

## **Washington Health Benefit Exchange Comments: Proposed Federal Rule – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022**

The Washington State Health Benefit Exchange (WAHBE or the Exchange) submits comments about the proposed Notice of Benefit and Payment Parameters for 2022 (Payment Notice), published by the United States Department of Health and Human Services (HHS) on December 4, 2020.

WAHBE respectfully expresses concern that the timeframe for submitting comments on the proposed Payment Notice is inadequate to solicit thorough stakeholder feedback on these complex and impactful proposed Exchange regulations. WAHBE also wishes to express concern that, if HHS is striving to finalize the 2022 Payment Notice before a federal administration change, HHS will have insufficient time to adequately review and consider stakeholder feedback and incorporate any changes into final regulations. We urge HHS to return to its previous practice of publishing these important annual Exchange proposed regulations with a full 60-day comment period and to build adequate time into the publication timeline to allow for thorough consideration of the stakeholder feedback received.

WAHBE appreciates that HHS continues to express interest in preserving flexibility for state-based exchanges to make decisions best tailored to advance efficiency and innovation at the state level. However, WAHBE urges HHS to reconsider some of the proposals included in this proposed Payment Notice that impose additional burdens and restrict decision-making for state-based exchanges

Equally as important as preservation of state flexibility in the operation of exchanges is the key role that HHS and CMS play in providing an adequate foundation for marketplaces, FFE, SBE-FP, or state-based exchanges, across the country. CMS plays an essential role in ensuring that all marketplace customers have equitable access to comprehensive health insurance and financial assistance to help them afford coverage. The foundation set by CMS provides assurance that, wherever a customer lives in the country, they will have access to a one-stop marketplace that provides comprehensive health insurance. Some of the proposed changes in this rule undermine this foundation and jeopardize the stability of the Exchanges and the individual market.

WAHBE is concerned about several proposed changes in this Payment Notice including a significantly reduced FFE user fee and allowing direct enrollment to serve as an alternative to a single public Exchange platform. These proposals signal CMS's intent to reduce the support provided by exchanges to consumers. These proposed changes have the potential to reduce the efficacy and undermine the role of exchanges across the country and will diminish the value exchanges are able to provide to consumers who rely on the individual market for their health coverage. These changes are contrary to the intent and goals of the ACA. WAHBE urges CMS not to finalize these proposed changes.

Exchanges are essential in assuring access to affordable, comprehensive health coverage for all and providing an equitable and consumer-friendly shopping experience. Exchanges are reliable, trustworthy sources for consumers in a changing health insurance landscape. Changes to undercut Exchanges could result in a significant increase in the uninsured and decreases in health outcomes.

WAHBE appreciates the opportunity to submit comment on the proposed 2022 Notice of Benefit and Payment Parameters and respectfully requests that HHS consider the feedback provided below as it works to finalize these regulations.

### ***Direct Enrollment***

The Washington Health Benefit Exchange opposes the proposed regulation changes allowing states to opt into an Exchange Direct Enrollment (Exchange DE) and urges HHS *not* to finalize these changes. The proposed direct enrollment changes undermine the single, streamlined platform written in the Affordable Care Act. State based exchanges, like the Washington Health Benefit Exchange, SBE-FPs, and Healthcare.gov are reliable, trustworthy sources for consumers to *apply and enroll* into coverage. Exchanges offer financial assistance to consumers and provide an unbiased shopping experience where they can easily compare all qualified health and qualified dental plans in an apples-to-apples format. In addition, Exchanges are designed as a one-stop shop for consumers to shop for compliant, affordable health insurance coverage. Washington is fully integrated with Medicaid and CHIP so consumers can enroll in one application in Medicaid, CHIP, or Marketplace coverage. Exchanges have been very successful at enrolling consumers and offering innovative tools to help consumers shop and compare plans<sup>1</sup>. Exchanges have made considerable investments into enrollment platforms. These platforms should not be discarded with no evidence that direct enrollment platforms are better suited to perform this work.

Exchanges are best positioned to be owners of the enrollment experience since Exchanges are unbiased entities that are held accountable by both federal and state agencies. Direct enrollment platforms have great potential for consumer harm because they are not held to the same standards as the Exchanges. Evidence shows the direct enrollment platforms can shift consumers away from compliant products without consumers even realizing, steer Medicaid-eligible consumers away from Medicaid coverage, and create obstacles to comparing all qualified health plans<sup>2</sup>. Direct enrollment platforms are not a substitute for Exchanges and should not be allowed serve as enrollment platforms for states.

