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February 13, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9926-P
P.O. 8016
Baltimore, MD 21244-8016

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

To Whom It May Concern:

The Silver State Health Insurance Exchange (hereinafter, the Exchange), the state agency tasked by statute with oversight and operation of Nevada's public health insurance marketplace, appreciates your consideration of the following comments related to the Notice of Benefit and Payment Parameters for 2020 (CMS-9926-P) proposed rule.

The Exchange thanks the administration for committing to preserve States' authority to manage their health insurance markets and to protect the autonomy exercised by State-based Exchanges (SBEs) to control implementation of policy, operations, and technical improvements to their marketplaces. The Exchange is concerned, however, that some of the policies proposed or raised for comment in the Payment Notice would likely undermine the stability and viability of the Exchanges and the individual market as a whole, in part by making coverage more costly for consumers. We respectfully offer the following comments and recommendations addressing specific provisions of the proposed rule.

Automatic re-enrollment

The proposed rule describes and seeks comment on the process of automatic re-enrollment in the Federally facilitated Exchanges (FFEs) and State-based Exchanges using the Federal platform (SBE-FPs). We understand the Payment Notice does not request input regarding the use of automatic re-enrollment by the SBEs and discourage the Department of Health and Human Services (the Department) from contemplating any rulemaking that might affect the authority of the SBEs to manage this aspect of the enrollment process in a manner best suited to State needs.

We agree that in general, Exchange enrollees are well-served by visiting the Exchange during the yearly open enrollment period to ensure household and income information is up-to-date and evaluate their plan options. We believe that adequately funded marketing and outreach can inform enrollees of the value of returning to the Exchange each year, while well-supported consumer assistance can facilitate coverage shopping and active re-enrollment. We do not

support eliminating the automatic re-enrollment process for individuals who decline during the open enrollment period to make a new plan selection. As the Payment Notice recognizes, the availability of automatic re-enrollment reduces burdens on both consumers and issuers. Without it, enrollment through the Exchanges almost certainly would be reduced. Moreover, because those who are currently healthy and use less care are likely to avail themselves of automatic re-enrollment at higher rates than those who anticipate using medical services, it is probable that taking away this option would cause the individual market risk pools to become both smaller and sicker. This in turn would likely lead to higher premiums and potentially reduced issuer participation; two issues that are particularly concerning in Nevada. We strongly urge the administration to maintain the automatic re-enrollment process in future years.

Navigator program standards (§155.210)

The Payment Notice proposes to allow, but no longer require, Navigators operating in the FFE states to provide assistance with certain post-enrollment activities, including help understanding basic concepts and rights related to health coverage and how to use it, the process of filing Exchange eligibility appeals, and the premium tax credit reconciliation process, among others. The Exchange appreciates that this proposal expressly would not affect the authority of SBEs, including SBE-FPs, to authorize or require Navigators to provide such post-enrollment assistance. Navigators have served as trusted resources for Nevada residents, not only during open enrollment, but year-round. The Exchange will continue to rely on these assisters to play a vital role in helping consumers navigate coverage options, especially as it relates to the confusion introduced in the market with an increased prevalence of short-term, limited duration plans.

Special enrollment periods (§155.420)

We share the administration's concern that consumers with individual market coverage outside of the Exchange who experience a decrease in household income that would otherwise render them eligible for premium subsidies are prevented, under existing policy, from transitioning to affordable coverage on the Exchange. It is likely this obstacle to affordable Exchange coverage has caused some individuals to become uninsured and has reduced the stability of the individual market risk pools. We therefore strongly support the proposal to make available, at the option of the Exchange, a special enrollment period for qualified individuals and dependents in such circumstances. This proposal would ensure off-Exchange enrollees have the same opportunity to obtain affordable Exchange coverage as is currently provided to individuals with job-based insurance who become eligible for premium tax credits due to a change in the affordability or value of their employer plan. We agree that, if adopted, the new special enrollment pathway is likely to promote continuous coverage and bolster market stability. Finally, we appreciate that, under the proposal, SBEs will retain discretion to implement this special enrollment period consistent with their operational capacity and their States' unique needs.

