenditure of $40 million to do even more outreach and promotion due to the COVID-19 pandemic and the large losses of insurance coverage that require more extensive outreach efforts.

[6] Covered California Annual Report and Fiscal Year 2020-21 Budget – Final. (July 16, 2020). <https://hbex.coveredca.com/financial-reports/PDFs/2020/fy-2020-21-annual-report-final.pdf>

Figure 3: Covered California's Proposed FY 2020-21 Operating Budget – Distribution by Major Functional Area – $440.2 Million – 1,419 Authorized Staff
(Dollars in Millions)



In contrast, the HHS' Centers for Medicare & Medicaid Services' (CMS) Fiscal Year 2021 performance budget provides an indication of the nature and scope of potential changes in spending that raise grave concerns about the ability of the FFE to adequately meet its required obligations under the ACA (see Figure 4. HHS Health Insurance Exchanges Transparency Table for the FFE[7]).

To provide a framework for comparison of Covered California and that of the FFE provides, Figure 5. FFE Spending Assuming All User Fee Revenue is Allocated to FFE Operations and Same Funding Proportions and Same Funding Level as Covered California – provides a frame of reference for what would be spent by the FFE if it were spending the same proportion of health care premium.

[7] U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services, Fiscal Year 2020 Justification of Estimates for Appropriations Committees. (Mar. 1, 2020). <https://www.cms.gov/files/document/fy2020-cms-congressional-justification-estimates-appropriations-committees.pdf>

Figure 4: HHS Health Insurance Exchanges Transparency Table for Costs in the FFE (Dollars in Thousands)[8]

Activity	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Enacted	FY 2020 President's Budget
Health Plan Bid Review, Management and Oversight	$ -	$300	$21,936	$40,595	$33,497	$43,960	$40,520	$39,846	$37,910	$40,914	$16,500
Payment and Financial Management	$ -	$1,698	$24,998	$25,832	$49,615	$43,733	$51,325	$47,640	$45,141	$51,463	$41,567
Eligibility and Enrollment 1/	$ -	$2,218	$3,433	$275,501	$339,754	$363,768	$445,249	$484,144	$392,660	$369,682	$310,053
Consumer Information and Outreach	$ -	$2,427	$32,610	$701,075	$704,136	$753,238	$805,833	$640,232	$591,948	$572,319	$306,550
Call Center (non-add)	$ -	$ -	$22,000	$505,446	$545,600	$566,178	$563,638	$540,197	$525,326	$496,525	$240,400
Navigators Grants & Enrollment Assisters (non-add)	$ -	$ -	$-	$107,513	$97,152	$75,996	$99,677	$51,166	$12,720	$10,000	$10,000
Consumer Education and Outreach (non-add)	$ -	$ -	$7,043	$77,436	$49,334	$54,897	$101,048	$16,599	$10,744	$10,000	$10,000
Information Technology	$2,346	$92,672	$166,455	$402,553	$770,957	$798,648	$664,083	$710,867	$767,413	$603,084	$520,819
Quality	$	$	$-	$	$17,189	$15,634	$11,736	$7,301	$7,240	$7,338	$5,000
SHOP and Employer Activities	$-	$366	$18,479	$25,076	$30,541	$42,717	$34,520	$16,500	$4,418	$2,500	$2,000
Other Exchange	$1,879	$14,906	$13,738	$4,400	$6,728	$3,614	$12,032	$49,584	$31,196	$52,948	$27,117
Federal Payroll and Other Administrative Activities	$429	$10,805	$43,493	$68,429	$80,000	$80,000	$85,000	$79,602	$70,892	$77,750	$50,000
Total	**$4,654**	**$125,392**	**$325,142**	**$ 1,543,461**	**$ 2,032,418**	**$ 2,145,312**	**$ 2,150,297**	**$ 2,075,714**	**$ 1,948,818**	**$ 1,777,999**	**$ 1,279,605**

8. Funding for Enrollment Assisters ended in FY 2017.
NOTE: Fiscal years 2010 through 2019 include obligations as of September 30 of each year.
NOTE: Before the Exchanges were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.
NOTE: The FY 2020 Enacted level is an estimate as of January 2020.

[8] U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services, Fiscal Year 2020 Justification of Estimates for Appropriations Committees. (Mar. 1, 2020). <https://www.cms.gov/files/document/fy2020-cms-congressional-justification-estimates-appropriations-committees.pdf>

Figure 5: FFE Spending Assuming All User Fee Revenue is Allocated to FFE Operations and Same Funding Proportions and Same Funding Level as Covered California

	Scenario 1. *Assumes All User Fee Funds are Allocated to FFE Operations, and Budget Spending Aligns Proportionally with Covered California by Expense Group*			Scenario 2. *Assumes FFE Budget Spending Aligns Proportionally with Covered California by Expense Group and was Constructed Using Covered California Funding Levels*		
Sources of Funds	**FFE Spending (in millions)**	**% of Total Appropriation**	**PMPM**	**FFE Spending (in millions)**	**% of Total Appropriation**	**PMPM**
User Fees	$1.479.7	100%	17.38	$1,847.9	100%	$21.70
Discretionary Fund						
Total Appropriation Request	**$1.479.7**	**100%**	**17.38**	**$1,847.9**	**100%**	**$21.70**
Use of Funds						
Health Plan Review, Bid Management, Oversight, and Quality	$47.4	3%	$0.56	$59.2	3%	$0.70
Payment and Financial Management	$38.8	3%	$0.46	$48.4	3%	$0.57
Eligibility and Enrollment	$464.8	31%	$5.46	$580.5	31%	$6.82
Consumer Information, Outreach, Call Center	$497.5	34%	$5.84	$621.3	34%	$7.30
Information Technology	$277.5	19%	$3.26	$346.6	19%	$4.07
Program Integrity	$30.2	2%	$0.35	$37.7	2%	$0.44
Planning and Performance	$14.0	1%	$0.16	$17.5	1%	$0.21
Administration and Staffing	$109.4	7%	$1.28	$136.6	7%	$1.60
Total Expenses	**$1,479.7**	**100%**	**$17.38**	**$1,847.9**	**100%**	**$21.70**

Covered California and independent researchers have documented the fact that it's spending on marketing and related policies – such as requiring its QHP issuers to offer standard patient-centered designs, it's active negotiating on behalf of consumers, fostering a competitive market environment where price-sensitive consumers hold QHP issuers accountable by their choices – contribute to the state having higher enrollment which results in a healthier risk mix in the on and off-Exchange individual market and premiums that are an estimated 20 percent lower than they would have been if California had the same risk mix as that seen in the FFE.[9]

While HHS seems to claim "success" in proposing to lower the user fee by .75 percent, it appears that this recommendation is based on HHS not understanding or not considering that additional spending to promote enrollment not only fosters the very purpose of the ACA – to expand meaningful coverage for Americans – additional spending to promote enrollment would actually have the direct effect of lowering health care premiums by far more than the .75 percent user fee savings. In its 2017 report, *Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets*,[10] Covered California estimated that its marketing and outreach efforts generated a return on investment of between of about three-to-one – meaning that every dollar spent on marketing resulted in a $3 reduction in health care premium.

The positive impact of reducing premiums is felt most directly by unsubsidized consumers who bear the full amount of health care premium increases. Subsidized consumers are largely shielded from the impact of premium increases since subsidies increase to offset premium increases. The result of this dynamic has been that in the FFE, subsidized enrollment has been relatively constant, but unsubsidized enrollment in the FFE has plummeted – as unsubsidized consumers have been priced out of coverage by recent federal decisions, such as prioritizing lowering the user fee rather than promoting enrollment.

Other than accounting for the transition of a small handful of states to a lower-cost model (e.g., from an FFE to an SBE), HHS provides virtually no information for the public to understand how the estimated user fee collection reduction of $270 million will impact the FFE's ability to adequately fulfill its required Exchange functions. HHS notes that the proposed reductions reflect enrollment, premium and contract estimates for the 2022 plan year.

Without this information, Covered California is greatly concerned that the proposal to reduce the user fee would kneecap the ability of the FFE to meet its obligations under the ACA, would result in fewer Americans receiving health care coverage and mean the Qualified Health Plan issuers would not be held accountable to consumer protection requirements.