### ***Definitions of QHP Issuer Direct Enrollment Technology Provider and Agent or Broker Direct Enrollment Technology Provider (§ 155.20)***

WAHBE opposes adding a new definition of QHP issuer DE technology provider. This would expand the use of enhanced direct enrollment to additional entities. There is evidence that current usage of the enhanced direct enrollment platform has brought confusion to consumers, prevents consumers from viewing a full set of plans, and can lead them to enroll in non-compliant insurance products<sup>3</sup>. Instead of widening definitions to minimize barriers to entry into direct enrollment and enhanced direct enrollment, HHS should focus regulatory efforts on assuring that these platforms are compliant and offer the experience afforded to consumers through the ACA.

### ***Consumer Assistance Tools and Programs of an Exchange (§ 155.205)***

WAHBE opposes loosening the requirements for QHP issuers or web-brokers participating in the FFE EDE program to comply with translation standards and urges HHS not to finalize this proposal. The proposal to loosen translation requirements for web-brokers and QHP issuers appears to violate Section 1557 of the ACA by creating barriers to coverage due to language. Over 25 million people in the United States are limited English proficient (LEP) so the impacts of this proposal should not be minimized. Loosening this standard could be significant in increasing barriers and health disparities. Communication is essential to individuals understanding their health coverage options and selecting a plan. The Washington Health Benefit Exchange devotes a great deal of time and resources to assure that Washingtonians can access coverage regardless of the language they speak and read. All platforms offering Exchange products should be held to the same commitment and standard.

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<sup>1</sup> Covered California, New Analysis Finds Leading State-Based Marketplaces Have Performed Well, and Highlights the Impact of the Federal Mandate Penalty Removal; <https://www.coveredca.com/newsroom/news-releases/2019/03/06/new-analysis-finds-leading-state-based-marketplaces-have-performed-well-and-highlights-the-impact-of-the-federal-mandate-penalty-removal/>

<sup>2</sup> Center on Budget and Policy Priorities, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm (Mar. 15, 2019), <https://www.cbpp.org/sites/default/files/atoms/files/3-15-19health.pdf>

<sup>3</sup> Center on Budget and Policy Priorities, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm (Mar. 15, 2019), <https://www.cbpp.org/sites/default/files/atoms/files/3-15-19health.pdf>

This proposed exception would allow for consumers to be directed to these platforms and have a negative experience because the platform is not offered in their native language. This could result in the consumer not enrolling into coverage or enrolling in products that don't meet their needs. Consumers are assured website content offered in their language when they enroll through the Exchange. Instead of directing individuals to platforms that do not meet their needs, HHS should maintain the current guidelines which assure that consumers stay on sites that meet their needs.

Limited English proficiency customers are entitled to and deserve information to make informed decisions. All enrollment platforms that offer qualified health plan and qualified dental plan products should be held to the same rigorous standards to assure that consumers are able to enroll into qualified coverage. If EDE platforms are not able to meet the translation standards set out for website content, they should not be allowed to participate in the program and offer QHPs and QDPs.

### ***Navigator Program Standards (§ 155.210) and Certified Applications Counselors (§ 155.225)***

WAHBE opposes allowing Navigators and certified application counselors, or Assistors, to use web broker sites to assist consumers applying for insurance affordability programs and QHP enrollment. Allowing Assistors to use web broker websites could compromise the statutory and regulatory obligations of the Navigator and CAC positions. Web broker sites can highlight certain issuers branding or utilize tools that highlight certain issuers over other issuers in the plan selection process. Assistors using platforms that employ these practices, and that are governed by less stringent rules, could impair an Assister's ability to remain impartial. Websites can also use nudges to drive consumer behavior so even a Assister with the best intentions could practice biased behavior if a website is designed in such a manner.

Assisters play an essential role in educating consumers on the benefits of the Affordable Care Act and insurance options that offer consumers protections of the ACA. Assistors recently have contended with the challenge of consumers being confused by private market websites that offer non-compliant products and utilize deceptive marketing practices.<sup>4</sup> Assistors frequently comment on the need for more regulation of third-party websites and would discourage efforts to grow the number of websites offering Exchange products especially if these websites also offer non-Exchange products.

