FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

February 19, 2019

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9926-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9926-P, RIN: 0938-AT37; Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2020

Submitted electronically via Regulations.gov

Dear Administrator Verma:

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

We appreciate the opportunity to provide comment on the Notice of Benefit and Payment Parameters for 2020.

We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Automatic reenrollment procedures (mentioned in Executive Summary)

Recommendation: Retain existing procedures, while increasing exchange access to data about changing income levels.

We strongly support the proposed rule's continuation of auto-enrollment procedures. Behavioral economics teaches, repeatedly, that imposing small procedural requirements results in a substantial reduction in program participation among eligible people. The literature is most abundant when it involves retirement savings accounts, but health coverage, if anything, presents greater complexity and increased risks of consumers losing coverage for procedural reasons. Without auto-enrollment, millions of consumers who retain coverage today would lose it, even though they continue to qualify for financial assistance and continue to desire benefits.

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The proposed rule seeks comments about both automatic re-enrollment procedures and "additional policies or program measures that would result in eligibility errors." Section 1413(c)(3)(A) of the ACA sheds a spotlight on the best approach to achieving this important goal: "Each applicable State health subsidy program shall, to the maximum extent practicable, establish, verify, and update eligibility… using… data matching arrangement[s]… and determine such eligibility on the basis of reliable, third party data…" Even though that section of the ACA specifically directs ACA insurance affordability programs to access data described in Social Security Act section 453(i), exchanges have still not been granted access to the National Directory of New Hires referenced in that section. Other need-based programs have access to that data, finding it very useful in tracking changing quarterly income as well as new employment. We urge HHS to develop appropriate arrangements through which this important and useful data source could become integrated into the federal data services hub, so that exchanges could both establish and renew eligibility based on reliable, third-party records. That approach strengthens program integrity, lowers operating costs, and reduces procedural burdens on consumers, thereby helping eligible people obtain and retain coverage.

Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets* and *Part 148 – Requirements for the Individual Health Insurance Market

Recommendation: Implement proposed requirements that guarantee appeal rights and advance notice for consumers regarding mid-year formulary changes, and clarify that such rights are available not just if a brand-name drug is removed from a formulary, but also if a brand-drug is moved to a higher cost-sharing tier. Clarify that consumers already taking a brand-name drug when mid-year formulary changes occur can continue taking the drug without penalty. Consider extending advanced notice requirements to 120 days and requiring all issuers to provide standardized notice language to enrollees and prescribers regarding mid-year formulary changes. Do not implement therapeutic substitution of reference-based pricing policies in marketplace plans.

Families USA agrees with CMS that lower prescription drug costs is a high priority. We therefore support the proposed changes in section §147.106(e)(5) that will allow mid-year formulary changes that facilitate inclusion of new generics on formularies, in conjunction with the proposed consumer protections and additional recommended protections. Specifically, we strongly support the inclusion of the consumer protection that requires issuers to provide enrollees the option to request coverage for a brand drug that was removed from the formulary under this proposed section of the rule through the applicable coverage appeal process under §147.136 or the drug exception request process under §156.122(c). The rule should clarify that these processes are available not just in instances when a brand-drug has been removed from a formulary, but for when a brand-drug has been moved to a higher cost-sharing tier and an enrollee seeks to have the brand-drug covered at the lowest tier.

Additionally, we recommend that brand-name coverage continue as provided prior to any mid-year formulary changes for consumers who are already taking a brand-name drug when a mid-year formulary change occurs. We believe that only consumers who are newly prescribed a drug after the mid-year formulary change should be subject to restrictions regarding brand-name coverage. Special additional protections may be necessary for conditions for which any delays in coverage for a needed brand-name drug could be threatening to the health of enrollees, such as HIV/AIDs or mental health conditions.

We also strongly support the inclusion of the advance notice requirements for any brand name drug that an insurer proposes to remove from or modify placement on the formulary. Expanding the notice time frame to 120 days or least 90 days will better allow consumers and their health care providers to prepare for such formulary changes. We advise CMS to consider requiring a standardized notice from issuers to consumers about such formulary changes, and testing that notice with consumers in advance of its application to determine whether the language is clear and understandable. The rule should also require advance notice to prescribers so that they can change their patients' prescriptions.

