

Washington Health Benefit Exchange Comments: Proposed Federal Rule – Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2019

The Washington State Health Benefit Exchange (WAHBE or the Exchange) submits comments about the proposed Notice of Benefit and Payment Parameters for 2019, published by the United States Department of Health and Human Services (HHS) on October 27, 2016.

As a state-based exchange, WAHBE appreciates the freedom provided under the regulations to determine whether, when, and how to implement many of the rules in a way that is best suited to Washington State. The Exchange is also aware that with flexibility can come an erosion of standards, and WAHBE cautions HHS to be aware of preserving the gains that have been made in the individual market over the past several years. As a state-based exchange, we are appreciative of the principles guiding the proposed rules – preservation of flexibility for states, reduction of regulatory burdens, and supporting a stable individual market with affordable offerings for consumers. WAHBE would acknowledge that, along with a number of the provisions addressed in the proposed regulations, continued enforcement of the individual mandate and the provision of federal funding for cost-sharing reductions are critical to helping alleviate the uncertainty that now endangers the stability of the individual health insurance market.

Rate Review (45 CFR 154.100, 154.200, 154.300)

WAHBE appreciates the flexibility for states to conduct their own rate review processes that is preserved in the proposed rule. Washington State has its own rate review process and sets its own standard for when to review rate increases; all rate requests are reviewed regardless of the increase, and issuers must demonstrate that all rates are reasonable and justified. Partly as a result of this process, Washington has seen smaller rate increases since 2014 than most other states. Although the proposed modification of the 10% threshold for review of rate increases to 15% does not directly affect Washington, the Exchange urges HHS to retain the current threshold of 10% for 2019 and future years. WAHBE emphasizes the importance of federal rate review to consumers in states with less active insurance regulators, and encourages HHS to be an active proponent of transparency in rates and moderation of premium increases by continuing to require justification of rate increases greater than 10%.

Standardized Plan Options in the FFM (45 CFR 155.20)

We are aware that the proposal to discontinue standardized plan options in the FFE for 2019 applies to states using Healthcare.gov, so these proposed rules do not directly impact WAHBE. WAHBE wishes to convey the value we find in standardized plan options and urges CMS to continue allowing issuers to submit these plans and supporting their display in Healthcare.gov. Because the offering of standardized plans is optional, the program does not undermine free market principles; on the contrary, it could encourage issuers to submit more varied plan designs.

Essential Health Benefits (45 CFR 155.170 and 156.100)

WAHBE appreciates the flexibility preserved for states to choose their EHB benchmark plan, and strongly urges HHS to maintain on a longer term basis the ability of states to determine their EHB benchmark based on the scope of benefits included in a typical employer plan in the state. While the Exchange supports state flexibility to identify state-specific EHBs, we also strongly encourage HHS to retain the current requirement that each state's EHB benchmark be based on a benchmark employer plan *in that state* or one of the three largest Federal Health Benefits Program plans nationwide. We think it important for each state's EHB to be reflective of employer plans that are typical to that state, and not to be based on what is typical in a different part of the country. The Exchange is also supportive of retaining some guardrails around the type of plans that can be considered "typical employer plans," and suggest that, for a plan to qualify for consideration to be used as benchmark, it must include all ten essential health benefits and provide minimum value, and not be a self-insured plan, indemnity plan, or HSA plan. WAHBE feels that maintaining these standards across the country is important to preserve the quality of coverage that exists in the individual market and helps to promote a level playing field nationwide, encouraging market stability and healthier risk pools.

Should HHS decide to make any changes to the standards for essential health benefits, no revisions to the current EHB landscape should be effective prior to 2020. Issuers are likely to have begun development of their 2019 plans before these proposed rules are finalized, and significant lead time will be needed for states to make any changes to their EHB benchmarks and for issuers to incorporate changes into their QHP plan designs. Additionally, if flexibility is granted, WAHBE urges not to allow for year-to-year changes to the EHB, as the process for implementing is complex and requires much lead time. It is recommended that an EHB is set for a number of years to prevent disruption across the health care system.