[9] National vs. California Comparison: Detailed Data Help Explain The Risk Differences Which Drive Covered California's Success. (July 11, 2018). <https://www.healthaffairs.org/do/10.1377/hblog20180710.459445/full>

[10] 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

This proposed reduction in the user fee should not be finalized unless HHS can clearly demonstrate how the proposed fee is adequate for the FFE to meet its statutory requirements under the ACA. To that end, Covered California makes the following comments and seeks clarification from HHS on the following points:

A.1. **Navigator Program Inadequacy and Underfunding.** The proposed reduction in the user fee appears to be based on a plan to continue the policy to fund the ACA required Navigator program at greatly reduced levels (funding of the ACA required Navigator program has decreased from a previous level of $100 million in 2016 to a proposed level of $13.5 million for plan year 2021). If that is the case, this level of funding would mean that Navigator services would be inadequate overall and would be particularly inadequate in supporting outreach and promotion for communities of color, those living in rural areas, non-English speakers and other underserved communities. The insufficient funding level is exacerbated by the current administration's policy of directing Navigators to direct consumers to non-ACA compliant insurance products – which can result in both a worsening of the risk pool and in consumers enrolling in products that are lower cost because they do not include ACA protections regarding scope of coverage, and pre-existing condition protections.[11]

A.1.1. The proposed user fee reduction, which appears to be recommending a continued low funding of Navigator programs, is being considered without conducting or making public any analysis on the impact of reduced Navigator funding with regards to:

A.1.1.1. Lower enrollment into subsidized insurance;

A.1.1.2. Lower enrollment of targeted communities that evidence has shown may particularly benefit from Navigator programs, such as communities of color; those living in rural areas; non-English speakers; and members of the LGBTQ community; and

A.1.1.3. Consumers that do enroll being more likely to enroll in lower value plans (Note: Covered California has documented that consumers receiving assistance in enrolling – whether from a Navigator, Agent or Call Center – are more likely to choose a higher value health plan with Cost-Sharing Reduction Subsidies).

A.2. **Marketing and Outreach Inadequacy and Underfunding.** The proposed reduction in the user fee appears to also be based on a plan to continue the current policy to fund marketing, advertising and outreach programs at greatly reduced levels (it appears funding of Consumer Education and Outreach has decreased from a previous level of $101 million in 2016 to the proposed level of $13.5 million for FY 2021). The direct result of cutting marketing is lower enrollment – which is evident in the reduction of new enrollment by about 1.9 million Americans from 2016 to 2021. In the absence of HHS providing any data or evidence supporting the policy of gutting marketing and outreach spending,

[11] Cooperative Agreement to Support Navigators in Federally-facilitated Exchanges. July 10, 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-Navigator-FOA.PDF

the only conclusion that can be made is that the spending reduction is a conscious effort to subvert the ACA and decrease enrollment of eligible individuals in programs to which they are entitled. Likewise, without data to support HHS not adequately allocating funds for marketing, generating earned media or supporting agents and other outreach efforts, the only reasonable conclusion is that the reduction in spending is having the intended effect – lower enrollment and attendant higher premiums due to worse risk mix, with the costs of that higher premium being born by the federal government and unsubsidized consumers.

A.2.1. To the extent the Fiscal Year 2021 President's Budget for Consumer Education and Outreach is the basis for this user fee proposal, there is no supporting analysis or assessment of the impact on enrollment caused by reducing Marketing and Advertising expenditures to nearly zero.

A.2.2. Within the Consumer Education and Outreach budget, there is no description of the proposed or budgeted amount for other outreach activities, and what types of those activities would be possible under this user fee proposal. Absent such descriptions it is impossible to assess the adequacy of such efforts.

A.2.3. Within the Consumer Education and Outreach budget – or in other budgeted areas in the HHS budget – there is no description of efforts to generate earned media that will promote enrollment. Absent such descriptions it appears HHS is making no effort to generate media coverage that would promote enrollment – while there is substantial evidence that earned media reinforces paid advertising to promote enrollment.

A.2.4. HHS appears to be making the recommendation to eliminate Marketing and Advertising without conducting or making public any analysis regarding the impact of cutting Marketing and Advertising on:

A.2.4.1. Enrollment into subsidized insurance;

A.2.4.2. Assessment of the impact on marketing to promote enrollment;

A.2.4.3. Assessment of the return on investment of marketing expenditures based on the healthier risk mix of the marginal enrollment being healthier than those who would otherwise enroll;

A.2.4.4. Assessment of the impact on premiums of unsubsidized consumers.

A.2.5. HHS appears to be making the recommendation to virtually eliminate non-marketing Outreach activities with no analysis on the impact this will have on:

A.2.5.1. Enrollment into subsidized insurance;

A.2.5.2. Non-marketing outreach activities to promote enrollment;

A.2.5.3. Investment of non-marketing outreach expenditures based on the healthier risk mix of the marginal enrollment being healthier than those who would otherwise enroll;

A.2.5.4. Premiums of unsubsidized consumers.

A.2.6. HHS appears to be proposing a budget and user fee without conducting or making public any analysis on the impact of proposed spending on efforts to promoted earned media – such as generating media coverage -- activities with regards to:

A.2.6.1. Enrollment into subsidized insurance;

A.2.6.2. The impact on earned media activities to promote enrollment;

A.2.6.3. The return on investment of earned media activities based on the healthier risk mix of the marginal enrollment being healthier than those who would otherwise enroll;

A.2.6.4. Premiums for unsubsidized consumers.

A.3. **Health Plan Oversight Inadequacy and Underfunding.** The proposed reduction in the user fee appears to also be based on a plan to drastically reduce spending on "Health Plan Bid Review, Management and Oversight" and "Quality" (the Fiscal Year 2021 President's Budget for these two areas is $28 million, a decrease of $25 million from the FY 2020 Budget amount of $52.2 million). This means that the FFE is spending approximately $175,000 to select, review and oversee quality and accountability for each of the 159 QHP issuers.

Covered California has a budget for Fiscal Year 2020-21 for Plan Management/Research of $28 million to conduct QHP selection, management, oversight and ensure consumers are receiving quality care. Among its staff are clinical staff, including physicians, an actuary, staff dedicated to QHP issuer oversight and a team focused on health care disparities and health equity. This means that Covered California spends about $2.5 million per each QHP issuer carrier it contracts with to assure consumers receive quality care and QHP issuers are complying with federal requirements. This means that based on dividing program costs across its QHP issuers, Covered California is spending approximately 14 times as much as the FFE for QHP issuer oversight.

In the absence of any description of how HHS is meeting its obligations to select and oversee QHP issuers, it appears that the large reduction in spending can mean that HHS has little resources to provide oversight of its QHP issuers, which collectively provide services to almost 7.5 million Americans; HHS does not conduct independent claims analysis to assess quality; HHS does not provide actuarial information to QHP issuers to help them "price right" for the actual and anticipated risk mix to promote stability; HHS does not have requisite clinical staff

to oversee QHP issuers; and HHS is not addressing health disparities and health equity.

A.3.1. To the extent the Fiscal Year 2021 President's Budget for Health Plan Oversight and Quality is the basis for this user fee proposal, it appears that HHS conducted no analysis on the impact of reducing funding for QHP oversight and quality by almost half on consumers and on the ability to effectively oversee QHP issuers.

A.3.2. Having trained and qualified individuals to oversee the quality functions of QHP issuers requires clinical staff and the capacity to independently assess the reports and activities of QHP issuers. It appears that under the proposed budget and user fee, HHS has made little or no assessment of the staffing and contractual requirements needed to conduct effective oversight, including:

A.3.2.1 Having adequate dedicated staff with requisite skills to oversee QHP certification and quality.

A.3.2.2 Having adequate numbers of physicians and other clinical professionals applying their clinical expertise are on staff to support effective oversight of QHP issuer quality (e.g., physicians, pharmacists; behavioral health professionals). (Note: Covered California employs a Chief Medical Officer and other clinical staff, and contracts with multiple clinical experts.) It appears that HHS has no dedicated lead physician responsible for overseeing health care quality in the QHPs serving over 7.5 million Americans. To the extent HHS engages in contracted services to support oversight of QHP issuers, it appears to be inadequate.

A.3.2.3 Understanding and addressing health care disparities and health equity should be a core function of quality oversight. It appears that under this proposed budget and user fee there are no resources or staff dedicated to addressing health care disparities and establishing the expectation to which QHP issuers are held accountable. (Note: Covered California has a dedicated Health Equity Officer and a team that assesses gaps and oversees efforts of QHPs to address health care disparities and health equity.)

A.3.3. For virtually all large purchasers of health care services, a core element of assuring health care quality and understanding the care being provided to their consumers is to collect, maintain and analyze claims-based data on all services provided. Covered California follows this practice by compiling and analyzing the claims and care experience of all Covered California enrollees across all of its contracted QHP issuers, with the core contract for these services costing about $2.1 million annually.

A.3.3.1. The Fiscal Year 2021 President's Budget for Health Plan Oversight and Quality and the proposed user fee do not appear to include any funding to conduct claims-based analysis of services provided. The

absence of such analysis suggests that the FFE is not conducting independent analysis and assessment of how QHP issuers are delivering quality care to Americans.

