Cascade Care Savings: State Premium Assistance Policy
Public Comments (Public Comment Period: April 5 – April 29, 2022)
May 10, 2022

Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Health Plan of Washington (Jill McMahon)
Comments Received: April 29, 2022

Kaiser Permanente appreciates several of the revisions provided in the third policy draft some concerns remain, as outlined below:

- **Three-Month Grace Period** – Kaiser Permanente continues to strongly object to state-subsidy-only members having the ability to receive a three-month grace period for non-payment of premiums. While we understand the intent to mirror the requirements in the federal APTC policy, its applicability is not the same and could have the following financial consequences and risks should it be implemented:

    - The federal government reimburses carriers the full APTC amount for the first month of unpaid premium by a member; the WAHBE state subsidy policy would reimburse the much smaller state subsidy.

    - The burden of covering the financial liability related to medical services rendered for a lesser state subsidy amount is not equivalent to the federal APTC payment for the same month, regardless of the anticipated low volume of state-subsidy-only members.

    - It is indicated that carriers can terminate a state-subsidy-only member's coverage on the last day of the first month of the grace period ***only if*** claims were pended in the second and third months of the grace period. Given Kaiser's model of care and current system limitations, this provision create enormous financial consequences for services provided by our internal Kaiser providers and facilities.

    - Finally, under existing regulation, WAC 284-170-431 , carriers are required to pay clean claims on a timely basis, which is defined as being within thirty days. Carriers who fail to do so may be subject to financial penalties and/or corrective action. WAHBE's proposed policy requiring carriers to pend claims for non-APTC eligible consumers during a state 90-day grace period would place issuers in conflict with this OIC requirement.

- **Special Enrollment Period (SEP)** —We believe the proposed SEP for this population is overly broad. There is a federal 60-day SEP trigger for someone newly eligible for APTC or CSR, due to a change in income. We do not recommend providing longer election periods for the State subsidy. Allowing unresponsive individuals and individuals who do not file their household tax information being afforded the ability to enroll at any point during the year is not good public policy. Consumer protections and ease in the enrollment are important, but so is consumer accountability and precedent-setting policy.

- **Coverage of Non-EHB Premiums** – Each previously published policy draft has indicated that premium assistance may be applied to premium amounts attributable to non-EHB services by describing $0 member premiums In the interest of transparency, we ask that WAHBE clarify in this policy whether state subsidies do or do not include the required $1 per member per month premium amount for coverage of non-Hyde abortion services.

LifeWise Health Plan of Washington and Premera Blue Cross (Skyler Mahjoubian)
Comments Received: April 28, 2022

LifeWise Health Plan of Washington and Premera Blue Cross ("LifeWise"), appreciates the opportunity to provide additional feedback on the Cascade Care Savings policy development. First, LifeWise supports several clarifications and changes in policy draft three. With regards to the special enrollment period (SEP), we thank HBE for clarifying that the SEP is only available to new enrollees and current enrollees not enrolled in Cascade Care silver or gold plans. We also appreciate the clarification that accumulator transfers will apply when enrollees stay with the same carrier. After careful review of draft three, LifeWise has significant concerns that a monthly SEP open to anybody who meets the income criteria will cause consumer confusion and weaken the financial efficacy of the market. The Affordable Care Act (ACA) established the fundamental market rule that, outside of open enrollment, only certain qualifying events trigger an SEP. An income level up to 250% FPL is not one of those triggers. Therefore, the proposed SEP is inconsistent with the ACA. We believe that such an inconsistency will confuse consumers and inevitably drive-up inquiries, complaints, administrative costs, and contribute to a poor member experience. We know that affordability is the number one factor for Washingtonians when considering which health plan to purchase. LifeWise reiterates the concerns raised from other carriers about adverse selection. The proposed SEP is open to the point where we should expect uncontrolled, frequent, jumping from plan to plan. This will negatively impact our ability to keeps costs low and potentially push people away from the market altogether. For all the reasons above, we urge HBE to reconsider the proposed SEP. Thank you.

