



March 2, 2019

Alex Azar, Secretary
Randy Pate, CMS Deputy Administrator and CCIIO Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9916-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9916-P, RIN: 0938-AT38; Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2021

Submitted electronically via Regulations.gov

Dear Secretary Azar and Deputy Administrator Pate:

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation – improvements that make a real difference in people’s lives. In all of our work, we strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers.

We appreciate the opportunity to provide comment on the Notice of Benefit and Payment Parameters for 2021. Understanding that this letter is being submitted after the official end of the formal comment period, we respectfully ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

While the NBPP includes many changes that affect affordability and access for consumers, we chose to focus our comments on ten key areas:

- 1) Automatic Re-enrollment Process
- 2) Risk Adjustment: Enrollment Duration Factors
- 3) Treatment of Prescription Drug Coupons
- 4) User Fees
- 5) Display of Value Based Insurance Designs
- 6) Special Enrollment
- 7) Eligibility Pending Appeal
- 8) Premium and cost sharing adjustment percentage
- 9) Drug Rebates in Medical Loss Ratios
- 10) Wellness Programs in Medical Loss Ratios

Automatic Re-enrollment Process

We strongly oppose all proposed modification to the automatic re-enrollment process for consumers whose premiums are fully paid by advance premium tax credits.

The following comments explain, as a matter of policy, why we oppose the proposal. As a preliminary matter, we note the conflict between the proposed policy and Further Consolidated Appropriations Act, 2020, § 608, Public Law No: 116-94. The section requires automatic re-enrollment for each person who “resides in a State with an exchange [operated by the Federal government],” who “is enrolled in a qualified health plan during [plan year 2020] and does not enroll in a qualified health plan for plan year 2021,” and who “does not elect to disenroll under a qualified health plan for plan year 2021” during the open enrollment period. It does not allow the kind of distinction made by the proposed rule – namely, consumers enrolled in a zero-net-premium bronze plan lose their APTC eligibility while others do not. We are not aware of any statutory authority for making such a distinction.

Moreover, as a matter of policy, the horizontal inequity of punishing people based on low income and their choice of a bronze plan rather than a higher-value plan seems impossible to justify. Those who need help the most are the ones who see that help withdrawn under the proposed rule. This distinction also violates core notions of market efficiency, where people make choices based on predictable consequences. The proposed policy would visit an enormous financial penalty, in an unpredictable way, based on someone’s choice of a bronze plan, rather than a higher value plan. Health insurance markets are already too complex for many consumers to predict the consequences of their choices. The proposed policy takes a challenging market and makes it worse.

The notice begins by acknowledging the importance of automatic re-enrollment in improving efficiency, reducing consumer burdens, and improving the individual-market risk pool. It then speculates, without evidence, that “there may be particular risk associated with enrollees who are automatically re-enrolled with APTC that cover the entire plan premium, since such enrollees do not need to make payments to continue coverage.” Based on that speculation, the proposed rule would end such automatic re-enrollment, perhaps replacing it with having the consumer “automatically re-enrolled without APTC,” or “where APTC for this population would be reduced to a level that would result in an enrollee premium that is greater than zero dollars, but not eliminated entirely.” The stated goal is “to ensure a consumer’s active involvement in re-enrollment, because any enrollment in a plan with an enrollee premium that is greater than zero would require the enrollee to take an action by making the premium payment to effectuate or maintain coverage, or else face eventual termination of coverage for non-payment.” The proposed rule adds, “If we were to implement such a change, we would conduct consumer outreach and education alerting consumers to the new process.”

