



## NY State of Health

### Comments on HHS Notice of Benefit and Payment Parameters for 2021

NY State of Health, the State's Official Health Plan Marketplace submits the following comments on the proposed regulations for 45 CFR Parts 146, 149, 155, 156, and 158; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans [CMS-9916-P].

#### **D. Part 155 - Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act**

1. Verification Process Related to Eligibility for Insurance Affordability Programs
  - Proposed Rule

With regard to Exchange requirements to verify applicant eligibility or enrollment in employer sponsored coverage, the proposed rule adopts a new alternative approach to replace the current procedures in § 155.320(d)(4)(i), under which an Exchange may design its verification process based on the Exchange's assessment of risk for inappropriate eligibility or payment for APTC or CSRs. As HHS continues to explore the best options for verification of employer-sponsored coverage, it notes that it will not take enforcement action against Exchanges that do not perform random sampling for plan years 2020 and 2021.
  - NY State of Health Comments

NY State of Health supports continued state flexibility on employer-sponsored coverage verification, including through approved alternative procedures. In addition, NY State of Health encourages Federal efforts to make available to states a reliable data source for this purpose.
2. Eligibility Redetermination During a Benefit Year (§ 155.330)
  - a. Process for Voluntary Termination Upon a Finding of Dual Enrollment via Periodic Data Matching (PDM)
- Proposed Rule

The proposed rule amends § 155.330(e)(2)(i)(D) to provide that Exchanges need not conduct an eligibility redetermination for APTC or CSRs for individuals who (1) are found to be dually enrolled in QHP coverage and MEC such as Medicare, Medicaid/CHIP, or the BHP; (2) have not responded to an Exchange notice to provide



updated information within 30 days; and (3) have provided written consent to the Exchange to end their coverage if they are found to be dually enrolled.

- NY State of Health Comments

NY State of Health supports the continued flexibility of State-based Marketplaces on the process for terminating coverage for individuals found to be dually enrolled during Periodic Data Matching (PDM).

### 3. Automatic Re-enrollment Process

- Proposed Rule

The proposed rule seeks to modify the automatic re-enrollment process for individuals who would be re-enrolled with advance payments of the premium tax credit (APTC) that would cover the entire plan premium, and instead considers two proposals: re-enrolling these individuals in the same plan, but 1) without APTC or 2) with APTC reduced to an amount greater than zero dollars. CMS solicits comments on whether this approach should be adopted by only the Exchanges using the Federal platform, or whether this should also be required for State-based Marketplaces.

- NY State of Health Comments

NY State of Health continues to oppose CMS' repeated attempts to implement policies that would restrict State-based Marketplaces' automatic reenrollment processes and capabilities, despite unanimous opposition from all the stakeholders involved. NY State of Health has strong processes in place to ensure the accuracy and integrity of the eligibility determinations. Restrictions on auto-reenrollment would only serve to make it harder for consumers to retain their coverage and thus result in lower enrollment levels, a less healthy risk pool, while significantly increasing state IT system and customer service costs.

Under NY State of Health's approved application process, consumers must actively affirm whether they will permit the Marketplace to use federal and state data sources to renew their eligibility. When asked, the overwhelming majority of QHP enrollees eligible for APTC (86 percent) affirmed that the Marketplace could use data sources to re-determine their eligibility for coverage. This allows NY State of Health to automate the first of two parts of the renewal process.

Auto-renewal is a two-part process: administrative renewal of eligibility and automatic enrollment into the consumer's same QHP. Consistent with the process in place when a consumer initially enrolls in QHP coverage with financial assistance, at renewal, when data sources for eligibility factors, such as income are either not available or do not align with what consumers submit on their application, consumers are required to submit



additional documentation, which the Marketplace manually reviews to determine eligibility. Consumers who have been determined to remain QHP eligible can be auto-re-enrolled into their same health plan, if it remains available. The amount of APTC that is applied at renewal is no more than the amount of APTC they received the prior year. Consumers eligible for a greater amount of APTC compared to the prior year, must return to the Marketplace and change their APTC election amount if they would like to apply more APTC towards their premium. As a result of these procedures, the number of enrollees who are auto-reenrolled with no premium owed is very small.