Molina Healthcare (Kristen Federici)
Comments Received: May 2, 2022

Thank you for the opportunity to comment on the components of the state subsidy program. We appreciate your consideration of feedback thus far, and changes you've made based on what you have heard from interested parties, most notably the narrowing of the accumulator language to just movement within the same health plan.

We have two outstanding concerns we would like to raise with you. First, we are very concerned about the Special Enrollment Period (SEP) language. Our data shows that SEP members are more expensive than regular members, and we are concerned about the broad SEP language you are considering. Given that the Medicaid population will have their own Qualifying Life Event (QLE) to allow them to enroll in a subsidized plan when redeterminations begin on that population, and loss of coverage is already a coverage QLE, we do not feel that an ongoing SEP is necessary for this population and would strongly urge you instead to plan on a more traditional Open Enrollment Period. We have included data below to show the cost of SEP members versus regular members for Molina over the last few years. In particular, please note that in 2019 the MLR for the SEP members was 10% worse than OEP members. And as you know, the impact of the additional cost and burden on the single risk pool, puts upward pressure of premium rates for all members.

In 2019 the medical loss ratio (MLR) for the SEP members was 10% worse than OEP members.
In 2020 the MLR for SEP members was 1% worse than OEP members.

2019			
PMPM Measures	**OPEN**	**SEP**	**Total**
Member Months	233,347	16,330	**249,677**
Average Members	21,213	1,485	**22,698**
Gross Premium	595	521	**591**
Risk Adj	139	186	**143**
MLR Rebate	-	-	-
Other Revenue	2	2	**2**
Net Revenue	**737**	**710**	**735**
Medical	387	459	**392**
Pharmacy	114	93	**113**
Capitation	0	0	**0**
Other Claims	(0)	(0)	**(0)**
Net Claims	**501**	**552**	**505**
Admin	78	69	**77**
Taxes and Fees	16	14	**16**
Net Expenses	**94**	**83**	**93**
Net Income	**142**	**75**	**137**
Federal MLR	**62%**	**72%**	**63%**

2020			
PMPM Measures	**OPEN**	**SEP**	**Total**
Member Months	386,141	52,837	**438,978**
Average Members	35,104	4,803	**39,907**
Gross Premium	482	453	**478**
Risk Adj	23	(45)	**15**
MLR Rebate	(26)	(26)	**(26)**
Other Revenue	(0)	(0)	**(0)**
Net Revenue	**479**	**383**	**467**
Medical	290	245	**284**
Pharmacy	87	48	**82**
Capitation	2	2	**2**
Other Claims	(0)	(0)	**(0)**
Net Claims	**379**	**295**	**368**
Admin	68	63	**67**
Taxes and Fees	22	20	**21**
Net Expenses	**89**	**84**	**89**
Net Income	**11**	**4**	**10**
Federal MLR	**77%**	**78%**	**77%**

Our second concern is related to the 90-day grace period. We appreciate your desire to align state subsidy grace period with the federal grace period requirements to reduce and recognize the relatively small population who will have a state-only subsidy, but this is a significant undertaking from an administrative burden perspective. Additionally, a significant difference between your 90-day grace period and the federal grace period is your required repayment of the subsidy for the period after the first 30-days. The federal program recognizes that health plans are taking the risk and bearing the burden of reimbursement for individuals who have not paid their premium for the first thirty days, and allows the plans to keep the subsidy payments for the second and third months. We would ask that if you proceed with these planned program changes, you mirror to the federal grace period and allow plans to retain those dollars from months two and three.
Again, we appreciate the opportunity to provide feedback and would be happy to meet to discuss this further if that would be of use to you. Please let us know if you have any questions.