Navigator Program (45 CFR 155.210)

The Exchange's Navigator program has been serving customers since WAHBE opened its doors in October 2013. At that time, we contracted with ten lead navigator organizations that included public health agencies, regional health networks, and community health centers, and collectively these lead navigator organizations enlisted more than 100 community-based organizations throughout the state to serve as our statewide navigator network. This basic structure is still in place, and the statewide network continues to conduct outreach and education, and provide application and enrollment support in their local areas.

Entering the 2018 enrollment period, we are still working with these ten lead organizations, who have helped extend our partner network to more than 230 organizations around the state with more than 820 navigators. Our Navigator efforts have evolved over the years, adding more customer-focused access to better reach those seeking help to find and enroll in health coverage. This is best exemplified by our 13 enrollment centers – jointly run with local health insurance brokers – that provide community-based access points for people to make an appointment or just drop in with their health insurance questions.

Navigators may work at any given time with QHP clients, Washington Apple Health (Medicaid) clients, or mixed households, so it is critical that any Navigator organization maintain a local presence in Washington. And given that the Exchange serves as single entry point for the individual insurance

market as well as those signing up for or renewing their Medicaid coverage, it would be difficult for out-of-state organizations to adequately serve in the Navigator capacity. Given the transitional nature of both the individual and Medicaid markets, consumers frequently require direct access to individuals who have previously assisted them on their accounts. Furthermore, many of these organizations are also addressing needs of their populations in other ways – additional financial assistance, job training, housing, etc. – that keep them in touch with customers and create a relationship with them that is beneficial for maintaining their health insurance coverage.

WAHBE’s relationship with our state-based Navigator program has been a positive one for Washington, the Exchange, and, most importantly, our customers who use our services. The changes regarding flexibility proposed in these regulations would do little to alter our approach and, with regard to maintaining a physical presence, could detract from the positive programmatic execution that we have today.

Direct Enrollment through Third-Party Entities (45 CFR 155.221 and 156.1230)

WAHBE has concerns about the proposal for HHS to no longer approve third-party entities that would conduct required audits of entities participating in direct enrollment activities. The Exchange values HHS oversight of exchanges as well as web-brokers and others conducting direct enrollment activities, and urges HHS to continue these activities to ensure that a level playing field is preserved across exchange marketplaces nationwide. Exchanges have to meet certain standards, and we believe the direct enrollment entities should be held to the same, if not more stringent, standards. WAHBE has general concerns around possible encroachment of other entities, such as web brokers, into responsibilities that have been delegated to exchanges under the ACA and in regulation, and which exchanges are in a better position to perform as federally- and state-monitored entities created with the primary mission of serving all individual-market consumers and their state-specific needs.

Program Integrity: Failure to File or Reconcile Taxes (45 CFR 155.305)

WAHBE is supportive of HHS’s proposal to remove the “direct notification” requirement applicable to exchanges suspending an enrollee’s tax credits due to failure to file or reconcile taxes in a previous year (FTR). This new requirement, which was finalized in the Notice of Benefit and Payment Parameters for 2018, would potentially have required exchanges to provide more explicit notice to individuals who lose eligibility for tax credits due to a failure to file or reconcile taxes without violating security protections over federal tax information, and would have presented some significant challenges to implement. WAHBE agrees with HHS’s assessment that the FTR processes and notifications currently being implemented by most exchanges provide adequate notice to consumers while also safeguarding sensitive tax information. WAHBE supports HHS’s proposal to allow states to continue using their current FTR processes, and encourages CMS to continue being receptive to states’ proposals of ways to make the FTR process more consumer-friendly and transparent.

Program Integrity: Income Verification (45 CFR 155.320)

WAHBE is supportive of giving states the flexibility to perform verification when attested income is between 100% and 400% of FPL and electronically verified income is under 100% FPL, if a threshold for inconsistency is met. We are supportive of allowing state-based exchanges to determine whether

performing this verification would be of value in their state marketplace. WAHBE would need time to make the IT and operational changes that would be required for implementation.