A.3.4. In its role in promoting the lowest and most accurate proposed premiums as possible, Covered California provides detailed information to QHPs in advance of their rate submissions regarding the current and anticipated risk mix of the covered lives in the individual market. This information is supported by contracts with actuaries, researchers and academics and has resulted in QHPs in California not having the wild variation in prices seen in much of the nation and stability in their participation in the marketplace. This information can be provided independent of a marketplace "actively negotiating" with QHP issuers but would give all QHPs better information from which to their QHPs.

A.3.4.1. The User Fee does not appear to reflect HHS incurring actuarial research or the development of data that could enable QHP issuers developing pricing in the FFE to price as accurately as possible based on their understanding the risk mix of the covered population and potential changes in that risk mix.

A.4. **Call Center and Consumer Appeals Inadequacy and Underfunding**. The proposed reduction in the user fee appears to be based on a plan to reduce spending on "Call Center" services (the Fiscal Year 2021 President's Budget for this area is $292 million, a decrease of $66 million from the Fiscal Year 2020 Enacted Budget amount of $359 million; and a decrease of $192 million from the actual expenditures in Fiscal Year 2017 of $484 million). Covered California's budget for Fiscal Year 2020-21 for its Service Center is $135 million, to support enrollment and customer service for eleven QHP issuers. In serving its consumers, both for new enrollment and servicing existing consumers, Covered California budgets for about 800 permanent staff and with temporary contracted staff that range from 250 to 1,000 staff (meaning at "peak" open enrollment period, Covered California has budgeted about 1,800 staff supporting enrollment and renewal functions).

In the absence of any description of how HHS is meeting its obligations to operate a Call Center, it appears that the large reduction in spending can only be attributed to HHS either planning for low enrollment or for those who seek services from the Call Center receiving inadequate assistance – resulting in lower enrollment and higher premiums. In the absence of any analysis it is impossible to ascertain if the lower Call Center budget is the product of HHS neglecting its obligations to support consumers, including those filing appeals and seeking resolution of problems.

A.4.1. To the extent the Fiscal Year 2021 President's Budget for Call Center is the basis for this user fee proposal, the reduction in funding calls to question the capacity of the user fee to meet consumers service needs under the ACA-required Call Center.

A.4.2. The reduction of the user fee appears to be based on significantly lower staffing to support new enrollees and servicing existing enrollees, which would be inadequate to meet consumers' needs.

A.4.3. The reduction of the user fee appears to be reducing staff from the peak open enrollment period of 2016 and 2017, based on service demands seen recently that have been the result of calculated decisions to decrease consumer inquiries and enrollment. The user fee should be based on meeting consumer demands based on adequate promotion, not based on the recent history of no promotion.

A.4.3.1. HHS does not appear to have analyzed the extent to which the change is based on a decrease in incoming calls (in change in number of calls and in percentage change).

A.4.3.2. HHS does not appear to have analyzed the extent to which the change in user fee is based on the increase in the use of technology, such as Integrated Voice Response (IVR) systems (note: for 2010, Covered California projects that about 2.2 million consumers will be served through its Integrated Voice Response system, while 2.1 will receive personal assistance) and the efficacy of IVR type systems employed.

A.4.4. The proposed budget and user fee appear to be based on a dramatic reduction in Call Center capacity – with a reduction of Call Center funding by half of what it was in 2017 – with no analysis of the implications of that reduction of funding. HHS does not appear to have conducted the analysis required to make deliberate adjustments to Call Center capacity, including:

A.4.4.1. HHS projections for utilization of the Call Center in the coming year will be at levels of new enrollment as seen in the most recent year versus new enrollment as seen in 2016 (when FFE new enrollment during the open enrollment period was 1.9 million higher). If that is the case, HHS is establishing a user fee that would restrain the ability of the Call Center to meet "normal" higher demand for services.

A.4.4.2. Impact on service levels and consumer satisfaction on new enrollment.

A.4.4.3. Impact on service levels and consumer satisfaction on retention of enrolled individuals.

A.4.4.4. Cost benefit analysis of levels and types of call center staffing on either performance metrics (e.g., calls answered, service levels or abandonment rates) or outcomes (e.g., enrollment and retention).

A.4.5. It appears that under this budget proposal and user fee, the FFE may experience poor performance in serving consumers – with many consumers waiting to have calls answered and many giving up rather than

waiting to have their calls answered. The impact of poor Call Center service is lower enrollment and likely higher premiums as it is likely that healthier individuals are more likely to abandon a call to enroll than would an individual with an active health condition.

The proposed user fee and budget do not appear to reflect analysis of the following:

A.4.5.1. Changes in expectations of service levels for consumers (e.g., the percentage of consumers having calls answered within 30 seconds of calling).

A.4.5.2. Changes in expectations of abandonment rates for consumers (e.g., the percentage of consumers who “give up” waiting and drop their call without getting assistance).

A.4.5.3. The impact on enrollment and the risk mix of those enrolling due to lower service levels in the Call Center.

A.4.5.3. Impact on the ability to address the needs of consumers who speak languages other than English. In particular, there is no data for each of the elements below, for 2016 versus the proposed year for which the user fee is intended to support consumers, which is critical as budgeting should not assume service demands based on the low enrollment and service needs over the past four years. (Note: Covered California seeks to maximize the ability of non-English speakers to be directly served by a customer service representative who speaks their language both in its hiring and in contractual requirements on the vendor that provides temporary/surge support. Even with these efforts, in the current year it has an interpreter service budget of about $2.3 million.). The proposed budget and user fee do not appear to reflect analysis of the following:

A.4.5.3.1 The number and percentage of calls that are from non-English speaking consumers.

A.4.5.3.2 The service levels and abandonment rates for non-English speakers compared to English-speakers.

A.4.5.3.3 The number and percentage of non-English calls that are handled by Call Center staff without the need for Interpreter Services.

A.4.5.3.4 The number and percentage of non-English speaking calls that are handled with assistance of Interpreter Services, the budget for such services and the adequacy of the user fees to support these services.

A.4.5.3.5. The extent to which services for non-English speaking callers has declined since 2016 with the drop-off in marketing in Spanish and other languages.

A.4.5.3.6 The extent to which non-English speakers have different service levels and abandonment rates than English speakers.

A.4.6. The proposed budget and user fee does not appear to be adequate to support for resolving consumer complaints in an efficient, fair, and timely manner. (Note: Covered California seeks to resolve all consumer problems at the lowest possible level. Its budget includes $9 million for handling of appeals through an interagency agreement with the California Department of Social Services and having an internal Ombuds Program funded at $2.1 million to provide consumers with objective unbiased assistance when other channels have been exhausted, and to identify systemic issues that can be addressed.)

A.4.6.1. To what extent does the proposed user fee and budget reflect resources to provide Ombuds-like support to consumers in the FFE?

A.5. **Information Technology Inadequacy and Underfunding.** The proposed reduction in the user fee appears to be based on a plan to reduce spending on "Information Technology" (the Fiscal Year 2021 President's Budget for this area is $431 million, a decrease of $181 million from the Fiscal Year 2020 Enacted Budget amount of $612 million). In the absence of any description of how HHS is meeting its obligations to service consumers, hold health plans accountable, or have the capacity to analyze and improve service, it is impossible to assess the impacts of these dramatic reductions in Information Technology expenditures.

A.5.1. To the extent the Fiscal Year 2021 President's Budget for Information Technology is the basis for this user fee proposal, it does not appear HHS conducted any analysis as to the impact of reducing funding will have on Information Technology.

A.6. **Inadequate Funding Based on Assuming Continued Low Enrollment.** It is possible that some portion of a reduction in the user fee would be based on increases in enrollment. The just closed 2021 FFE enrollment shows: (1) a decrease in new enrollment of 5.4 percent compared to 2020 and a 58 percent decrease in new enrollment compared to 2016 (1.9 million fewer new enrollees); and (2) a net change of total enrollment of 6.6 percent compared to 2020.

A.6.1. It appears that HHS is projecting continued low enrollment – reflecting the enrollment over the past three years – which could have major implications both for the user fee generated and the levels of service that need to be provided. HHS should make public the enrollment assumptions that support the changes in the user fee.

A.7. **Inadequate Funding to Support Small Employer Efforts.** The proposed regulation is silent on the extent to which the FFE will support the Small Employer Health Option Program (SHOP), and the proposed reduction in the user fee appears to be based on a plan to maintain the action of basically zeroing out support for SHOP (Fiscal Year 2021 President's Budget for this area is $200,000,[12] following the same amount for Fiscal Year 2020, down from $34.5 million in Fiscal Year 2016). California's SHOP program – Covered California for Small Business – which has approximately 63,590 members enrolled as of November 16, 2020, through 7,756 employers – is supported by administrative service contracts of about $16.5 million and a marketing budget of $1.3 million.

A.7.1. To what extent does this user fee reflect the FFE based on a continued policy of not supporting enrollment in SHOP programs in FFE states?

