February 19, 2019

Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9926-P
P.O. Box 8016
Baltimore, MD 21244-801620201

RE: HHS Notice of Benefit and Payment Parameters for 2019; Proposed Rule

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments to the Department of Health and Human Services (the "Department") in response to the Department's Notice of Benefit and Payment Parameters for 2020 Proposed Rule ("Proposed Rule"). This Proposed Rule sets forth payment parameters provisions related to the risk adjustment and risk adjustment data validation programs; cost-sharing parameters; and user fees for Federally-facilitated Exchanges ("FFE") and State-based Exchanges on the Federal Platform ("SBE-FP"). It also proposes changes that would allow for greater flexibility related to the duties and training requirements for the Navigator program and proposes changes that would provide greater flexibility for direct enrollment entities, while strengthening program integrity oversight over those entities. It proposes policies that are intended to reduce the costs of prescription drugs. It includes proposed changes to Exchange standards related to eligibility and enrollment; exemptions; and other related topics.

The Proposed Rule was published in the Federal Register on January 24, 2019, by the Department of Health and Human Services ("HHS" and "the Department").[1] This Proposed Rule suggests amending the provisions and parameters previously offered to implement many provisions of the Patient Protection and Affordable Care Act, as amended and revised by the Health Care Education Reconciliation Act of 2010 (collectively referred to in the proposed rule as the "Patient Protection and Affordable Care Act" or "PPACA"). [2]

Overview

We appreciate the Department's stated intent and rationale for several proposal changes but remain concerned that as drafted, these proposals will have the opposite effect in three particular instances. Our comments will address our concerns on the:

[1] Proposed Rule, 84 Fed. Reg. 227-321. (January 24, 2019) (to be codified at 45 C.F.R. pts. 146, 147, 148, 153, 155, and 156) [hereinafter referred to as the "Proposed Rule"] https://www.govinfo.gov/content/pkg/FR-2019-01-24/pdf/2019-00077.pdf

[2] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).

1. Discussion in the preamble to end the practice of automatic re-enrollment which will undercut prior investment and smoothly functioning operations;

2. Proposed questions in the preamble on ways to address silver loading which may instead inject additional uncertainty and volatility in the markets if current guidance is changed;

3. Proposed regulatory changes to permit, which if finalized as drafted will instead limit, the ability of issuers and employers to make mid-year formulary changes.

Given the stated intent and goals of the proposals, we believe that the Department will refine the proposed changes to ensure the desired outcomes are achieved rather than furthering the harm we believe would result if the proposal on mid-year formulary changes is finalized as drafted and if changes are made to automatic re-enrollment or silver loading.

Automatic Re-enrollment

The preamble includes discussion about the automatic re-enrollment process maintained by exchanges since the program's inception. We support and appreciate the recognition that "automatic re-enrollment significantly reduces issuer administrative expenses and makes enrollment in health insurance more convenient for the consumer."[3] This process however did not simply occur but was one that required significant investment on the part of issuers and the Department. Additionally, as the Department mentions, automatic re-enrollment is a standard and common practice in Medicare and the commercial market.

The Department suggested that "there is a concern that automatic re-enrollment eliminates an opportunity for consumers to update their coverage and premium tax credit eligibility."[4] However, this opportunity is hardly eliminated and still exists for all current enrollees. As the Department explains: "Currently, enrollees in plans offered through a Federally-facilitated Exchange or a State-based Exchange using the Federal platform can take action to re- enroll in their current plan, can take action to select a new plan, or can take no action and be re-enrolled in their current plan."

Instead, concerns about consumer confusion could be allayed through other methods. CMS should study the effectiveness of its current communications strategy and develop more effective means of targeting and informing impacted enrollees, in order to address the concerns of confusion while also ensuring coverage is maintained. Perhaps as open-enrollment enters its final week, a notification could be sent to currently enrolled individuals reminding them that if they have had a change in circumstances, they may want to take action and that if they don't they will be automatically re-enrolled in their current plan. This is what many employers provide and addresses the concerns of confusion while also ensuring coverage is maintained.

The Chamber supports the automatic-enrollment process and urges the Department to protect the current automatic re-enrollment process as it exists.

