

## Washington Health Benefit Exchange Comments: Proposed Federal Rule – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020

The Washington State Health Benefit Exchange (WAHBE or the Exchange) submits comments about the proposed Notice of Benefit and Payment Parameters for 2020 (Payment Notice), published by the United States Department of Health and Human Services (HHS) on January 24, 2019.

As a state-based exchange, WAHBE appreciates HHS's continued approach reflected in the proposed regulations of allowing state exchanges the freedom to regulate their own marketplaces. WAHBE emphasizes the need for HHS to continue to allow state-based exchanges to respond to trends in our state insurance markets in a way that best addresses the needs of our consumers. In Washington State, individual market consumers have faced rising premiums as well as increasing cost-sharing. Consumers feel that they are paying more for less, and question the value proposition of their health coverage – especially those consumers who don't have immediate health care needs. Policy changes at the federal level, including encouragement of non-ACA-compliant health plans as alternatives to the individual market, termination of federal cost-sharing reduction (CSR) payments to issuers, and elimination of the individual mandate penalty, have cumulatively undermined the health of exchange risk pools and destabilized the individual market nationwide. The Exchange continues to seek out state-specific opportunities to support the hundreds of thousands of Washington residents who rely on the individual market for comprehensive health coverage. WAHBE supports HHS in its intent to reduce regulatory burden on consumers and states and allow state exchange and insurance bodies the flexibility to respond to local market needs.

The Exchange encourages HHS to consider the impacts of the proposed regulations, first and foremost, through a consumer lens, and prioritize consumer needs as it considers potential policy direction for future years. Some of the changes proposed in the Payment Notice are likely to cause significant consumer confusion as well as financial harm, endangering consumers' ability to maintain any health coverage at all. WAHBE encourages HHS to honor its long-standing commitment to making affordable, comprehensive coverage available to all who seek it in the individual market by pursuing regulatory changes that strengthen the individual market risk pool and provide consumers with health coverage they can understand and use.

WAHBE offers comment on specific provisions of the proposed Payment Notice below.

### ***Automatic Re-Enrollment at Renewal and Funding of Cost-Sharing Reductions Through "Silver Loading"***

The Exchange appreciates the opportunity to provide comment on automatic re-enrollment at renewal ("auto-renewal") and loading of the cost of CSRs on exchange silver plans ("silver loading") in advance of potential HHS rulemaking regarding these practices. Auto-renewal and silver loading are two of the most important tools that WAHBE has implemented in recent years in efforts to minimize destabilizing forces in the Exchange market and reduce burdens on our consumers caused in part by federal policy changes that have increased costs and created uncertainty in the individual market. WAHBE strongly recommends that HHS leave these tools in place for exchanges with no changes in future years.

#### *Auto-Renewal*

The Exchange strongly urges HHS not to limit the practice of automatic re-enrollment at renewal in exchanges. Auto-renewal plays a critical role in ensuring continuity of coverage and care for consumers year-to-year, providing consumers with a safety net so that they don't inadvertently find themselves without coverage after

open enrollment has ended, and easing burdens on consumers and carriers. Auto-renewal is an essential operation of exchanges and aligns the exchange market with insurance industry standards, including in the employer-sponsored insurance and Medicare markets. In Washington State, auto-renewal in the Exchange is consistent with carrier practice in the outside market and with interpretation of state guaranteed renewability law. The Exchange has facilitated automatic re-enrollment during renewals for our population since 2014. It has become an expected and appreciated aspect of enrollment through the Exchange, and disruption to this process in future years would result in unnecessary and avoidable consumer loss of coverage, confusion, and burden.