Navigators enroll consumers into health care coverage regardless of the health coverage program eligibility. Creating platforms that separate Medicaid and QHP shopping complicates the job of a Navigator by requiring them to visit multiple different platforms depending on the eligibility result. How would families that are eligible for multiple programs be handled in an Exchange DE platform? Through the Washington Exchange, households with Medicaid and QHP eligibility are able to enroll through the same platform within the same process. These households benefit from shopping together to simplify the process and to ensure that the entire family's needs are met.

Navigators play an important role in assisting some of the most complex cases. As such, Navigators undergo thorough training to understand eligibility, enrollment, as well as the Exchange website. Navigators are super users of our website and are expected to know the ins and outs of the application. Introducing Assistors to several additional websites would require more trainings and time that could be spent helping vulnerable consumers.

### ***Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)***

#### ***QHP Information Display on Web-Broker Websites***

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<sup>4</sup> Lack of ACA Navigator Funding Leads to Consumer Confusion, Decreased Enrollment; Olivia Hoppe and Adam Searing; Georgetown University Health Policy Institute; January 2019; <https://ccf.georgetown.edu/2019/01/25/lack-of-aca-navigator-funding-leads-to-consumer-confusion-decreased-enrollment/>

WAHBE opposes the new exception in QHP display requirements for web-brokers proposed in § 155.220(n). This proposed regulation allows for a site to display minimal QHP information when there is no enrollment in the QHP products on the website. Web-brokers that display QHP products should all be held to the same standards regardless of a consumer's ability to select a plan on the site because a consumer is still using the information on the site to view plans and shop. Web-broker sites are built for the purpose of displaying plans for consumption. Consumers could use a web broker's site to form an opinion about a QHP then come onto the Exchange to buy the product and miss all the critical information on the Exchange since they already thought they viewed information on another site. The minimal display requirements proposed are not sufficient to show consumers other possible plan options. This new exception could be misleading to the consumer and cause them to make a decision that may not be in their best interest.

In addition, WAHBE is concerned about the amount of re-work for Assistants in educating consumers who used one of these websites to shop then came onto the Exchange and saw a different set of information about health plans. Standardization is key to avoid confusion and to ensure that consumers are aware of what they are enrolling in. We encourage HHS to not to finalize § 155.220(n).

***Standards for Direct Enrollment Entities and for Third Parties to Perform Audits of Direct Enrollment Entities (§ 155.221)***

WAHBE opposes the addition of §155.221(j) to establish a process for states to elect a new Exchange Direct Enrollment (DE) option in which a state can request to allow private sector entities (including QHP issuers, web-brokers, agents and brokers) to operate enrollment pathways and encourages HHS *not* to finalize this proposal. The proposal to allow states to rely on web-brokers and other entities is built on the argument that Exchanges are costly and have many flaws including chokepoints at open enrollment and an inability to keep up with e-commerce innovation. As a successful state-based exchange, we would like to respond to this flawed rationale.

Per the Washington Exchange's experience, it is possible for Exchanges to operate on modern technology and to support high demand. WAHBE's migration to a cloud infrastructure (using Azure Gov) has given us the capability to tailor our website CPU, storage, etc. to the number of online users. As such, WAHBE can spin up to serve high open enrollment volume and spin down outside of OE to reduce operating costs. Rather than assuming Exchanges will never be able to support high volume, exploring cloud first re-architecting and designing to peak volume would be recommended. In addition, policy changes could address chokepoints like extending open enrollment periods past the 45-day timeframe employed this open enrollment.

While partnerships between the public and private sectors can be advantageous to consumers, the premise to allow states to shift to DE is flawed. Public websites use the same technology as private websites and when soundly managed they can operate just as smoothly. Distributing visitors to a myriad of private sites may eliminate an existing choke point but will create challenges in terms of integration and reconciliation.