FFE and SBE-FP User Fee Rates for the 2020 Benefit Year (§155.50)

We appreciate our partnership with the Department while operating as an SBE-FP. As we have

previously expressed, it has been challenging to adequately perform required functions and plan for future operations in light of the significant yearly fluctuations in the imposed SBE-FP user fee rate. We are transitioning from the federal platform to a state-based system in part to remove this uncertainty and increase budget and operational stability. While we recognize that the Payment Notice identifies the general factors that determine the proposed FFE and SBE-FP user fee rates for the 2020 benefit year, we respectfully urge the administration to adopt a more predictable and transparent approach to the calculation of these fee rates, including by providing greater detail about the share of costs associated with each of the functions performed by the federal platform.

Silver-loading

In response to the administration's decision to stop reimbursing issuers for the cost of providing federally mandated cost-sharing reduction (CSR) subsidies — subsidies on which a significant number of our Exchange enrollees rely — Nevada issuers participating on the Exchange adopted a premium rating practice referred to as "silver-loading" which is specifically designed to hold consumers harmless from the negative effects of the federal policy reversal. Nationwide, the practice has reduced premiums, cost-sharing, or both for nearly 2 million consumers and increased the number of Americans with coverage by between 500,000 to 1 million.[1] Should the administration revoke States' authority to allow silver-loading in 2021, after permitting such flexibility for three years, the effect on the markets would be significant and serious. Such a decision would make coverage more costly for millions of consumers and cause some of these individuals to become uninsured, while likely producing relatively sicker and less stable risk pools than would be expected if States were to remain in control of this regulatory decision. We therefore strongly urge the administration to continue its existing policy of allowing States to determine for themselves whether and how to implement silver-loading.

Prohibition on discrimination (§156.125)

The Payment Notice states that some issuers that include a Medication-Assisted Treatment (MAT) drug on their formulary for certain medically necessary purposes nevertheless exclude coverage of the drug when used for opioid use disorder treatment. In light of this, we appreciate that the Department emphasizes that it is potentially discriminatory for issuers to reduce the generosity of a benefit for a subset of individuals if doing so is not based on clinically indicated, reasonable medical management practices and supported with documentation. It is critically important that benefits used to treat opioid use disorder are not limited or excluded in the absence of a nondiscriminatory, evidence-based justification and the Exchange wholeheartedly supports the Department's attention on this issue.

Premium adjustment percentage (§156.130)

The Payment Notice proposes to change the methodology used to determine the annual premium

[1] Anderson, D., Norris, L., Sprung, A., et al., "Implications of CMS Mandating A Broad Load of CSR Costs," *Health Affairs*, May 15, 2018; Congressional Budget Office, "Appropriation of Cost-Sharing Reduction Subsidies," March 19, 2018.

adjustment percentage, a measure that, among other things, is used to calculate consumers' annual maximum out-of-pocket spending limit and, in practice, the amount of premium tax credit consumers may receive to assist in the purchase of a health plan sold through the Exchange. In particular, the proposal would increase the maximum out-of-pocket cap, requiring consumers to spend more on deductibles and other cost-sharing expenses before reaching the limit, and decrease the size of the premium tax credit an eligible consumer could expect to receive. The heightened exposure to out-of-pocket costs would disproportionately harm Americans with preexisting conditions and already high medical costs, while the reduction in premium subsidies would have the effect of hiking premiums for the majority of enrollees on the Exchanges.

The Payment Notice asserts that making the premium tax credit less generous is warranted in part because it would counteract increased spending on premium subsidies due to the administration's decision to terminate CSR reimbursements and the consequent actions by States to allow silver-loading. Yet the premium tax credit program was designed for the purpose of making coverage more affordable, not less, and we respectfully suggest its consumer benefits should not be reduced in order to offset permissible State efforts to safeguard their residents' coverage.

Though the administration has expressed its commitment to improving the affordability of coverage for individual market enrollees, the Payment Notice acknowledges that the proposed change to the premium adjustment percentage would actually make coverage more expensive for consumers. By the administration's own calculations, 100,000 enrollees would lose coverage through the Exchanges due to increased costs and most of these individuals would become uninsured. We urge the administration to retract this proposal.

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We look forward to working with the Department on these proposals and in our ongoing efforts to improve access to affordable Exchange coverage.

Thank you for your time and attention. Please feel free to contact me should you have any questions or desire any additional information.

Respectfully,

Heather Korbulic
Executive Director
Silver State Health Insurance Exchange