A.8. **Inadequate Funding to Address Capacity to Respond to Economic Declines Increasing Need for ACA Safety Net Programs.** The proposed regulation is silent on the extent to which, if any, the reduced user fee will allow the FFE to respond to the needs of Americans during the COVID-19 pandemic and resulting economic crisis. Covered California dedicated an additional $40 million to outreach and promotion efforts for the current year based on the millions of Californians potentially losing job-based coverage needing to understand how to access affordable health care through Exchanges and Medicaid. The public health and economic effects of COVID-19 are expected to extend into at least 2022.

A.8.1. The proposed user fee does not appear to reflect the FFE planning to have the capacity to provide resources to make the availability of subsidized marketplace coverage or Medicaid coverage known to eligible Americans who may need services in event of a continued recession.

A.9. **Potentially Inaccurate Analysis of Premium Increases that Serve as Basis of User Fees.** The proposed reduction in the user fee may be based on assumptions that in 2021 there would be a significant increase in premiums. CMS recently reported declining average benchmark plan premiums over the last several years – which in 2020 appear to actually have been driven by health plans correcting over-pricing in 2019; and in 2021 health plans having far lower health care expenses due to reduced non-COVID services.

A.9.1. HHS should make public the premium assumptions that are reflected in the user fee proposal for 2022.

[12] President's Budget for Fiscal Year 2021, Department of Health and Human Services. https://www.whitehouse.gov/wp-content/uploads/2020/02/hhs_fy21.pdf.

B. New Marketplace Option

The current definition for "Exchange" is a governmental agency or non-profit entity that meets part 155 applicable standards and makes QHPs available to qualified individuals and/or employers.[13] HHS proposes a new interpretation of the definition in 45 CFR 155.20 to collectively refer to State-based Exchanges (SBEs), FFEs, State-based Exchanges on the Federal Platform (SBE-FPs), and newly proposed Direct Enrollment (DE) Exchanges. In making this proposal, HHS does not propose amending the definition "Exchange" to reflect this proposed interpretation into regulatory text. Instead, even with no apparent regulatory action that would support expanding the definition of what it means to be an Exchange, HHS proposes an option for states to elect the Exchange Direct Enrollment (EDE), thereby ceding to private sector entities the ability to operate the enrollment pathways through which consumers can apply for coverage, receive an eligibility determination for advanced payments of premium tax credits (APTC) and cost-sharing reductions (CSRs), and purchase a QHP that is offered through the Exchange. While the Exchange Direct Enrollment would still be nominally "established and operated" by a state or HHS, the state or HHS would turn over nearly all Exchange functions to the new private-sector entity and allow this private entity to operate in any of the public Exchanges.

> B.1. As proposed, a state adopting this provision could choose to eliminate HealthCare.gov as an enrollment option for consumers, many consumers would have no source of consistent standard information to inform their selection of health plans.
>
> B.2. This proposal is very similar to Georgia's recently approved 1332 waiver application. As proposed, this regulation, if adopted, it would mean that any state could implement similar policies in that state without seeking a waiver with no assessment by HHS as to whether the policies adopted by the state are consistent with the stated intent of the ACA.

Today, the FFE allows two types of entities to assist consumers with enrollment in QHPs, Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE). Direct Enrollment allows insurers and brokers (including web-brokers) to use their own websites to screen consumers for eligibility for ACA subsidies. If the consumer appears to be eligible for ACA subsidies, they are directed to the Exchange to complete their application and receive their eligibility determination. Once the consumer receives their eligibility determination, they return to the DE website to select and enroll in a QHP (or non-QHP as they are marketed and sold by brokers). These approved private sector entities have historically operated side-by-side with the HealthCare.gov application. Alternatively, EDE allows issuers and brokers to assist consumers with the entire application process, eliminating any direct contact between consumers and the Exchange. These issuers and brokers are explicitly certified to assist consumers in completing their application and enrollment, including ACA subsidy eligibility.

The proposed new option appears to take additional policy steps to privatize the ACA Exchange model, reducing consumer protections and allowing private brokers to

[13] 45 C.F.R. § 155.20 (2012).

promote non-ACA compliant products resulting in both increased costs to the individual common risk pool and potential harm and confusion to consumers. HHS is proposing at 45 CFR 155.220 to allow states to delegate all front-end Exchange functions to approved private entities operating in the DE and EDE pathway. Under this proposal, states that adopt this flexibility would support back-end functions for these non-Exchange websites operated by private sector entities. Eliminating the need for a centralized enrollment website, these states would instead make available a basic website providing minimal QHP information for comparison and a listing, with links, to approved partner websites for consumer shopping, plan selection, and enrollment activities.

This proposal appears to be directly at odds with the ACA, which created Health Insurance Exchanges (Exchanges) under 1311(b) as a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.[14] By doing so, the ACA created an opportunity for consumers to go to one place to search for health coverage options while obtaining easy to read and standardized information on QHP's available to them.[15]

As established by the ACA, Exchanges are required to do more than present QHPs and determine eligibility for consumers.[16] Section 1311 of the ACA details the intent and responsibilities of Exchanges which includes the whole spectrum of responsibilities for the education, shopping, and eligibility and enrollment process. Exchanges must perform a variety of functions including operating a telephone service center, certifying QHPs, providing a website where consumers can view standardized information regarding QHPs, development of an online calculator for consumers to better understand the costs of coverage, and establishment of a navigator program to provide fair and impartial assistance to consumers. In addition to mandating procedural functions for Exchanges, the ACA includes specific consumer protections.

B.3. This proposed regulation fails to ensure that an Exchange meets all of the functional requirements detailed in Section 1311 of the ACA. The proposed regulation contains no justification for how all the statutory responsibilities imposed on Exchanges would be met.

In some areas, the proposed regulations appear directly at odds with the ACA. For example, Section 1311(d) of the ACA requires, among other things, Exchanges *to only make QHPs available for purchase and to present these QHPs in a standardized format*.

B.4. Allowing private Exchanges to sell non-ACA compliant products is inconsistent with section 1311. Fostering enrollment in non-ACA compliant products would have the impact of encouraging consumers to enroll in products that may be lower cost specifically because they continue to apply exclusion

[14] U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, Initial Guidance to States on Exchanges (Nov. 8, 2010) <https://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges>
[15] https://www.cdc.gov/aca/marketplace/index.html
[16] Sec. 1311. Pub. L. (March 23, 2010) 111-148 Stat. 119

policies for those with pre-existing conditions, do not offer the Essential Health Benefits, or annual and lifetime limit protections of the ACA.

In its proposal, HHS directly contradicts Section 1311(d)(4)(F) which requires Exchanges to provide streamlined access to health coverage and to promote continuity of care. By allowing states to cease utilization of ACA Exchanges that provide one simple location to shop for, apply for, and enroll in QHPs with premium tax credits and cost-sharing reductions, HHS is unnecessarily creating roadblocks for consumers to access health coverage or easily transition between health coverage. By forcing consumers to purchase health coverage through third-party entities that offer non-ACA compliant coverage, HHS is creating confusion for consumers which will result in consumers not enrolling in coverage, consumers enrolling in non-ACA compliant coverage, and consumers not being made aware of their eligibility for zero-premium Medicaid coverage.

B.5. In direct contradiction of the requirements of the ACA of assuring consumers who are eligible for streamlined access to Medicaid programs in their state, what safeguards or requirements will HHS employ to ensure that third-party entities do not steer potential Medicaid eligible consumers away from zero-premium Medicaid coverage and toward non-ACA compliant coverage?

At 45 CFR 156.50(c)(3), HHS proposes to entice states to make this sudden shift to the Exchange Direct Enrollment pathway by charging a user fee (1.5 percent) that guarantees little or no Exchange support beyond IT services.[17] This proposal allows private entities to be the sole source for consumers to educate themselves on health coverage, while also being able to steer consumers away from QHPs or zero-premium Medicaid where eligible, and into lower-cost, less comprehensive plans.

B.6. The proposed regulation provides no analysis of the potential impact on total premiums – including the potential impact of premiums being reduced more by effective implementation of the core Exchange functions than by lowering the user fee – and the impact on consumers of providing fewer services or less effective services. In particular, it appears that no analysis was done regarding the impact on total premiums of:
(1) Migration of healthier consumers to non-ACA compliant plans resulting in a deterioration of the risk pool for the common ACA individual market;
(2) The extent to which consumers that would have been eligible for Medicaid in a state adopting the Direct Enrollment Exchange would be less likely to find and enroll in Medicaid coverage for which they are eligible?