WAHBE has been a leader of innovation since our inception and has implemented a wide range of technologies to assist our consumers to apply and enroll in coverage. WAHBE recently upgraded our entire shopping experience including simplifying navigation, updating the user interface, improving the ADA experience, and making updates to our decision support tool. Exchanges are able to innovate and respond to consumer needs within the market. Furthermore, due to the public nature of Exchanges, they are well-positioned to design an experience that prioritizes the consumer experience and ensures that a consumer is easily able to shop and compare all plan options. Evidence shows that consumers shopping through an Exchange are less likely to have difficulty finding an affordable health plan than consumers off Exchange.<sup>5</sup>

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<sup>5</sup> Decision-Making Experiences Of Consumers Choosing Individual-Market Health Insurance Plans; Joachim O. Hero, Anna D. Sinaiko, Jon Kingsdale, Rachel S. Gruver, and Alison A. Galbraith; Health Affairs 2019 38:3, 464-472

The proposed rule asserts that direct enrollment is better equipped to handle enrollment and would increase enrollment and innovation in the individual market. However, DE has been in operation since 2013 in the FFE, and EDE since 2018, and these platforms represent just one-third of all enrollments. These platforms have not led to significant increases in enrollment. The proposal to eliminate the platform that accounts for the most enrollment seems irresponsible and unjustified.

WAHBE respectfully disagrees with the administration's interpretation that an Exchange can continue to meet obligations and the minimum functions outlined in the statute without operating a singular consumer-facing enrollment website. The administration just approved Georgia's Section 1332 waiver for this exact proposal signaling that there is a statutory requirement that needs to be waived to pursue this enrollment option. The proposed regulation cites 1311(c)(5) and (d)(4)(C) of PPACA as the basis for the argument that enrollment functions can be provided by a broker without a waiver. However, there are several other portions of Section 1311 that clearly state that the Exchange is responsible for operating a single enrollment platform for consumers to enroll in coverage<sup>6</sup>. For example, section 1311(d)(2) states that an offering of coverage is a requirement of an Exchange and "an Exchange shall make available qualified health plans to qualified individuals and qualified employers."

Finally, WAHBE would like to comment on the premise that DE would enhance the shopping experience for consumers. Consumers rely on public Exchanges, like Healthcare.gov and the Washington Health Benefit Exchange, to provide them with an unbiased, fully-ACA compliant shopping platform. Misleading marketing and health insurance scams have increased exponentially in recent years with the availability of short-term health plans and, most recently, during the COVID-19 pandemic.<sup>789</sup> Eliminating a reliable, trusted source of information and shifting enrollment to privatized platforms is not in the best interest of consumers.

In addition, the EDE shopping experience would create new barriers for consumers that are determined eligible for Medicaid or CHIP. Direct enrollment platforms can divert enrollees from reaching the Exchange application. An analysis found that one direct enrollment platform marketed specifically to Medicaid-eligible consumers and encouraged Medicaid-eligible enrollees to enroll on their platform.<sup>10</sup> Other direct enrollment platforms are not clear when enrollees are eligible for Medicaid and where they should go to seek coverage. Exchanges offer a one-stop shop for consumers to enroll into ACA compliant coverage. Washington's exchange allows a consumer to apply and enroll in Medicaid, CHIP, or Marketplace coverage without ever leaving the site. For households that have eligibility for both Medicaid and marketplace coverage, this single streamlined process allows the entire family to apply and enroll on the same site. Exchange DE would create an environment where consumers must navigate multiple websites to find coverage which could lead them to substandard plans or discourage them from coverage altogether. Exchanges are trusted platforms that provide an unbiased, complete shopping experience for all consumers. Shifting from Exchanges to privatized platforms would increase consumer confusion, introduce significant barriers to coverage, and ultimately could increase the number of uninsured.

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<sup>6</sup> The 2022 Proposed Payment Notice, Part I: Exchange Provisions; Katie Keith; Health Affairs; November 2020; <https://www.healthaffairs.org/doi/10.1377/hblog20201127.118789/full/>

<sup>7</sup> Misleading marketing of short-term health plans amid COVID-19; Christen Linke Young and Kathleen Hannick; USC-BROOKINGS SCHAEFFER ON HEALTH POLICY; <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>

<sup>8</sup> Misleading marketing, insurance scams increase amid COVID-19 outbreak; Haefner; Beckers Hospital Review; March 2020; <https://www.beckershospitalreview.com/payer-issues/misleading-marketing-insurance-scams-increase-amid-covid-19-outbreak.html>

<sup>9</sup> Results of Covert Testing for Selected Offerings; GAO-20-634R; Published: Aug 24, 2020. Publicly Released: Sep 16, 2020; [U.S. GAO - Private Health Coverage: Results of Covert Testing for Selected Offerings](https://www.gao.gov/assets/20/634/20634r.pdf)