In NY State of Health's experience, automating re-enrollment complements processes that have been put in place to ensure program integrity regarding the disbursement of APTC. Federal and state audits have found that NY State of Health's systems are operating in compliance with federal rules, including income verification to ensure accurate disbursement of APTC. Because of NY State of Health's current system rules, a limited number of enrollees in very specific circumstances may be impacted by the proposed change to auto-reenrollment. But to undo current automatic re-enrollment processes would still require costly IT system changes and increase call volumes to NY State of Health's Customer Service Center, increasing costs further, even though the impacted population is small. NY State of Health estimates that re-working current automatic re-enrollment processes would cost up to \$1.5 million, and may require postponing other important IT system changes that impact a far greater share of NY State of Health enrollees. Further, shifting from automatic re-enrollment to manual processes could result in an increase rather than a decrease in eligibility errors, potentially resulting in government misspending. Elimination of automatic re-enrollment will make it more difficult for consumers to stay covered, risking inadvertent gaps in coverage, which raises costs that are borne by consumers.

NY State of Health strongly supports state flexibility to continue auto-reenrollment that are coupled with strong eligibility determination procedures and ensure program integrity with respect to the disbursement of APTC.

Finally, if this proposal was finalized, it should be optional for State-Based Marketplaces, and the implementation start date should be postponed as it is infeasible to incorporate such complex systems changes at this stage in the year.

## 5. Special Enrollment Periods

- Proposed Rule

The proposed rule amends section 155.420 to allow Exchange enrollees and their dependents who are enrolled in silver plans and become newly ineligible for cost-sharing reductions (CSRs) to switch to a QHP one metal level higher or lower, if they choose. CMS also proposes to require Exchanges to apply plan category limitations to dependents who are currently enrolled in Exchange coverage and whose non-dependent household

member qualifies for a special enrollment period to newly enroll in coverage. CMS further proposes to shorten the time between the date a consumer enrolls in a plan through certain SEPs and the effective date. CMS proposes to allow enrollees granted retroactive coverage through a special enrollment period the option to select a later effective date and pay for only prospective coverage. CMS proposes to allow individuals and their dependents who are provided a qualified small employer health reimbursement arrangement (QSEHRA) on a non-calendar year basis to qualify for the existing special enrollment period for individuals enrolled in any non-calendar year group health plan or individual health insurance coverage. CMS also proposes to allow enrollees whose requests for termination of their coverage were not implemented due to an Exchange technical error to terminate their coverage retroactive to the date they attempted the termination, at the option of the Exchange.

- NY State of Health Comments

NY State of Health strongly supports continued state flexibility with respect to special enrollment periods. NY State of Health also supports the proposal to allow individuals and their dependents who are offered a non-calendar year plan year QSEHRA to qualify for a special enrollment period to enroll in or change their individual health insurance coverage through or outside an Exchange.

## **E. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, including Standards Related to Exchanges**

### 3. State Selection of EHB-Benchmark Plan for Plan Years Beginning on or after January 1, 2020 (§ 156.111)

#### a. Annual reporting of state-required benefits

- Proposed Rule

The proposed rule amends section 156.111 to require states, beginning in plan year 2021, to annually identify required benefits mandated by state law and report which of those benefits are in addition to Essential Health Benefits (EHB). States would report in a format and by a date specified by HHS. If a state fails to comply with the annual reporting deadline, HHS will make the determination regarding which benefits are in addition to EHB in the state.

- NY State of Health Comments

Consistent with CMS' overarching goal of reducing administrative and reporting burdens on states, NY State of Health recommends CMS leverage existing reporting related to EHB for the stated purpose rather than creating a new, duplicative report.