[3] Proposed Rule, at 229.
[4] Ibid, at 229.

Silver Loading

Despite the cessation of federal funding for the cost sharing reduction ("CSR") benefit in October of 2017, eligible consumers with incomes up to 250 percent of the federal poverty level ("FPL") continue to be legally entitled and eligible for reduced cost-sharing benefits. As the Chamber articulated in the spring, summer and fall of 2017 leading up to and following the President's announcement and decision to stop making CSR payments, there needs to be a solution to help offset the cost that health insurance providers must absorb as they continue providing this mandated benefit in a way that minimizes the burden of the federal government's decision upon consumers.

Silver loading is the most consumer-friendly way to do this, as premium tax credits offset additional premium impact that results from the government's decision not to make the required payments. Broadly distributing premium increases, however, would impose additional burdens upon those who do not qualify for reduced cost sharing or premium tax credits and would likely result in loss of coverage and degradation of the individual market risk pool. Absent a legislative solution, the Department must permit relief and not penalize private businesses that are still mandated to waive out-of-pocket costs for eligible consumers. There are two positions that the Chamber would support on this issue, either a clarification that:

1. Silver loading is permitted to offset unreimbursed cost sharing that issuers are required to waive for low-income and working families; or

2. The Department will defer to states and afford states the flexibility to permit silver loading.

Several recent court decisions suggest that the government breached an implied contracts and may ultimately be held responsible for reimbursing plans for unpaid CSRs in 2017 and 2018.[5] While these cases will ultimately end up in the Supreme Court, businesses must continue to fulfill their mandate to waive these cost sharing amounts and solutions that at least temporarily relieve the financial exposure of doing so in a way that minimizes negative impacts upon consumers should be permitted.

Mid-Year Formulary Changes

We support the current ability of plans, whether offered by insurers or employers, to make mid-year formulary changes and adjustments. While we appreciate the stated intent of the proposal to allow mid-year formulary changes when a generic becomes available, we are concerned that as worded the proposed changes would instead preclude several other standard practices that currently reduce spending and promote effective high-value care. Our concern arises not simply because of the language in §146.152 (f)(5) but because of the repeated discussion of guaranteed renewability of coverage for employers and individuals as it relates to this new proposed section.[6]

[5] https://ecf.cofc.uscourts.gov/cgi-bin/show_public_doc?2017cv2057-20-0
https://ecf.cofc.uscourts.gov/cgi-bin/show_public_doc?2017cv0877-48-0
https://ecf.cofc.uscourts.gov/cgi-bin/show_public_doc?2018cv0005-28-0
https://ecf.cofc.uscourts.gov/cgi-bin/show_public_doc?2017cv1542-32-0

[6] Proposed Rule, page 313

The Chamber urges the Department to clarify that it does not intend to adopt any proposals that would preclude the presently available formulary practices that currently allow mid-year modifications and flexibility.

There are already many instances when plans are able to make mid-year formulary changes. We recommend that HHS broaden the description of instances in which issuers and employers can modify formularies mid-year to include currently permitted instances such as when:

- A biosimilar drug is available; or
- A lower-priced brand-name therapeutic equivalent or authorized generic is available; or
- A brand-name drug changes its price; or
- An over-the-counter ("OTC") version of the drug is available; or
- The issuer becomes aware of a patient safety issue with a drug; or
- There is a shortage of a preferred generic drug; or
- New research or evidence becomes available about the efficacy of a drug or that expands the indications of a drug; or
- A new drug (whether a brand or biosimilar or reference biologic) that is clinically effective becomes available.

If finalized as proposed, the changes would likely increase spending by inadvertently restricting issuers to controlling costs ***only*** when a generic equivalent is available for a brand name drug.

III. CONCLUSION

We urge the Department to continue to work carefully, pragmatically and cooperatively with the numerous stakeholders to minimize unnecessary costs for, and burdens on, employers and to provide flexibility as employers work to comply with the law. We appreciate the re-evaluation of prior standards for benefit and payment parameters given the current status of the exchanges and the experience the Department has gleaned during the past five years of implementation. We look forward to continuing to work together in the future.

Sincerely,

Katie Mahoney
Vice President, Health Policy
U.S. Chamber of Commerce