<sup>10</sup> Center on Budget and Policy Priorities, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm (Mar. 15, 2019), <https://www.cbpp.org/sites/default/files/atoms/files/3-15-19health.pdf>

### ***Verification of Eligibility for Employer Coverage (§ 155.320)***

WAHBE is supportive of HHS's proposal not to take enforcement action against exchanges that do not perform random sampling as required under §155.320(d)(4) through plan year 2022. As HHS continues to explore a new alternative approach to verifying employer-sponsored coverage to replace the procedures in paragraph (d)(4)(i), WAHBE encourages HHS to take into consideration the results of its random sampling pilot efforts which determined that only a small percentage of sample enrollees received tax subsidies inappropriately. WAHBE encourages HHS to weigh the benefit of any alternative approach against potentially significant costs to exchanges of performing such verification and continue to investigate as part of that cost/benefit analysis whether a significant problem exists that needs to be solved through regulatory action.

### ***Special Enrollment Periods (§ 155.420)***

#### *Exchange enrollees newly ineligible for APTC*

WAHBE strongly supports HHS's proposal to allow enrollees newly ineligible for APTC and enrolled in an exchange plan to change to QHP of a different metal level in a special enrollment period (SEP). Enrollees that experience a loss of premium tax credits face a financial hardship under existing rules that limit new plan selection to the same metal level since their selection of a plan was likely impacted by the premium, which will increase, perhaps significantly, with their loss of APTC. Consumers that are no longer eligible for subsidies and must stay in their existing metal level tier are at risk of discontinuing coverage during the coverage period when their premium goes up following loss of APTC. This puts a strain on the health of the risk pool that could be avoided if consumers were permitted to select a plan at another metal level.

In response to HHS's request for comment on whether this flexibility should be limited to only enrollees who lose APTC eligibility due to a change in household income or family size, WAHBE encourages HHS to finalize the rule as proposed and allow this flexibility to any enrollee (and dependents) who loses eligibility for APTC, regardless of the cause. WAHBE cautions that limiting this flexibility to a subset of enrollees who lose eligibility for APTC will inadvertently harm consumers who, through no fault of their own, lose eligibility for APTC and therefore can no longer afford the premium in their current plan. An example would include a family covered under a QHP, one member of which receives an offer of affordable employer-sponsored coverage with dependent coverage, making the whole family ineligible for APTC in their QHP. Should the rest of the family members need to stay in their QHP because their portion of the premium for the employer coverage would be too expensive, they should also be able to choose a QHP that is more affordable to them following their loss of APTC. Additionally, WAHBE cautions that adopting different plan-selection rules for specific subsets of enrollees who experience a loss of eligibility for APTC would be hard to communicate to stakeholders, technologically challenging, and costly for exchanges to implement.

HHS requested comment on whether it should reduce the implementation burden of this proposal by permitting enrollees who qualify for this SEP to change to a plan of any metal level (not specifically a lower metal level). WAHBE encourages HHS to adopt this proposal and exempt the special enrollment periods due to becoming newly ineligible for APTC (155.420(d)(6)(i) and(ii)) from plan category limitations altogether. This approach would reduce implementation burden and cost for WAHBE. WAHBE anticipates that any plan changes would be driven by an enrollee's need for a lower premium to maintain coverage and agrees with HHS's reasoning that preserving the coverage of exchange enrollees without breaks in coverage is the most effective way of preserving a healthy risk pool.

Finally, WAHBE encourages HHS to go further with this proposal to allow enrollees newly eligible for APTC and enrolled in an exchange plan to change to a QHP of a different metal level in a special enrollment period (SEP). Premium tax credit eligibility can play a big part in overall plan selection choices. Consumers may be

incentivized to buy up in metal level due to their eligibility in tax credits which is a win for both consumers and carriers.

#### *Untimely notice of triggering event*

WAHBE supports HHS's proposal to allow qualified individuals, enrollees, and dependents who do not receive timely notice of a triggering event and were otherwise reasonably unaware that a triggering event occurred to select a new plan within 60 days of the date that they knew, or reasonably should have known, of the occurrence of the triggering event. WAHBE also supports the proposal to allow such persons to choose the earliest coverage effective date that would have been available if they had received timely notice of the triggering event.