An enormous volume of behavioral economics research shows that requiring even modest procedural steps to claim benefits results in substantially reduced participation levels, even among those who are eligible for assistance. Notice and outreach will not solve the problem, as demonstrated by abundant evidence. The proposed policy changes suggested in the rule would lead to disenrollment and the termination of health coverage for people who qualify for federal financial assistance. The following examples are taken from a research summary prepared for the HHS Assistant Secretary for Planning and Evaluation:¹

¹ Fredric Blavin, Stan Dorn, and Jay Dev. *Using Behavioral Economics to Inform the Integration of Human Services and Health Programs under the Affordable Care Act*. Urban Institute, 21 July 2014. <https://www.urban.org/sites/default/files/publication/22956/413230-Using-Behavioral-Economics-to-Inform-the-Integration-of-Human-Services-and-Health-Programs-under-the-Affordable-Care-Act.PDF>

“In theory, whether someone must complete a simple form to enroll in a retirement savings plan or to opt out of enrollment should not have a major impact on participation levels. A minor, short-term inconvenience hardly seems commensurate with the long-term benefits of accumulating retirement savings. In reality, considerable research shows that such default arrangements have a significant effect on retirement savings outcomes at every key decision point, including plan participation, savings rates, asset allocation, and post-retirement savings distributions.”

“For example, one literature summary noted that “in a typical company” where employees must complete a form to establish a 401(k) account, “only about one-third of employees enroll on their own during the first six months of employment.” By contrast, when a new employee is automatically enrolled in such an account unless he or she completes a form opting out, “90 percent of employees accept default enrollment.”

“Another example involves a study aptly titled, “\$100 Bills on the Sidewalk.” The study analyzed seven companies that offered employer matches to worker contributions into 401(k) accounts. In effect, workers over 59 ½ years of age could obtain free employer matching payments; because of their age, they could immediately withdraw their employee contributions, without penalty. Nevertheless, at each firm, between 20 and 60 percent of these older workers failed to claim their employers’ maximum contribution, with losses as high as 6 percent of annual income. At the median firm, 31 percent left employer contributions unclaimed, averaging 2 percent of annual income. The researchers conducted an intensive education intervention, which they found increased participation rates by just one-tenth of one percentage point....”

“Louisiana’s experience illustrates the impact of requiring families to check a simple opt-in box before their children can obtain expedited Medicaid coverage based on SNAP receipt. Since February 2010, Louisiana has implemented Express Lane Eligibility (ELE) to qualify children as financially eligible for Medicaid using findings already made by the SNAP program. Children who received SNAP but not Medicaid were mailed Medicaid cards they could use to obtain care. To meet ELE’s statutory requirement for parental consent, the state informed families that using the Medicaid cards would also provide consent to enrollment.”

“According to the congressionally mandated evaluation of ELE, approximately 18,000 previously uninsured children joined Medicaid through ELE in 2010. This represented a 3 percent increase in total children’s Medicaid and CHIP coverage, with ELE accounting for 28 percent of all new enrollees between February and July.³⁸ However, information technology problems led Louisiana to change its approach to enrollment. Starting in January 2011, children could not receive Medicaid through ELE unless their parents first consented by checking a box on the SNAP application form. Even though the check-box was highlighted, bolded, prominently placed on the second page of the SNAP form, and written in very clear language, the average number of children enrolled via ELE as a result of monthly SNAP applications fell by 62 percent after this change was made.”

To justify the certain loss of coverage that would result from the proposed rule, CMS hypothesizes that those who do not make premium payments may be more likely to be claiming erroneous APTC amounts. Not one shred of evidence suggests that the presence or absence of premium payments is correlated to financial eligibility for APTCs or the likelihood of providing a notification to an exchange that a

household's economic circumstances have changed. Before taking steps that are certain to take coverage away from hundreds of thousands of people, CMS needs an evidentiary base with solid proof, not speculation and guesswork.