Covered California believes in the value and support found in utilizing agents, but we are concerned that this proposed Exchange Direct Enrollment pathway is based on the belief that enrollment through the EDE pathway would be optimized because it would rely on the agents operating those sites to market and promote enrollment. Since 2016, the last year in which enrollment marketing promotion was not impacted by the current administration's efforts to reduce almost to zero marketing, there has been a 45 percent

[17] Jeff Wu, Deputy Director for Policy, Centers for Medicare and Medicaid Services, SBE CEO Call. December 14, 2020

decline in new unsubsidized enrollment[18] (a drop of about 1.9 million). During this same period, CMS has embarked on an increased reliance on EDE enrollment.

B.7. HHS does not appear to have analyzed the impact on marketing done by brokers compared to marketing done by HHS in 2016 and the impact of the reduction in federal spending on marketing since 2017. This analysis is critical to understand the implications of expended EDE options and their relation to FFE direct marketing expenditures.

Covered California is concerned about the negative consumer impacts from states or the federal government abdicating the public role of protecting consumers from loosely-governed third party entities who may be ill-equipped, ill-prepared, or misaligned in providing accurate and timely guidance and support. Currently, Exchanges are the only place consumers can go to receive complete, standardized information about plans and products that meet minimum essential coverage requirements (QHPs).

B.8. HHS does not appear to have evaluated the potential effects on consumers of eliminating ACA Exchanges and the implications of those effects on the required elements of the ACA. In particular, it does not appear that HHS assessed the potential impact in:

(1) lowering enrollment into subsidized insurance;

(2) increasing enrollment in non-ACA compliant plans that may have gaps in coverage;

(3) consumers seeking non-ACA compliant plans but being deemed ineligible due to pre-existing conditions?

Additionally, Section 1311 of the ACA states that Exchanges are required to maintain an internet website where enrollees of QHPs could find standardized comparative information on QHPs.

B.9. To the extent the only Exchange options in a state are private agents, HHS has not demonstrated how the ACA requirement for standardized comparative information would be met.

In addition to the comments detailed above, Covered California asks HHS to address the comments below that are associated with specific proposals to create an Exchange Direct Enrollment Pathway:

B.10. Section 1311 and subsequent regulations (45 CFR 155.20) clearly defines "Exchanges." As proposed, HHS is reinterpreting the definition of an "Exchange" to include the new Direct Enrollment Exchanges. How is this not in direct conflict with the statutory requirements of Section 1311 of the ACA? HHS cannot change

[18] Unsubsidized Enrollment on the Individual Market Dropped 45 Percent from 2016 to 2019. CMS.gov (Oct. 9, 2020)

the definition of an Exchange without amending current regulations (45 CFR 155.20).

B.11. The proposal to end reliance on ACA Exchanges for enrollment appears to be in direct contradiction with the requirement in Section 1311(i) to establish and operate a navigator program that works to enroll consumers through the Exchange.

B.12. HHS does not appear to have conducted any analysis to determine the impact and implications of removing the possibility for consumers to shop for and enroll in coverage through an Exchange that would seek to increase consumer protections and positively impact the consumer shopping experience versus a private EDE seeking to maximize its commissions.

B.13. HHS does not appear to have conducted any analysis on the implications for enrollment or consumer experience from removing the enrollment pathway, HealthCare.gov, which 66 percent of enrollees used in 2019, and the impact of a change on consumer experience and maintain or improve consumer protections.

B.14. Requiring consumers to shop and enroll via third-party websites appears to be in direct conflict with Section 1311(e)(1)(B), which requires Exchanges to avoid adverse selection on behalf of consumers when third-party entities are allowed to market and offer non-ACA compliant coverage. HHS has not appeared to conduct any analysis in the implications of adverse selection in the common risk pool individual market.

B.15. HHS has not provided an explanation for how the proposed Exchange Direct Enrollment Pathway would fulfill the spirit of the requirement that Exchanges must make available QHPs in the interests of qualified individuals.

B.16. The “skinny” Exchanges do not appear to meet the requirements in Section 1311(d)(7) for Exchanges to ensure public accountability in areas such as objective information on the performance of plans; availability of automated comparison functions to inform consumer choice; fair and impartial treatment of consumers, plans and other partners; and prohibitions on conflict of interest.

B.17. As proposed, consumers may be forced to enroll through third-party websites that will not have a standardized display of information and may show non-ACA compliant plans, potentially leading to choice error. HHS does not reconcile this proposal with Section 1311(d)(4)(F) which requires Exchanges to streamline access for consumers while promoting seamless access for applicants for other health programs beyond coverage through Exchanges.

B.18. HHS does not appear to have conducted any analysis or research to anticipate how the risk pool would be affected, given that choice error will likely occur, and some health consumers would select cheaper non-ACA compliant coverage.

B.19. HHS has not fully described what requirements would be placed on Exchange Direct Enrollment entities to ensure that they are providing consumers

with access to ACA-compliant plans and Medicaid plans should they be eligible, before presenting non-ACA compliant plans to them.

B.20. HHS does not adequately describe what requirements would be placed on Exchange Direct Enrollment entities to avoid directing consumers toward non-ACA-compliant plans or away from zero-premium Medicaid (e.g. misleading website text listing “Health Insurance” or “Obamacare Insurance”).

Reduced Consumer Protections Requirements for Web-Brokers

For states that choose not to eliminate reliance on their ACA Exchange, HHS makes several proposals to eliminate consumer protections in these states. Current regulations require EDE entities, such as QHP issuers and web-brokers, to translate website content into any non-English language that is spoken by a limited English proficient (LEP) population that makes up 10 percent or more of the total population of the relevant state. Web-brokers are currently required to translate website content within one year of registering with the Exchange, while QHP issuers are currently required to translate website content beginning no later than the first day of the individual market open enrollment period.

Citing the need to incentivize these entities to enter and test the ACA market, HHS proposes at 45 CFR 155.205(c)(2)(iv)(B) and (C) to give QHP issuers and web-brokers 12 months from the date the QHP issuer or web-broker begins operating its FFE-approved EDE website in the relevant state to comply with website content translation requirements as a condition of participation in the FFE-EDE program.

HHS also proposes at 45 CFR 155.220 to allow assisters in the FFE and in SBE-FP states to use web-broker non-Exchange websites for classic DE and EDE under certain conditions. If a web-broker non-Exchange website does not facilitate enrollment in all available QHPs in the state, it would be required to identify for consumers the QHPs, if any, for which the web-broker website does not facilitate enrollment by prominently displaying a standardized disclaimer provided by the Exchange. This disclaimer would state that the consumer can enroll in such QHPs through the Exchange-operated website and would display a link to the Exchange website. HHS would issue guidance on the form and manner in which the disclaimer should be displayed. HHS is creating another unnecessary roadblock for consumers getting coverage when they need it. Under this option, if a web-broker does not facilitate enrollment in all available QHPs, a consumer would need to navigate multiple websites in order to fully compare all available QHPs.

Current regulations do not allow non-Exchange QHPs to be displayed on the same website pages as comparable non-QHP individual coverage. However, DE entities are allowed to display both Exchange and non-Exchange QHPs on the same website pages, as long as the DE entity's website makes clear that APTC and CSRs are only available for Exchange QHPs. HHS now proposes at 45 CFR 155.221(b)(1) that DE entities be required to display and market health plans in three different categories – that would now expressly allow for promotion of non-ACA compliant products:

1. QHPs offered through the Exchange. These products must be isolated from the other categories of products to distinguish for consumers the products for which APTC and CSRs are available.
2. Individual health insurance coverage offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits). These products are subject to ACA market-wide requirements as QHPs, but not available with APTC and CSRs.
3. All other products, such as excepted benefits. These products are not subject to ACA market-wide rules, nor are APTC and CSRs available with such products,

and therefore they are substantially different from the plans that fall into the first two categories. While this is being proposed to limit consumer confusion, HHS does not propose further requirements on the order or manner in which consumers are presented these three different pages. Covered California is concerned DE entities promote non-ACA compliant plans to the detriment of QHPs – leading to consumers making poor choices and higher costs for consumers purchasing ACA compliant products due to risk selection impacts.

HHS should address the issues below that are associated with the specific proposal to allow assisters to utilize web-brokers' non-Exchange websites and changing display requirements for DE and EDE entities:

B.21. HHS does not reconcile their proposal to give EDE entities 12 months to

comply with website translation requirements to become an EDE with the core of the ACA. In particular, allowing EDE entities to limit the services provided to limited English proficiency consumers in the name of "testing the market" does not meet the clear legal requirements or support intent of the ACA to foster broad enrollment of all eligible individuals.

B.22. The proposed regulation to allow Navigators to utilize non-Exchange web-broker websites does not comply with Section 1311(i), which requires Exchanges to establish a Navigator program to conduct public education activities to raise awareness of QHP availability and facilitate enrollment in QHPs.