HHS requested comment regarding the threshold for income verification when attested income is lower than electronically-verified verification. WAHBE appreciates the flexibility given to states to increase the threshold over the previous 10% standard. Increasing the threshold to 25% has resulted in reducing burdens for consumers, most notably those with seasonal or part-time employment, whose annual incomes vary during different times of the year and from year-to-year. We strongly support HHS continuing to allow states flexibility to set their own threshold.

Program Integrity: Verification of Employer-Sponsored Coverage (45 CFR 155.320)

WAHBE strongly supports HHS's proposal to continue to grant exchanges flexibility with respect to developing alternative ways to verify applicants' eligibility for enrollment in affordable employer-sponsored coverage (ESI). WAHBE also appreciates HHS's proposal to revisit state verification of SHOP Exchange participation and federal employment through CMS data channels, and recommends that HHS remove these required forms of verification. In Washington, we have determined that performing these verifications would offer little value, as we have no carrier participation in SHOP for 2018 and a very limited population who would be impacted by verification of federal employment. We recommend that states be permitted to adopt these or other specific methods for verifying ESI on a state-specific basis, to best reflect each state's needs and resources.

Program Integrity: Authorization to Access FTI (45 CFR 155.335)

WAHBE encourages HHS to retain the current authorization period for exchanges to access FTI, as it strengthens both program integrity and market stability by ensuring that exchanges are using the most current tax information to calculate subsidy eligibility and encourages continuity of enrollment year-to-year. The Exchange does not believe reducing the time period that exchanges are authorized to access FTI to something less than five years would impact timeliness of change reporting.

Annual Open Enrollment Period (45 CFR 155.410)

Although no changes were made to the 2019 open enrollment period in these proposed regulations, we wanted to take this opportunity to express concern regarding the November 1 – December 15, 2018 open enrollment period for 2019 coverage. WAHBE believes that a six-week open enrollment period may not provide adequate time for consumers, issuers, brokers, assisters, and exchanges to successfully perform enrollment and renewal-related activities, and WAHBE suggests that HHS provide flexibility for a longer annual open enrollment period for state-based exchanges.

Special Enrollment Periods (45 CFR 155.420)

WAHBE appreciates HHS's continued efforts to strengthen market stability through regulatory refinement of the role of special enrollment in the individual market. The Market Stability regulations finalized earlier in 2017 introduced several new limitations on how current enrollees may change plans when they experience special enrollment events. These changes address concerns about enrollee use of special enrollment periods (SEPs) to change metal levels mid-year based on emerging health needs.

WAHBE is scheduled to make the information technology changes necessary to implement these restrictions in the spring of 2018.

These proposed regulations would further restrict enrollees' ability to change plans during certain special enrollment events, and attach special enrollment rights at the member level (rather than the household level) for the first time. WAHBE strongly urges HHS to delay making further changes to SEPs at this time, and study the impact of the most recent limitations to SEPs to determine whether further changes are necessary. If HHS adopts further restrictions on special enrollment periods, WAHBE recommends that state-based exchanges be granted flexibility around whether and when to adopt these additional restrictions. Additionally, these changes would result in a significant system change for WAHBE, and therefore state flexibility in implementation is imperative.

WAHBE is supportive of HHS's proposed clarification that the prior coverage requirement applicable to certain special enrollment events would be waived if an applicant lived in an area with no QHPs during the 60 days prior to the special enrollment event.

Termination Effective Dates (45 CFR 155.430)

Although WAHBE supports and has already implemented the changes proposed in this regulation, we urge HHS to provide state-based exchanges with flexibility in whether and when to implement these changes. WAHBE believes it is important to retain the ability for state-based exchanges and issuers to determine together, within the guardrails of current regulation, the coverage termination dates that work best for their consumers and state marketplaces.