Advocates: Northwest Health Law Advocates, Economic Opportunity Institute, Dziedzic Public Affairs (Emily Brice, Sam Hatzenbeler, Erin Dziedzic)
Comments Received: April 29, 2022

Ms. Christine Gibert, Policy Director
Washington Health Benefit Exchange
Submitted via email: cascadecare@wahbexchange.org

Re: PY 2023 Cascade Care Draft Subsidy Policy and Standard Plan Designs

Dear Ms. Gibert and WAHBE colleagues:

Thank you for the opportunity to submit additional feedback to the Washington Health Benefit Exchange (WAHBE) regarding the draft Cascade Care Savings Policy for PY 2023 ("Savings Program Rules" or "Program Rules") and Appeals Procedural Rules ("Appeals Rules"). We write to share collective feedback from our perspective as consumer advocates.

As we have detailed in previous comments, we strongly support WAHBE in pursuing Cascade Care policies that expand affordability and access for Washington State consumers. Based on preliminary

data, WAHBE's suite of Cascade Care programs are already working to encourage consumer selection of higher-value plans. We support the draft Savings Program Rules and Appeals Rules as the next step in expanding marketplace affordability.

We are particularly supportive of the following elements of the Savings Program Rules:

- **Grace period policy in Section 8(6).** The proposal to align the state Savings program grace period with the federal grace period will prevent unnecessary uninsurance and churn by giving enrollees a reasonable opportunity to catch up on premium payments, while fairly splitting any financial risk from payment delinquency among providers, carriers, and enrollees. As we noted in our previous comments, this approach will minimize operational complexity for consumers, WAHBE, carriers, and providers— particularly given the limited number of individuals who will be eligible for Cascade Care Savings without federal advance premium tax credits (APTCs). Also, as WAHBE presented at the April 12th Cascade Care Workgroup meeting, the most recent Exchange report on grace periods showed that at least 77% of consumers were able to make a catch-up payment and fewer than 14% were terminated for nonpayment.

- **Special enrollment period policy in Section 9.** We also strongly support WAHBE in proposing an ongoing special enrollment opportunity (SEP) for individuals with incomes under 250% FPL who are not yet enrolled in a silver or gold Cascade Care plan. This proposal will promote coverage and with careful monitoring, can be introduced without posing an undue adverse selection risk. As we have previously noted, available data suggests that broad SEPs for low-income enrollees promote coverage without introducing undue risk. This proposal also aligns with federal policy and would offer a critical safety net at the end of the public health emergency. We particularly appreciate that currently-enrolled individuals who switch plans under this SEP would not lose any cost accumulators if enrolled with the same carrier.

We are particularly supportive of the following elements of the Appeals Rules:

- **Unified appeals process throughout.** We appreciate that WAHBE has solidified a unified appeals process for federal and state programs in Section 6 of the draft Savings Program rules and throughout the draft Appeals Rules. As we noted in previous comments, it is best for WAHBE to maintain one consolidated policy governing enrollee appeals to reduce the risk that hearing officers could apply two different standards to the appeals process. We appreciate efforts throughout the draft rules to achieve this goal.

- **Appeal timeline in Section 4.** We applaud WAHBE for aligning the appeal timeline for federal and state programs in the draft Appeals Rules. In a previous version of the rules, WAHBE allowed aggrieved individuals to request an appeal within 90 days for federal programs (as required by federal law), but only allowed 30 days for state premium assistance. We are glad to see that WAHBE is now proposing a unified 90 day standard for all eligibility determinations, with the possibility of a good cause exception for exceptional circumstances requiring a longer timeline. This unified 90-day timeline will be simpler for WAHBE, clearer for consumers, and offer enrollees a greater chance to maintain their coverage. The longer timeline also recognizes the reality of slower mail delivery times given recent changes to U.S. Postal Service delivery standards.[1] (*Please note*: There is a remaining reference to the 30-day timeline in Sec. 5(1)(b) that should be deleted for consistency).