B.23. HHS does not reconcile allowing Navigators to utilize non-Exchange web-broker websites with Section 1311(i)(3)(B), which requires Navigators to distribute fair and impartial information concerning enrollment in QHPs --- when those broker entities can and will promote non-ACA compliant products. HHS does not appear to have conducted any analysis or research to test how the visibility of cheaper, non-ACA compliant plans would affect enrollment in QHPs.

C. 1332 Guidance into Regulation

Section 1332 of the ACA permits states to apply for State Innovation Waivers (1332 waivers) to pursue innovative strategies for providing residents with access to quality, affordable health insurance while retaining the basic protections of the ACA. Although many of the law's market reforms and consumer protections cannot be waived, section 1332 of the ACA permits states to seek waivers of requirements related to (1) QHPs, including Essential Health Benefits (EHBs), metal tier coverage, and cost-sharing limits; (2) the premium tax credit, and (3) cost-sharing reductions, and the individual and employer mandates. Section 1332(b)(1) lists the criteria under which a 1332 waiver may be granted. In addition to complying with procedural requirements, a 1332 waiver proposal must also meet the substantive criteria (or guardrails) and show that the waiver proposal will:

1. Provide coverage at least as comprehensive as the current EHBs offered through Exchanges,

2. Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as it would be absent the waiver,
3. Provide coverage to at least a comparable number of residents of the state as it would absent the waiver, and
4. Not increase the federal deficit.

In 2015, HHS and the Department of the Treasury (the Departments) released guidance that took a strict interpretation of the statutory guardrails, reaffirming important consumer protections in the ACA.[19] The Departments defined "coverage" as minimum essential coverage (MEC) which would not allow states to consider non-ACA compliant coverages like short-term, limited-duration insurance in their coverage estimates toward satisfying the coverage guardrail. Additionally, a 1332 waiver application would only be approved if just as many, if not more, consumers were projected to be enrolled in coverage that is at least as comprehensive as the state's EHB benchmark plan. The 2015 guidance also placed strict measures on the affordability guardrail, ensuring that consumers would not face increased spending on premiums, cost-sharing, or out-of-pocket costs relative to their income. Finally, this guidance required that waivers could not reduce the number of people with coverage meeting the 60% actuarial value. Despite this strict adherence to the statutory text, eight states were granted 1332 waivers.

In 2018, the Departments released new guidance that attempted to undercut consumer protections put in place by the ACA and prior guidance.[20] First, the Departments encouraged 1332 waiver proposals that advance one or more of the five principles outlined in the new guidance:

1. Provide increased access to affordable market coverage (e.g. short-term, limited-duration insurance, Association Health Plans) over public programs and increase issuer participation and promote competition;
2. Encourage sustainable spending growth by promoting more cost-effective coverage, restraining federal spending, and eliminating state regulations that limit market choice and competition (e.g. waivers should not drive new enrollment in ACA-compliant coverage and should instead direct consumers to non-ACA compliant coverage);
3. Foster state innovation;
4. Support and empower those in need, especially those who are low-income or have high health care costs and may need financial assistance; and
5. Promote consumer-driven healthcare.

This new guidance also introduced new, less restrictive interpretations of the requirements to meet the statutory guardrails listed in section 1332 of the ACA. Specifically, the Departments now interpret the coverage, affordability, and comprehensiveness guardrails to mean:

1. States no longer need to ensure that a 1332 waiver provides coverage that qualifies as MEC as the Departments now consider any health insurance

[19] See Waivers for State Innovation (44 Fed. Reg. 78131 et seq. (Dec. 16, 2015) <https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf>

[20] See State Relief and Empowerment Waivers (83 Fed. Reg. 53575 et seq. (Oct. 24, 2018) <https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf>

coverage[21] as acceptable forms of coverage when assessing the coverage guardrail, including group health insurance individual health insurance short-term, limited-duration insurance, and Association Health Plans.

2. 1332 waivers do not need to demonstrate that as many consumers will be enrolled in comprehensive and affordable coverage. States may now simply demonstrate that comprehensive and affordable coverage is available for consumers to choose from, while also offering and promoting less comprehensive and affordable plans without failing to meet the coverage and affordability guardrails.
3. The Departments specified that the comprehensiveness and affordability findings would focus on the aggregate effects of the 1332 waiver. Under the 2015 guidance, the Departments explicitly accounted for effects across different groups of state residents, namely vulnerable residents including the elderly, low income, and those with serious health issues. Under the new guidance, a state could meet the comprehensiveness and affordability guardrails by meeting the statutory guardrails as a whole, even if particular groups within a state would lose comprehensive or affordable coverage.
4. When evaluating the comprehensiveness of coverage available under the 1332 waiver proposal, the Departments will continue to look to the EHB requirements. However, the Departments will now allow a state to compare access to coverage under the 1332 waiver to the state-selected EHB benchmark plan, any other state's EHB benchmark plan, or any other plan selected by the state that could become its EHB benchmark plan.

The new 2018 waiver guidance went into immediate effect. The Departments gave the public 60 days to comment but never publicly responded to any comments received as would be required under the normal rulemaking process. Additionally, the new 1332 waiver guidance changed the Departments' position without giving a reasoned explanation for the change. An agency reversing a prior policy "must show that there are good reasons for the new policy" and provide "a reasoned explanation . . . for disregarding facts and circumstances that underlay or were engendered by the prior policy."[22]

HHS should address the issues below that are associated with specific proposals at 31 CFR 33.108, 33.120, 33.128, and 45 CFR 155.1308, 155.1320, 155.1328 to codify the 1332 waiver guidance from 2018:

> C.1. Given that this proposed regulation specifically calls for allowing an Exchange to promote coverage in plans that may have very high deductibles, not cover many services required under the ACA, have annual or lifetime limits, and a range of coverage exclusions, this proposal is not consistent with section 1332(b)(1)(B) of the ACA which requires the state waiver to "provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable."

[21] 45 C.F.R. § 144.103
[22] *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009).

C.2. The proposed regulation is inconstant with the intent of the ACA to promote actual coverage by having a policy under which section 1332(b)(3) would only be met if state's residents actually will have coverage under the waiver as they would absent the waiver yet 1332(b)(1)(A) and (b)(1)(B) would be met if affordable and comprehensive coverage is simply available to state residents, whether or not they are actually covered.

C.3. Including non-ACA compliant coverage in the comprehensive coverage guardrail does not align with the requirement under section 1332(b)(1)(A) that a state must show that it will provide coverage "at least as comprehensive as the coverage defined in [the EHB provisions] as offered through Exchanges."

C.4. Expanding the definition of "coverage" to include short-term, limited-duration insurance does not comply with the section 1332 statutory guardrails when short-term, limited-duration coverage are exempt from the ACA's consumer protections, does not qualify as MEC, and is not included in the statutory definition of "individual health insurance coverage" under 42 U.S.C. § 300gg-91(b)(5).

C.5. The 2018 interpretation of the 1332 waiver guardrails does not fulfill the overall goals of the ACA to provide quality, affordable health care for all Americans.

C.6. It does not appear that HHS conducted any analysis on how this specific proposal, if adopted, could have the following potential results:

a. More consumers enrolling in lower premium non-ACA compliant plans;
b. Consumers seeking enrollment in non-ACA compliant plans being denied coverage due to having pre-existing conditions;
c. The extent to which consumers enrolling in non-ACA compliant plans would experience financial responsibility for care that cost more than ACA limits on annual or lifetime costs;
d. The extent to which consumers enrolling in non-ACA compliant plans would need services that are Essential Health Benefit not covered by the non-ACA compliant plans;
e. The health impacts on consumers enrolling in non-ACA compliant plans;
f. The impact on the ACA common risk pool based on enrollment in non-ACA compliant plans and the attendant impact on premiums;
g. The extent to which premium changes in the ACA common risk pools are born by unsubsidized consumers, the federal government, and/or subsidized consumers.

D. Special Enrollment Changes

Metal Level Change: Newly Ineligible for APTC

HHS is proposing to add new language in 45 CFR 155.420(a)(4)(ii)(C) to allow current Exchange enrollees and their dependents to enroll in a QHP of a lower metal level if they qualify for a special enrollment period (SEP) upon becoming newly ineligible for Advanced Premium Tax Credits (APTC). Covered California supports HHS' proposal to provide additional flexibility for current Exchange enrollees and their dependents and has already incorporated and exceeded this level of flexibility in state regulations.[23] Covered California currently provides an SEP for enrollees without restriction to movement in metal level. The following comments are provided to request further review of the alternatives reviewed and elicit clarification on the regulation as proposed.

Existing federal regulations[24] prevent certain individuals that are eligible for an SEP from changing to a different level of coverage unless their level is no longer offered, in which case they can move up or down one metal level. This restriction can leave some consumers with no choice but to terminate their coverage because they cannot afford that premium payment. This proposed regulation will give consumers an opportunity to change metal level with the loss of eligibility to financial assistance, but it does not account for those who experience other qualifying life events.