#### *Reduction or cessation of employer contributions to COBRA as special enrollment period trigger*

WAHBE supports HHS's proposal to extend cessation of employer contributions to COBRA as a special enrollment trigger in the individual market both inside and outside of exchanges. WAHBE also strongly encourages HHS to extend this special enrollment trigger to cases in which an employer reduced, but does not cease entirely, contributions to COBRA coverage. WAHBE agrees with HHS's reasoning that it is important to make this special enrollment opportunity available to individuals whose COBRA coverage may become unaffordable to them following a reduction of employer contributions, as these individuals would be likely to become uninsured otherwise when they can no longer afford their COBRA premiums and they were incented to elect COBRA coverage and forgo exchange coverage under circumstances that have changed.

#### *Special enrollment period verification*

WAHBE strongly encourages HHS *not* to adopt the proposed requirements that state-based exchanges conduct eligibility verification for special enrollment periods. HHS states in the preamble to the proposed rule that, in 2017, HHS required exchanges using the federal platform to conduct pre-enrollment verifications for special enrollment periods and allowed state exchanges the flexibility to adopt policies that fit the needs of their state. HHS goes on to note that most state exchanges have indeed now implemented a process to verify most special enrollment periods. WAHBE suggests that the approach taken by HHS in 2017 regulations – to *encourage, but not require* state-based exchanges to implement pre-enrollment SEP verification and to allow state exchanges the flexibility to adopt policies to fit their state needs – struck the right balance and has proven successful to achieve HHS's goal of protecting the exchange risk pool and preventing fraudulent enrollments. In light of HHS's own findings that most state-based exchanges implemented pre-enrollment SEP verification, and the absence of evidence in the proposed rule that there is a current, significant, or ongoing problem, WAHBE suggests that further regulatory action is unnecessary and burdensome.

In Washington, we have developed a state-specific approach to pre-enrollment SEP verification in partnership with carriers and our state legislature. For a period, WAHBE was required to perform SEP verification, which WAHBE undertook to the best of our ability. After attempting to perform this function for more than a year, WAHBE stopped performing SEP verification in 2016 and this function was returned to carriers. Carriers currently perform verification for Washington SEP enrollees. Special enrollment verification returning to WAHBE would impose a large fiscal and operational burden including hiring additional staff and making changes to technology platforms. WAHBE strongly encourages HHS to preserve the flexibility it provided in 2017 and continue to allow state-based exchanges to develop the system for pre-enrollment SEP verification that best suits the state's needs.

A requirement that all state-based exchanges perform pre-enrollment SEP verification – seemingly an effort to solve a problem that does not exist – would place a significant fiscal burden on WAHBE, negatively impact Washington health insurers, interfere with customer enrollment, and result in a negative customer experience in Washington.

### ***FFE and SBE-FP User Fee Rates for the 2022 Benefit Year (§ 156.50(c))***

HHS proposes to lower the FFE user fee for 2022 to 2.25% of monthly premiums continuing the trend it has followed in recent years, down from 3.0% in 2020 and 2021 and 3.5% in 2019 and previous years. HHS proposes to lower the SBE-FP user fee for 2022 to 1.75% of monthly premiums, down from 2.5% in 2021. WAHBE strongly urges HHS not to continue down the path of defunding the federal exchange and encourages HHS to maintain the FFE and SBE-FP user fees for 2022 at their 2021 rates (3.0% and 2.5%, respectively).

WAHBE emphasizes the importance of HHS fully funding the federal exchange platform, including providing robust funding for marketing, outreach, and education. User fees should be used to support marketing and outreach which has been reduced significantly in recent years, including essential resources like the Navigator program. Marketing investments have the potential for much greater returns when it comes to lowering health care costs than lowering user fees given these investments result in more Americans obtaining coverage. In addition, ensuring adequate funding for the federal exchange is critical not just for the states that utilize the FFE and SBE-FP platforms but for all ACA marketplaces across country. Healthy individual markets across the country rely on a thriving federal insurance marketplace as the foundation.

HHS has the responsibility to transition the federal marketplace to the incoming administration with an adequate foundation including preserving sufficient levels of funding critical to support the federal exchange's essential functions. WAHBE strongly urges HHS *not* to finalize these proposed funding cuts in the final months of an outgoing administration that would severely endanger the viability of the federal exchange as it continues to provide critical health insurance to millions of Americans during a pandemic.

