



NY State of Health
Comments on HHS Notice of Benefit and Payment Parameters for 2022

NY State of Health, the State's Official Health Plan Marketplace submits the following comments on the proposed regulations for 31 Part 33 and 45 CFR Parts 147, 150, 153, 155, 156, 158, and 184; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations [CMS-9914-P].

NY State of Health notes that the compressed timeline to provide comments on the Payment Notice for 2022 limits the ability of States, Exchanges, and other key stakeholders to engage in a comprehensive review of the various changes set forth in the proposed rule.

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2022

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

4. Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)
a. Navigator and Certified Application Counselor Use of Web-broker Websites

• Proposed Rule

The proposed rule seeks to make significant changes to sections 155.220 and 155.221 to allow states to permit issuers, web-brokers, agents and brokers to assist consumers in enrolling in QHPs. Additionally, the rule seeks to modify current policy that prohibits Navigators and CACs ("assisters") from using web-broker websites to assist with QHP selection and enrollment. The proposal would permit, but not require, assisters in FFEs and SBE-FPs, to the extent permitted by state law, to use web-broker websites to assist consumers with QHP selection and enrollment. This proposal is optional for State-based Marketplaces.

• NY State of Health Comments

NY State of Health supports allowing States and State-based Marketplaces to choose to preserve the prohibition on assisters using web-broker websites.

5. Standards for Direct Enrollment Entities and for Third Parties to Perform Audits of Direct Enrollment Entities (§ 155.221)

c. FFE, SBE-FP, and State Exchange Direct Enrollment Options

• Proposed Rule

The proposed rule seeks to add § 155.221(j) to establish a process for states to elect an Exchange Direct Enrollment (DE) option where states could engage approved private-sector entities (including QHP issuers, web-brokers, agents and brokers) as the pathway for consumers to shop, apply for, and enroll in coverage through the Exchange.

- NY State of Health Comments

NY State of Health supports State flexibility for State-based Marketplaces to determine whether to permit private-sector entities to assist consumers in enrolling in QHPs. NY State of Health also encourages CMS to strengthen the oversight of these private sector direct enrollment entities.

When individual consumers apply for coverage, they often do not know whether they are eligible for insurance affordability programs or QHPs, particularly if their employment situation or their household composition has changed. Direct enrollment entities would complicate and could hinder the ability of consumers who may be eligible for programs such as Medicaid or the Children’s Health Insurance Program (called Child Health Plus in New York) to obtain an eligibility determination and connect with the coverage for which they qualify.

8. Special Enrollment Periods (§ 155.420)

d. Special Enrollment Period Verification

- Proposed Rule

The proposed rule seeks to amend § 155.420 to add paragraph (f) to require Exchanges to conduct eligibility verification for at least 75 percent of new enrollments through special enrollment periods for consumers who are not yet enrolled in exchange coverage.

- NY State of Health Comments

New York supports efforts to reduce adverse selection in the individual insurance market, while minimizing unnecessary administrative burdens on consumers. However, we oppose a one-size fits all requirement to verify 75 percent of SEP requests for the reasons explained below. State-based marketplaces should continue to have flexibility regarding SEP verification.

New York’s Marketplace currently requires applicants seeking a SEP to answer detailed questions during the application process. And, as an integrated eligibility platform, NY State of Health independently verifies loss of minimum essential coverage, the most common SEP qualifying event, for persons previously covered by Medicaid, the Basic Health Program (called the Essential Plan in New York), and the Children’s Health Insurance Program (called Child Health Plus in New York). However, there are no known, reliable, electronic data sources for many SEPs.

Given the unique nature of each state Marketplace, New York strongly encourages HHS to allow states the flexibility to establish systems in collaboration with the state’s insurers that will ensure the integrity of the SEP application process and meet the needs of their consumers. Moreover, as acknowledged in the proposed regulation, imposing a 75 percent verification requirement on State-based Marketplaces would result in significant unfunded costs, including document processing and increased customer service call handling. New York opposes this requirement, especially in the absence of evidence of misuse of the SEP and where targeted reviews may prove more effective and less disruptive for consumers.

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

3. Premium Adjustment Percentage (§156.130(e))

- Proposed Rule
CMS proposes to maintain the same methodology [updated in 2020] to calculate the premium adjustment percentage.
- NY State of Health Comments
CMS’ proposed premium adjustment percentage increases consumers’ “applicable percentage” used to determine Premium Tax Credit (PTC) amounts, which will result in higher post-tax credit premiums for consumers. The result of maintaining the same methodology would be higher consumer premium contributions and lower federal tax credits.

This methodology was revised in plan year 2020 to account for increases in individual market premiums, which resulted in higher annual limits on out-of-pocket costs and higher required contribution from subsidized enrollees. New York opposes maintaining this methodology to calculate premium growth as it results in higher consumer costs and reduced enrollment levels among younger, healthier enrollees, and represents yet another federal proposal that would weaken the stability of the individual market.

11. Quality Rating System (§ 156.1120) and Enrollee Satisfaction Survey System (§ 156.1125)

- Proposed Rule
CMS seeks comment on which level or levels of the QRS hierarchy should be removed.
- NY State of Health Comments
New York agrees that revising the QRS hierarchy to eliminate one or two rating levels of QRS can reduce the risk of overweighting on certain measures. Two levels of rating information can provide enough quality information for consumers to make a choice. Under the current rating methodology (average of average), we suggest that CMS keep the global and domain level ratings and eliminate the summary ratings. Global ratings calculated from three equally weighted summary indicators dilutes the information going into that global rating. New York feels that the global rating should be derived from the domain scores.
- Proposed Rule
CMS proposes to make the full QHP Enrollee Survey results publicly available in an annual Public Use File.

- NY State of Health Comments
New York supports public transparency with the QHP Enrollee Survey results. In addition, we would like CMS to permit States to collect a de-identified survey response file that includes demographic information needed to appropriately case mix adjust the QHP Enrollee Survey results. Currently, CMS does not permit QHP issuers to release this information to States. This would facilitate a better understanding of opportunities for improvement.

IV. Provisions of the Proposed Rule for State Innovation Waivers – Department of Health and Human Services and Department of the Treasury

A. 31 CFR Part 33 and 45 CFR Part 155 – State Innovation Waivers

1. Section 1332 Application Procedures (31 CFR 33.108 and 45 CFR 155.1308), Monitoring and Compliance (31 CFR 33.120 and 45 CFR 155.1320), and Periodic Evaluation Requirements (31 CFR 33.128 and 45 CFR 155.1328)
- Proposed Rule
CMS proposes to incorporate by reference its 2018 published Guidance regarding the guidelines for 1332 waivers, known as “innovation” waivers. [See, “State Relief and Empowerment Waivers,” 83 FR 53575 (Oct. 24, 2018)]. The 1332 waiver process allows for States to apply for approval of the waiver of certain requirements regarding coverage in the individual and small group market.

NY State of Health Comments

The guidelines for section 1332 waivers affect insurance markets and important consumer protections. For example, increased flexibility regarding short-term health insurance plans that are less comprehensive than ACA-compliant plans has the potential to draw enrollees and risk from the more comprehensive plans. This may increase premium for consumers with pre-existing conditions and other health needs who rely on comprehensive plans.

The proposed wholesale incorporation of 2018 guidance on an accelerated timetable does not provide sufficient opportunity to address the impact of these requirements to date and the potential prospective impact, including the potential negative consequences for consumers seeking affordable coverage to meet their health needs.