The preamble to the rule considers whether therapeutic substitution policies should be allowed for marketplace plans. We are concerned that implementing these policies may jeopardize consumers' access to clinically indicated drugs. Replacing a consumer's drug with a chemically different drug can sometimes save money without posing any health risks to consumers, but that is not uniformly the case. We are concerned about the impact that therapeutic substitution could have on consumers who take drugs for conditions including mental health conditions, who react uniquely to an individual drug's chemical composition and for whom other drugs may prove ineffective or even harmful. We believe that plans should have appropriate utilization management options that maintain the ability of consumers to work with providers to easily access the type of drug they need, in accordance with clinical guidelines. We do not think that allowing therapeutic substitution in marketplace plans will achieve this goal and we urge HHS not to implement this proposal.

Additionally, the preamble considers whether reference-based pricing should be implemented in marketplace plans to help attenuate increases in pharmaceutical spending. Although we share the goal of lowering pharmaceutical spending, we are concerned that this policy would have limited impact on underlying drug prices while limiting consumer access to needed drugs. This policy puts a great deal of burden on the consumer to determine which drugs are least expensive in order to avoid higher out-of-pocket costs than they have previously experienced. Prescription drugs are not easily "shoppable" by consumers, who rely on providers to indicate which drugs they need based on clinical guidelines. Furthermore, reference pricing based on drugs within the same therapeutic class could put consumers in a position of choosing between the drug that works best for them based on its specific composition and paying much more for that drug than they do now, or obtaining a drug that is not specifically indicated for them to avoid unaffordable costs. We believe that marketplace issuers have significant pharmaceutical utilization

management opportunities available to them through other policies and do not support implementing reference-based pricing in the marketplace.

§153.320 HHS risk adjustment

Recommendation: Support the proposed general approach, especially the proposed reduction to the RXC factor for Hepatitis C medication and the increased use of EDGE server data to calibrate risk-adjustment factors. Use EDGE server data to re-calibrate enrollment duration factors to distinguish SEP enrollees from part-year OEP enrollees.

In general, the risk adjustment program serves critically important objectives, earning our strong support. Risk adjustment has made it possible for carriers to serve chronically ill patients, observing the ACA's anti-discrimination rules, while receiving enough revenue to cover reasonable claims costs. An effective risk adjustment system helps achieve the core goal of encouraging competition based on value offered to consumers, rather than based on successful avoidance of undercompensated risks.

In that spirit, we want to single out for special commendation two features of the proposed rule. First, the proposed reduction in value for the RXC factor involving Hepatitis C medications is an important, positive step that minimizes plan incentives to "game" risk-adjustment, at consumers' expense. The former, extraordinarily high risk factor made it possible for insurers to garner significant and unwarranted revenue by delaying the start of Hepatitis C care until late in the calendar year. Such delays let carriers claim two years of risk-adjustment bonuses for a single course of treatment. That perverse incentive, which threatened consumer health along with program integrity, is largely eliminated by the proposed rule.

Second, we applaud CCIIO's increased use of EDGE server data to calibrate the risk adjustment model. The individual market is different, in important ways, from the markets described in commercially available data sets that were the touchstones to previous calibration efforts. The gradual shift to increased use of EDGE server data avoids market disruption while moving towards a more accurately calibrated model. In our view, this represents a health policy tour de force that merits celebration.

In that same vein, we urge increased use of EDGE server data to examine the potential need to further improve enrollment duration factors. Prior research suggests that SEP enrollees present a very different risk profile from OEP enrollees who drop coverage mid-year. CCIIO's enrollment duration factors appear to adequately address the latter situation, but not the former. In the past, CCIIO may not have been able to address this shortcoming. Selection into individual coverage that starts mid-year involves very different dynamics than mid-year commencement of employer-based coverage. The former situation often involves someone who has lost employer-sponsored coverage, faces a sudden drop in income, and is faced with difficult decisions about which household needs to prioritize. Health insurance premium payment may not have pride of place except for those who expect to use services. By contrast, mid-year coverage commencement at an employer plan

typically involves someone who moved from one job to the next. The question of whether to accept a coverage offer from the new employer rarely involves the kind of hard questions that face mid-year enrollees in the individual market.

Now that CCIIO is accessing EDGE server data to calibrate its risk adjustment model, we strongly urge the agency to examine whether enrollment duration factors should vary, depending on whether part-year enrollment began at the start of the year or in the middle of the year. Carriers continue to avoid SEP enrollees, fearing adverse selection and undercompensation. It is no surprise that people who lose employment and employer-sponsored insurance continue to be a group with low mid-year enrollment in individual health insurance. With this population, risk adjustment is not serving its goal of enabling plans to serve eligible consumers, confident of receiving compensation correlated to foreseeable risks. And this particular population – those who lose employer-based coverage mid-year –is especially important to achieving the even more fundamental goal of reducing the number of uninsured. Recalibrating enrollment duration factors to provide more appropriate compensation for SEP enrollees could have positive, transformative consequences that merit your serious exploration.