### ***Annual Reporting of State-Required Benefits (§ 156.111)***

WAHBE has no comment specifically on the proposed July 1, 2022 deadline for states to submit to HHS a reporting package for their second year under this new reporting requirement. Similar to comment provided by Washington Health Benefit Exchange to the proposed Notice of Benefit and Payment Parameters for 2021, we continue to ask for clarity on why HHS has placed this burdensome additional reporting requirement on states. HHS has not responded to request to define the scope of the problem that this reporting requirement seeks to address, despite state requests to understand from HHS the nature of the problem that this new requirement is intended to solve. Identification of mandates required by state law that are in addition to the essential health benefits is an activity performed annually by the Washington State by the Office of the Insurance Commissioner, and those findings are reported publicly by the Insurance Commissioner to the Washington State Legislature. We continue to request transparency regarding the value that HHS seeks to add in requiring an additional level of reporting to a process that is already quite thorough and open to public scrutiny in Washington State.

### ***Premium Adjustment Percentage (§ 156.130(e)) and Provisions Related to Cost Sharing (§ 156.130)***

There is a proposed average 6.1% increase in a consumer's MOOP costs from plan year 2021 to plan year 2022. This increase will impact every individual market consumer in all exchanges across the nation. For 2022, a 6.1% is a total of \$550 annually for an average of \$45 monthly. In addition, this change is more detrimental on families with an annual cost of an additional \$1,100 and monthly estimated cost of \$91. WAHBE encourages the administration to implement stabilizing measures to reduce and or mitigate negative financial impacts on consumers.

WAHBE echoes the comments we provided on the Notice of Benefit and Payment Parameters for 2020, which incorporated a change to the methodology for calculating the premium adjustment percentage that had previously been in place since 2015, in response to the proposed premium adjustment percentage for the 2022 benefit year.

The new premium adjustment percentage (PAC) methodology, which HHS proposes to continue for 2022, includes individual market premium trends in the PAC calculation, resulting in higher maximum annual limits on



consumer cost sharing and a higher required contribution percentage for purposes of qualifying for affordability exemptions than under the previous PAC methodology in place through 2019. Because this methodology is used by the Department of Treasury and IRS to determine the required contribution percentage and eligibility for tax credits, the new methodology results in reduced tax credit eligibility for the most vulnerable consumers and those impacted most acutely by the ongoing pandemic and economic downturn. These changes directly harm lower-income consumers.

The current PAC methodology, which HHS proposes to continue into 2022, results in the annual maximum out-of-pocket cost for an individual increasing to \$9,100 in 2022 (from \$8,550 in 2021). This out-of-pocket maximum is likely to be felt most acutely by individuals in bronze plans, whose plan out-of-pocket maximums, and often deductibles, are set at the federal maximum out-of-pocket limit. Individuals enrolling in bronze plans typically do so because they are seeking the lowest premiums, and many of WAHBE's most vulnerable and lowest-income consumers gravitate toward bronze plans. Continued utilization of this PAC methodology will directly harm individuals in bronze plans, a growing population in Washington for 2021 with over 100,000 individuals selecting bronze coverage. WAHBE strongly recommends that HHS return to the PAC methodology used before 2020 considering the direct and acute harm to consumers that it will continue to cause.

HHS estimated last year that PAC changes would cause 100,000 individuals to lose coverage due to unaffordability and net premiums to increase by \$181 million annually for exchange consumers, beginning in 2020. The harm caused in 2020 due to this methodology change will only have been exacerbated by the pandemic. WAHBE strongly encourages HHS to reassess the wisdom of keeping this methodology change in place for 2022 as consumers continue to feel the financial impacts of the pandemic throughout 2021. HHS should take the opportunity it has in finalizing the 2022 Notice of Benefit and Payment Parameters to return to a premium adjustment percentage methodology which will be less punishing toward consumers who are relying on the exchanges for critical health insurance in this unprecedented time.

WAHBE opposes the proposal to publish the premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitations on cost sharing, and required contribution percentage in guidance beginning with the 2023 benefit year. Exchanges and the public should have the opportunity to review and comment on these provisions each year through the notice of benefit and payment parameters.