The proposed NBPP describes CMS as “concerned that automatic re-enrollment may lead to incorrect expenditures of APTC, some of which cannot be recovered through the reconciliation process due to statutory caps.” In fact, that risk is particularly low for zero-net-premium enrollees because, as CMS itself argued as recently as November 2019, such enrollees claim less than their full APTC amount in paying premiums. To support a revised approach to federal Basic Health Program payments, CMS asserted that zero-net-premium enrollees leave a significant amount of potential APTC assistance unclaimed, because bronze premiums are less than full APTC amounts. In its final payment rule for 2020, CMS explained, “the PTC paid on behalf of those enrollees was 23 percent less than the full value of the APTC.”² Accordingly, if a consumer overclaims APTC amounts, the federal government is particularly unlikely, in the case of zero-net-premium enrollees, to lose money it cannot recapture through reconciliation. The failure to claim full APTC amounts leaves a significant margin for error, so that even if the full claimed APTC amount turns out to be excessive, the amount actually used to purchase coverage may be less than the amount deemed appropriate after reconciliation. If there are any excess APTC payments, they are less likely to be uncollectable because they will be smaller in magnitude. Put simply, the administration is proposing policies that are certain to increase the number of uninsured, without any credible supporting factual basis.

Risk Adjustment: Enrollment Duration Factors

We support implementation of the revised approach to adult enrollment duration factors in the individual market, without delaying to obtain an additional year of EDGE server data.

The proposed rule notes that CMS has found that enrollment-duration (ED) risk factors for adults would be more predictive of risk if they were linked to hierarchical condition categories (HCCs). CMS further observes that MarketScan data upon which risk-adjustment was originally based reflect patterns in the large group market, which may not apply to the individual and small-group markets. CMS suggests that the individual and small-group markets exhibit different risk patterns with part-year enrollees. Difficulties with existing EDGE server data in the small group market have apparently led CMS to propose a one-year delay in implementing the new approach to ED factors.

This issue is critically important in the individual market. Carriers generally avoid enrolling consumers during special enrollment periods (SEPs), fearing adverse selection that is not adequately compensated by risk adjustment. The proposed modification to ED factors would provide carriers with sufficient funding to compensate for the distinctive risk profile of consumers who enroll in the individual market via SEPs.

A large proportion of the uninsured lose coverage because of job loss. This particular population — those who lose employer-sponsored insurance and become uninsured — is one of the very few that did

² CMS. “Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020.” 84 FR 59529, 59532 (November 5, 2019).

not experience major coverage gains, starting in 2014.³ If carriers can be incentivized to quickly enroll consumers, via SEPs, as soon as they lose employment-related coverage, a huge hole in our existing coverage system would begin to close.

The absence of adequate data about the small-group market does not justify delay implementing the new approach with the individual market. The main purpose of risk adjustment is to compensate for foreseeable adverse-selection risks. Such compensation encourages carriers to compete based on price and the quality of coverage offered, rather than to compete through avoidance of undercompensated risks. Partial-year enrollment in the small-group market does not present the same kind of adverse selection possibilities that are front and center in the individual market, which is the market of last resort for those who lose employer-based coverage. Given the importance of filling the gaps in coverage that result when consumers lose employer-sponsored insurance, we urge CMS to move forward with the new ED approach for adults as soon as possible.

Treatment of Prescription Drug Coupons

We oppose the proposed change to previous language in § 156.130(h) such that counting drug copay coupons toward annual limits is optional for all plans, regardless of whether a generic equivalent is available. Instead, we recommend that plans be required to count the coupons towards annual limits when there is no generic equivalent approved by the FDA, and make it optional to count when competitors exist. In addition, we urge HHS to require that coupons count towards annual limits whenever a patient has a medical necessity to take a particular medicine, rather than its generic equivalents.

In the notice, HHS proposes changing § 156.130(h) to state that, “to the extent consistent with applicable state law, amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers for specific prescription drugs may be, but are not required to be, counted toward the annual limitation on cost sharing.” We are concerned that this revised change will have far-reaching consequences for consumers when plans opt to not count these coupons toward annual limits across the board.

Copay coupons for prescription drugs that have generic competition are often used to nudge consumers toward higher-priced brand name products, which in turn can increase overall spending on prescription drugs. However, in cases where either there are no generic equivalents available or the use of the brand name drug is medically necessary for a patient, copay coupons serve as a lifeline for patients who cannot otherwise afford to reach their annual cost sharing limit. In those cases where a drug is medically necessary or where there are no generic equivalents, not counting the coupon towards annual out of pocket limits would leave patients paying more out of pocket, relative to their current spending, in order to reach the annual cost share limit.