§155.210(b)(2) and (e)(9) Navigator program standards

Recommendation: Retain requirements for navigator programs in the FFE to provide assistance with basic concepts and rights related to health coverage and how to use it, and to receive training in that area. This should be mandatory for all navigators in all exchanges. If the rule makes any changes to standards (b)(2)(v), (vii) and (ix); and standards (9)(i),(iii) and (v), at a bare minimum, rules should still assure that post-enrollment assistance is available to consumers in every exchange and that all navigators know where to refer consumers for this.

The proposed rule would make consumer assistance with a number of topics optional, and not mandatory for FFE navigators in 2019. State based exchanges already have discretion regarding how they provide consumer assistance in these areas. We are concerned that there will be no place for consumers to turn for help if they face certain enrollment or post-enrollment issues. Moreover, many of these issues are directly related to the statutory duty to “facilitate enrollment in qualified health plans”:

- Consumers who are new to private coverage should be told at least the basics of how to use their plans and how to compare their choices. Especially, unless consumers understand the ideas of provider networks, deductibles, coinsurance and copayments, they will not be able to effectively choose a plan that meets their needs.
- Navigators who assist with enrollment must be able to inform consumers about their recourse to appeal if their application does not result in enrollment in a health plan. Navigators spend a great deal of time assisting consumers with data matching inconsistencies, and it is imperative that the

new rule requires and allows navigators to help consumers resolve enrollment issues.

- Consumers who have sought help with enrollment should be able to expect that they will be given some guidance on what it means to use advance premium tax credits and their responsibility to reconcile.
- In order to fulfill the statutory duties of establishing relationships with uninsured and underinsured consumers, and of providing information in a manner that is culturally and linguistically appropriate to the needs of the population, navigators will continue to need training related to serving individuals with limited English proficiency and individuals with disabilities.
- While we agree that not all navigators can be effectively equipped to deal with post-enrollment issues, they should at least know that appeals processes exist for those denied care and they should know the basics of how consumers can initiate appeals and where consumers can get help with them. Each exchange should have at least one referral source available for consumers to get further assistance with those issues, although that appeals entity as well as the consumer assistance program or ombudsman may be located outside of the exchange. The statute requires navigator entities to provide such referrals.

The proposed rule would make it grantees' choice whether to offer assistance in any of these topics in the FFE as well as in state based exchanges. We agree that some individual navigators within a navigator program may focus on outreach, particularly given recent funding constraints, and so might not need extensive training on post-enrollment issues, but the navigator entity as a whole must still provide a full array of assistance and ensure that people are appropriately trained for their job responsibilities. We recommend that training and assistance requirements for the above topic areas remain intact in 2020. In states that continue to provide tax penalties under the individual mandate, navigators should also continue to receive training regarding individual responsibility. In all states, every navigator should receive training and be able to provide assistance regarding provider networks, deductibles, coinsurance and copayments.

If you make any of the proposed changes in training (regarding issues other than plan design, which should be fundamental for every navigator), we strongly urge you to ensure that every community in which navigators operate has at least one source of assistance on the post-enrollment issues (such as one program with fuller training, or some people in each program with additional training and adequate capacity to provide requested help), and that all navigators know where to refer these issues.

The rule seeks comment on how much time is spent providing the information that would no longer be required. We are concerned that this query is paving the way to reduce funding accordingly. Navigator grantees and applicants that will perform these functions should be funded to provide them, in addition to other outreach and enrollment duties.

§155.220 Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

Recommendation: Modify 45 CFR 155.220(c)(3)(ii)(A) to require any web-broker that has an agreement with the FFE to display all QHP information that consumers would be able to view on the Exchange website. Require that web brokers facilitate enrollment in all QHPs. Prohibit Navigators and CACs from using web-broker sites until and unless web brokers are required to display comprehensive information about and facilitate enrollment in all QHPs. Require direct enrollment entities to meet standards regarding serving consumers who may be or are eligible for coverage under Medicaid or CHIP.

