



February 19, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 (CMS-9926-P)

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the proposed rule, **Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020**, published in the *Federal Register* on January 24, 2019.

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that deliver affordable, high-quality coverage and care. ACHP members are non-profit, provider-aligned health plans that provide coverage in all lines of business for more than 21 million Americans across 34 states and the District of Columbia. Our community-based member organizations improve the health of the communities they serve and are on the leading edge of care coordination, patient-centered medical homes, accountable health care delivery, information technology use and other innovations to improve affordability and the quality of care.

Silver Loading

In 2017, HHS discontinued making federal cost sharing reduction payments to insurers, based on a legal opinion issued by the Department of Justice. In the proposed rule, CMS notes that the Administration supports a legislative solution that would appropriate a permanent source of funds for CSR payments. ACHP supports the continuation of federal CSR payments to issuers and looks forward to working closely with the Administration and Congress to achieve this goal. However, ACHP recognizes that in the current political climate a legislative

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solution may be a long way off. In light of that, we ask HHS to postpone any changes until it is confirmed that CSR payments will resume.

Silver loading by insurers in the wake of the decision to halt the payment of CSRs was essential in ensuring that premiums did not jump dramatically and that consumers had access to affordable health coverage. ACHP recommends that the practice of silver loading continue as Congress considers long-term actions to improve the stability of the individual market. This will ensure that coverage is not disrupted for millions of working Americans and that plans have predictability as they price products.

Many options exist for ensuring a vibrant, stable individual market. Putting in place a permanent program will allow health plans to set consistent rates, help prevent premiums from rising dramatically and ensure consumers have access to a competitive marketplace.

Automatic Re-enrollment

Under current regulation, plan enrollees may be automatically re-enrolled in their current plan unless they actively select a different plan. In the proposed rule, CMS raises several concerns with auto-reenrollment and seeks comment on the reenrollment process.

ACHP strongly believes that plan enrollees should have the option of being automatically re-enrolled. Eliminating auto re-enrollment will be burdensome on plan enrollees and could lead to an increase in the number of Americans without health insurance. Behavioral science has long documented the power of inertia in humans, particularly when faced with complicated choices. In the proposed rule, CMS has stated that it is looking to decrease errors and general consumer confusion. If CMS chooses to abolish auto re-enrollment in future plan years, it could have the opposite effect as consumers are faced with an increased number of steps before they are able to obtain health coverage.

Eliminating auto-reenrollment would make it harder for health plans to enroll beneficiaries and would make it harder for consumers to select an appropriate health plan. It is not clear what proposal CMS would implement moving forward, but should consumers specifically have to select a health plan each year, it will add unnecessary steps that will increase the likelihood that consumers are enrolling in coverage that is not appropriate for their medical needs, or that they will go without coverage.

Current guidelines enable a consumer who feels that their current health care coverage is inappropriate for their needs, to select an alternate plan. Auto-reenrollment, common in the commercial market, allows consumers who are happy with their coverage to maintain their current plan without the hassle of re-enrolling in a plan that they are satisfied with. Lanhee Chen, Director of Domestic Policy Studies at Stanford University, proposed in Health Affairs to make enrollment into insurance as automated as possible, citing the burdens of enrollment and plan selection that have an outsize impact on program participation.¹ Having

¹ <https://www.healthaffairs.org/doi/10.1377/hblog20180501.141197/full/>

to re-enroll every year could well discourage consumers from selecting a plan at all and could lead to an increase in the number of uninsured. We urge CMS to continue auto-enrollment.

Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

CMS is proposing to permit issuers to make mid-year formulary changes when a generic equivalent of a prescription drug becomes available. A plan would be permitted to add the new generic and remove the equivalent brand drug from its formulary or move the brand drug to a different cost-sharing tier on the formulary. ACHP supports this proposed modification and believes that the ability to substitute generics mid-year will allow issuers to adapt to constantly fluctuating pharmaceutical costs and reduce drug costs overall.

ACHP believes that this flexibility should be granted to all issuers. ACHP also believes that a required 60-day, written notification period to plan enrollees is sufficient for enrollees to respond to any formulary changes.

Risk Adjustment Data Validation (“RADV”) Requirements when HHS Operates Risk Adjustment

Implementing Current RADV Policy

ACHP member plans must be able to rely on consistent policymaking that is not disruptive to current accepted business practices or otherwise alters prior guidance on which plans have relied in creating their risk adjustment program. Accordingly, ACHP encourages CMS to follow its current RADV policy, beginning with application of 2017 RADV applied to 2018 risk adjustment results, without further delay or material change. We support evaluating prospective improvements to RADV methodology that achieves risk adjustment’s goals, but further delay of application of 2017 RADV results to 2018 risk adjustment transfers would be unreasonable. ACHP appreciates the willingness of CMS to solicit input from plans on future changes to RADV methodology that will not introduce additional market disruption.

Second Validation Audit and Error Rate Discrepancy Reporting

ACHP opposes the proposal to shorten the window for plans to confirm findings of a second validation audit (“SVA”) or calculation or risk score error rate from 30 to 15 calendar days. Fifteen days is an inadequate amount of time for coders to review records and draft responses during SVA.

Adjusting RADV Error Estimation Methodology

ACHP supports the current policy to adjust both positive and negative outliers to an average risk score and determining settlements without adjustment to the sampling process. This is

the best approach to accomplish timely settlements with financial transfers that reflect actual differences in issuer risk.

Varying Initial Validation Audit Sample Size

CMS is asking for input on an approach using HCC failure rates to determine sample size and an appropriate minimum sample size. ACHP recommends varying the sample size based on HCC failure rate, sample precision, and issuer size, with sample sizes large enough to meet desired precision targets to lend additional credibility to RADV adjustments.

Premium Adjustment Percentage

In the rule, CMS proposes modifications to the premium adjustment calculation. HHS proposes to incorporate in the calculation of the premium adjustment percentage the growth of individual market premiums instead of only including the growth of premiums in the employer market for insurance.

Should CMS finalize this change, the impact would be to raise the limit on beneficiary cost sharing, raise individual's required contribution amounts, raise employer shared responsibility payment amounts, reduce premium assistance tax credits and lower federal spending for premium assistance tax credits. Also, fewer individuals would qualify for premium assistance tax credits. This could lead to a further reduction in exchange enrollment, which would likely trigger higher premiums for those that remain in exchange plans.

We urge CMS to maintain its current premium adjustment percentage and refrain from any alteration of the methodology at this time. This change would undermine the stability of the individual market and could lead to a higher proportion of the population going without health insurance. Premium adjustment methodology should constantly be assessed and improved. However, the proposed methodology changes in the notice, along with the current lack of CSR payments and uncertain future of silver loading, could have the unintended effect of destabilizing the individual market.

ACHP appreciates CMS' response to recommendations that we have put forth. Thank you for considering our views on the proposed rule. If there are questions or a need for additional information, please contact Anthony Montoya, at amontoya@achp.org.

Sincerely,



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President and CEO
Alliance of Community Health Plans