In previous comments on the proposed notice, we suggested that the agency not count these coupons toward limits in cases where competition exists, but allow them to count when there is no generic equivalent or when using a particular medicine is medically necessary.

³ John A. Graves and Sayeh S. Nikpay. “The Changing Dynamics Of US Health Insurance And Implications For The Future Of The Affordable Care Act.” *Health Affairs* 36, NO. 2 (2017): 297–305.

User Fees

We urge HHS to increase the budget for outreach and enrollment assistance beyond 2020 levels.

The proposed NBPP seeks comment on whether to decrease user fees in the FFM since enrollment has declined. However, it does not detail the costs that are paid from the user fees nor how the budget for those services would change. From 2017 through 2019, enrollment in marketplace plans through the FFM declined: it went from 9.2 million in 2017, to 8.7 million in 2018, to 8.4 million in 2019, but over that same period, state based marketplace enrollment held steady.⁴ Preliminary reports show 8.3 million enrolled in the FFM in 2020.⁵ As enrollment has declined both in the federal marketplace and in Medicaid and CHIP, the uninsured rate has begun to climb, showing the need for greater outreach. Polling data in 2018 showed that a few weeks before the end of the open enrollment deadline, one-fourth of those who buy their own insurance or are uninsured did not know the deadline for renewing or enrolling in coverage.⁶

At least part of the decreased enrollment was likely due to the marked decline in media outreach and in-person enrollment assistance. Navigator funding for the FFM declined from \$63 million in 2016 to \$10 million in 2019, and the administration reduced funding for outreach outside of navigator programs by 90%.⁷ The NBPP proposes reducing user fees, which fund outreach and enrollment assistance, because enrollment has declined. We urge you to take a different path in building the appropriate percentage for user fees: design those fees in such a way that, combined with other federal resources, they will support an increased amount of advertising, outreach, and enrollment assistance that was in place in 2016.

If other administrative functions of the exchange now cost less than the amount generated by user fees, and outreach/enrollment functions are enhanced for 2021, we would support a reduction in user fees that would also reduce premiums. Unfortunately, the cost analysis in the NBPP does not provide sufficient data to determine whether that is the case.

Display of Plans Offering Value-Based Insurance Designs (VBID)

We urge HHS to provide search functions that help consumers find plans that offer \$0 cost sharing and pre-deductible services, and that provide high-value services at low cost for targeted conditions. We suggest some modifications to the proposed model value based design.

⁴ Centers for Medicare and Medicaid Services, "Health Insurance Exchanges 2019 Open Enrollment Report," March 25, 2019, <https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report>

⁵ Centers for Medicare and Medicaid Services, "2020 Federal Health Insurance Exchange Enrollment Period Final Weekly Snapshot," January 8, 2020, <https://www.cms.gov/newsroom/fact-sheets/2020-federal-health-insurance-exchange-enrollment-period-final-weekly-enrollment-snapshot>.

⁶ A. Kirzinger, et al, *KFF Health Tracking Poll – November 2018*, Kaiser Family Foundation, November 28, 2018, <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-november-2018-priorities-congress-future-aca-medicaid-expansion/>.

⁷ K. Pollitz, et al, "Limited Navigator Funding for Federal Marketplace States," Kaiser Family Foundation, November 13, 2019, <https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>.

The preamble to the rule suggests a non-mandatory VBID design for health plans. It solicits comments on both the design and how to display plans that offer VBID. We support designs that make high-value services more affordable by providing pre-deductible coverage and no or low cost sharing for those services. HHS should evaluate the impact on access to services in both the high and low value tiers, stratified by disability, gender, race, ethnicity and language before promoting plans as “value-based.”