Families USA agrees that web brokers should be prohibited from displaying recommendations for QHPs based on compensation the web-broker, agent, or broker receives from QHP issuers. However, we are very concerned that the rule as written does not prevent this practice. The rule as written permits web brokers to display a disclaimer stating that information required under §155.205(b)(1) for a QHP is available on the Exchange Website, and provide a Web link to the Exchange Website, instead of actually providing accurate and complete information on a given plan available to consumers through the Exchange.

By allowing web brokers to link to plan information on the Exchange instead of actually displaying it on their sites, HHS is providing web brokers permission to promote the plans for which they receive compensation while discouraging purchase of those they do not. By requiring consumers to engage in an extra step to view plans that are not displayed comprehensively on the web brokers' site, we believe that consumers using the web brokers' site will be steered into the plans for which comprehensive plan information is immediately available, rendering the sites biased towards certain plans. It is very concerning that HHS directly states that web brokers may implicitly recommend QHPs based on compensation they receive by listing those that are not offered by issuers with whom they have contractual agreements at the bottom of the listings of all QHPs offered through the Exchange. This is an endorsement of the practice of web brokers recommending QHPs for which they receive compensation over those for which they don't, even if the QHPs for which they do not receive compensation may be better suited for the consumer. **We strongly urge that 45 CFR 155.220(c)(3)(ii)(A) be modified to require any web-broker that has an agreement with the FFE to display all QHP information that consumers would be able to view on the Exchange website.** As the rule notes, web brokers can obtain this information directly from Exchange websites by integrating with the FFEs' Marketplace application programming interface (API). This should be mandatory for all FFE- approved web brokers. **Furthermore, to fully protect consumers from steering and biased plan information, HHS should require that web brokers facilitate enrollment in all QHPs, not just those for which they receive financial compensation**.

Given that web brokers are not currently required to display all plan and benefit information or facilitate enrollment in all QHPs but can simply display a disclaimer

and link for Exchange plans for which they do not facilitate enrollment, we oppose the proposal to permit Navigators and certified application counselors (CACs) to use the Website of a web-broker while assisting an applicant to enroll in a QHP offered through the Exchange.

Consumers rely on Navigators and CACs for fair, accurate, and impartial information regarding health plan options, in accordance with regulatory requirements. Presenting comprehensive information about some plans and only a disclaimer and link for others is not an unbiased display of plan options and will put Navigators, CACs, and the consumers they serve in a difficult situation as they expect an unbiased experience but instead encounter a platform that steers consumers into some plans over others if not all plan information is comprehensively displayed. Furthermore, consumers rely on Navigators to provide advice regarding substantive benefits or comparative benefits of different health plans, in accordance with federal law and regulations. If a web-broker site interferes with Navigator's advice by recommending certain plans over others, this will compromise the ability of the Navigator to provide unbiased, impartial information. Finally, Navigators and CACs may not receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or a non-QHP. We are concerned that a web-broker that displays disparate information about plan offerings may violate Navigator's prohibition on indirect consideration from health insurance issuers. **We therefore urge HHS to prohibit Navigators and CACs from using web-broker sites until and unless web brokers are required to display comprehensive information about and facilitate enrollment in all QHPs.**

We support the proposal to require a web-broker to provide HHS with a list of the agents or brokers who, through a contract or other arrangement, use the web broker's non-Exchange Website to assist consumers with completion of QHP selection and/or for the Exchange eligibility application, in a form or manner to be specified by HHS. We support collecting this information daily the month before and during open enrollment, and monthly during other times of the year to ensure the information is accurate in the event HHS needs to conduct targeted oversight.

We also support HHS creating a public list of certified web brokers in FFEs and SBE-FPs. This list in the past has been helpful to understand what entities are FFM-certified web brokers versus potentially more nefarious actors.

Finally, we believe greater clarity is required regarding direct enrollment entity obligations to meet standards for serving consumers who may be or are ultimately eligible for Medicaid or CHIP. Such standards as applicable to exchanges are outlined under 45 CFR 155.345 and 155.310. We urge HHS to implement similar standards for direct enrollment entities to ensure that applicants who apply for coverage through a direct enrollment entity but are eligible for Medicaid or CHIP are appropriately enrolled in the coverage program for which they are eligible.

Specifically, we believe standards similar to those in sections 155.345(d) and 155.310(d) and (g) would be appropriate for direct enrollment entities.

§155.221 Standards for direct enrollment entities and for third-parties to perform audits of direct enrollment entities.