Exemptions (45 CFR 155.605)

WAHBE is generally supportive of the proposed change to the standard for eligibility for an exemption from the individual mandate, which provides that the affordability exemption would be based on the premium of the lowest-cost Exchange plan in a rating area if there is no bronze plan sold through the Exchange. WAHBE supports this change insofar as it ensures that consumers would not be excluded from accessing an affordability exemption just because they may not have a bronze plan option in the Exchange – a situation which consumers in Washington State will face in 2018. While we support the availability of the affordability exemption to all consumers, we acknowledge that providing exemptions based on silver level plans will result in more individuals qualifying for exemptions, because those premiums are higher. WAHBE firmly believes that the higher the percentage of the population that remains continually insured, the more insulated the market is from fluctuations based on risk pool changes and the more affordable health coverage will be for consumers.

WAHBE recommends a few modifications to the rule as proposed. First, WAHBE recommends that HHS make this change applicable earlier than most provisions in this rule – effective beginning with the 2018 plan year rather than the 2019 plan year. We ask HHS to clarify that if a bronze plan is not available, individuals could seek an exemption, if otherwise eligible, when they file taxes for 2018. WAHBE also recommends that HHS clarify that the determination of the lowest-cost plan is made at the *county* level rather than the rating area level, since plans may be offered in some but not all counties within a rating area. Finally, WAHBE recommends that HHS clarify that the determination of the “lowest-cost Exchange plan” on which to base eligibility for an exemption should be made without consideration of catastrophic plans.

SHOP (45 CFR 155.700)

WAHBE appreciates and supports the full flexibility given to state-based exchanges with respect to implementation of the proposed rule, narrowing the functions performed by SHOP exchanges.

Healthcare.gov User Fees for 2018 (45 CFR 156.50)

The 2019 FFE user fee is proposed to be 3.5% of monthly premiums, the same as in previous years. WAHBE would like to emphasize the importance of outreach and education activities to maintaining a healthy risk pool and stable individual market, and urges HHS to ensure that the overall user fee includes an adequate allocation for funding of such activities.

Premium Adjustment Percentage for 2019 (45 CFR 156.130)

WAHBE urges HHS to revisit the methodology used to determine the increase in the premium adjustment percentage for 2019, in light of the challenges to affordability its impact may exacerbate for many consumers. An increase in out-of-pocket maximum from \$14,700 in 2018 to \$15,800 in 2019 is likely to make individual market insurance unaffordable for more families in 2019. We understand that, even under a revised methodology, deductibles are likely to remain high for the foreseeable future, and therefore encourage HHS to consider how varying plan structures could influence consumer behavior and improve the risk pool, as well as make using coverage more affordable for consumers.

WAHBE also suggests that, for future years, HHS revisit the methodology used to identify test plans for determination of out-of-pocket limits for cost-sharing reduction tiers. The two silver-level PPOs and one HMO used as test plans are not reflective of the cost-sharing structures of typical silver plans in Washington State. Washington saw significant shifts in plan network type and structure in 2017 and 2018, and offers that this trend may be emerging nationwide in 2018 silver plans.

Cost-Sharing Protection for Individuals from 250% - 400% FPL (45 CFR 156.130)

WAHBE is supportive of provisions that are protective of consumers and serve to improve affordability in products offered in the individual market. Our understanding of this proposal is that a new cost sharing tier would be created for individuals 250-400% of FPL, such that individuals in this income bracket (who otherwise qualify for subsidies) signing up for a silver plan would receive a silver plan with an actuarial value of 70%. This would presumably allow issuers to structure base silver plans at the lower end of the de minimis range (66% AV), but protect consumers up to 400% FPL from experiencing those lower AV plans.

While supportive of provisions that insulate some enrollees from increased cost sharing, WAHBE is concerned about how this proposed change could impact unsubsidized enrollees in silver plans. We do not presume that issuers would receive a federal reimbursement for provision of the 250%-400% FPL cost-sharing reduction, so our expectation is that silver plan premiums would increase to offset the additional cost to carriers of providing this cost-sharing reduction to a segment of the silver-enrolled population. The unsubsidized population would, potentially, encounter a premium increase in silver plans which would not be offset by an increased tax credit, while also finding themselves in lower AV silver plans. In Washington, nearly 40% of Exchange enrollees are unsubsidized. While these individuals

have family incomes that do not qualify them for APTC, many of them are facing rising premiums and deductible increases that make health insurance a challenge to afford. WAHBE is supportive of changes that improve affordability across the individual market as a whole, and recommends caution when considering changes that may benefit a portion of the population to the detriment of a different segment of the market.