- **Financial assistance pending appeal in Section 5(6).** We strongly support new language in

Section 5(c) which clarifies that individuals may continue to receive financial assistance pending their appeal for the *full* range of financial assistance programs, including Cascade Care Savings and premium assistance provided through the child care worker sponsorship program. This is consistent with federal law, which recognizes aid pending appeal as a critical continuity-of- coverage protection for enrollees who receive an inaccurate eligibility redetermination resulting in the loss or reduction of financial assistance. See 45 CFR § 155.525. Without aid pending appeal, these enrollees could face a needless coverage gap.

We urge WAHBE to retain these consumer-friendly policies in the final Rules. However, we are concerned that some elements of the draft rules are not yet clear.

We ask WAHBE to address the following remaining issues prior to finalizing the rules:

1. Recommendations for Draft Savings Program Rules

a. Clarify aspects of the Program Rules that are inconsistent with the immigrant-related 1332 waiver.

We applaud WAHBE for its plans to move forward with a 1332 waiver application to support immigrant coverage. We understand that such coverage will not be available until PY 2024, while the currently proposed Cascade Care subsidy program only governs PY 2023. However, we are concerned that some elements of the draft Savings Program Rules appear to restrict eligibility in a way that would present concerns when the 1332 waiver is approved.

WAHBE has made one helpful addition to address this concern in Section 4(1)(e) of the draft Savings Program Rules, by clarifying that individuals are not precluded from Savings Program eligibility if they choose not to consent to ongoing verification of federal tax information. We support this change and welcome the opportunity to dialogue with WAHBE staff how to operationalize the auto-renewal process so that individuals can retain Cascade Care Savings year-over-year if they have not filed taxes, reconciled taxes, or checked the box that authorizes Healthplanfinder to verify tax information year-over-year. This will be an important policy area to explore ahead of PY 2024.

But there are still other remaining elements of the draft Savings Program rules that will be misaligned with the new immigrant population in 2024. Specifically:

- Section 4(3) requires an individual to receive an eligibility determination for federal APTCs and cost-sharing reductions (CSRs) prior to receiving state premium assistance. This will not be appropriate for the new immigrant population, who are by definition ineligible for these federal programs. *Recommendation:* We are hesitant to recommend specific language at this stage because it is still uncertain how WAHBE's new immigrant program will intersect with Washington Apple Health, including the new Medicaid-equivalent program and existing programs such as Alien Emergency Medical and Pregnancy/After-Pregnancy coverage. We suggest that this language will need revision in PY 2024 once such details are known, but as a placeholder WAHBE could consider the following revision to Section 4(3):

  "To be eligible for state premium assistance, individuals must receive an eligibility determination for any <u>available</u> insurance affordability programs, including:
  a. Washington Apple Health
  b. Advanced Premium Tax Credits <u>and</u> ~~c.~~ Cost-sharing reduction Subsidies<u>, if the individual has attested to citizenship or lawfully present status</u>."

- Section 4(4) indicates that the Exchange will verify data matching inconsistencies, including citizenship/lawful presence status. We understand that as an operational matter, WAHBE only conducts this verification if an applicant has attested to citizenship/lawful presence status. For the purposes of clarity with the new population, however, we recommend addressing this issue directly in the Savings Program Rules. *Recommendation*: WAHBE could modify Section 4(4)(a) to clarify that WAHBE only confirms citizenship/lawful presence "<u>if applicable</u>" or alternatively, if the individual has provided "<u>an attestation of</u> citizenship/lawful presence status."

- Section 4(1)(b) and Section 6(1) indicate that an applicant will only be considered for state premium assistance eligibility if the person is determined for Qualified Health Plan coverage. While this is incompatible with the new immigrant program, we expect this issue will be resolved by the 1332 waiver, which would make new immigrants eligible for Qualified Health Plans if approved. *Recommendation*: Monitor the language in these sections to ensure the language is compatible with PY 2024 policy.