Recommendation: Prohibit direct enrollment entities from marketing and displaying non-QHP health plans and/or off-Exchange products until after the consumer has completed the QHP shopping experience.

If direct enrollment entities are permitted to display non-QHP plans, we strongly support requirements that these plans be displayed in a way that ensures consumers understand that they are not QHPs, are not eligible for APTCs and CSRs, and may not offer the same comprehensive benefits as QHPs.

We are concerned that the proposed rule as written may confuse consumers and steer them into non-QHP plans. To minimize the likelihood of these issues, **we recommend that HHS prohibit direct enrollment entities from marketing and displaying non-QHP health plans and/or off-Exchange products until after the consumer has completed the shopping experience.** As currently proposed, we are concerned that the rule will make it possible for direct enrollment entities to entice consumers into non-QHP plans through intensive marketing that could confuse and distract consumers intending to purchase QHP coverage based on a belief that direct enrollment entities offer a shopping experience and guarantee of comprehensive coverage similar to the Exchange.

§155.415 Allowing issuer or direct enrollment entity application assisters to assist with eligibility applications.

Recommendation: If issuer and direct enrollment entity application assisters are permitted, require them to comply with requirements for assisters under 155.225(c),(d),(f) and (g).

We are concerned about the creation of issuer and direct enrollment entity application assisters leading to consumers receiving biased information about health plan options that does not reflect the full range of marketplace options. As described in our comments on section 155.220, the currently proposed display requirements for direct enrollment entities fail to provide comprehensive, unbiased information to consumers.

Under current rules, assisters must comply with 155.225, stating that they shall: *Provide information to individuals and employees about **the full range of QHP options** and insurance affordability programs for which they are eligible, which includes: providing **fair, impartial,** and accurate information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process;*

We believe that all assisters, including assisters affiliated with direct enrollment entities, if permitted, should be required to comply with Sections 155.225(c),(d),(f) and (g). Unless direct enrollment entities will allow for assisters to provide the same level of information about all QHPs, we oppose allowing assisters to use issuer or web-broker sites for the enrollment process.

Given the extensive and increasing amount of sales calls and other solicitation for health insurance—from entities both reputable and fraudulent— that consumers receive, we urge HHS to take extra care that any entity it approves for assisting consumers is providing fair, impartial, and accurate information in accordance with existing requirements for assisters.

§155.420 Special enrollment period

Recommendation: Finalize the proposed new SEP and make it available nationally.

We strongly support this additional special enrollment period. In some states, people who are ineligible for premium assistance receive better prices for off-exchange plans; however, it is in their interests to join the exchange when they become eligible for premium tax credits, and they should be allowed to do so. We agree that this will be a significant factor in their ability to maintain continuous coverage for the full plan year. Most people with incomes below 400 percent of poverty would not be able to afford to maintain individual market coverage without premium tax credits. We recommend that the new SEP be a required special enrollment period rather than an Exchange option. Making the new SEP a national standard simplifies media outreach to encourage enrollment. The outreach plan for 2020 should include ongoing outreach about this and other special enrollment opportunities.

Part 156

Silver loading (mentioned in the Summary)

Recommendation: Continue current policy of silver loading. Do not restore CSR payments unless low- and moderate-income consumers receive additional financial assistance.

We support the administration's decision not to change its policy on silver loading. Shifting to a broad loading posture (that is, loading CSR payments onto all plans instead of silver marketplace plans) would have substantially raised premium costs for millions of consumers. Premiums for plans outside the silver metal tier would have risen, augmented by a drop in premium tax credit (PTC) value resulting from lower benchmark silver-tier premiums. Many would have become uninsured, and others would have retained coverage at the cost of paying considerably more for insurance.

For similar reasons, we do not support the simple restoration of CSR payments. As with broad loading, that initiative would reduce PTC values, increasing costs for the many consumers who use their PTCs to purchase coverage outside the silver metal tier. The administration should make no change in this policy unless and until litigation concludes in a way that resolves the issue definitively. At some juncture, Congressional lawmakers could couple CSR restoration with a substantial increase in the generosity of PTCs and CSRs for low-wage, working families and moderate-income consumers. In that context, CSR payment restoration would make sense, since the consumers otherwise harmed would be made whole. But without such an

increase in financial assistance, such restoration would undermine affordability of coverage and increase the number of uninsured.

§156.122 Prescription drug benefits

Recommendation: Require QHPs to provide advance notice to CMS of any mid-year formulary changes. Require issuers to maintain and display up-to-date formularies at all times.