#### ***Enforcement Remedies in Exchanges (HHS Civil Monetary Penalty) (§ 156.800)***

This proposed rule would codify HHS authority to impose civil monetary penalties for non-compliance with applicable Exchange requirements in state exchanges in situations where HHS steps in to enforce requirements around safeguarding federal funds (i.e., APTC, CSR, and user fees). WAHBE respectfully requests that HHS publish data that illustrates the problem that this proposed change is aiming to address. Has HHS identified state exchanges failing to adequately enforce ACA provisions and the need for HHS to impose civil monetary penalties? WAHBE is not aware of the extent to which this problem may have been identified by HHS and requests that HHS share data on instances where HHS's annual audit, reporting, and oversight requirements applicable to state exchanges have been inadequate to correct such issues. Without public data that illustrates a rationale for the civil monetary penalties, WAHBE suggests that the remedy proposed in the rule does not seem to be necessary and urges HHS not to adopt the proposed regulation until data can be shared.

#### ***Quality Rating System (§ 156.1120) and Enrollee Satisfaction Survey System (§ 156.1125)***

WAHBE encourages CMS to route any changes related to the QRS hierarchy through the QRS Technical Expert Panel (TEP). The QRS TEP is comprised of subject matter experts who will be able to give feedback on the proposed changes to the methodology and weigh this proposed change against any other QRS methodology changes that are being considered.

WAHBE appreciates the flexibility given to SBEs in the display of QRS and urges CMS to grant additional flexibility to states in the display of the star ratings. Technical details about display, including required notices, often come to SBEs too late to be implemented for the upcoming plan years.

WAHBE supports the proposal to publicly publish full QHP Enrollee Survey results in an annual Public Use File. To make survey results more user-friendly and to increase participation in the survey, WAHBE also requests that CMS devise an alternative survey and survey administration protocols to deploy a shorter survey that is more relevant to people's interests and more adaptable to alternative survey technologies.

***Issuer Use of Premium Revenue: Reporting and Rebate Requirements (§ 158.130 and 158.240)***

WAHBE expresses concern over the proposal to continue to allow estimated MLR rebates for the previous year to be prepaid by carriers to enrollees in the form of a premium credit (as outlined in 2020 COVID-19 guidance) or a lump sum payment. This year, prepayments caused significant operational burden to WAHBE with impacts to our Sponsorship program. In addition, the timing of prepayments could be problematic given consumers may favor certain carriers during open enrollment if they are given checks prior to plan selection. WAHBE urges delaying this proposal until the impacts of MLR prepayments can be assessed more thoroughly and disagrees with linking this proposal with reducing the issuer's responsibility to pay MLR rebates in full.

WAHBE urges HHS not to finalize the proposal that would allow issuers that prepay at least 95% of the total estimated MLR rebate owed for the previous year to defer payment of any additional rebate owed until the MLR rebate deadline for the following year. WAHBE does not believe such an incentive is necessary to encourage issuers to prepay estimated amounts owed a few months earlier than the required payout date in the case of a public health emergency.

Additionally, WAHBE suggests that a delay of a full year before the additional amount owed would have to be paid to enrollees is a significant delay and is likely to harm consumers. For example, this proposal would mean that an MLR payment owed for 2022 and calculated and 95% prepaid during 2023 would then be required to be paid in full by September 30, 2024. Consumers enrolled in 2022 could have moved or changed contact information by 2024 and carriers may not be able to locate consumers to whom rebates are owed. WAHBE suggests that the benefit to carriers would be minimal and not worth the harm it would cause consumers.

***Provisions of the Proposed Rule for State Innovation Waivers – HHS and Department of the Treasury (31 CFR Part 33 and 45 CFR Part 155)***

WAHBE discourages HHS from incorporating the 2018 Section 1332 Waiver Guidance in full into the ACA Sec. 1332 regulations by reference in this proposed 2022 Notice of Benefit and Payment Parameters. WAHBE posits that the Notice of Benefit and Payment Parameters is not the appropriate vehicle for publication of significant regulatory interpretation of ACA Section 1332 and urges HHS to release any such regulatory proposal in full (as opposed to incorporating 2018 guidance by reference) and as part of a full 60-day notice and comment period. HHS's approach of requesting comment on proposed regulation by reference to previous guidance is likely to result in minimal and insubstantial stakeholder feedback. A full notice and comment period with proposed regulations published in full is warranted for a proposed regulatory change of such import and substance.