Prohibitions on states' ability to conduct auto-renewal are not necessary to advance HHS's stated goals of preserving program integrity and ensuring the appropriate administration of premium tax credits. Currently, the Exchange has comprehensive processes in place during auto-renewal for checking consumer data against federal sources, verifying income and adjusting tax credit eligibility accordingly, and discontinuing premium tax credits for consumers who fail to file and reconcile their federal income taxes or who have not given the Exchange the authority to access their tax information. The current robust framework for updating and verifying information when changes are reported throughout the year and ensuring accurate eligibility decisions provides effective mechanisms for preserving program integrity. CMS exercises strong oversight over exchange functions through the annual programmatic audit and SMART reporting, which will become even more robust as CMS implements proposed changes to these oversight tools included in the forthcoming finalized Program Integrity regulations.

Auto-renewal is a critical tool for exchanges to support continuous enrollment of consumers and contribute to stability in the individual market. This practice facilitates predictability for issuers in anticipating their consumer mix for the following year and consistency for consumers in their carrier, coverage, and providers. Many consumers rely on auto-renewal each year to make the process of choosing a plan easier, and eliminating exchanges' ability to perform auto-renewal would result in customers losing their coverage and being uninsured for the following year. The Exchange strongly urges HHS to refrain from limiting states' ability to conduct automatic re-enrollment and to continue implementing this tool in the Federally Facilitated Marketplace (FFM).

### *Silver-Loading*

Like auto-renewal, silver loading has been a valuable tool that Washington State has used to protect consumers from premium increases and minimize the impact of destabilizing forces in the individual market. When the federal government ceased direct federal funding of CSRs in 2017, states took different approaches to how the costs for CSRs, still required to be provided by carriers, were reflected in premiums. Some states chose to direct carriers to load the cost of CSRs onto silver plan rates in exchange plans, called "silver loading." Washington State implemented this approach in 2018 and 2019 to minimize the negative impact of the rate increases caused by the lack of federal funding on individual market enrollees.

The Exchange's primary concern with respect to the state of the individual market in Washington is affordability. Each year, premiums continue to go up while consumers find themselves spending more and more on their out-of-pocket medical costs. Consumers without significant health issues – notably the "young invincibles" – are the most likely to drop coverage when it is perceived as unaffordable and of little value. These consumers are vital to attract and retain to the individual market to provide a healthy and balanced risk mix. Unsubsidized consumers are also likely to drop coverage when it becomes unaffordable, as they are not shielded from steeply rising premiums and out-of-pocket costs by tax credits and cost-sharing reductions. Both the young invincibles and the unsubsidized are essential parts of a robust, healthy individual market and the Exchange is committed to finding solutions for challenges to the affordability problem that are inclusive of these two populations.

The Exchange is supportive of finding a permanent solution that would reinstate direct federal funding of CSRs to carriers, making silver loading unnecessary. As long as federal funding of costs of required CSRs continues to be withheld, states must be permitted to implement solutions to ease the burden on consumers. In order to protect consumers both inside and outside the exchanges, silver loading or other approaches appropriate for local markets should be permitted at each state's option until a permanent solution for funding of the CSR program can be identified and implemented. The Exchange strongly urges HHS to make no changes to states' ability to use appropriate tools to attempt to stabilize their individual markets and protect consumers.

### **Premium Adjustment Percentage**

The Exchange strongly encourages HHS not to make changes to the methodology for calculating the premium adjustment percentage at this time, and to retain the approach to measuring premium growth that has been in place since 2015. The proposal to include individual market premium trends in the premium adjustment percentage calculation would result in higher maximum annual limits on consumer cost sharing and a higher required contribution percentage for purposes of qualifying for affordability exemptions, changes that directly harm lower-income consumers. Of particular concern is the likely use of the revised premium adjustment percentage proposed in the Payment Notice by the Department of Treasury and IRS for determining the required contribution percentage in Code Section 36B(c)(2)(C), on which eligibility for tax credits is based. HHS estimates that these changes will 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. Affordability for our consumers is the Exchange's number one concern, and we urge HHS not to take action to make health coverage even less affordable and further destabilize the individual market. The Exchange strongly recommends that HHS reconsider this proposal in light of the direct and acute harm to consumers that it will cause.