D.1. Covered California encourages that HHS consider "additional flexibility to allow enrollees and their dependents who become newly eligible for APTC in accordance with paragraph (d)(6)(i) or (ii) to change to a QHP of a higher metal level" and remove the metal level change restrictions altogether.

Plan Selection Change for Enrollees Who Did Not Receive Timely Notice of Triggering Event

HHS proposes to add 45 CFR § 155.420(b)(5) and § 155.420(c)(5) to allow individuals who did not receive timely notice of a triggering event (and were otherwise unaware that a triggering event occurred) to select a new plan within 60 days from the date they became aware or reasonably should have known about the triggering event. Additionally, changes to the effective date regulations would allow these consumers to choose the earliest effective date that would have been available had they received timely notice of the triggering event or select a prospective effective date. Covered California is generally in support of the proposed regulation as written, aside from clarifications requested.

Currently, and in most cases, when an individual enrolls in a QHP, their enrollment start date is prospective. This reduces administrative burden for both the Exchanges and QHP Issuers and prevents potentially costly consumer liabilities. Under federal regulations, when a consumer enrolls retroactively, they must pay all past due premiums to become current on their enrollment. If they are unable to do so, the consumer is prospectively enrolled in coverage. This could lead to the gap in coverage this proposed regulation is trying to eliminate.

[23] Cal. Code Regs., tit. 10 §6504 (a)(7)
[24] 45 CFR 155.420(a)(4)(iii)(A)

D.2. Covered California asks that HHS clarify if additional options will be available to consumers who will experience a large gap in coverage if they are unable to pay all premiums at once.

Covered California agrees that several scenarios could occur where consumers miss the opportunity to take advantage of their SEP. Reducing gaps in coverage and allowing consumers flexibility when situations arise through no fault of their own makes sense. However, this change could result in an administrative burden for Covered California and possible consumer confusion.

D.3. Covered California requests that HHS further define "reasonably should have known". We believe leaving this decision to those providing enrollment assistance would be burdensome on Exchange operations and would require escalations processes to individually guide consumers to the date that they "reasonably should have known".

D.4. Covered California also seeks clarification on the limitation of how far back a consumer can request enrollment. We propose that HHS make it clear in their final regulations that this SEP is not available across benefit years as it would be administratively burdensome to implement.

Clarify Trigger for COBRA Coverage

Covered California strongly supports clarifying that either complete cessation or reduction of employer contributions toward the cost of COBRA coverage would trigger an SEP for Exchange coverage. As is the case with federal regulations, Covered California regulations [25] note "exhaustion of COBRA continuation coverage" as a qualifying life event, with no detail regarding employer contribution. We welcome the opportunity to clarify that either a complete cessation or reduction of the employer contribution would allow an SEP.

D.5. Regarding a potential threshold for employer contribution reduction, we recommend not specifying a threshold.

Because of the administrative burden on the Exchange to track and update a threshold year-to-year, the confusion it would cause consumers to accurately identify and calculate a qualifying reduction, the potential of employer gaming to reduce contribution just above the qualifying threshold, and the wide range of plan costs and employer contribution levels, we believe it is more efficient to not specify a reduction threshold and instead accept any reduction as a trigger for special enrollment.

As with the federal Exchange, an SEP due to exhaustion of COBRA coverage has already been available to individuals enrolling in a QHP on Covered California. Our regulations do not speak to employer contribution level as a factor to qualify for special enrollment. Nonetheless, loss of COBRA coverage is a very infrequently used qualifying life event, representing only 39 enrollments in the 2019 coverage year at Covered

[25] Cal. Code Regs., tit. 10 § 6504(b)

California. Given this low number, we do not anticipate that these amendments would have a negative impact on the risk pool, nor would they increase costs for enrollment partners. In the interests of consumer fairness and aligning risk, we support the proposed implementation of these amendments in both the Exchange and off-Exchange markets.

75% verification for SEP enrollments

Under the proposed regulation, HHS generally expands to SBE the SEP pre-enrollment verification requirements for the FFE and SBE-FPs issued under the 2017 Market Stabilization final regulation.[26] This expansion under the proposed 45 CFR 155.420 added paragraph (f), would require SBEs, unless granted a modification from HHS, to conduct SEP verification for at least 75 percent of new enrollments through SEPs granted to consumers not already enrolled through the applicable Exchange.[27] If an SBE were unable to verify eligibility for an individual newly enrolling in Exchange coverage through an SEP for which it requires verification, either electronically using available data sources or through submitted supporting documentation, then the individual would be ineligible for coverage. This requirement would be effective beginning with plan year 2024.

Covered California believes that HHS has failed to provide clear and compelling reasoning, supported by evidence, to justify imposing this administrative burden on SBEs. The preamble to the proposed regulation states that "… all State Exchanges now conduct either pre-or post-enrollment verification of at least one special enrollment type, and most State Exchanges have implemented a process to verify the vast majority of special enrollment periods requested by consumers." It also notes that HHS "anticipates" a positive outcome on program integrity but concedes that since most SBEs already conduct SEP verification, any positive premium impact would be minimal.[28] We believe these statements expose the proposed regulation as an arbitrary exercise of regulatory authority that will only add cost to current operational practices in SBEs without producing an offsetting positive policy outcome in the form of reduced premiums for consumers or reduced premium tax credit expenditures born by taxpayers.

Further, we have serious concerns that successful SEP verification strategies implemented by SBEs could be jeopardized by imposition of this proposed regulation. While HHS states that they will provide a process for modifications by SBEs, it seems unlikely that SBEs would be able to continue their current practices without changes. To the extent federally required changes deter young and healthy individuals from enrolling in coverage, premiums could become more expensive. Brookings Institution researchers have noted that "both economic theory and empirical evidence imply that the sickest individuals will be the most motivated to bear the burdens required to enroll, while healthier individuals will be most likely to be deterred."[29] Covered California believes that states are best positioned to design implementation strategies that

[26] 82 Fed. Reg. 18346 (Apr. 18, 2017) <https://www.govinfo.gov/content/pkg/FR-2017-04-18/pdf/2017-07712.pdf>
[27] 85 Fed. Reg. 78572 (Dec. 4, 2020) p. 78663. <https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>
[28] 85 Fed. Reg. 78572 (Dec. 4, 2020) p. 78663. <https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>
[29] The Brookings Institution: Trump administration's proposed change to ACA special enrollment periods could backfire. M. Fiedler, (February 17, 2017).

successfully balance program integrity and consumer experience to ensure maximum uptake by all eligible individuals.

California has one of the healthiest risk mixes in the nation: the health status of those enrolled in California being about 21 percent healthier than the rest of the nation in 2019.[30] Covered California has estimated that our healthier risk mix has resulted in savings of approximately $2.5 billion per year for enrollees and the U.S. Treasury, totaling $12.5 billion from 2014 to 2018.[31] This healthier risk mix has also helped keep premiums down for consumers, with premium rates increasing by less than one percent for plan years 2020 and 2021. Covered California has achieved these results under the existing regulatory regime which allows for state flexibility in designing SEP verification approaches.

The preamble states that the proposals in the regulation "would provide states with additional flexibilities, reduce unnecessary regulatory burdens on stakeholders, empower consumers, ensure program integrity, and improve affordability."[32]

As we struggle to understand how *imposing a regulation* would reduce regulatory burden and how *minimal premium impact* would improve affordability, we request the following information and clarification about the proposed regulation:

D.6. Data showing how the SEP verification policy impacted the risk mix and premiums in FFE states;

D.7. The policy rationale for setting a required percentage and data showing how the 75 percent threshold was determined as the appropriate amount;

D.8. Data demonstrating an SEP program integrity issue within SBEs;

D.9. Analysis conducted or used to demonstrate that vulnerable populations would not be disproportionally impacted by this proposed regulation; and

D.10. Covered California asks for further clarification about the process and timeline to be granted a modification to the requirement and under what circumstances a modification will be issued.

Finally, we believe it is disingenuous for HHS to claim that the proposed SEP verification requirement supports enrollment in full-year coverage[33] given the lack of evidence and analysis supporting this new regulation. HHS has many other mechanisms to support year-round coverage, such as marketing and promoting coverage options for millions of Americans during the COVID crisis and limiting short-term junk plans and other non-ACA compliant plans.

[30] U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, Premium Stabilization Programs <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs>
[31] Covered California's First Five Years: Improving Access, Affordability, and Accountability. (Dec. 2019). <https://hbex.coveredca.com/data-research/library/Chart_Pack-First_Five_Years_Dec2019.pdf>
[32] 85 Fed. Reg. 78572 (Dec. 4, 2020) p. 78573. <https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>
[33] 85 Fed. Reg. 78572 (Dec. 4, 2020) p. 78628. <https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>

E. Qualified Health Plan (QHP) Issuer Audits

HHS is proposing modifications to current audit activities at 45 CFR 156.480 including non-compliance issues with QHP issuers and compliance reviews. Covered California supports HHS' efforts to conduct audits and compliance activities to ensure that the FFE, SBE, and QHP issuers comply with federal mandates regarding APTC and CSR payments received on behalf of millions of consumers. We appreciate that the proposed language provides more clarity regarding the details of the audit process and expectations from auditees.