Families USA supports the requirement that for plan years beginning on or after January 1, 2020, QHP issuers in the FFEs would be required to notify HHS of any mid-year formulary changes. However, these notifications should not just occur annually but in advance of the changes so that the formulary information required to be provided to the exchange under section 156.122(d) remains up to date. We recommend modifying section 156.122(d) to reflect that QHPs must provide information about any formulary changes before they take effect and that QHPs are required to ensure that formularies posted on their websites and formulary information provided to CMS and the FFE is up-to-date at all times.

Cost-sharing requirements and drug manufacturers' coupons

Recommendation: If insurers are not required to count manufacturer coupons for brand-name drugs towards cost-sharing limits when generic drugs are available, still require insurers to count such coupons if an enrollee has been granted an exception that indicates they require a brand-name drug.

Families USA shares CMS' concerns about distortions in the pharmaceutical market caused by manufacturer rebates and discounts. However, we believe manufacturer coupons fulfill an important need in our current health care system as critical drugs are on the market with no equivalent at unaffordable costs to those who rely on them.

We recommend that if the policy to exclude manufacturer coupons for brand-name drugs from annual cost-sharing limits when generic drugs are available is implemented, enrollees who indicate they may need a brand-name drug qualify for the appeals process in §147.136 or the drug exception process under §156.122(c). If they are found to require a brand-name drug, the insurer should be required to count brand drug coupons for that enrollee toward their cost-sharing limits.

§156.130

Premium adjustment percentage and annual limitation on cost sharing

Recommendation: Retain the previous methodology for calculating premium growth; do not include increases in direct purchase insurance prices that are attributable to changes in the government's payment policies and changes in the scope of benefits

The proposed rule would change the methodology for growth in premiums to include direct purchase individual insurance since 2013 - a change from previous

policy. The proposal's own estimates find that this would be harmful to consumers, causing 100,000 people to lose marketplace coverage. It would raise premiums for at least 7.3 million marketplace consumers, increasing premiums, for example, by $196 for a family of four with income of $80,000. It would raise cost sharing by $400 for families with private insurance who face major illness. CMS should not deliberately take an action that will harm consumers and leave them uninsured.

Several aspects of the methodology are flawed. First, this proposal starts with 2013 as the base year; but the indexing provisions of Section 1401 of the statute start with 'the calendar year after 2014' (2015) and then use the preceding year, or 2014 as the base year. Since essential health benefits did not go into effect until 2014, starting earlier than that does not compare the prices of like individual insurance products.

Second, for reasons laid out in the 2015 notice of benefit and payment parameters, CMS should disregard growth in individual market premium prices that took place while the market was stabilizing. The same reasons that CMS cited in determining that individual market prices should not be part of the calculation through 2018 still apply, so it does not now make sense to add growth in the direct purchase market to the employer sponsored market for the same years. Through 2018, factors such as the cessation of risk corridor payments and reinsurance, and the end of cost-sharing reduction payments, account for unstable premium prices. Indeed, the Council of Economic Advisors explained in its recent report that while "premiums almost doubled in just a few years" between 2014 and 2018, "from 2018 to 2019 the benchmark ACA premiums dropped by 1.5 percent."[1]

The end of cost-sharing reduction payments, estimated to contribute about 9 percent to premiums,[2] should not be considered part of premium growth. These payments were originally separated from premiums, and Congress would not have anticipated them as part of the premium growth formula when enacting the law.

It is unknown how actions taken in the past year to deregulate insurance will impact premium prices going forward. CBO projects that the Association Health Plan rules and the Short Term Limited Duration Insurance Rule will increase gross premiums by 2.5 percent.[3] This was not an action that Congress anticipated in passing the Affordable Care Act, and any growth in individual market premiums that results should be disregarded in future years' premium adjustment percentages. At the point that the individual market stabilizes, CMS can rebase its premium adjustment formula. Other governmental measures, such as the producer price index, gross domestic product, and consumer price index, rebase from time to time.

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1 Council of Economic Advisers (February 2019) "Deregulating Health Insurance Markets: Value to Market Participants" https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf

2 Matthew Fiedler (August 2018) "How Would Individual Market Premiums Change in 2019 in a Stable Policy Environment?" https://www.brookings.edu/wp-content/uploads/2018/08/Individual-Market-Premium-Outlook-20191.pdf.