Actuarial Value of Dental Plans (45 CFR 156.150)

WAHBE encourages HHS to retain the 70% and 80% actuarial value categories for qualified dental plans. We think the designation of dental plans as “low” or “high” has been incorporated into consumers’ understanding of dental plans available through exchanges, and provides helpful information to consumers when trying to choose a dental plan. We have observed that, over time, consumers have gained an understanding of the association between metal levels and out-of-pocket costs in qualified health plans, and think this understanding has translated to dental plan, as well. We encourage HHS to retain these AV levels in dental plans to continue offering a simple, one-word cue to consumers conveying an element of dental plan value.

Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements

WAHBE has concerns regarding the proposals to modify the medical loss ratio (MLR) calculation (§158.221) and to relax the standards for states to modify the MLR in their states (§158.301). The medical loss ratio requirement provides an important consumer protection in the individual market. It ensures that a greater share of premiums are devoted to the costs of care and protects consumers from excessive health insurer profits. The Urban Institute found that consumers in the individual market experienced significant gains from the implementation of the current MLR formula. Low MLR insurers reduced their administrative costs as a share of premiums by 4.2 percentage points. The current MLR rule has been effective in incentivizing insurers to reduce their administrative overhead costs, so we discourage any modifications that would loosen the MLR rule for issuers.

The single QIA amount proposal to ease the burden of reporting on issuers (§158.221(b)(8)) is concerning to WAHBE given issuer’s varying dedication of resources to quality. Through administering the Quality Improvement Strategies (QIS) program in Washington, WAHBE has seen issuers who are much further than others in reforming their payment and delivery systems to incentivize quality and value. Allowing issuers to administer a single QIA amount would remove the intended incentive for issuers to perform these quality improvement activities within the market. We encourage CMS to retain mechanisms that incentivize quality in the individual market.

While we appreciate HHS’s dedication to further stabilizing the market, medical claims, rather than administrative costs, were the main drivers of negative financial experiences within the individual market – so we do not believe that loosening MLR restrictions would resolve the underlying financial concerns of issuers.

Comment Requested: Incentivizing Innovation and Supporting Sustainability in State-Based Exchanges (45 CFR 155.106 and 155.200)

WAHBE is appreciative of HHS’s interest in supporting the retention and financial self-sustainability of state-based exchanges. In Washington, the Exchange was created in 2011 with bipartisan support and

has been self-sustaining since 2015, as required under the ACA. The Exchange is funded through receipt of a portion of a state premium tax on insurers and a per-member per-month assessment on issuers participating in the Exchange. Washington's Exchange provides a common entry point for consumers who may be eligible for Medicaid, CHIP, or QHP coverage, and allows consumers to determine what financial help they may be eligible for and enroll in health coverage for their whole family, through a single streamlined application process. One in four Washingtonians enroll in their health coverage using the Exchange's online portal, where consumers can search for plans that have their doctor in network, learn about the estimated annual out-of-pocket costs of available QHPs, and compare plans on an apples-to-apples basis. For 2018, there are seven issuers offering QHPs in the Washington Exchange, with plan options in all counties.

While Washington has a relatively robust and stable individual market, we, like other states, have recently seen fewer plans and carriers, as well as significant premium increases. The largest drivers of price increases for 2018 have been medical and pharmaceutical costs, as well as uncertainty about federal funding of cost-sharing reductions and enforcement of the individual mandate. HHS can reduce uncertainty in the individual market from year to year by incentivizing innovation and supporting sustainability of state-based exchanges.

WAHBE urges HHS to be supportive of exchanges' ability to rely on varied funding sources as determined on a state-by-state basis and to champion the availability of full-year health coverage that offers a full spectrum of benefits. WAHBE also encourages state flexibility to allow for growth and innovation in the programs and products that exchanges can offer. Support from HHS in these areas will support sustainability of exchanges.