If WAHBE does not adopt changes in this area to the Savings Program Rules for PY 2023, we seek assurances that WAHBE expects to update the rules ahead of 1332 waiver implementation to remove or modify these eligibility restrictions for the newly-eligible immigrant population.

b. Revise definition of "eligible household" to clarify it may include individuals who are not eligible.

We remain concerned that the proposed definition of an "eligible household" in Section 3(4) could be read to inadvertently limit individuals from state premium assistance eligibility if they have individuals in their tax filing households who are not eligible for state premium assistance. Under the proposed rules, an "eligible household" is a "tax filing household consisting of one or more individuals, *all of whom* are eligible enrollees" (emphasis added). The proposed rules define "tax filing household" in Section 3(3) as "a federal tax filing unit." The draft rules then go on to apply these terms in Section 5, related to calculation of the premium assistance amount for "eligible households."

We are confused by these definitions, which appear to preclude otherwise eligible enrollees from state premium assistance if their tax filing households include individuals who are not also eligible enrollees – for example, individuals whose family members are enrolled in Washington Apple Health or ineligible for Exchange coverage for other reasons, such as immigration status. We recognize this is a complex set of definitions that relate back to federal tax household rules governing premium tax credit eligibility. We have recommended a preliminary potential change to the language below, but would be glad to discuss this language in a call if helpful.

Recommendation: "Eligible Household means a tax-filing household <u>that includes</u> ~~consisting of~~ one or more individuals~~, all of~~ who~~m~~ are eligible enrollees."

c. Clarify that the Savings Program Rules are effective for eligibility determinations made prior to January 2023.

Section 2 of the draft Saving Program Rules includes language stating that the policy is in effect "beginning in plan year 2023"— that is, January 2023. We recommend a minor change to clarify that the policy is also in effect for eligibility determinations made in November and December 2022 for coverage starting in the 2023 plan year.

Recommendation: "This Policy, governing the administration of the State Premium Assistance Program, is effective beginning <u>for coverage effective</u> in plan year 2023."

d. Share information about how the waitlist will function in the case of low funds.

We understand from the April 12th Cascade Care Workgroup meeting that the Program Rules will not include guidance on how the Cascade Care Savings waitlist will function in the case of low program funds, but that HBE is looking into functionality to track requests for Cascade Care Savings made after program enrollment is frozen. *Recommendation*: We would appreciate the opportunity to review and comment on this mechanism once it is further developed, so we can partner to support a well- functioning system for consumers and assist in any legislative advocacy to expand program funding if needed. It will also be important for this waitlist functionality to incorporate privacy protections for individual information, given the new immigrant population anticipated in PY 2024.

2. <u>Recommendations for Draft Appeals Procedural Rules</u>

a. Address significant concerns about the impartiality of second-level appeals.

We appreciate that Section 13 of the draft Appeals Rules attempts to address the issue of "second level" appeals for appellants who disagree with the decision of an Exchange presiding officer related to eligibility for the state Cascade Care Savings or child care worker premium assistance programs. We recognize that the Exchange is unable to leverage the HHS appeals process for this purpose.

However, we have serious concerns with the solution WAHBE has proposed for second level appeals related to state programs. In Section 13(2), WAHBE indicates that an individual seeking a second-level appeal of the Exchange's decision about eligibility for a state program may only make this appeal *to the same Exchange entity that made the decision*. This is unacceptable. While the rule specifies that another presiding officer must hear the second appeal, WAHBE proposes no solution to the possibility of bias against the appellant on the part of the second presiding officer, given the collegial relationship between the second presiding officer, the first presiding officer, and WAHBE staff/vendors. There is no meaningful protection for the appellant against the reality that these individuals are all paid staff of the same organization, possibly co-located in the same office, and possibly supervised by the same Exchange legal counsel.

We urge WAHBE to reconsider this inappropriate proposal, particularly because it highlights a longstanding concern of legal advocates about the sufficiency of WAHBE's procedural protections. As we have noted since WAHBE's inception as a quasi-public entity, it is highly problematic that WAHBE views itself as outside the purview of the state Administrative Procedures Act, Ch. 34.05 RCW, and thus in its view excepted from the standard due process protections that agencies must follow, such as allowing appellants to petition for judicial review following the exhaustion of administrative remedies.