3 Congressional Budget Office, (May 2018) "Federal Subsidies for Health Insurance Coverage for Consumers under Age 65:2018 to 2028," https://www.cbo.gov/publication/53826.

There is no reason that CMS has to take this harmful proposed action. CMS should withdraw this proposal and use the previously established methodology to calculate premium growth.

Cost-sharing requirements regarding brand name drugs

Recommendation: Do not implement provisions allowing issuers to exclude brand-name drugs from EHB.

We are concerned about the complexity of the proposal under 156.130 and its potential negative impact on consumers. Consumers rely on their providers to understand which drugs they need to take based on their individual characteristics, drug allergies, and previous experiences with medications. Placing the burden on the patient to either ensure that their drugs, when appropriate, are generic drugs, or face complex financial penalties we believe is an ineffective way to address the underlying prices of prescription drugs. We are also concerned that the complexity of this policy proposal will lead to coverage errors, as insurers will have to accurately determine when to cover a brand name drug as EHB and when not to, including for consumers who receive exceptions to obtain brand-name drug coverage. In the event of an exception under this proposed policy, it is not clear to us now the plan ensures that the consumers can apply advanced premium tax credits to the portion of the premium that is for brand drugs.

§156.50 User Fee Rates for the 2020 Benefit Year

Recommendation: Designate a sufficient amount of user fees to restore outreach and enrollment activities to previous levels.

The proposed rule explains how the portion of user fees attributable to risk adjustment are calculated but does not explain its assumptions regarding the volume of outreach or enrollment assistance planned for 2020. We have commented on section 155.210 that navigator programs must be able to provide post-enrollment assistance, and on section 155.420 that outreach will be needed about the new special enrollment period as well as all special enrollment rights. In the last two years, funding for outreach and enrollment were drastically reduced. Though fortunately, due in part to automatic reenrollment, a fairly large number of consumers remained enrolled in the marketplace; however, we believe that more consumers, including young people who help the individual market attain a good risk profile, will enroll if outreach and enrollment help are boosted. We recommend that each year's NBPP explain its assumptions regarding outreach and enrollment funding and that this NBPP raise fees sufficiently to restore outreach and enrollment to previous levels.

§156.125 Prohibition on discrimination

Recommendation: We support the clarification.

The proposed rule reminds issuers that decreasing the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices is potentially discriminatory, and that issuers should therefore not exclude coverage of MAT for treatment of an opioid

disorder when the medication is covered in other circumstances. We greatly appreciate this guidance. We urge CMS to call issuers' attention to additional areas of common parity violations and discriminatory treatment in future rules.

§156.280 Segregation of funds for abortion services

Recommendation: Withdraw this proposed change, which threatens to undermine access to reproductive services. Plans already must abide by the Hyde amendment.

The proposed rule would require health insurers who offer non-Hyde abortion coverage – who already must ensure that no federal funding is used for that non-Hyde coverage – to offer "mirror" plans that do not include that coverage, unless this conflicts with state law. This will burden 75 insurers in 17 states, according to the proposal's own estimates.

This provision is not in keeping with Congressional intent. The ACA allows insurers to elect whether or not to provide abortion as part of a health insurance plan, unless prohibited by state law. In enacting the Affordable Care Act, Congress assured Hyde Act compliance in Section 1303. As Senator Patty Murray explained during the enactment of the ACA, "All Americans should be allowed to choose a plan that allows for coverage of any legal health care service, no matter their income, and that, by the way, includes women. "[4] However, under this proposal, increased burden could cause insurers to exit the marketplace or to stop providing coverage of a full range of reproductive services. There are currently marketplace insurers in every state and county, but a number of states and counties have only one or two issuers. Retaining issuers and plans should be an administrative priority.

The proposal cites no evidence that anyone has rejected enrollment in a marketplace plan because abortion services can be covered, nor that offering more plans that do not cover non-Hyde abortions will boost enrollment.

Reproductive services should be no different than any other health service offered by a plan. Abortion is a safe, legal, and constitutionally protected form of medical care in the United States. Like any other covered benefit, people who do not need a service or choose not to use it due to their own beliefs do not have to use that service. The service should still be available to those who choose or believe otherwise. Setting a different rule would take us down a slippery slope where those objecting to any service (certain vaccines, for example, or services after a suicide attempt) could advocate for the creation of plans and required offering of plans that excluded that coverage.