Comment Requested: Ways to Improve Program Integrity (45 CFR 155.320 and 155.330)

In the proposed regulations, HHS expresses an intent to address methods for strengthening program integrity in future rulemaking. The Exchange encourages CMS to move forward with providing a Medicare data matching service for updates to exchanges on Medicare *enrollment* status, rather than eligibility for Medicare. WAHBE would greatly appreciate CMS's partnership to provide data matching to help us better identify individuals that are not eligible to change QHPs or are no longer eligible for APTC because of a change to their Medicare enrollment status. WAHBE has recently begun sending a notice to individuals around their 65th birthday to let them know that they may no longer be eligible for tax credits in their QHP due to Medicare eligibility, and prompting them to make appropriate enrollment changes.

Additionally, WAHBE has recently implemented mobile app functionality and will be leveraging this functionality and push notifications to provide electronic reminders about reporting changes more frequently.

Comment Requested: Quality Rating System (45 CFR 156.1120)

HHS did not propose any changes to the quality rating system, but solicited comment on if and how CMS should account for social risk factors in quality reporting. WAHBE appreciates HHS's acknowledgement of the importance of social risk factors to overall health, and encourages inclusion of risk factors in issuer quality reporting, including income level, receipt of subsidy, race and ethnicity, and geographic area of residence. Exchanges would currently be able to supply data on income level, receipt of subsidy,

and geographic area of residence, as these factors are used to calculate QHP eligibility. WAHBE has struggled with capturing race and ethnicity data in the past for potential use in health disparities initiatives, because issuers in Washington do not routinely collect this information.

Comment Requested: Value-Based Insurance Design

WAHBE appreciates the opportunity to comment on value-based insurance design (VBID) within the individual market. We believe it has the potential to offer more consumer-friendly plan designs and can contribute to stabilization of the individual market over the longer term.

HSA-eligible high-deductible health plans (HDHPs) are not prevalent on the Washington health insurance marketplace. Many counties have no HSA options and our most populous county, King County, only has one plan offering a HSA for 2018. While WAHBE would appreciate more HSA options in the marketplace for our higher income consumers, we also are aware that consumers need significant education and tools to be able to use the HSA benefit. In addition, many of our consumers may not have the disposable income to contribute funds to a HSA account.

WAHBE is supportive of value-based insurance designs that eliminate or reduce cost-sharing for high-value care, without meeting a deductible. This could include no cost-sharing for medications that control chronic conditions or no cost-sharing for doctor visits that are needed to monitor and manage chronic conditions.

WAHBE encourages HHS to consider state flexibility in advancing VBID, as states will approach the issue with different, innovative solutions. We look forward to working with HHS, carriers, providers, and consumer advocates to bring greater value of services to the products being offered on the Exchange.

Comment Requested: Reducing Drug Costs and Encouraging Drug Price Transparency

WAHBE appreciates HHS's commitment to addressing prescription drug costs and drug price transparency. WAHBE is generally supportive of mechanisms that lower prescription drug costs, as these costs are getting passed to the consumer in the form of higher premiums each year. Prescription drug costs attributed to a 15-20% increase in premiums for the 2018 plan year, higher than most factors going into rate-setting.

WAHBE introduced a formulary look-up tool for open enrollment in response to a need from consumers to check to see if their prescription drugs are covered when shopping for health plans. We currently rely on the Healthcare.gov Marketplace API for some of our prescription drug information. This API has been reliable and more comprehensive than most, but has shortcomings in accurately displaying the correct prescription drug information to the consumer. We encourage HHS to invest in this API to allow for price transparency and to encourage efficient consumer behavior through understanding differences in prescription drugs (e.g., cost savings of generic drug when available).

In addition, WAHBE encourages a mechanism for issuers to flag any changes in their formulary when submitting formulary files through SERFF. Prescription drug coverage is essential to consumers choosing the right plan. Any changes should be highlighted in issuers' submissions so exchanges have the mechanisms to notify consumers of these changes.

WAHBE strongly encourages HHS and Congress to bring down the cost of prescription drugs. We can continue to provide consumers with information on the drug prices available to them, but states lack the leverage to truly tackle prescription drug pricing.