Audit Activities

In the preamble, HHS solicits feedback regarding how they can engage and coordinate with SBEs and federal authorities to address non-compliance issues with QHP issuers. This will be accomplished by HHS conducting routine audits and additional compliance reviews.

Most aspects of the preamble and the proposed regulations primarily focuses on the QHP issuers as the auditee. While HHS provides more details about the HHS audit process, the proposed regulations do not make direct reference regarding any HHS' coordination efforts with SBEs. Covered California recommends that HHS re-consider the SBEs role (with respect to the QHP issuer) and revise the issuer requirements and the audit process accordingly. This is necessary since SBEs contract with QHP issuers and manage and monitor the issuers' performance and compliance.
In addition, it appears that HHS intends to apply the same auditing process to all Exchanges (regardless of Exchange type). The auditing process should not be a "one size fits all," since states have implemented different processes related to federal reporting of APTC and CSR data to HHS. Some states rely on their QHP issuers to submit the federal reports to HHS to obtain federal payments for subsidies. However, for other states, the SBEs themselves prepare and submit the federal report directly to HHS.

Specifically, in California, our records are determined as the single source of truth for all eligibility determinations (e.g. APTC and CSR)). Federal payment of the APTC and CSR are based on Covered California's submission of the federal report (and not the QHP issuers' submission). Therefore, it is important that the audit process differentiates the uniqueness of each state and does not apply a uniform approach for all Exchange types. The preamble and/or proposed federal language should distinguish this difference.

The preamble and proposed regulations specify that HHS may recoup any federal subsidy payments identified as not adequately substantiated by the QHP issuers. The HHS recoupment process also applies when the issuer fails to respond or cooperate with the audit process. HHS may recoup up to 100 percent of federal subsidies made to an issuer for the benefit year(s) that are subject to the audit if the debt is not paid by the issuers. Covered California submits the following questions and comments for response:

E.1. Rather than relying on the issuers to remit payment directly to HHS due to any audit findings, HHS should leverage its existing process. For example, HHS makes monthly federal subsidy payments to QHP issuers who participate in the Exchanges from the Policy Based Payment reporting process. Covered California recommends that HHS applies any debt owed by an issuer to the monthly payment process by making the appropriate adjustments. This would allow for HHS expedient recovery of debts owed by the QHP issuers. As a result, HHS would not be required to recoup up to 100 percent of federal subsidies for the benefit year(s) being audited.

E. 2. Covered California recommends that HHS consider another approach rather than defaulting to a full 100 percent in the event HHS is unable to recoup payment. The 100 percent appears to be excessive and unreasonable, particularly in situations where the debt owed by the QHP issuers are substantially lower. Covered California recommends that this recoupment be lowered to the actual calculated non-compliance amount, rather than the 100 percent.

E. 3. The proposed regulations specify that HHS will provide at least 15 calendar days advance notice of their intent to conduct an audit, letters, and inquires, including requests for supplemental or supporting information. Audit activities require a lot of resource planning and coordination for Exchanges and QHP issuers. Therefore, Covered California recommends that at least 30 calendar days advance notice be considered.

E. 4. The proposed regulations specify the requirement “to submit complete and accurate data to HHS or its designees that is necessary to complete the audit, in the format and manner specified by HHS, no later than 30 calendar days after the initial deadline communicated and established by HHS at the entrance conference.” Based on Covered California’s role over the QHP issuers, audit planning and coordination is required. Therefore, Covered California recommends at least 45 calendar days to meet the requirement.

E. 5. The proposed regulations specify that a written extension request is required to be submitted within the applicable timeframe of 15 calendar days. Covered California recommends at least 30 calendar days, considering the additional coordination required as the State Exchange responsible for managing and monitoring the QHP issuer.

E. 6. The proposed regulations specify that HHS would share its preliminary audit findings with the issuer and further proposes that the QHP issuer would then have 30 calendar days to respond to such findings in the format and manner as specified by HHS. Covered California contends that the State Exchange is bypassed, and there is no direct reference to its role. Therefore, Covered California recommends at least 60 calendar days to provide for the additional coordination required as the State Exchange responsible for managing and monitoring the QHP issuer and to allow for the State Exchange’s due diligence and verification of the issuer’s response to the findings.

E.7. Further, the proposed regulations specify how HHS will capture audit results for inclusion in the final audit report, and the proposed plan for corrective actions and response time of 30 calendar days. Covered California recommends at least 60 calendar days to provide for the additional coordination required as the State Exchange responsible for managing and monitoring the QHP issuer, and to allow for the SBEs due diligence and verification of the QHP issuer's corrective actions.

Compliance Reviews

The proposed regulations specify several, substantial modifications to HHS' Oversight of the Administration of the Advance Payments of the Premium Tax Credit (APTC) and Cost-sharing Reductions (CSR), and user fee programs (§ 156.480). Beyond the traditional audits, the proposal seeks to expand the oversight tools available to HHS to also conduct compliance reviews on QHP issuer's compliance with the applicable federal APTC, CSR, and user fee standards. The proposal also specifies consequences of not complying with the audit and oversight activities. Further, these added oversight tools are to be applied to all Exchange types. Therefore, Covered California questions the reasoning for applying the "one size fits all" audit and compliance approach to unique Exchange models.

The proposed regulations specify HHS' enforcement actions, including imposing civil monetary penalties (CMPs), in situations where state authorities fail to substantially enforce those standards of the applicable federal APTC, CSR, and user fee standards with respect to the QHP issuers participating in SBEs. Covered California recommends that HHS clearly define their criteria as to when and how HHS determines "state authorities fail to substantially enforce those standards." As discussed above, in the proposed regulations, HHS does not make direct reference regarding any HHS' coordination efforts with SBEs who manage and monitor the QHP issuers.

E. 8. HHS should consider developing collaborative oversight and balanced enforcement efforts in coordination with the responsible SBE. Additionally, HHS should consider implementing well-defined monitoring processes such as the review and monitoring of the state's remediation efforts to address and enforce QHP issuer non-compliance, before imposing civil monetary penalties.

The proposed regulations rename 45 CFR § 156.480(c) to "Audits and Compliance Reviews" and clarifies the authority would apply to audits and the proposed HHS compliance reviews. As stated in part, "HHS or designee may audit and perform compliance reviews." Further, *"a compliance review may be targeted at a specific potential error and conducted on an ad hoc basis. For example. HHS may require an issuer to submit data pertaining to specific data submissions. We believe this flexibility is necessary and appropriate to provide HHS a mechanism to address situations in which a systematic error or issue is identified during the random and targeted auditing of a sample of QHP issuers, and HHS suspects similarly situated issuers may have experienced the same systematic error or issue but were not selected for audit in the year in question."* While HHS believes that flexibility is necessary and appropriate, Covered California contends that the proposed ad hoc nature of these compliance reviews may place an added administrative burden on both the QHP issuers and the

SBEs, who manage and monitor the QHPs. These potential ad hoc compliance reviews, in addition to the scheduled audits, may shift resources away from the main mission of Covered California.

F. QRS Levels of Hierarchy Comment Requests

Since the establishment of the ACA, HHS continues to establish standards and requirements related to QHP issuer data collection and public reporting of quality rating information in all Exchanges. During the 2020 QRS and QHP Enrollee Survey Call Letter process, HHS received many comments requesting removing levels of the quality rating system (QRS) hierarchy to streamline and improve consumer understanding. As part of this regulation, HHS requests comments on the possible removal of one or more levels of the QRS hierarchy to simplify the QRS hierarchy and improve the overall quality of QRS data collection at 45 CFR 156.1120 and 156.1125.

Covered California agrees with the interest in simplifying the QRS hierarchy if such work will:

(1) Improve QHP scores' reliability to better distinguish true performance differences
(2) Ensure that the measures and domains' contribution to the Global and Summary Indicator Ratings are based on weights that are proportionate to their importance.

The hierarchy's composite level is a candidate to eliminate as there is not a compelling interest to report performance at the composite level and the composite level is not needed to ensure appropriate weighing of the QRS measures and domains.

Covered California agrees with the proposed release of the full QHP Enrollee Survey results to the public. However, the most pressing enrollee survey issue is the declining enrollee response rate. The generalizability and utility of the survey results are in jeopardy as response rates fall well below 20% for certain QHPs. The looming fall-off in reportable survey scores also complicates the efforts to improve the QRS measures hierarchy.