We do not concede WAHBE's view, particularly as WAHBE assumes additional responsibilities for conferring benefits under the new state premium assistance programs. We have consistently noted this concern in dialogue with WAHBE staff, including during legislative deliberations about E2SSB 5377, the Cascade Care Savings enabling statute. In these recent conversations, we were assured by WAHBE staff that WAHBE would follow an "APA-like" process for rules and appeals. We are disappointed to see that WAHBE has now proposed a lesser standard that does not allow for a meaningful second level review.

It is possible that a court would disagree with WAHBE's position regarding whether the proposed process is sufficient to meet due process. We note that federal regulations indicate that appellants may even seek *third-level* review of HHS decisions. 45 C.F.R. §155.505(g). We also note that at least one other peer Exchange recognizes judicial review of Exchange appeal decisions, including a state subsidy program similar to Cascade Care Savings – the Massachusetts Health Connector recognizes that appellants may

appeal Exchange appeal decisions in state court after exhausting administrative processes.

Recommendation: We seek dialogue with WAHBE about how to better address second-level appeals for state programs. There are a number of different routes WAHBE could explore, such as using the Office of Administrative Hearings as a neutral entity for second-level appeals. We would appreciate the opportunity for a discussion with WAHBE prior to finalizing this ill-advised proposal.

b. Clarify that individuals may appeal eligibility determinations regarding qualified dental plans.

We are concerned that the proposed Appeals Rules do not adequately indicate that eligibility determinations related to qualified dental plans (QDPs) may be appealed.

In Section 2(8), the draft rules define "eligibility determination" as a "...decision made by the Exchange that an applicant or enrollee is eligible or ineligible for enrollment in a *qualified health plan* and/or financial assistance…" (emphasis added). Section 3(a) and (b) further specify that individuals may only appeal eligibility determinations related to qualified health plans, with no mention of qualified dental plans. We presume this is an oversight rather than intentional omission, given that Section 2(9) defines "enrollee" to include individuals "enrolled in a health and/or dental plan through Washington Healthplanfinder."

Recommendation: WAHBE should clarify that individuals may appeal eligibility determinations related to qualified dental plans. There are at least two drafting options to achieve this goal – WAHBE could define "qualified health plan" to include qualified dental plans, or WAHBE could instead modify Sections 2(8) and Section 3 to clarify that eligibility determinations related to qualified dental plans are appealable.

c. Correct internal reference discussing the content of the notice of hearing in Sec. 9.

Section 9(1) of the draft Appeals Rules requires that the notice of hearing must state that if the appellant fails to attend or participate in a pre-hearing/hearing, the appeal will be dismissed as set out in Procedural Rule 16. This reference to Procedural Rule 16 is confusing, as Procedural Rule 16 relates to Accessibility Assistance/Interpreters. In a previous version of the rule, the same section referenced Procedural Rule 5 instead of 16. This prior reference appears to be more consistent with the goal of the sentence, since Procedural Rule 5 governs the circumstances in which the Exchange may dismiss appeals. It is possible the WAHBE intended to modify this section to clarify that the notice of hearing should comply with the accessibility standards set forth in Section 16. If this is the intent of the sentence, we recommend clarifying the sentence structure.

Recommendation: Revise Section 9(1) to clarify whether the sentence is intended to refer to dismissals, language/interpretation assistance, or both.

Thank you for considering these recommendations. We appreciate your partnership as we work together to ensure affordable access to high-quality and high value plans in Washington State. Please contact us to schedule any follow-up conversation these comments may warrant.

Sincerely,

Emily Brice, Northwest Health Law Advocates Sam Hatzenbeler, Economic Opportunity Institute Erin Dziedzic, Dziedzic Public Affairs.

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