We request that the final NBPP explain whether the Michigan design has demonstrated effectiveness across racial and ethnic groups, a crucial step omitted in commonly used medical algorithms.⁸ We also seek the following modifications:

1. Lower cost insulin products (which are bio-similar, so not covered as generics) should be zero or low cost sharing so that people screened will have ready access to treatment. In the proposed design, glucose testing is considered a high value service, but not insulin.
2. VBID should address prevalent public health concerns and health equity. We urge you to consider designs that waive cost sharing for all prenatal visits and all prescriptions during pregnancy; and that waive cost sharing for postpartum visits for mother and child. The Pregnancy Model Home design, tested in North Carolina, for example, shows the value of a comprehensive postpartum visit between 14 days and 42 days to ensure that patients receive all recommended components of care and are transitioned to the appropriate primary care setting.⁹
3. At least some psychotherapies or counseling for depression and substance use should be considered high value, and not just the medications for these conditions. The SUPPORT Act requires that the provision of MAT occur in a “qualified practice setting” that provides referrals to follow up-services, including behavioral services.¹⁰ For pregnant and postpartum women at risk of depression, the US preventive task force rates referral to counseling as grade B.¹¹ VBID should ensure that the recommended counseling is easily affordable. We are concerned that this design puts all “specialists” on the low-value tier without distinguishing behavioral health services and without reference to mental health parity requirements.

We are also concerned that OB/GYNs providing maternity and prenatal care would be classified as specialists and hence placed on the low-value tier. Doing so could exacerbate existing disparities and public health concerns. Prenatal care and substance use disorder treatment

⁸ Starre Vartan, “Racial Bias Found in a Major Health Care Risk Algorithm,” Scientific American, October 24, 2019, <https://www.scientificamerican.com/article/racial-bias-found-in-a-major-health-care-risk-algorithm/>.

⁹ Pregnancy Medical Home Care Pathways Improve Quality of Perinatal Care and Birth Outcomes. - PubMed - NCBI N C Med J. 2015 Sep-Oct;76(4):263-6. doi: 10.18043/ncm.76.4.263. www.ncbi.nlm.nih.gov

¹⁰ Summary on SAMHSA’s webpage, “Medication-Assisted Treatment,” <https://www.samhsa.gov/medication-assisted-treatment>, accessed February 24, 2020.

¹¹ US Preventive Services Task Force Final Recommendation Statement: Perinatal Depression, February 12, 2019, <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/perinatal-depression-preventive-interventions>

(including specialists) are pre-deductible and zero cost in the Oregon PEBB plans cited in the preamble.¹²

4. CMS’s innovation center and state Medicaid programs have researched new delivery models and service bundles to address health conditions. There is growing research on the effectiveness of doulas in improving birth outcomes.¹³ States have incentivized performance on dental screenings and fluoride varnishes for children, delivered by a range of providers practicing at the top of their licenses.¹⁴ We urge you to consider ways of bringing such interventions into private health insurance plans. Stand-alone dental plans, unfortunately, do not generally provide preventive dental exams for children at no cost.

Search tools on healthcare.gov should enable consumers to filter to find plans offering services pre-deductible and with services (in addition to preventive care) at \$0 cost sharing; and the drop down boxes should continue to identify specific \$0 cost sharing services, clearly identifying what is offered pre-deductible. State based marketplaces such as Covered California have used shading in addition to words in their plan comparison charge to help people quickly identify pre-deductible and \$0 cost services. Healthcare.gov should include information for patients with targeted conditions, such as diabetes, depression, high blood pressure, etc. that explains that special plans might be more affordable for their conditions and explains where to find detailed information in plan descriptions.

Special Enrollment

We support the changes in 155.420 to allow enrollees to move a metal level when they become eligible for cost-sharing reductions.

The NBPP proposes several consumer-friendly changes in special enrollment: people would be allowed to move to a higher or lower metal level plan if they became newly eligible for cost-sharing reductions, which make other metal levels more affordable. Families would not need to wait as long after paying premiums for special enrollment to be effective. We support these changes.

Eligibility Pending Appeal

Under 155.525, we support allowing consumers the option to request either full or partial retroactive coverage if successful in an appeal. Permit consumers to enroll in any plan requested pending an appeal, and provide the opportunity to switch to a plan of the consumer’s choice at the appeal’s conclusion.