In the preamble to the proposed rule, HHS discusses the reasoning behind its original decision to base the premium adjustment percentage on per enrollee employer-sponsored insurance (ESI) premiums, noting that this methodology was chosen because ESI premiums reflected trends in health care costs *without being skewed by individual market premium fluctuations resulting from the early years of implementation of the PPACA market reforms*. HHS noted in past regulatory guidance that it might, in the future, change this methodology *after the initial years of implementation of the market reforms, once the premium trend [became] more stable*.

In Washington State, the Exchange market grew during the first years of Exchange implementation, accompanied by some fluctuations in premiums and carrier participation. By 2017, we saw premium increases begin to stabilize, consistency in carrier participation, and signs that the new market was beginning to settle (as anticipated by HHS in 2015). Unfortunately, just as the Exchange market in Washington seemed to be hitting its stride, this stability was shaken with the withdrawal of federal funding for CSRs, which remained the obligation of carriers to fund. As a result, some consumers saw premium increases of nearly 50% entering the 2018 plan year. During 2018, federal regulations were issued encouraging the proliferation of non-ACA compliant health plans as alternatives to comprehensive ACA coverage, and the federal government zeroed out the individual mandate enforcement mechanism effective for 2019. These actions by the federal government have undermined the progress made nationwide in the individual market during the first years of ACA implementation. HHS's 2015 vision of a stable individual market after the initial years of ACA reform has not come to fruition, in no small part due to destabilizing influences at the federal level.

As a result of federal policy decisions made over the last two years, volatility in exchange premiums has increased. The proposed change to the premium adjustment percentage would only exacerbate the volatility of the individual market, and will further penalize Exchange consumers for distorted premium increases that they have already borne by reducing their tax credits and increasing their out of pocket costs. The Exchange urges

HHS not to change the premium adjustment percentage methodology at this time, so as not to further harm consumers and destabilize the individual insurance market as it struggles to adapt to the significant policy changes it has endured in recent years.

### ***Addressing Prescription Drug Costs; Removal of Brand-Name Drugs from the Essential Health Benefits***

The Exchange appreciates HHS's commitment to addressing rising prescription drug costs and supports efforts to encourage the appropriate utilization of lower-cost and generic prescription drugs. We are supportive of HHS's proposal to permit mid-year additions of generic drugs to the formulary and changes to tiering, but generally recommend that HHS defer to state law on formulary regulation. In Washington, Exchange carriers all encourage use of generics through mechanisms such as tiered formularies, step therapy, and prior authorization. WAHBE encourages HHS to incentivize carriers to implement plan designs that encourage lower cost and generic drugs while continuing to allow state insurance bodies to regulate precisely when and how carriers may change their formularies.

The Exchange urges HHS to approach imposing new regulatory requirements with respect to therapeutic substitution with caution. WAHBE appreciates the potential for cost-savings that therapeutic substitution could offer, and encourages HHS to gather data on existing standards, best practices, and evidence-based recommendations with respect to therapeutic substitution before requiring any particular approach through regulation. Similarly, we are supportive of HHS's intention to obtain more information regarding use of reference-based pricing to control prescription drug costs before including any requirements through regulation.

The Exchange recommends against HHS's proposal to control prescription drug costs by permitting (or requiring) issuers to exclude of certain brand drugs from the essential health benefits (EHB) package, an approach which would result in the treatment of prescription drugs as EHBs varying by issuer (and possibly by drug, and by plan). WAHBE would be supportive of HHS encouraging state regulatory bodies to consider defining EHB to exclude brand drugs in certain circumstances, but has serious concern about the proposal to permit (or require) issuers to exclude brand drugs from the EHB in certain plans and for consumers for whom a generic substitution is found to be medically appropriate. Any re-definition or limitation of the prescription drug essential health benefit should be under the authority of the insurance regulatory body in each state, just as other aspects of definition of the EHB are.