By making it more difficult for women to obtain legal abortion services, the proposed rule could increase the number of women who become sole caretakers of their children and increase the likelihood that their new families will face economic hardship. [5]

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4 155 CONG. REC. S12,665 (2009)

5 ANSIRH, *Issue Brief: Socioeconomic Outcomes of the Women Who Receive and Women Who are Denied Wanted Abortions* 1 (2018), https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_

§156.1120, 156.1125, 156.1130 Quality Standards

Recommendation: Require the stratification of quality measures by race, ethnicity, language, socioeconomic status, sex, gender identity, sexual orientation, disability, and other demographic factors and prioritize the inclusion of disparities-sensitive and health equity measures in the Meaningful Measures areas across domains.

The use of measurement in eliminating health inequities is an important, albeit underused, tool. Measurement can help policymakers, providers, consumers, health care organizations, and other stakeholders identify where inequities prevail and persist.[6] Public reporting on quality measures can help health care consumers decide which health plan is best for them and their families, and where they want to receive care.[7]

We appreciate CMS including "eliminating disparities" in its cross-cutting measure criteria as part of the Meaningful Measures framework. It is critical to use all possible levers for addressing health and health care disparities. As just two of many examples, when compared to their white peers, African Americans are three times as likely to die from asthma, and American Indian and Alaska Natives are twice as likely to be diabetic.[8] These inequities have profound impacts on the health of communities of color, who disproportionately shoulder the weight of such inequities. Eliminating disparities among these and other groups is critical for ensuring equitable health outcomes are achieved for all, no matter ethnic and racial background.

In addition to the excess rates of preventable deaths and disease, there is also an economic imperative to eliminate disparities.[9] The United States is becoming increasingly diverse; addressing health disparities now is an investment in the health of the workforce of tomorrow and in the nation's economic vitality. Disparities also restrict overall improvements in quality of care and health, resulting in a more costly health care system. Eliminating disparities now would produce a more immediate economic benefit, as, according to a recent analysis, disparities cost approximately $93 billion in unnecessary medical care, and $42 billion lost in productivity annually.[10]

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outcomes_issue_brief_8-20-2018.pdf.

6 National Quality Forum (NQF). (2017, September 14). *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity.* Retrieved from https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx

7 Morris, C., & Bailey, K. (2014). *Measuring Health Care quality: An Introduction.* Retrieved from https://familiesusa.org/sites/default/files/product_documents/HSI%20Quality%20Measurement%20Intro_factsheet_final_web.pdf

8 Families USA. (n.d.). *Racial and Ethnic Health Inequities among Communities of Color Compared to Non-Hispanic Whites.* Retrieved from https://familiesusa.org/product/racial-and-ethnic-health-inequities-among-communities-color-compared-non-hispanic-whites

9 Orgera, K., & Artiga, S. (2018, August 8). *Disparities in Health and Health Care: Five Key Questions and Answers.* Retrieved from https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

10 *Ibid.*

By encouraging QHP issuers to align with the Meaningful Measures framework, the inclusion of eliminating disparities criteria presents an important opportunity to focus quality improvement initiatives and resources on those strategies known to reduce disparities. However, measurement can inadvertently worsen or contribute to disparities if it does not adequately account for disparities in risk factors, experiences, quality of care, and health outcomes.[11]

By stratifying measures by demographic and social factors, providers, consumers, and policymakers can better detect disparities and evaluate the impact of specific payment and delivery changes on outcomes for communities of color and other underserved groups. Not stratifying in this way may miss important information about a QHP's quality improvement strategy, including if it unintentionally contributes to disparities.

We appreciate CMS building on the work of the National Quality Forum (NQF) in forming the Meaningful Measures framework. In order to further build on NQF's recommendations, we recommend CMS also incorporate NQF's findings and recommendations related to disparities-sensitive and health equity measures. Currently, the Framework includes only one health equity measure. Including more of these measures can help prevent the inadvertent widening of inequities as they can detect the size of disparities and the prevalence of a condition among a population with social risk factors[12].

Thank you for the opportunity to submit these comments. If you have any questions, please contact Cheryl Fish-Parcham at Families USA, 202-628-3030 or at CParcham@familiesusa.org.

Respectfully submitted,

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Director of Access Initiatives

11 Hernandez-Cancio, S., Albritton, E., Fishman, E., Tripoli, S., & Callow, A. (June 2018*). A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems.* Retrieved from https://familiesusa.org/sites/default/files/product_documents/FamiliesUSA_Policy-Options_Report.pdf
12 NQF, *op. cit.*