¹² Oregon Public Employee Benefit Board, 2020 Summary of Benefits, <https://www.oregon.gov/oha/PEBB/Documents/summary-web.pdf>.

¹³ Kenneth J. Gruber, Susan H. Cupito, Christina F. Dobson, “[Impact of Doulas on Healthy Birth Outcomes](#)” J Perinat Educ. 2013 Winter; 22(1): 49–58. doi: 10.1891/1058-1243.22.1.49
PMCID: PMC3647727.

¹⁴ See Washington model Medicaid contract, https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf and Texas pay for quality, <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program>.

The NBPP asks several questions about consumer choices pending and after an appeal. We support giving consumers as much flexibility as possible while an appeal is pending. Some consumers may want to choose the lowest cost plan available pending appeal when they are not certain how much of the bill premium tax credits will ultimately pay; others may want a plan that covers more of their expenses pending an appeal. In either case, once an appeal is decided, and the appellants know what premium assistance they will get going forward, they should have an opportunity to switch to any plan that they determine will best meet their needs.

At the conclusion of a successful appeal, some consumers will want full retroactive coverage, particularly if they used health care at the outset of the contested period, while others will not have the funds to pay for full retroactive premiums and may want a shorter retroactive period.

We agree with the comments of the National Health Law Program on appeals.

Premium and cost sharing adjustment percentage

We oppose changes affecting premium adjustments and annual limitations on cost sharing.

As we commented last year, we disagree with the change in the formula for determining the annual premium adjustment percentage and annual limitation on cost sharing. The indexing change results in reduced premium tax credits and higher net premiums for most subsidized consumers. It also increases the limits on total out-of-pocket costs for millions of people, including both those with individual and with employer-based coverage, causing them to pay higher costs when they face major illness. HHS could improve affordability by going back to the previous formula for premium growth. If, contrary to our recommendation, HHS continues to factor in individual market growth, HHS should disregard years previous to 2014 since insurance plans on the individual market prior to 2014 did not cover essential health benefits and so were not comparable products.

Drug Rebates in Medical Loss Ratios

We support these adjustments to § 158.140(b)(1)(i) and § 158.160(b)(2).

The Notice recommends modifying MLR rules so that drug rebates received by an entity on behalf of an insurance issuer, typically pharmacy benefit managers (PBMs) be deducted from the claims calculation, less any portion of those rebates and concessions retained by PBMs, which is proposed to then be reported as non-claims costs. We support these adjustments.

PBMs operate by negotiating discounts and concessions from pharmaceutical manufacturers and passing those concessions on to the insurance issuers for which they are contracted. Under MLR rules as they stand, concessions awarded to these PBMs are not adjusted for in the claims calculation, while any rebate or concession given directly to an issuer is. This discrepancy rewards issuers who use a PBM to negotiate concessions by counting those concessions in their claim value. Because claims are the key to determining whether an issuer has met the MLR, this practice falsely inflates MLR for issuers who otherwise may not be meeting the threshold.

Wellness Programs in Medical Loss Ratios

We urge HHS not to count health-contingent wellness programs as quality improvement activities, proposed in 158.150.

The notice proposes to allow issuers to include expenditures on wellness programs as quality improvement activities in their medical loss ratio calculations. We are concerned that this change will induce more states and plans to implement discriminatory health-contingent wellness programs, though evidence shows that workplace wellness programs do not improve health or control costs. These programs may include a reward of up to 30 percent of the cost of self-only coverage for attaining a health outcome, and thus they effectively re-institute health status rating that the Affordable Care Act has banned. We are especially concerned because under guidance issued by HHS this fall for wellness demonstrations, individuals facing premium surcharges due to failure to comply with a wellness program will not receive higher premium tax credits to help cover the surcharge. In effect, insurers will may credit in their MLR calculations for programs that deter coverage for people who cannot achieve a health outcome. We urge you to withdraw this proposal.

Thank you for your consideration of these comments. If you have any questions, please contact Cheryl Fish-Parcham at cparcham@familiesusa.org or 202-628-3030.

Respectfully submitted,

Frederick Isasi
Executive Director at Families USA