The proposed rule would cause significant confusion for consumers. Prescription drug coverage could vary significantly for drugs included in formularies, issuer-by-issuer, and even between plans of the same issuer. Further, prescription drug coverage would vary even for individuals covered within the same plan, based on whether a generic drug was determined to be medically appropriate for a given individual. It would be nearly impossible for exchanges to make these nuances of coverage transparent to consumers, and is likely to result in consumer confusion, frustration, delays in needed care, and benefit appeals. Moreover, the proposal that issuers would calculate a plan's EHB factor to take into account exclusion of certain brand drugs is not implementable, because as proposed the determination of whether a brand would be included in EHB would vary by enrollee, depending on whether the brand drug is determined to be medically appropriate for that individual. To prevent harm to consumers, reduce confusion, and advance transparency, the Exchange strongly suggests that HHS refrain from taking any action under this proposal other than to suggest its consideration by state regulators, with the expectation that implementation would be consistent across carriers.

### ***Rules Relating to Coverage of Abortion Services and Segregation of Premiums for Such Services***

Washington State is among the group of states that has made provision of non-Hyde abortion services a requirement of insurance coverage in the individual, small group, and large group markets. Therefore, the

requirement of an exchange QHP issuer that offers a plan that covers non-Hyde abortion services to offer at least one “mirror plan” in the exchange that excludes such services does not apply in Washington State. However, although not directly applicable to Washington consumers, the Exchange strongly urges HHS to omit this proposal from the final Payment Notice, as it is likely to cause significant consumer confusion and harm. Distinguishing between otherwise-like plans that do provide non-Hyde abortion services and plans that do not provide that coverage will create a confusing and inordinately negative consumer experience, and, for the first time, would require all carriers in exchanges across the country (except for states that have laws mandating the provision of non-Hyde abortion services) to offer a set of benefits mandated by HHS beyond the EHB requirements. This proposed change would represent an encroachment into states’ well-established authority to regulate such benefit design questions, and HHS should reject setting such a precedent. State insurance regulators are the best entities to propose such a requirement for the issuers in their state markets.

### ***Proposed New Special Enrollment Period***

The Exchange strongly supports the proposed new special enrollment event for individuals without current exchange coverage to access a special enrollment period in an exchange plan if they experience life changes that make them newly eligible for a premium tax credit in the exchange. WAHBE suggests two technical changes to this special enrollment event as currently proposed. Currently, only income changes are included in the special enrollment event, when other tax-related changes could also cause an individual enrolled in an off-exchange plan to become eligible for tax credits through an exchange plan. WAHBE recommends revising 45 CFR 155.420 proposed section (d)(6)(v)(A) to read “(A) Experiences a decrease in household income *or tax filing status*,” in order to account for circumstances in which an income change, *or a tax family composition change or the resolution of a tax return from a prior tax year* causes an individual to become newly eligible for a premium tax credit in an exchange plan.

Additionally, WAHBE proposes modifying 45 CFR 155.420 proposed section (d)(6)(v)(C) in two ways, by revising the language to read “(C) Had ~~minimum essential coverage as described in 26 CFR 1.5000A-1(b)~~ *coverage as described in section (a)(5) above* for one or more days during the 60 days preceding the date of the financial change *or change in tax filing status*.” These proposed changes will incorporate the loss of other coverage that is not minimum essential coverage (MEC) but is treated as MEC for special enrollment purposes in this special enrollment event, and will reflect the inclusion of other tax related changes in part (A) of this subsection.

### ***Conclusion***

The Exchange continues to emphasize the need for HHS to consider proposed changes through a consumer lens. Exchange consumers are struggling with plans with high premiums and out-of-pocket costs, and they are challenged to see the value proposition of having health care. The Exchange encourages HHS to take the opportunities available as it finalizes these regulations to strengthen the individual market rather than destabilize it further, and to prioritize the needs and concerns of health care consumers.